

MAKING MEDICARE RESTRUCTURING WORK

Final Report of Study Panel  
on Medicare and Markets

The Role of  
Private Health Plans in  
**Medicare:**

Lessons From the Past,  
Looking to the Future

November 2003

NATIONAL  
ACADEMY  
OF SOCIAL  
INSURANCE

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# Chapter 1: Introduction

The National Academy of Social Insurance (NASI) convened a study panel in 2001 to consider the role of markets and private health plans in Medicare, as part of its broader project on the future of the Medicare program. The study panel met four times, convened several additional conference calls, and commissioned original research in pursuit of its mission. This is the panel's final report.

Proponents of increasing the role of market forces and private health plans in Medicare argue that original Medicare's fee-for-service payment system is antiquated and inherently incapable of meeting the challenges of modern health care delivery, serving poorly both beneficiaries and taxpayers.<sup>1</sup> They maintain that it creates incentives for unnecessary (sometimes harmful) and uncoordinated medical care, leaves beneficiaries exposed to substantial financial risk, inefficiently allocates resources, thwarts innovation through outdated benefits and rigid payment systems, lacks accountability, and invites excessive Congressional involvement in the program's management and operations. They further suggest that Medicare ought to provide beneficiaries with the same array of private health plans through which many working-age Americans get health insurance.

Opponents of market-based reform in Medicare, while agreeing that benefit coverage and financial protections for beneficiaries must be greatly improved, argue that market forces will undermine a very popular social insurance program that has effectively improved the health care and financial status of elderly and disabled Americans. In their view, competition among private health plans, variations in their individual practices, and plan movement in and out of the Medicare market inevitably undermine beneficiaries' financial security, create inequity in benefits, promote unevenness in coverage, and disrupt relationships with physicians. In their view, shifting benefits and administrative requirements can overwhelm those with cognitive or sensory impairments. Competition among private health plans creates incentives for plans to avoid the sick and market to the healthy, increasing the vulnerability of frail Medicare beneficiaries. They assert that cost control through competition is more myth than reality.

Neither of these idealized visions speaks to reality of the Medicare program: a vital asset of beneficiaries, but one that reflects serious shortcomings, inefficiencies, and inequities. Neither idealized vision offers a realistic portrayal of the capacity for market reforms to improve Medicare's performance and enhance the well being of beneficiaries.

## CLARIFYING THE SCOPE OF OUR INQUIRY

Medicare is the largest health care program in the United States and has far-reaching effects on the American health care system. This federal program provides health benefits for almost 41 million Americans. Its policies and payment practices affect the financial viability of large numbers of health care providers. Throughout its history, it has involved private health insurance and private health plans in several roles. Since its inception, private insurers have acted as “fiscal intermediaries,” – paying Medicare claims and setting medical policies at the local level. Many Medicare beneficiaries purchase private supplemental (Medigap) policies that cover certain costs or services not paid by original Medicare, and some Medicare beneficiaries receive retiree health insurance from their former employers.

These roles for private insurers have important implications for the adequacy and fairness of the Medicare program. But they are not the primary focus of this report (though we will explore some aspects of the market for Medigap insurance). We will instead consider the role of private health plans as an alternative to Medicare’s fee-for-service insurance program. Under the auspices of Medicare+Choice, beneficiaries have the option of enrolling in a variety of private health plans as alternatives to original Medicare. The vast majority of these are “managed care” plans, which offer enrollees access to a selected panel of health care providers, while expanding coverage and potentially coordinating services.

Over the past decade, there have been numerous proposals to expand the role of private health plans as an alternative to original Medicare, to change the terms on which these plans “compete” to enroll Medicare beneficiaries, and even to replace the fee-for-service program entirely with subsidies for the purchase of private insurance. The panel interpreted its charge broadly and set as its goal strengthening Medicare overall. The panel began its work with the view that Medicare has been a highly successful program that has made extremely valuable contributions to improving the lives of its beneficiaries, and that original Medicare and private health plans have both contributed to its success. Despite its achievements, Medicare has some shortcomings. To this end, the panel evaluated the performance of both private health plans and original Medicare along a number of dimensions to assess both strengths and weaknesses.

This study panel convened during a time of great uncertainty for managed care in both public and private sectors. In the private sector, complaints from both providers and consumers and a backlash against restrictive managed care practices during the mid 1990s gave rise to fierce debates in Congress and state legislatures over “a bill of rights” for health plan enrollees. In Medicare, enactment of the Balanced Budget Act of 1997 brought sweeping and unexpected changes to the program. As study panel member Rashi Fein wrote in 1999, “Put simply, we neither fully understand what has transpired nor have any real feel for what may still occur. We

do not understand why the changes are taking place or what is and will be forcing them.” The panel took as its charge to increase understanding, where possible, and to clarify the limits of our knowledge elsewhere.

The rapid pace of change in health care has given study panel members a certain degree of humility about their task. The managed care practices that prevail in 2003 are quite different than those most common only five years earlier. The terms under which private health plans participate in Medicare have also shifted dramatically and the number of geographic areas in which private health plans offer their services to Medicare beneficiaries has shrunk considerably. The implications of other changes are playing out over a longer time period, but may be even more difficult to predict with any accuracy. The knowledge and comfort level that beneficiaries have with managed care plans will undoubtedly change as new beneficiaries, with greater experience with such plans during their working years, enter the program. Whether this will make these plans more or less attractive to Medicare beneficiaries remains to be seen.

In the face of these changes, the study panel recognizes that it is unwise to make detailed predictions about the impact of particular managed care plans or techniques. Instead, they sought a broader perspective on the benefits that might be achieved from choices between original Medicare and private health plans. They based these assessments on the past experiences of beneficiaries in original Medicare compared to those in private health plans, as well as the experience in employer-based insurance for people with health needs most like the elderly and disabled.

## **OBJECTIVES OF THIS REPORT**

This study panel believes that an appropriate evaluation of the benefits of private health plans in Medicare must begin with an objective analysis of Medicare’s current performance in both original Medicare and M+C. Medicare was enacted with the promise to provide financial security and access to medical care as good as that available to working-age Americans. It no longer does so. We believe that it is vital to return policy-makers’ attention to this original aspiration. In addition, the growing involvement of private health plans in Medicare has coincided with, and to some extent encouraged, a shift in aspirations for the program. This has clouded the program’s mission, leading to confused and sometimes conflicting expectations. Only by clarifying these objectives can we be clear about when and whether they can be furthered through the involvement of private health plans.

The study panel faced one daunting challenge in its work. It was unclear whether the problems currently experienced in Medicare+Choice are inherent in the use of private health plans for

Medicare enrollees, or are a byproduct of the particular ways in which Medicare currently contracts with and pays those private health plans. Perhaps these problems were not created by market reforms, so much as by Medicare's failure to actually make use of the market to set the prices paid to private health plans. To sort this out, we also examined the experience of employers that used competitive models for employee health benefits, particularly for retiree health benefits. From this, we concluded that some of the problems currently experienced by Medicare+Choice could indeed be remedied through appropriate reforms. Others, however, appeared to be integrally related to the involvement of private health plans in the provision of health care.

Medicare was enacted to provide financial security and access to mainstream medical care. To this end, it was designed to pay generously for medical care, and in so doing, to provide older Americans with access to the full range of doctors and hospitals, allowing them to freely choose their preferred health care providers. But soon after Medicare became operational, it became clear to policy-makers that open-ended fee-for-service insurance arrangements could become quite costly. Their struggles to contain costs, while maintaining adequate financial protection and access for Medicare beneficiaries, have created ongoing tensions for the program since its early years.

From the start, Medicare beneficiaries were expected to pay a portion of the costs of their medical care, as typically required in private health insurance policies. Over time, as health care costs grew faster than beneficiaries' incomes, these cost-sharing arrangements became increasingly burdensome and a growing threat to beneficiaries' financial security. This was particularly true for those with limited financial means and chronic health problems. This shortcoming has been compounded by Congress' failure to update Medicare coverage to keep pace with changing medical technology, most notably the shift in treatment to outpatient settings and the growing importance of prescription drugs. When most large employers added outpatient prescription drug benefits to their employees' policies, Congress did not follow suit. The growing burden of cost-sharing expenses and increasing costs for uncovered services led many beneficiaries to purchase private supplemental (Medigap) policies. Those who could not afford them, and who were not sufficiently poor to be eligible for Medicaid, are unprotected, with neither financial security nor adequate coverage for needed medical care.

Allowing Medicare beneficiaries to join private health plans was intended to address these shortcomings. The private health plan option was designed to save Medicare money by setting payments at 95 percent of the expected costs of care for beneficiaries with similar demographic characteristics living in the same county. In addition, to the extent that private health plans could provide health care for less than the Medicare payment amount, they were required to

offer expanded benefits to Medicare enrollees in the form of either reduced cost sharing or expanded benefits.<sup>2</sup>

We now have had more than two decades' experience with private health plans in Medicare. In chapter two we review this historical experience. In chapter three, we assess what has been learned in terms of the capacity of both original Medicare and private health plans to help achieve Medicare's core mission of providing financial security and access to medical care to Medicare beneficiaries, while operating in a cost-effective fashion.

Over time, Medicare's mission has expanded to include providing insurance to people with disabilities and end-stage renal disease. In addition to this broadening of the beneficiary population, one can identify several emerging objectives of the program. First, policy-makers and the American public have come to recognize that Medicare has an increasingly important role in protecting and improving the quality of medical care, not just for Medicare beneficiaries, but also for the entire population. Second, many believe that Medicare should do more to ensure that all beneficiaries, regardless of race, ethnicity, or socio-economic status, receive the same quality of care and treatment. Third, over the past four decades Congress has expanded Medicare's mission in various ways, including ensuring the financial viability of hospitals that serve a disproportionate number of poor people. Finally, over the past four decades Medicare has become a touchstone for the political identity of older Americans. In the assessment of the study panel, this sense of political solidarity provides an essential bulwark against fiscal pressures that might otherwise threaten the legitimacy of the program.

Because these additional objectives were not a part of Medicare's original mission, their importance remains a matter of ongoing debate. As policy-makers have focused attention on the involvement of private health plans in Medicare, some of these new goals have been highlighted, others obscured. On the one hand, concerns about the impact of managed care practices on enrollees with chronic illnesses have added to policy-makers' worries about quality of care for Medicare beneficiaries who are disabled or in frail health. On the other hand, concerns about disparities in use of health care and outcomes among Medicare beneficiaries have been given almost no attention in policy-makers' assessments of Medicare+Choice.

This study panel believes that these other objectives merit policy-makers' attention for several reasons. First, the track record of Medicare's fee-for-service program has been less than exemplary in these areas. Second, while many of these problems are not unique to Medicare and reflect problems common in the U.S. health care system, the study panel believes that Medicare, as a social insurance program and the largest single purchaser of health care, should lead the way to a better health care system. Finally, the study panel thinks that the impact of

private health plans on these goals is an essential part of assessing their role in Medicare. We expect that enrollment in these plans will exacerbate some of these problems, while in other cases distracting attention from the problems while allowing them to persist. Policy-makers must be cognizant of these potential consequences when considering future program reforms.

In chapter four of this report we explore the magnitude of quality problems and disparities in care in original Medicare and assess the implications of market-oriented reforms. In chapter five we turn to the broader social roles of the Medicare program. This exploration involves two distinct issues: Medicare's impact on the health care system, and its influence on beneficiaries' political attitudes. Although Congress has addressed some of the system-level effects of private health plans on Medicare (particularly related to medical education), we believe that more comprehensive responses are required to protect vulnerable parts of our health care system. More strikingly, there has been little overt attention among policy-makers to the political consequences of market reforms. Using data from a new survey specially commissioned by this study panel, we explore for the first time the impact of Medicare+Choice on beneficiaries' connections to, and support for the Medicare program.

## **THE PLACE OF THIS REPORT IN THE BROADER DEBATE OVER MEDICARE REFORM**

The role of market-oriented reforms and private health plans in the Medicare program has been the topic of a number of earlier reports, including one from NASI (Bernstein and Newhouse 1998). This report builds on NASI's earlier efforts and focuses on the effects of private health plans in Medicare for beneficiaries, whose well being has received less attention than it deserves in recent policy discourse.

## **NOTES**

<sup>1</sup> In this report, the terms "original Medicare," "FFS Medicare," and "FFS" are used interchangeably.

<sup>2</sup> Plans also have the option of placing excess funds in a benefit stabilization fund, although this option has not been chosen often.

# Chapter 2:

## The History of Private Health Plans in Medicare

In the view of the study panel, understanding the history and evolution of Medicare managed care is critical to any thoughtful analysis of Medicare — both fee-for-service and managed care. In the words of philosopher George Santayana, “Those who can not learn from the past are doomed to repeat it.” His words have special meaning with respect to Medicare managed care because many of the policy decisions made as long ago as 1972 still have important effects on the program today. This chapter traces the history of private health plans from Medicare’s inception to the present, and explains how key policy decisions made through the years reverberate in the Medicare Choice program today.

### AN ERA OF GRADUAL EXPANSION

#### The Early Years

Congress created Medicare in 1965 as an open-ended entitlement program to meet the health care needs of elderly Americans. Medicare’s enactment was preceded by years of often-contentious debate about universal health insurance. The debate was so protracted in part because even proponents of reform were divided among those who favored a government-run insurance program, and those who preferred subsidies to private insurers. In 1965, a compromise was finally reached with an agreement to provide health insurance to the elderly, modeled after the existing employer-based health insurance market, with benefits, administration, and payment methods based on Aetna health plan for federal employees. (Marmor 2000). At that time, virtually all private health insurance reimbursed for care on a fee-for-service basis, meaning that physicians and other health care providers were paid for each service they provided, and so that is how most of Medicare was structured.

However, from the beginning of Medicare, some beneficiaries received care through private organizations that contracted with the federal agency responsible for administering Medicare (originally the Social Security Administration, later the Health Care Financing Administration and, now the Centers for Medicare and Medicaid Services (CMS)).<sup>1</sup> Most of these early arrangements were designed for retirees in employer or union-sponsored arrangements that could not accommodate Medicare’s fee-for-service reimbursement system. Reimbursement to these plans was on a cost or charge basis for Part B services only.<sup>2</sup>

## **The Social Security Amendments of 1972**

In the Social Security Amendments of 1972, Congress expanded the types of plans eligible to contract with Medicare to include cost and risk-sharing contracts with federally qualified health maintenance organizations (HMOs).<sup>3</sup> In cost contracts, Medicare pays the HMO the actual cost it incurs in furnishing Medicare covered services (less the estimated value of beneficiary cost sharing) subject to a test of “reasonableness,” which has never been enforced. In risk contracts, the price is fixed in advance. If the HMO’s costs are more than the Medicare payment amount, they absorb the losses or carry them over to the next year. If the costs are less, plans share the savings with Medicare on a 50-50 basis, with plans’ profit limited to 10 percent of the Medicare payment.

Costs were determined by calculating an adjusted average per capita cost (AAPCC), which is Medicare’s estimate of what it would spend for a typical beneficiary not enrolled in an HMO who obtains care on a fee-for-service basis in the beneficiary’s county of residence. Separate AAPCCs are established for different categories of beneficiaries, based on age, sex, geographic area, beneficiaries residing in a nursing home, and beneficiaries dually eligible for Medicare and Medicaid. Basing payments on local costs had important ramifications for Medicare that still raise issues even today, because it perpetuated wide disparities in spending for health care in different communities—sometimes even adjacent communities—and in different parts of the country. For risk contracts, the 1972 law also required an operating history of at least two years and a minimum enrollment of 25,000, at least half of whom are not Medicare beneficiaries.<sup>4</sup>

The industry’s response to the 1972 amendments was resoundingly negative. Between its passage and the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, only one HMO elected to contract with Medicare on a risk basis.

## **The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982: A New Beginning for Risk Contracts**

Congress incorporated changes in TEFRA designed to encourage more enrollment in risk-based plans. TEFRA substantially modified the 1972 law by eliminating the requirement to share profits with Medicare, which the plans judged onerous. It also lowered the minimum enrollment to 5,000, and permitted new types of medical plans to contract with Medicare.

When Congress eliminated the requirement for profit sharing, it revived a proposal that it considered and rejected in 1972. In TEFRA, Congress set payments to HMOs at 95 percent of the AAPCC. The sole purpose of this provision was to ensure savings of 5 percent to Medicare.<sup>5</sup> In setting payment rates below FFS costs, Congress codified one of the early tenets of managed care: it contains costs because it is more efficient than FFS care.

TEFRA also required plans to submit an adjusted community rate (ACR): its estimate of what it would charge commercial enrollees for a benefit package comparable to Medicare, adjusted for differences between commercial enrollees and Medicare beneficiaries. The ACR includes a profit margin equal to what the plan anticipates for commercial enrollees. If the ACR is less than payments projected by Medicare, then the plan may give the difference back to beneficiaries in the form of additional benefits, such as prescription drugs, dental care, or other services not covered by Medicare. The plan may also waive Medicare deductibles, coinsurance, or make payments beyond Medicare coverage limits, such as covering more than the Medicare lifetime limit for inpatient hospital care. Alternatively, the plan may also choose to place some or all of the difference in benefit stabilization fund for use in future years, in case the difference between the ACR and the Medicare payment is smaller. What the plan may not do is pocket the excess payment; it must choose one of these alternatives.

If the difference between the ACR and the additional benefits provided by a plan is less than the Medicare payment, the plan may charge beneficiaries a premium to cover the difference, or may absorb the loss. The principle of allowing plans to provide additional benefits or waive cost sharing requirements for Medicare beneficiaries has had important and long-lasting implications. It established an expectation, still very much alive today, that beneficiaries who enroll in managed care will get “free” benefits beyond those covered by Medicare. Clearly, this has been a powerful inducement for beneficiaries to enroll in managed care plans.

In some respects, the TEFRA model for risk plans is similar to the commercial HMO market in that payments are set prospectively and include all services provided to a beneficiary. In one fundamental respect, however, Medicare risk plans are unlike commercial HMOs. In the commercial market, employers negotiate with health plans to find a price at which the employers are willing to buy and the plans are willing to sell. In contrast, the payment rates for Medicare risk plans are determined by law. Thus, Medicare payments are administratively set and not truly determined by the market, even though managed care is widely viewed as the market driven part of Medicare.

During Congressional debate on TEFRA, some members expressed concern that HCFA would not be able to set the AAPPCs accurately, and that plans might be overpaid or underpaid. To minimize that possibility, TEFRA included a provision requiring the Secretary of the U.S. Department of Health and Human Services (HHS) to certify to Congress that HHS was “reasonably certain” that it had developed an appropriate methodology for computing the AAPCC to assure actuarial equivalence between HMO and FFS Medicare beneficiaries. That slowed down implementation until 1985, when the Secretary provided the requisite

certification to Congress, based on experience with 32 risk-based demonstration projects between 1980 and 1984 (GAO 1989a).

The commercial HMO market was thriving when TEFRA was implemented, and continued to grow for a while, although it was somewhat volatile. From 1986 to 1994, enrollment in commercial HMOs increased from 26 to 50 million, with employers beginning to turn to managed care to control costs (GAO 1995). However, according to a Salomon Smith Barney analysis, 149 HMOs went bankrupt from 1986 to 1993, and 80 plans disappeared or merged during that time.

Despite this instability, the virtues of managed care were widely touted, while the fee-for-service system was faulted for providing excess care and services of marginal value. In 1991, the HCEA Administrator, Gail Wilensky, and a colleague wrote "... only a few lonely observers call for a return to unbridled fee-for-service plans." In a view widely shared, they said, "Properly structured to allow consumer choice, coordinated care can provide strong incentives for accessible, high-quality, patient-oriented care, while encouraging cost-conscious decision making" (Wilensky and Rossiter 1991).

Based on these high expectations and the fact that beneficiaries who enrolled in HMOs generally got "free" benefits, HCEA encouraged the growth of Medicare managed care. From 1986 to 1994, enrollment in Medicare risk plans increased from slightly less than 1 million to 2.3 million, or about 7 percent of beneficiaries. Like the private insurance market, participation in the Medicare risk program was somewhat unstable, with 18 percent of plans withdrawing in 1987, 22 percent in 1988, and 29 percent in 1989 (Zarabozo 1999). Inadequate reimbursement was frequently cited as the reason for plan withdrawals. However, GAO reported that reimbursement rates might not have been the only reason why plans dropped out. They indicated that a number of the plans that dropped out had relatively few Medicare enrollees, which made the Medicare market relatively financially unattractive, and that plans' inefficiency may have contributed to their not faring well in the Medicare risk program (GAO 1989b).

At the same time the administration was encouraging managed care, researchers were questioning whether Medicare payment rates were too high. Beginning in the early 1980s, several studies found that Medicare HMOs generally enrolled healthier beneficiaries than those who elected to remain in FFS, and that the AAPPC risk adjusters did not appropriately account for their better health status. This is known as "favorable selection." In 1986, GAO reported that mortality rates for Medicare enrollees in risk plans were 77 percent of the projected mortality rate for the group. They estimated that the HMO payment rate would have to be

lowered by an additional five percent to adjust for these mortality differences alone. Mathematica Policy Research, under contract to HCFA, reported in 1989 that, because of favorable selection, Medicare paid between 15 and 33 percent more for beneficiaries in risk plans than it would have if they had been treated in FFS (GAO 1989b). Other researchers reported similar findings. GAO also reported that the process used to determine the ACRs was susceptible to manipulation and error because HCFA did not: (1) enforce its own requirements that HMOs use their own historic cost and utilization data to calculate the ACRs; (2) follow the prescribed methods of accounting for differences between Medicare and commercial members volume and cost of services; and (3) document the calculations (GAO 1989b).

Despite concerns that Medicare might be paying more than it should, some made proposals to increase Medicare payments. In 1989, Congress considered a proposal to raise the AAPPCC from 95 to 100 percent. The first Bush Administration proposed an outlier pool (equal to two percent of the AAPPCC payments) to pay HMOs for very high cost patients. In their view, the adjusters in the AAPPCC did not adequately compensate plans for the high cost cases that plans might encounter. While neither proposal was enacted, the fact that proposals were offered to increase payments is indicative of the underlying tension between paying appropriately for managed care and encouraging enrollment.

### **Medicare Enrollees in an Expanding Market For Managed Care: Plans' Motives for Involvement**

Despite the fact that almost a million beneficiaries were enrolled in managed care by 1988, enrollment was concentrated heavily in a few urban areas where payment rates were high, while rural areas and urban areas with low rates attracted few plans (Merlis 2001). Enrollment continued to grow rapidly through the early and mid-1990s. Enrollment increased to almost 2 million by 1990, doubled by 1996, and was over 6 million by early 1997 (HCFA 2000b).

A 1996 GAO report further validated the persistently concentrated nature of enrollment, with 45 percent of enrolled beneficiaries residing in just four states: California, Florida, Pennsylvania, and Texas (GAO 1996). The vast majority of Medicare HMO enrollees (87 percent) lived in 10 states, while California alone accounted for 39 percent. Between 1991 and 1995, the number of HMOs enrolling Medicare beneficiaries declined in five states. Nineteen states had no HMOs with Medicare risk contracts.<sup>6</sup> In addition to geographic concentration, enrollees were also concentrated in a small number of HMOs, with ten plans accounting for 44 percent of enrollment.

GAO identified two factors as the most important in influencing plans' decisions to enroll Medicare beneficiaries. States with the highest levels of Medicare HMO enrollees tended to be

those with the highest HMO penetration in the general population. Second, counties with the highest Medicare payment rates (over \$500 per month per beneficiary) also tended to have higher levels of Medicare participation, while counties with the lowest payment levels (under \$375 per month) had low Medicare penetration rates, as shown in Table 2.1.<sup>7</sup> However, approximately 40 percent of counties with high payment rates had low Medicare penetration, which GAO could not readily explain.

**Table 2.1**

<b>Percent of Counties with High and Low Medicare Risk-Contract HMO Penetration Rates by AAPC Rates, 1994</b>			
AAPC rates	Counties	Low <sup>a</sup>	High <sup>b</sup>
Low (under \$375)	2, 788	93	3
Moderate (\$375-\$500)	434	72	15
High (over \$500)	25	40	40

<sup>a</sup> Penetration rate-percent of Medicare beneficiaries enrolled in risk-contract HMOs-less than or equal to 1 percent.

<sup>b</sup> Penetration rate-percent of Medicare beneficiaries enrolled in risk-contract HMOs-greater than 5 percent.

Source: GAO 1996.

Medicare beneficiaries may choose either managed care or fee-for-service, so managed care plans have marketed extensively to Medicare beneficiaries to generate enrollment. GAO found that two factors contribute to higher enrollment in managed care: reduced premiums and additional benefits. Table 2.2 shows the additional benefits offered by plans, and an increase in free benefits between 1993 and 1995 for almost every benefit. The number of plans offering prescription drugs increased from 32 percent to 49 percent just in those years.

GAO reported that HMO premiums for Medicare beneficiaries ranged between \$22 per month to \$111, with a median of \$39. Table 2.3 shows that the number of plans not charging any premium increased from 26 percent in 1993 to nearly 50 percent in 1995. The percentage of plans with premiums between \$40 and \$79.99 decreased from 42 percent to 21 percent from 1993 to 1995.

Table 2.2

**Number and Percent of HMOs with a Risk Contract Providing Additional Benefits to Medicare Beneficiaries, 1993 and 1995**

Additional Benefit Provided	HMOs			
	1995 <sup>a</sup>		1995 <sup>b</sup>	
	Number	Percent	Number	Percent
Routine Physicals	102	96.2	154	96.3
Immunizations	94	88.7	139	86.9
Eye Exams	89	84.0	142	88.8
Ear Exams	68	64.2	118	73.8
Health Education	35	33.0	39	24.4
Outpatient drugs	34	32.1	78	48.8
Foot Care	28	26.4	55	34.4
Dental Care	26	24.5	56	35.0
Eyeglasses	5	4.7	8	5.0
Hearing Aids	1	0.9	6	3.8

<sup>a</sup> Data as of December.

<sup>b</sup> Data as of August.

Source: GAO 1996.

**Other Reasons for Increased Enrollment in Medicare Managed Care**

GAO said that employers also probably contributed to increased Medicare enrollment in risk plans in two ways. Almost two-thirds of employers offered retiree coverage in the mid-1980s, but that fell to 45 percent by 1993. Increased employer use of HMOs for both active workers and retirees meant that many workers would continue in managed care after retirement. Second, the erosion of retiree health coverage probably played a role in higher Medicare enrollment because retirees are more likely to choose managed care to get lower premiums and extra benefits.<sup>8</sup>

**Table 2.3**

**Range of Premiums Charged Medicare Beneficiaries by HMOs  
with a Risk Contract, 1993 and 1995**

Range of premiums charged	HMOs			
	1993 <sup>a</sup>		1995 <sup>b</sup>	
	Number	Percent	Number	Percent
\$0	27	25.5	79	49.4
\$0.01-\$39.99	28	26.4	42	26.3
\$40.00-\$79.99	45	42.5	33	20.6
\$80.00 or more	6	5.7	6	3.8

<sup>a</sup> Data as of December.

<sup>b</sup> Data as of August.

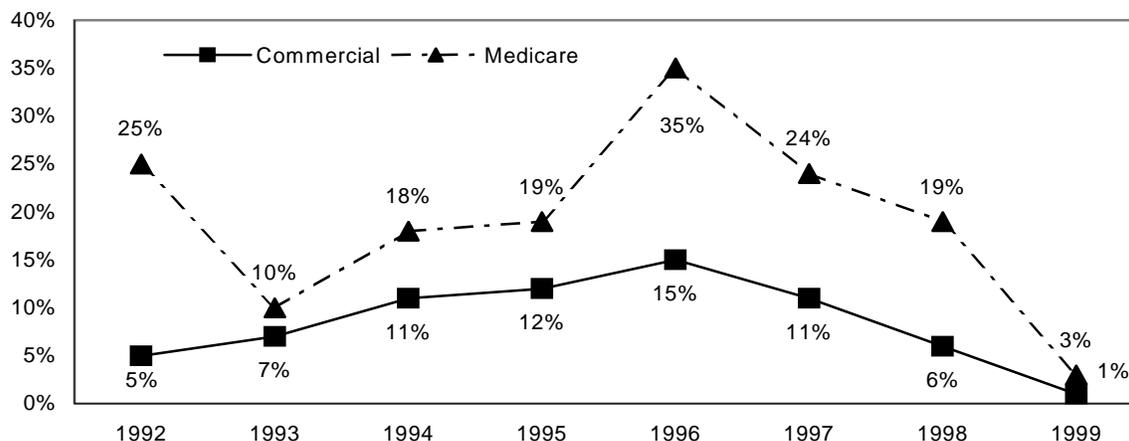
Source: GAO 1996.

On other fronts, Medicare supplemental insurance (Medigap) became less attractive because of sharp price increases in the mid 1990s. In 1996, the peak year for enrollment growth, the largest Medigap plan, offered through AARP, raised its rates 27 percent, and another 13 percent in 1997 (Merlis 2001). In addition, many Medigap insurers switched to attained age ratings (which also increased premiums for older enrollees) (Alecxi et al. 1997).

Medicare FFS spending was also rising much more rapidly than private insurance spending, which made the Medicare risk market more lucrative to health plans, and also enabled them to offer generous additional benefits. From 1993-1997, Medicare spending per enrollee increased 7.5 percent, compared to 3.5 percent for private insurance (Merlis 2001). In addition, HMOs expanded rapidly in the private sector in the early and mid—1990s, with an annual growth rate that peaked at 15 percent in 1996, before turning downward. Medicare managed care enrollment followed a similar, but higher trajectory, as shown in Figure 2.1, topping out at 35 percent in 1996.

Figure 2.1

Annual Growth in HMO Enrollment, 1992–1999



Source: Merlis 2001.

### THE BALANCED BUDGET ACT OF 1995: A TEMPLATE FOR FUTURE MARKET REFORMS

After the defeat of the Clinton health care reform bill in 1994, many Republicans campaigned on a unified platform called the “Contract for America,” whose central tenets called for smaller government and a balanced budget.<sup>9</sup> Because Medicare is the second largest domestic social program, after Social Security, reductions in Medicare spending had to be a large component to balancing the budget. The impetus to reduce Medicare spending was buttressed by the 1995 Report of the Medicare Trustees, which projected that Medicare would become insolvent by 2002.<sup>10</sup> Subsequently, Congress passed the FY 1996 budget resolution, which called for \$270 billion in Medicare savings from FY 1996 through 2002.<sup>11</sup>

In the fall of 1995, Congress passed a balanced budget bill that met the \$270 billion target and incorporated major structural reforms for Medicare. In addition to reductions in payments to virtually all Medicare providers, the bill’s goal was to move Medicare from a government financed and regulated program to a more market-based system in which Medicare beneficiaries could choose from a wide array of health plans or remain in the traditional FFS program.<sup>12</sup> CBO projected that enrollment in the new health plans would increase from 6 percent of enrollees in 1996 (3 million beneficiaries) to 25 percent (10.3 million beneficiaries by 2002) (CBO 1995).

Under this legislation, Medicare payments to plans would have been transformed from an open-ended entitlement program based on defined benefits to a defined contribution program. In a

defined benefit program, beneficiaries are eligible for the amount, scope, and duration of benefits specified by law or policy. In a defined contribution program, beneficiaries are entitled only to a contribution level set in advance. Health care spending in excess of the defined contribution amount would be the responsibility of the beneficiary. The defined contribution would have been established by gradually delinking payments to plans from FFS expenditures, and establishing an allowed annual rate of growth in payments.

Congressional debate on the bill was heated and protracted, with multiple points of controversy. Proponents argued for the changes as a means to provide the elderly and disabled with insurance arrangements comparable to those of working age Americans. Rep. Everett, (R-AL) summed up the arguments for the bill, “This historic legislation empowers seniors by offering choices through MedicarePlus coverage, which includes coordinated care, preferred provider organizations, local union or association policies, HMOs, private fee-for-service, medical savings accounts, or continuing traditional Medicare. Most of these choices are currently available for every other American. Why should senior citizens continue to get the short end of the stick?”<sup>13</sup>

Others argued that the bill would reduce geographic inequities in the program. Rep. Gunderson (R-WI), for example, argued for provisions that would reduce disparities in the AAPC payments, “My home state of Wisconsin, with 769,000 Medicare beneficiaries, is one of fifteen states that currently do not have a Medicare HMO option available to them. It is difficult to understand how beneficiaries who paid into the Medicare trust funds at the same rate and pay the same part B premium now receive very different AAPC payments. This is not equitable or fair.”<sup>14</sup>

Although President Clinton vetoed the bill, in part because of the steep proposed reductions in Medicare spending, it is important in the history of Medicare managed care because many of its tenets and key provisions laid the groundwork for the balanced budget debate of 1997 and ultimately became law.

### **THE BALANCED BUDGET ACT OF 1997**

The impasse between the Congress and the Clinton Administration over a balanced budget continued throughout 1996. In 1997, the President and Congress finally reached an agreement to balance the budget. The budget resolution provided for elimination of the budget by 2002 and reductions in Medicare spending of \$115 billion from FY 1998 to 2002.<sup>15</sup>

The resulting bill, the Balanced Budget Act of 1997 was signed into law on August 7, 1997. Medicare was the single largest contributor, accounting for \$112 billion of the net deficit reduction of \$127 billion from FY 1998 – 2002. <sup>16</sup> CBO projected that the bulk of the savings

in the first five years, \$78.1 billion or more than two thirds, would come from reducing payments to nearly all FFS providers.<sup>17</sup> The BBA also provided for \$21.8 in net reductions to payments for private health plans over five years (Moon, Gagel, and Evans 1997).<sup>18</sup>

### **Creation of the Medicare+Choice Program**

The BBA established a new subtitle of Medicare law, Part C — Medicare+Choice— to govern the new plan options. In creating the Medicare+Choice program, Congress attempted to ameliorate nearly every shortcoming in the old risk payment rates and achieve multiple, interrelated, and highly complex goals, including:

- eliminating the deficit;
- moving Medicare to a more market-based system by creating new types of health plans, modeled on the private sector and encouraging beneficiaries to enroll in the new plans;
- creating a defined contribution model to serve as the prototype for future Medicare reform or restructuring;
- reducing the geographic disparities in payments to managed care plans to make more plans available in lower cost areas;
- revising the payment formula so that it properly accounts for the health status of enrolled beneficiaries;
- establishing a multi-pronged education program to inform beneficiaries about their health plan choices; and
- preserving the free additional benefits that many Medicare risk plan enrollees receive.

Congress attempted to achieve several of these goals through changes in payment rates to plans. Table 2.4 shows the changes made in the calculation of the payment rates. The annual capitation rate to plans was set at the highest of these three amounts for each county: a rate calculated as the blend of local and national rates; a minimum payment “floor”; or the minimum increase established in law. (Appendix A provides a more detailed explanation of the M+C payment provisions.)

The BBA also changed the definition of organizations eligible to participate from HMOs and HMO-like organizations to include those licensed as risk-bearing entities. The new plan types were intended to give Medicare beneficiaries health plan choices similar to individuals who have employment-based insurance. The existing risk-based HMOs were folded into the M+C program and become one type of coordinated care plan, while cost based plans were gradually phased out.<sup>19</sup> The other, new coordinated care plans include PSOs and PPOs. The BBA also

**Table 2.4**

<b>Major Factors for Determining Payments to Medicare+Choice Plans</b>	
Factor	BBA97
Blended counties (blend of local and national rates)	6 years to 50% area-specific.50% national by 2003. National rates are adjusted for differences in input prices.
Minimum payment ("floor") counties	\$367 in 1998 (minimum of \$367 of 150% of 1997 payment outside US). 1999-2002 previous year's payment times annual percentage increase.
Minimum percent increase ("hold harmless") counties	1998 102% of 1997 AAPCC; 1999 and thereafter 102% of prior years rate.
Treatment of GME/DSH	Carved out over 5 years. DSH is not carved out.
Budget neutrality	Total Medicare+Choice payments may not exceed what would have been spent if area specific percentage for local rates were 100%.
Annual percentage increase	1998 increase in Medicare per capita expenditures minus .8 percentage points; 1999-2002 increase in Medicare per capita expenditures minus .5 percentage points; after 2002 increase in Medicare per capita expenditures.
Risk adjustment	Payments adjusted by Secretary to reflect demographic and other factors. Study to be done and, starting 2000, payments risk adjusted based on Secretary's recommendations.

Source: CRS 1997b.

created new private fee-for-service plans (PFFS) and authorized a demonstration of medical savings accounts.

The BBA required M+C plans to provide the same benefits as Medicare FFS. It retained the requirement that plans must provide additional benefits or reduced cost sharing if the Medicare payment is less than the cost of providing the benefits, as measured by the ACR.<sup>20</sup>

### **NEW PLAN TYPES IN THE BBA**

#### **Provider-Sponsored Organizations**

Provider-sponsored organizations are capitated plans sponsored by providers, such as hospitals or physicians. PSOs may be sponsored by entities not licensed as insurers. They were created in response to concerns expressed by hospitals that they could do as good a job managing costs as HMOs if they were given the opportunity.

#### **Preferred Provider Organizations**

PPOs are groups of hospitals and physicians that contract with an insurer to provide services on a FFS service basis at discounted rates to enrollees. They were added because they are increasingly popular in the private insurance market.

#### **Private Fee for Service Plans**

PFFS plans are defined contribution FFS plans offered through an insurer that are not subject to the same requirements as other plans or FFS providers. They are permitted to charge unlimited premiums and are not subject to limits on the amounts physicians may charge beneficiaries. They were established in response to concerns that limits on payments in other types of M+C plans might ultimately result in rationing of care, and that beneficiaries should be free to choose to pay more than Medicare allows in order to get the kind of health care they want.

#### **Medical Savings Account Demonstration**

The MSA demonstration consists of two parts: a high deductible insurance plan (referred to as an MSA plan) and a medical savings account, referred to as a Medicare+Choice MSA. Beneficiaries choosing to enroll in the MSA demonstration may not have any form of supplemental insurance, including Medigap. The insurance plan has a minimum deductible of \$6,000 per year, indexed for inflation. After the beneficiary pays the deductible, which can be met only for covered Medicare services, including coinsurance and deductibles, the plan pays for 100 percent of Part A and B expenses at the rate charged by the provider (not the Medicare allowed payment), or 100 percent of what Medicare would have paid for these expenses, without regard to deductibles or coinsurance, whichever is less.

*-continued-*

*-continued-*

For the MSA part of the demonstration, contributions to a beneficiary's MSA account will be made from the balance remaining in the capitation rate after the premium for the MSA account has been paid. Contributions and interest paid to MSA accounts will be exempt from taxes. Withdrawals will also not be subject to taxation if they are used to pay for qualified medical expenses (as determined by the Internal Revenue Service).

Similar to the other new plan types in Medicare+Choice, part of the impetus for the MSA demonstration is to allow beneficiaries the same range of choices as in the private market. The other premise for the demonstration is to test the premise that beneficiaries would make wiser choices about health care if they did not have the first dollar coverage provided by HMOs, Medigap and many retiree health plans. Some experts have long argued that first dollar coverage has contributed to excessive health care spending.

### **Other Relevant Provisions of the BBA**

**Coordinated Open Enrollment Period/Medigap Reforms.** In order to facilitate choice of plans, the BBA provided for a coordinated open enrollment period, a specified period of time during each year when beneficiaries are given a wide range of comparative information about M+C plans and permitted to select a health plan for the following year. Some improvements in Medigap coverage were designed to permit beneficiaries to switch more easily between FFS and M+C plans.

**Medicare National Education Program.** The BBA created a multi-pronged education campaign, including the "Medicare and You" handbook, a toll free telephone line (1-800-Medicare), an Internet site ([www.medicare.gov](http://www.medicare.gov)), and regional education programs. The existing health insurance counseling programs complemented the new program.<sup>21</sup>

**Quality Assurance and Beneficiary Protections.** The BBA established new quality assurance requirement for M+C plans. They were required to have a quality assurance program that stresses health outcomes and provides for measuring health outcomes and other indicators of quality. Coordinated care plans were also required to provide for internal peer review, establish written protocols for utilization review, and establish mechanisms to detect both under-and-over-utilization. All M+C plans were also required to obtain external review of the quality of inpatient and outpatient services, although plans with an excellent record of quality assurance could receive a waiver.

**Competitive Pricing Demonstration.** Using the broad demonstration authority of the Social Security Act, HCEA attempted in the mid 1990s to demonstrate the effect of market pricing for Medicare managed care plans. Competitive pricing demonstrations, in which Medicare risk plans could submit sealed bids to cover Medicare beneficiaries, had been announced in

Baltimore, Maryland and then Denver, Colorado. Health plans objected strenuously to the demonstrations, and ultimately they were all blocked by both political and legal means. In the BBA, the Administration sought and received explicit authority to conduct these types of demonstrations.

## **REALITY FALLS SHORT OF EXPECTATIONS**

### **Implementing BBA**

Prior to the enactment of the BBA, CBO projected rapid growth in Medicare managed care plans from 11 percent to almost 25 percent by 2002 and 35 percent by 2007 (CBO 1997a). CBO increased its projection of managed care enrollment to 27 percent by 2002 because of the new plan choices. They projected enrollment in PSOs would go from zero to 3 percent, and the MSA demonstration would reach its capped enrollment of 390,000 (CBO 1997b).<sup>22</sup>

What actually happened in the wake of the BBA was not what anyone expected. Instead of the 6 percent increase in spending that CBO projected, total Medicare spending grew by only 1.5 percent in 1998. In 1999, Medicare spending dropped by almost 1 percent, for the first time in history (CRS 2001a).

Although Medicare FFS spending fell off precipitously and the link between FFS spending and the M+C rates would ultimately dampen M+C rates, the early signs looked promising for the M+C program.<sup>23</sup> The percentage of Medicare beneficiaries enrolled in plans continued to rise rapidly, reaching 16 percent in 1998 and nearly 17 percent by December 1999 (CRS 2002). By that time, however, there were hints that the rosy scenario of ever-increasing enrollment in M+C plans probably would not continue. In mid-1998, before all the M+C provisions took effect, 45 plans announced that they were terminating their contracts, affecting 407,000 beneficiaries, of whom 51,000 did not have access to another M+C plan. The industry's unexpected response to the BBA led to much speculation about why plans withdrew, and to calls for Congressional action to modify both the FFS and M+C provisions of the BBA.

GAO argued against Congressional action, saying that sweeping amendments to the BBA were not warranted (GAO 1999b). In testimony before the Senate Finance Committee, William Scanlon, Director of Health Financing and Public Health Issues at GAO, cited the following in defense of letting the BBA stand:

- The net effect of the BBA reforms was modest, and held down per capita payment growth by only a little more than 1 percent;
- Although an unusually large number of plans withdrew in 1999, a number of plans applied to enter or expand their participation;

- Lower payment rates alone were not responsible for the withdrawals, and some withdrawals were likely to be normal reactions to market competition and conditions;<sup>24</sup> and
- Recent data showed that Medicare payments to M+C plans still exceeded the cost of providing Medicare benefits.<sup>25</sup>

Shortly after that, the plans announced another round of withdrawals and reductions in service for 2000. The overall number of withdrawals and reductions was lower than in 1999, although the number of beneficiaries “orphaned” — left without access to another M+C plan — grew. Forty-one plans terminated their M+C contract for 2000, while fifty-eight plans announced service area reductions, affecting 327,000 beneficiaries and leaving 79,000 beneficiaries orphaned.

### **THE BALANCED BUDGET REFINEMENT ACT OF 1999**

Congress responded to this instability by passing the Balanced Budget Refinement Act of 1999 (BBRA) in November 1999, which President Clinton signed quickly.<sup>26</sup> The BBRA contained a number of provisions designed to shore up M+C, and provide greater protections for beneficiaries dropped by plans.

#### **KEY PROVISIONS OF THE BBRA**

- Slowing the Secretary’s proposed phase-in of the risk adjusters, so that only 10 percent of payments would be based on the adjusters in 2000 and 2001, and up to 20 percent in 2002;
- Providing a bonus payment of 5 percent in the first year and 3 percent in the second year to new plans that enter a county that wouldn’t otherwise have a plan;
- Reducing the exclusion period for plans that want to reenter a county from five years to two years;<sup>27</sup>
- Permitting M+C plans to offer different premiums, benefits, and cost-sharing within a service area, as long as these are uniform within a county;
- Lowering the reduction in the growth percentage for 2002 from .5 percentage points to .2 percentage points, thus increasing payments to plans;
- Relieving PPOs of the quality assurance programs required of other coordinated care plans in M+C;
- Reducing the user fees charged to M+C plans for the Medicare education program; and
- Delaying the competitive pricing demonstration.

Most of these provisions took effect upon enactment, but came too late to have any effect in 2000. Clearly, Congress hoped that the BBRA would stem, if not reverse, the tide of withdrawals and service reductions for 2001. However, the plans gave the BBRA a decidedly cool reception. More plans (fifty three) withdrew than in any other year, and more beneficiaries than ever were affected. Of the 934,000 beneficiaries whose plans withdrew, 159,000 had no access to another other M+C plan. Fifty-three plans reduced their service areas for 2001. Nationwide, just two managed care companies, Aetna and CIGNA, accounted for more than half the beneficiaries affected by the withdrawals. In response to this news, some members of Congress asked GAO to determine whether Medicare payments were adequate to pay for Medicare-covered benefits and the extent to which payments to individual plans varied from expected FFS costs. The GAO concluded that, in 1998, Medicare spent about 21 percent more, or \$5.2 billion (approximately \$1,000 per beneficiary) on M+C enrollees than it would have if they remained in FFS. Of this amount, \$3.2 billion was due to inadequate risk adjustment and the remaining \$2 billion to an error in forecasting spending that was built into the BBA payment formula. About two-thirds of plans got payments at least 10 percent higher than those beneficiaries would have cost in FFS. Only nine plans had received payments below the expected FFS costs of those enrollees.<sup>28</sup>

Congress ultimately did not agree with GAO's long-held and strongly stated view that M+C plans were being paid too much. A broad coalition of providers, including M+C plans, lobbied Congress for further payment concessions (known as give-backs) to the BBA, citing further declines in CBO's projections of Medicare spending as evidence that the BBA cut too deep, and that the reductions were beginning to threaten providers' ability to continue providing services to Medicare beneficiaries. They cited CBO's July 2000 projection that Medicare spending would be 20 percent lower than their estimate when the BBA was enacted to support their claim (CRS 2001a).

#### **THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000**

In response to continuing pressure from both FFS and M+C providers regarding payment levels, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) in December 2000, which was incorporated into the Consolidated Appropriations Act and signed by President Clinton.<sup>29</sup> The bill included increases in M+C payments and a number of reductions in regulatory burdens sought by the industry.

## KEY PROVISIONS OF BIPA

- The minimum payment amounts were increased, with a differentiation between those in Metropolitan Statistical Areas (MSAs) with a population of more than 250,000 and those not in metropolitan areas. Establishing different floor payment amounts for MSA and non-MSA areas was intended to achieve two goals: attracting plans to MSAs that they were reluctant to enter, and further boosting payments in rural areas. The bill set the minimum payment in MSAs at \$525 per beneficiary per month for 2001. For non-MSA areas, the minimum is \$475.<sup>30</sup>
- The minimum update of the M+C payment rate was increased from 2 percent to 3 percent for 2001. After 2001, the minimum increase reverts to 2 percent.
- The phase-in of the risk-adjuster was further slowed, with 10 percent of payment (instead of the 20 percent required in the BBRA) based on the current risk adjustment methodology until 2003. The bill mandated development of a new risk adjuster, beginning in 2004, to be based on both inpatient and ambulatory care. The new system will be phased in on a slower basis, and not fully implemented until 2007.
- Plans were permitted, for the first time, to offer reduced Part B premiums to enrollees as part of providing any required additional benefits or reduced cost sharing, beginning in 2003.
- The bonus payment for plans entering a new area was extended.
- Payments to M+C plans will be increased during the year if Congress passes a law that results in increased costs to the plans.
- The Secretary is prohibited from implementing any new regulations, except at the beginning of a calendar year, that impose new, significant regulatory requirements on the plans.
- The Secretary is required to make decisions, within ten days, approving or modifying marketing materials used by M+C organizations, effective January 1, 2001.<sup>31</sup>
- The bill expressly states that Medicare law regarding benefits, including co-payments, and marketing materials will preempt state law.
- The bill permitted M+C plans served by more than one Medicare contractor whose coverage policies are different to choose the policy most advantageous to beneficiaries for all M+C enrollees.
- In order to make M+C more compatible with retiree health plans offered by employers or labor unions, the Secretary is given authority to modify requirements that impede greater cooperation between these types of plans.
- M+C's quality assurance plans are required to have a new focus on racial and ethnic minorities, and the Secretary is required to report on plans' progress in meeting this requirement.
- The Chief Actuary is required to review ACR plan submissions.
- A civil penalty of \$100,000 or more may be levied against M+C plans if they terminate their contracts mid-year, or do not provide appropriate notice of the termination.

Congress and the Bush Administration hoped that the combination of increased payments and reduced regulatory burden would stabilize the M+C program, increase supplemental benefits, and make it attractive to new plans. Most of the BIPA payment provisions took effect on March 1, 2001, and HHS recalculated payments within two weeks of its passage. Plans that had withdrawn or reduced their service areas were permitted to file new ACRs for 2001. However, only four plans did so, and they served only 13,000 beneficiaries in eleven counties in 2000 (CRS 2002). Perhaps part of the plans' reluctance to reenter the program stemmed from the fact that the 3 percent minimum payment increases were effective only for 2001; in 2002, the payment formula reverts to the BBA formula.

BIPA permitted plans to do any of the following things with the increased payments: reduce premiums or cost sharing, enhance benefits, deposit the increase in the stabilization fund; or "stabilize or enhance beneficiary access to providers" by increasing payments for services. Overwhelmingly, the new money went for increased spending for current benefits with 71 percent of the total going to providers, largely in the form of payment increases. Plans put 18 percent of the money into enhanced benefits, and 11 percent into the stabilization fund.

Given the fact that the plans had very little time after the passage of BIPA to assess its effects before they had to make decisions about whether to reverse their withdrawal or service area reductions for 2001, their actions for 2002 are probably a better barometer of their reaction to BIPA. While the number of withdrawals and service area reductions were lower than any year since the BBA took effect, they were still substantial. Twenty-two plans withdrew, and thirty-six plans announced service area reductions, affecting 536,000 beneficiaries. Of those, 38,000 had no access to any plan, and an additional 52,000 had access only to a private FFS plan. Post BIPA, some plans expanded their service areas. In 2002, there were new 239 service areas, but only 6,500 new enrollees.<sup>32</sup> Nearly half of the new service areas were in counties subject to the rural payment floor. Table 2.5 shows contract terminations and withdrawals from 1999 through 2003.

**Table 2.5**

**Medicare + Choice Contract Terminations and Service Area Reductions,  
1999-2003**

	Effective January 1999	Effective January 2000	Pre-BIPA, Effective January 2001	Effective January 2002	Effective January 2003
Terminations	45	41	65	22	8
Service area reductions	54	58	53	36	21
Number of enrollees before withdrawals	6,056,000	6,347,000	6,242,000	5,579,000	5,000,000
Total enrollees affected	407,000	327,000	934,000	536,000	216,000
Affected enrollees with no access to any plan	51,000	79,000	159,000	38,000	36,000
Affected enrollees with access limited to PFFS plan	N/A	N/A	N/A	52,000	15,000

Note: Enrollee counts rounded to the nearest thousand and enrollee count before January 2002 withdrawals represent data from September 2001.

Source: Data furnished by CMS for NASI.

**THE CURRENT STATUS OF MEDICARE+CHOICE**

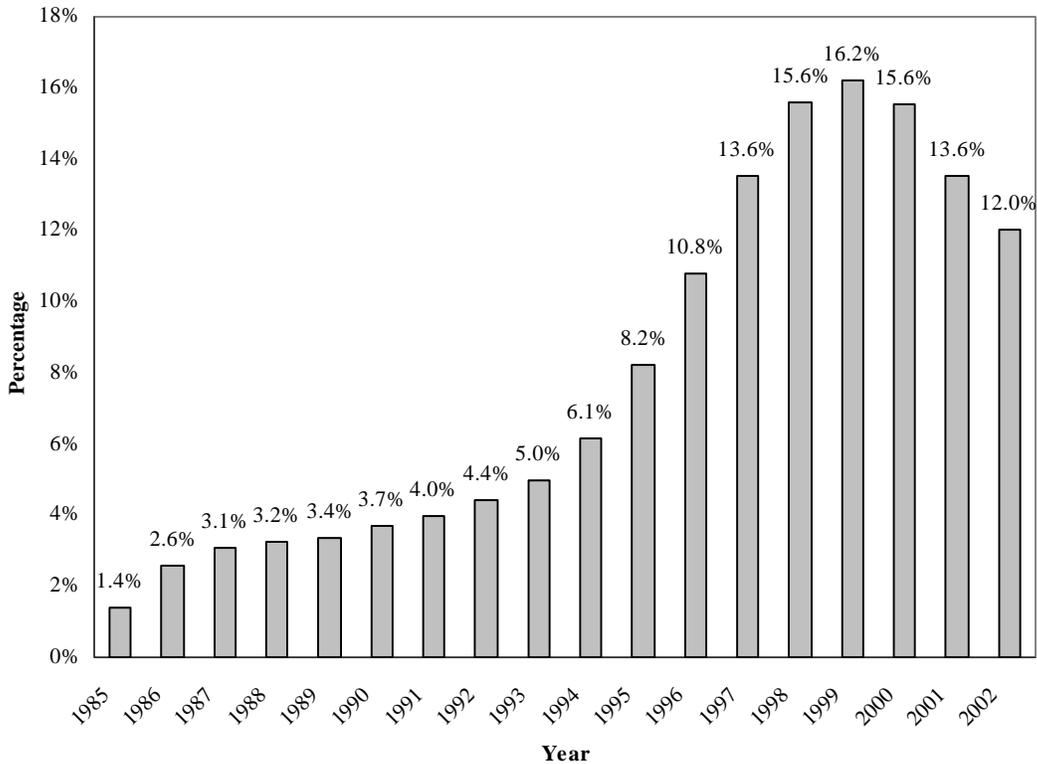
This history of almost continual change in policy, market conditions and private plan involvement has left a legacy of uneven and unstable insurance arrangements for Medicare beneficiaries. We review here the patterns of plan participation, benefit options, and enrollment instability.

**Uneven Patterns of Enrollment**

How have all these changes affected the M+C program and Medicare beneficiaries? Figure 2.2 shows the number of beneficiaries enrolled in M+C plans.

**Figure 2.2**

**Number of Enrollees in Medicare Managed Care, 1985–2002**

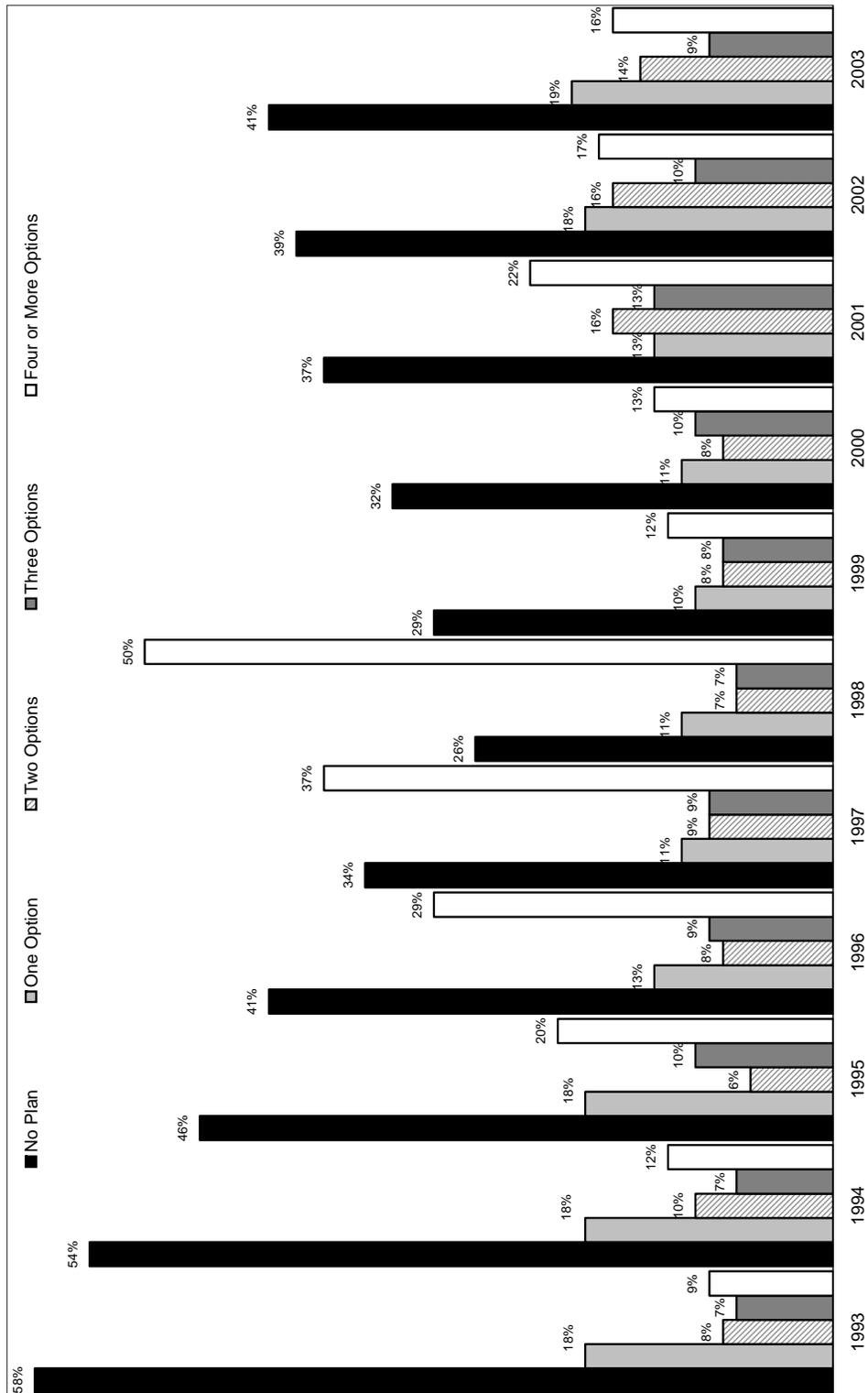


Source: Data furnished by CMS for NASI.

Distribution of Coordinated Care Plans: Two of the BBA's goals were to increase beneficiary access to private health plans, and to foster the growth of managed care in rural areas. Instead, access has eroded steadily since 1998, when 74 percent of beneficiaries had access to at least one plan. By 2003, only 59 percent of beneficiaries could choose a coordinated care plan (CMS 2003). Approximately 216,000 beneficiaries were affected by plan withdrawals and service area reductions.

And despite efforts to encourage expansion into rural areas and unserved areas, M+C is now even more concentrated in major metropolitan areas. A recent study of sixty-six large markets by Mathematica Policy Research found that these markets accounted for 76 percent of M+C enrollees in 1999, and 79 percent in 2002, even though only 43 percent of Medicare beneficiaries lived there. Most of the balance of M+C enrollment is concentrated in other urban areas. Even though 24 percent of Medicare beneficiaries live in rural areas, they account for a very small share of M+C enrollment (Gold and McCoy 2002). According to CMS, only 13

**Figure 2.3**  
**Beneficiary Access to M+C Plans, by Percent of Total Medicare Population, 1993–2003**



Source: Data furnished by CMS for NASI.

percent of beneficiaries in rural (non-MSA) areas had access to a plan in 2003. Enrollment also remains highly concentrated in four states: California, Florida, Pennsylvania, and New York. Those four states accounted for 54 percent of M+C enrollment in 2001, even though only 30 percent of Medicare beneficiaries reside there.

The BBA also intended to give beneficiaries a choice of competing plans. Figure 2.3 shows that choice of plans was highest in 1998, before the BBA took full effect. Since then, the percentage of beneficiaries with a choice of three or more plans has been lower.

Enrollment in M+C also has a regional flavor (CRS 2002). In western and southwestern states where managed care is more prevalent in the private sector, beneficiaries obviously feel more comfortable with it and more willing to choose managed care once they become Medicare eligible. In 2001, 37 percent of Medicare beneficiaries in Arizona and 38 percent of beneficiaries in California were enrolled in M+C plans (CRS 2002).

### **Implementation of the MSA and Private FFS Plans**

To date, no beneficiaries have enrolled in the MSA demonstration. The private fee-for-service (PFFS) plans have been implemented with a bit more success, but remain limited in enrollment. The BBA established different standards for PFFS plans than for coordinated care plans. The key differences in requirements between coordinated care plans and PFFS plans are that PFFS plans:

- Do not have provider networks. Any provider may participate if they are eligible to serve Medicare beneficiaries and agree to accept the payment terms and conditions offered by the plan;
- Pay providers on a fee-for-service basis without placing providers at financial risk;
- Do not provide financial incentives to providers based on the volume or type of services they provide;
- May bill enrollees directly for up to 15 percent of the plan's PFFS payment rate;<sup>33</sup>
- Are not required to obtain the Secretary's approval of premiums (although they are required to provide additional benefits to beneficiaries if their payment rate exceeds the cost of providing the services and to demonstrate that the actuarial value of their cost sharing does not exceed the cost sharing under original Medicare);
- Are not required to provide proof of provider availability; and

- Are not required to comply with some quality assurance requirements, including those relating to internal peer review, written protocols for utilization review, and mechanisms to detect over or underutilization (CRS 2001c).

PFFS plans receive the same capitation payments as M+C plans and are also eligible for a 5 percent bonus in the first year the plan provides services in an area with no other M+C plans, and a 3 percent bonus in the next year.

Thus far, three organizations, Sterling Life Insurance, Humana, and Unicare (Wellpoint), are approved to offer PFFS plans. None of the plans has a sufficient track record to assess its performance; compared to either original Medicare or M+C coordinated care plans. The Sterling plan was approved by CMS on May 8, 2000, and had 20,000 enrollees as of July 2003.<sup>34</sup> Sterling is offered in twenty-five states, with 14 million eligible beneficiaries residing in counties served by the plan. Humana's PFFS plan was approved for marketing on December 30, 2002, and had 994 enrollees as of July 2003. The plan is being offered in all counties in Iowa, Minnesota, and Wisconsin, and in parts of North and South Dakota. Approximately 1.5 million Medicare beneficiaries live in areas served by the plan. Unicare was approved in April 2003, and had 286 enrollees as of July 2003. Unicare is offered in seven states (Illinois,

**Table 2.6**

<b>Approved Private Fee-For-Service Medicare Plans</b>				
	Monthly Premium (In addition to Part B)	Out of Pocket Limit	Prescription Drugs	Co-payments
Sterling Life Insurance	\$89	No Cap	No Outpatient Coverage	Flat rate per visit
Humana	\$19	\$5,000 Annually	Unlimited w/\$10 co-pay on 30 day supply	20% of Medicare approved payment
Unicare	\$9	No Cap	No Outpatient Coverage	Flat rate per visit

Source: Sterling Life Insurance 2003, Humana 2003, and Unicare Life & Health Insurance 2003.

Indiana, Kentucky, Minnesota, Nebraska, Virginia and Wisconsin; approximately 1.6 million Medicare beneficiaries live in areas served by the plan.

Because PFFS plans offer a distinctive combination of premiums and cost-sharing requirements, they provide options that may prove appealing to some beneficiaries. Sterling also offers beneficiaries who want to leave and return to original Medicare access to a Sterling Medigap policy without regard to health status or claims experience. This is a substantial benefit that M+C enrollees do not receive if they leave an M+C plan voluntarily.

Under the BBA, Sterling could have set its payment rates lower or higher than the Medicare FFS payment rate, and could have permitted substantial balance billing. However, Sterling chose to use the same provider payment rates as original Medicare, and it prohibits providers from billing beneficiaries more than Sterling pays them.

In 2003, 37 percent of beneficiaries have access to a PFFS plan, although Sterling operates primarily in rural areas not served by a coordinated care plan. Of the 1,598 counties with a Sterling plan, 1,078 are counties where the M+C payment is set at the rural floor. Of the remaining counties, 350 are paid at a non-floor rate; of these, 286 are rural counties and sixty-four are located in MSAs. In the remaining 170 counties, payments are set at the MSA floor rate.

In 2001, the Medicare Payment Advisory Commission (MedPAC) reported that M+C payment rates in floor counties were approximately 112 percent of FFS costs. In 2002, it said that the floor payment rates inappropriately provided incentives “for private health plans to enter areas where they are least likely to influence market behavior or contain costs” (MedPAC 2002). Even though plans cannot keep the difference between FFS costs and the floor payment rate and must return those payments either in the form of extra benefits to enrollees or to the benefit stabilization fund, the higher payment rate can be used to make the plan more attractive to beneficiaries by lowering cost sharing or providing additional benefits.

In terms of its attractiveness to beneficiaries, Sterling might be more attractive to beneficiaries than a Medigap policy, particularly for those in poor health who cannot afford Medigap, or for those who value more predictable cost sharing because Sterling emphasizes fixed cost sharing. However, those with limited incomes or a greater aversion to risk may be deterred from enrolling (Gold 2001).

### **Shifting Patterns of Benefits**

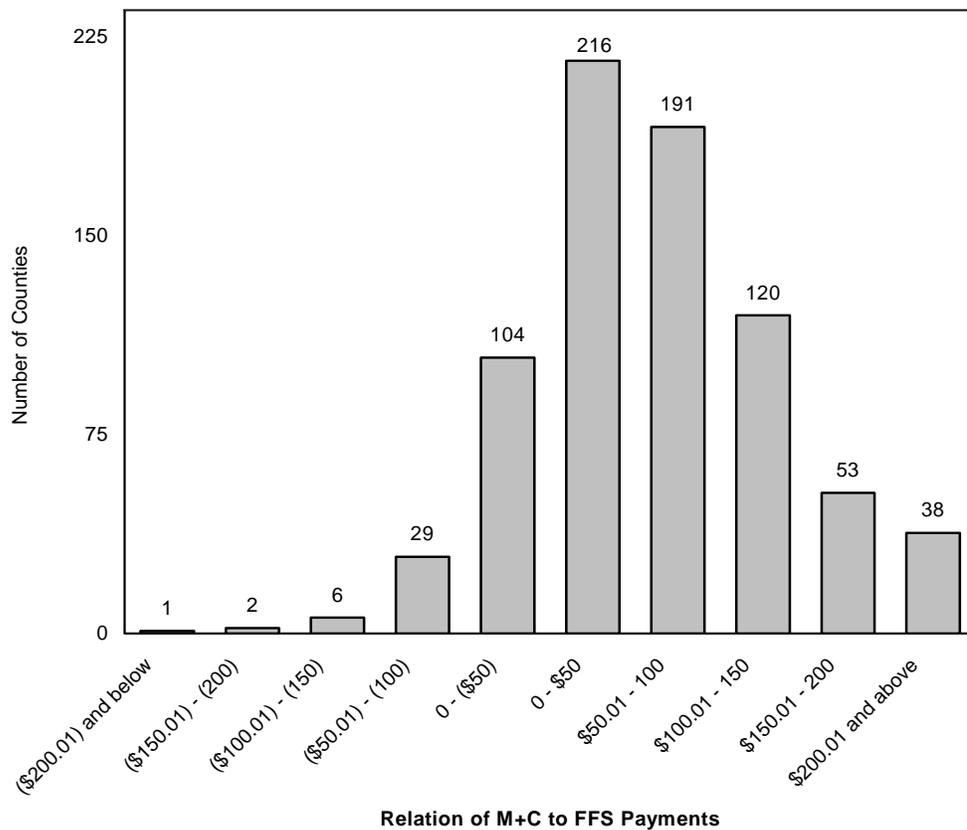
Since 1999, plans have substantially changed what they charge beneficiaries and the benefits M+C enrollees receive. In 1999, 85 percent of M+C enrollees were in plans that did not

charge a premium. By 2003, only 29 percent were enrolled in zero premium plans. In addition, beneficiaries in plans with premiums faced substantial increases in premiums. The average premium, weighted for enrollment, was \$6.37 per month in 1999 and \$37 in 2003.<sup>35</sup> If the 39 percent of plans with a zero premium are excluded, the average premium rose from \$32.11 in 1999 to \$60.00 in 2003 (Achman and Gold 2002b; CMS unpublished data). The actuarial value of cost sharing for Medicare-covered services increased from \$25 in 2002 to \$34 in 2003.

In the last few years, many plans (including zero premium plans and those that charge a premium) began requiring enrollees to share in the costs of Medicare-covered services. For

**Figure 2.4**

**Ratio of M+C Payments to FFS Payments in Non-Floor Counties, 2003**



Source: Estimates based on preliminary data furnished by CMS for NASI.

those enrolled in zero premium plans, the average monthly cost sharing rose from \$17 in 2001 to \$38 in 2003. Approximately 36 percent of M+C enrollees are in a plan with premiums

**Table 2.7**

**Supplemental Benefits for Basic Plans in Medicare+Choice Contract Segments, 1999-2002**

Supplement Benefit	Weighted by Enrollment			
	1999	2000	2001	2002
Prescription Drugs	83.9	78.0	70.2	71.4
Preventive Dental	69.9	39.0	28.6	14.3
Vision Benefits	97.8	96.2	94.7	86.7
Hearing Benefits	91.3	92.0	77.7	53.2
Physical Exam	100.0	100.0	100.0	100.0
Podiatry Benefits	26.9	28.20	29.4	26.0
Chiropractic Benefits	20.9	6.8	6.0	3.5
Number of Contract Segments/ Number of Enrollees	6,254,616	6,094,767	5,577,787	4,937,106

Note: Enrollment for 1999-2001 is from March of each year. Enrollment for 2002 is from September 2001 and does not include enrollee switching due to changes in benefits, premiums, and/or withdrawals.

Source: Achman and Gold 2002b.

exceeding \$50, and 15 percent have premiums over \$80 per month. For those in plans that charge premiums, average monthly cost sharing rose from \$13 in 2001 to \$31 in 2003.<sup>36</sup> The major change in cost sharing was the imposition of a copayment for an inpatient hospital admission. In 1999, only 4 percent of M+C beneficiaries had to make a co-payment when they entered the hospital. By 2002, 80 percent were required to do so (Achman and Gold 2002a).

In addition to increasing premiums and requiring beneficiaries to share in the costs of services, plans have also reduced the number and scope of supplemental benefits over the last few years. In 1999, 84 percent of M+C enrollees had drug coverage as part of a basic plan. In 2003, 69 percent did so. Plans have also dramatically reduced the total value of drug coverage and have started imposing restrictions on the types of drugs covered. In 1999, 22 percent of M+C enrollees had unlimited drug coverage (that is, no dollar limit on the amount of covered drugs). By 2003, unlimited drug coverage had virtually vanished: less than one percent of M+C

enrollees had no limits on their drug coverage (Achman and Gold 2003). Only 14 percent had coverage of \$2,000 or more. The bulk of M+C enrollees, 48 percent, had drug coverage of less than \$500 (CMS, unpublished data).

Plans have also been providing fewer supplemental benefits since 1999. As shown in Table 2.7, the percentage of plans providing preventive dental care, vision care, hearing benefits, and chiropractic services all declined between 1999 and 2002. There were, however, two exceptions to the erosion in supplemental benefits. All plans continued to provide physical exams, and the percentage of plans covering podiatry held steady at 26 percent from 1999 to 2002 (Achman and Gold 2002b).

The net result of these changes in premiums and benefits is that M+C beneficiaries are spending more out of pocket. One recent study estimated that out-of-pocket spending for the average beneficiary increased 10 percent from 2002 to 2003, and has doubled since 1999 (Achman and Gold 2003).

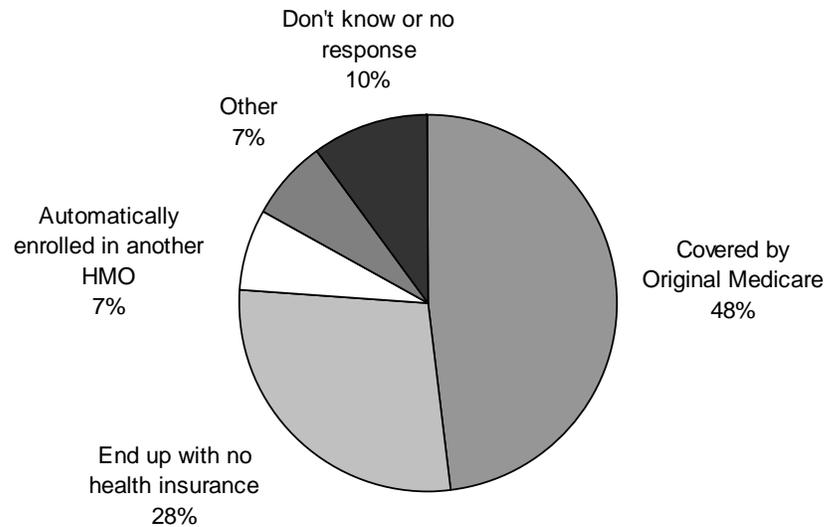
Preliminary data also show that the vast majority of counties in which payments are not set by the floor payment will receive payments in excess of FFS costs in 2003, as shown in Figure 2.4. Of the 760 counties not subject to the floor payment, payments in 142 counties are below FFS costs, while payments will exceed FFS costs in 618 counties.

### **Effects of M+C Instability on Beneficiaries**

CMS contracted for a survey to help the agency determine how to help beneficiaries enrolled in M+C plans that terminated or reduced service areas for 2001 (Booske et al. 2002). The survey showed that withdrawal of their health plan had negative effects on beneficiaries' mental and physical health, as well as financial repercussions, with disproportionate effects on the most vulnerable. Seventy-one percent of beneficiaries were very or somewhat concerned that they would no longer be able to pay for health care. Over 60 percent were very or somewhat concerned that they would have to change their personal physician or nurse, and 21 percent reported that they had to change their personal provider. Forty percent of beneficiaries reported that they were seeing a specialist when their former plan left the M+C program, and 22 percent reported that they had to stop seeing their specialist. Eleven percent reported having trouble getting the health care they wanted or needed, and 22 percent reported delaying seeking medical care because they were worried about the cost. Fifteen percent said they did not get some prescribed medication since leaving their former plan. Disabled beneficiaries, those in fair or poor health, and minority beneficiaries reported the most trouble with access to care.

**Figure 2.5**

**Beneficiary Understanding of the Implications of Plan Withdrawal**



**Source: Booske et al. 2002.**

As far as understanding the implications of plan withdrawal, the survey showed substantial confusion among beneficiaries, as illustrated in Figure 2.5. Less than half of beneficiaries understood that original Medicare would cover them when they were dropped by their health plan. Twenty-eight percent thought they would end up with no health insurance, while 7 percent thought they would be automatically enrolled in another health plan. Ten percent said they did not know, or did not respond to the question. Beneficiaries with less than a ninth grade education and minority beneficiaries were less likely to accurately understand the consequences of plan withdrawal.

More than 60 percent of beneficiaries who said they received enough information about the withdrawal had an accurate understanding of the consequences of plan withdrawal, compared to about 40 percent of those who said they did not have sufficient information. Disabled beneficiaries, the oldest beneficiaries, and African Americans were less likely than other beneficiaries to say that they had enough information. About two-third of beneficiaries found out about the withdrawal from the plan itself, with 18 percent finding out from newspapers, radio, or television. Virtually all beneficiaries recalled receiving a letter from their plan informing them of the withdrawal.

The study concluded that the withdrawals had real effects on large numbers of beneficiaries, with disproportionate effects on the most vulnerable. The provision of information helped ameliorate these problems for some beneficiaries. But the problem may not have been lack of information, but either too much information, or information they found confusing. Therefore, giving more information without simplifying it might prove to be counterproductive. Information about withdrawals should be tailored to meet the specific needs of vulnerable beneficiaries.

Instability in M+C also had effects on the continuity of care for Medicare beneficiaries, many of whom have chronic conditions that require ongoing care. Having the same primary care provider over a period of time should result in the provision of better care because the physician has an established relationship with the patient, understands the patient's medical history, and is able to judge the patient's condition and response to treatment against historical markers. Having to change physicians is unsettling and disruptive to beneficiaries; it could produce delays in access to care and increase the risk of medical errors.

Most studies of M+C have focused on plan withdrawals or service area reductions, but little research has been done on instability within plans stemming from physician turnover. The Commonwealth Fund sponsored a study that analyzed turnover rates (physicians who did not stay in an M+C plan for at least one year) for thirty-eight states for 1999 (Dallek and Dennington 2002). As shown in Figure 2.6, the dropout rate averaged 14 percent, but ranged from a low of 4 percent in Minnesota to 36 percent in Nevada. Six states (Maryland, Oklahoma, Texas, Nebraska, Wisconsin, and Nevada) and the District of Columbia had dropout rates of 20 percent or higher. Several local markets were roiled by high physician turnover. For example, turnover rates for plans in St. Petersburg, Florida, ranged from 23 to 61 percent.

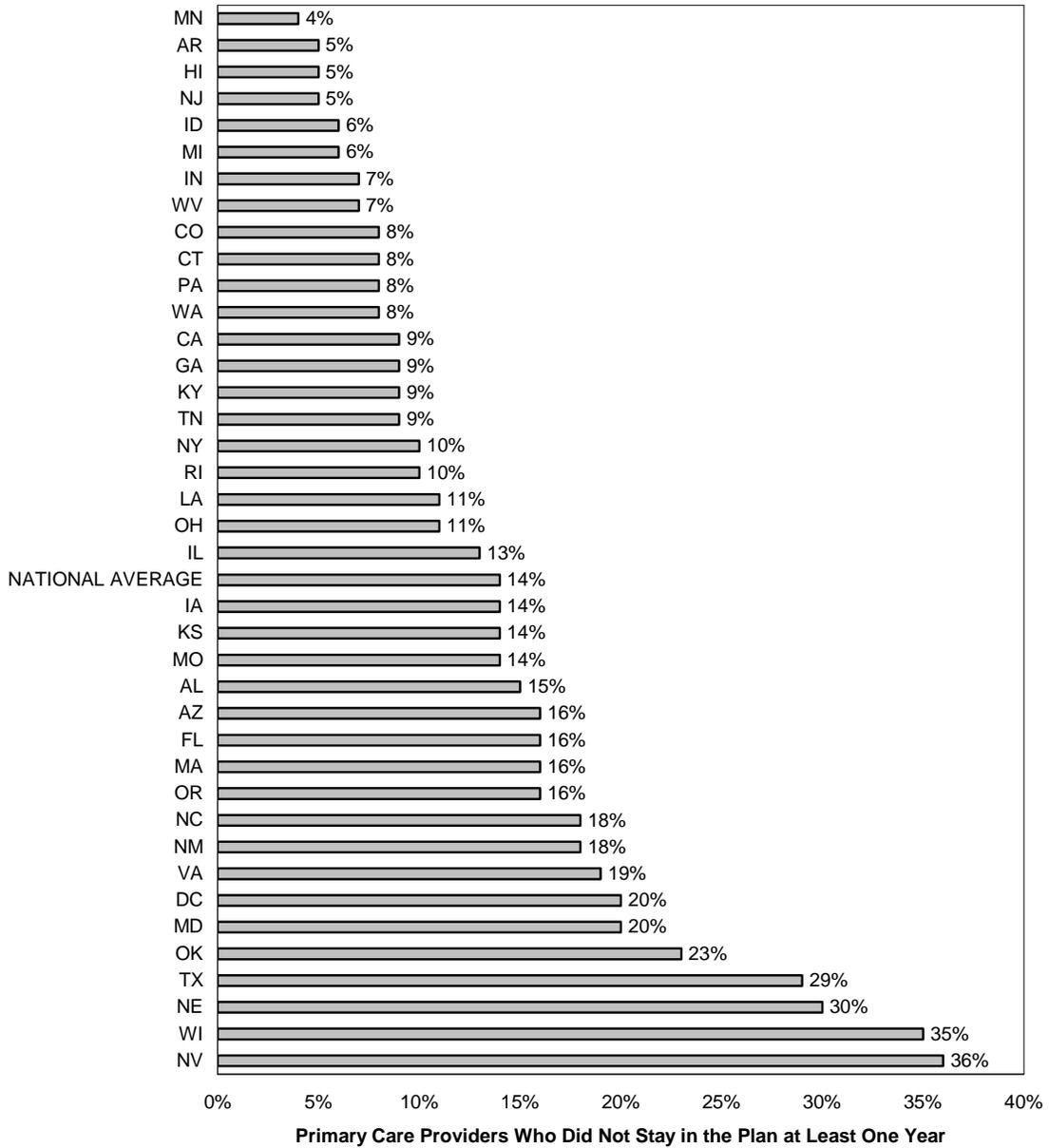
Several reasons were identified for high turnover among physicians: payment rates that physicians considered insufficient, high rates of denials of claims, payment delays, and financial instability in large physician organizations. Regardless of the reason for turnover, the study panel is concerned about its implications for patient care, and on beneficiaries' views of Medicare. For Medicare to retain its legitimacy as a public program, beneficiaries need to have a sense that the program is stable and will provide health care when they need it. Disruptions in physician-patient relationships do little to foster the appropriate sense of stability.

### **Factors Influencing Plan Withdrawals and Service Area Reductions**

In 1997, when the BBA was enacted, almost everyone expected that managed care enrollment would continue to grow rapidly, especially since the BBA provided beneficiaries with a much broader range of choice in plans. Instead, as Table 2.7 shows, enrollment rose through 1999,

Figure 2.6

Primary Care Provider Turnover Rate by State, 1999



Source: Dallek and Dennington 2002.

and has fallen every year since. Enrollment has declined even though Congress passed two laws increasing payments to M+C plans, and raised FFS payment rates, which could result in higher M+C payments. Studies have shown that other factors besides M+C payment rates, such as the underwriting cycle and market forces, as well as plans' business strategies affected decisions to withdraw.<sup>37</sup>

**Payment Rates.** Initially, most analysts assumed that the contraction of the M+C market was directly attributable to the payment reductions of the BBA. It seems clear that the BBA reductions had a powerful effect on plans' decisions to withdraw from Medicare. According to the Center for Studying Health System Change (HSC), which has tracked developments in public and private markets in twelve communities since 1998, the Medicare reductions "could not have come at a worse time."

Health care costs grew slowly in the mid 1990s, while Medicare payments for managed care rose much more quickly, making the Medicare market very attractive to health plans. But in the latter part of the decade, health care costs started escalating, especially for prescription drugs. Around the same time, the BBA caused a dramatic slowdown in Medicare FFS spending and sharp reductions in the rates of increase for M+C plans. While their costs were rising rapidly, Medicare payment increases to health plans were typically restricted to 2 percent. The collision of rising costs and Medicare payment restrictions spelled withdrawals from Medicare for some health plans. Between 1998-2001, when most plans received the minimum 2 percent update, plans with higher payment rates in 1997 were less likely to withdraw. Similarly, plans in rural areas that received the highest payment updates in 1998 (when the new floor payment took effect) were less likely to withdraw.

**The Underwriting Cycle and Market Forces.** In a predictable pattern known as the underwriting cycle, commercial insurance premiums grow more slowly than health care costs for several years, and then more quickly than costs for several years thereafter. When costs are lower than premiums, plans typically try to increase market share by holding down premium increases. In turn, this causes profits to shrink, and plans respond by raising premiums.

In the early 1990s, health care costs increased more slowly than expected, making plans more profitable and encouraging new entrants to the market. By 1996-97, plans shifted their focus to increasing market share by keeping premiums below costs to capture new business. Plans were able to offset declining profit margins in the commercial market with comfortable M+C profit margins. Even in other communities where M+C profit margins and penetration were lower, Medicare was perceived as an opportunity for expansion, and plans expected M+C payments to continue increasing at a rapid rate.

However, by 1999, when the BBA reductions had taken effect, many plans had suffered significant losses from the years when they kept premiums low to build market share. In general, plans switched strategies from growing market share to restoring profitability, and Medicare no longer seemed as profitable. Plans reacted by withdrawing from M+C or freezing enrollment, scaling back additional benefits, imposing cost-sharing requirements, and raising premiums.<sup>38</sup>

There was also a marked shift in providers' willingness to be part of M+C plans. In the mid-1990s, providers were anxious to be part of M+C plans to guard against losing revenue or patients as the managed care market grew. By 2000-01, many providers did not feel pressure to accept M+C contracts as it became clear that beneficiaries were not flocking to M+C plans in great numbers. They were in better negotiating positions with plans, and forced plans to pay them more to keep them. As a result, some plans had trouble maintaining a viable provider network while remaining profitable.

**Business Strategies.** The structure of health plans and their business decisions also played important roles in withdrawals. For-profit plans and nationally owned plans were more likely than non-profit and locally owned plans to withdraw, and plans with low market penetration were more likely to withdraw than those with a substantial market share in a particular market. Other factors include: a lack of local decision-making with regard to plan liability (i.e. decisions are made by national headquarters, not local plan offices), the number of plans in a county, and Medicaid experience. Rates of termination in rural counties were much higher than urban counties, even after controlling for payment category (Lake and Brown 2002).

Given the financial incentives and market pressures under which private health plans operate, it may prove impossible for CMS to pay plans enough to stabilize their involvement in all parts of the country, without making these payments excessive. In GAO's assessment: "The Medicare+Choice program has already been expensive for taxpayers... the vast majority of plans have gotten paid more for their Medicare enrollees than the government would have paid had these enrollees remained in the traditional fee-for-service program. Raising payment rates to a level sufficient to retain the plans leaving Medicare would mean increasing the excess that currently exists in payments for plan enrollees, relative to their expected fee-for-service costs. In areas of the country where there are few beneficiaries and providers are in short supply, no reasonable payment rate increase is likely to entice plans to participate in Medicare... In our view, efforts to protect the viability of Medicare+Choice plans come at the expense of ensuring Medicare's financial sustainability in the long term" (GAO 2000b).

**Proposals to Stabilize M+C.** In response to the continuing instability of the M+C program, the managed care industry has lobbied Congress to take action to improve the “inadequate funding” of the program. In 2003, Congress took action to increase payments to physicians and some hospitals, but M+C plans did not receive any increases. However, the Administration took action on its own motion to shore up the M+C program. On August 27, 2002, HHS Secretary Thompson announced a new Medicare PPO demonstration in which thirty-three plans in twenty-three states have agreed to participate. Under the demonstration, beneficiaries will have a broader choice of physicians than in other forms of managed care, with cost sharing varying according to which health care providers they select. Premiums are expected to range between \$60 and \$80 per month, with participating plans expected to offer prescription drug benefits. They will be reimbursed at 99 percent of the FFS rate, or the local M+C payment rate, whichever is higher. One of the demonstration’s distinguishing features is risk sharing. Participating PPOs are responsible for bearing the risks of any costs up to 2 percent higher or lower than actual costs. Beyond the 2 percent, the PPOs will have the option of sharing the risk with the federal government or assuming the risk entirely by themselves.

#### **THE BUSH ADMINISTRATION’S MEDICARE REFORM PROPOSAL**

In March 2003, President Bush outlined a broad framework for Medicare reform and coverage of prescription drugs. Although some aspects of the President’s plan were not well received in Congress, the FY 2004 budget resolution allocates \$400 billion over ten years for outpatient prescription drug coverage. In June 2003, the House and the Senate approved bills with different provisions regarding Medicare reform and prescription drug coverage. A conference committee was appointed to reconcile differences between the House and the Senate, and hopes to report an agreement in early fall 2003. Some of the critical differences between the House and the Senate bills, which could prove difficult to resolve, are the extent to which Medicare should use private health plans to deliver all Medicare benefits and a separate prescription drug benefit. The House bill would require direct competition between original Medicare and private health plans by 2010, and would permit delivery of a separate prescription drug benefit only through private health plans. The Senate bill does not establish direct competition between original Medicare and private health plans, and provides for a government-administered drug benefit in areas of the country where there are not two private health plans delivering drug benefits.<sup>39</sup>

#### **EVALUATING THE PAST, CONSIDERING THE FUTURE: FINDINGS OF THE STUDY PANEL**

The panel drew a number of lessons from its review of the history of private health plans as an alternative to original Medicare. Some of these relate to specific program goals; we defer our discussion of these findings to Chapters Three and Four. Others involve the broader dynamics of market forces and private health plans as they interface with Medicare.

The panel draws seven key findings from the historical record about the dynamic role of markets in Medicare:

**Finding 1: Early decisions about how to structure the participation of private health plans in Medicare have had lasting and problematic ramifications; repeated Congressional efforts to ameliorate unforeseen effects have sometimes done more harm than good, and have damaged the government's reputation as a reliable business partner.**

In the Social Security Amendments of 1972, Congress set payment rates for managed care based on the fee-for-service costs in the county where the beneficiary resides. In many respects, this decision was rational and quite practical, because Medicare was designed to follow local practice patterns, rather than being a monolithic national system. However, the long-term effects of this decision have grown to be one of the most troubling aspects of the current M+C program because of the extremely wide variation in health care spending patterns in different parts of the country. Geographic variations are more troubling and have more pronounced effects in managed care than fee-for-service, because in very high cost areas, they have made the Medicare market much more profitable for health plans. Beginning with the BBA in 1997, Congress has tried several times through different methods to lessen the disparity between high and low cost areas. By any measure, these efforts have been unsuccessful. The end result in 2003 is that the M+C program is even more concentrated in major metropolitan areas and in four states: California, Florida, Pennsylvania, and New York. Only 13 percent of beneficiaries in rural areas even have an opportunity to participate in an M+C plan, although the majority of Medicare beneficiaries have access to a plan.

In 1982, with the enactment of TEFRA, Congress made other decisions that have also had lasting effects on the program. Permitting plans to waive coinsurance and deductibles and provide “free” benefits when the Medicare payment rate exceeded their costs has had at least two effects. Providing extra benefits has made it much easier for plans to attract enrollees in those areas, and has fostered much more robust Medicare managed care markets in high-cost areas. Thus, it further exacerbated the tendency of plans to choose high cost rather than low-cost areas.

Allowing the provision of extra benefits has also had a profound effect on the culture of Medicare managed care and on the expectations of beneficiaries. Many policy-makers and health policy analysts have viewed managed care positively because it allowed beneficiaries to get some important benefits not covered by Medicare without cost to them or explicitly identifiable cost to the program. From the perspective of beneficiaries, not having to pay coinsurance or deductibles and getting “free” benefits was very appealing. Proponents of managed care have often cited the provision of extra benefits as a reason for encouraging

Medicare beneficiaries to enroll in managed care. In the last couple of years, this argument has become much less persuasive because of the rapid erosion of extra benefits in the M+C program.

Congress made another important decision in TEFRA to set payment rates at 95 percent of FFS costs. Through that decision, Congress established one of the key tenets of Medicare managed care: it is a cost containment tool. At the time Congress made that decision, the prevailing wisdom was that managed care saved money, in both the public and private sector, because physicians managed care and reduced inappropriate hospitalizations. While health care spending trends since then called into question managed care's ability to control costs over the long term, there can be no question that it was one of the early defining principles of Medicare managed care.

**Finding 2: Over time, Congress has increased policy objectives for private health plans to the point that not all objectives can be met because some objectives are contradictory.**

Early on, the expressed purpose of Medicare managed care was to save Medicare money. As years passed, Congress added new objectives. Providing extra benefits came to be seen as one of the ancillary benefits to Medicare managed care, and assertions that managed care could provide better quality than FFS gained credence. In most ways, these objectives were complementary, although GAO has long maintained that Medicare managed care does not save money because of favorable selection.

Beginning in the mid-1990s, however, Congress began to expect more from managed care. The failed 1995 BBA and the 1997 BBA illustrate the multiple additional goals Congress set for it. First, along with FFS Medicare, managed care was to make a major contribution to deficit reduction. In addition, managed care was still expected to be more effective than FFS, as evidenced by the risk adjusters. Simultaneously, Congress expected enrollment to grow dramatically because beneficiaries would be attracted to new plan choices. These expectations were layered over those already existing — to provide additional benefits and improve quality of care. Congress also attempted to redress inequities in the underlying program by starting to reduce disparities among payment areas and providing incentives for plans to move to rural and other unserved areas.

In short, the BBA attempted to fix all the underlying problems in managed care and transform it into a more market-based program for a much higher percentage of beneficiaries. Some also wanted M+C to lay the groundwork to transform Medicare into a defined contribution program. The drafters of BBA cannot be faulted for their timidity. Although it was not apparent at the time, hindsight indicates that it was impossible to achieve all of its goals

simultaneously. At least two of them were in direct conflict. It proved impossible to reduce spending and expand the program at the same time.

Since the passage of the BBA, Congress has further confounded the goals of M+C without achieving two of its principal objectives: reducing spending and expanding participation in M+C plans. In the BBRA and BIPA, Congress took a host of actions to reverse the spending cuts, encourage participation in new areas, and loosen regulatory requirements. But even these actions were not enough to stem the tide of withdrawals, increases in premiums and declines in additional benefits. In the process, Congress has also retrenched on some of its objectives: paying M+C plans less than FFS costs, implementing risk adjusters, and assuring that all plans meet quality standards.

These conflicting goals are also evident in expectations about choice among private health plans. Is M+C expected to provide beneficiaries with access to a managed care plan that coordinates their health care, or simply make available any private insurance alternative to original Medicare? These distinctions are important, because they suggest different assessments of the historical record and future prospects for private insurer involvement.

**Finding 3: Effective competition among M+C plans is strongest in urban areas. Having multiple plans, each with distinctive provider panels, is highly unlikely to be feasible in rural areas because of the difficulty of building and sustaining viable networks in sparsely populated areas.**

In addition to creating conflicting expectations for the M+C program, Congress has not sufficiently clarified some of its expectations. For example, Congress has not specified whether the intent of M+C is simply to offer a private insurance alternative to beneficiaries, or to produce competition among several different private health plans in each market. M+C has been reasonably successful at providing beneficiaries with choices among several different private health plans, if those beneficiaries live in large urban areas (i.e., communities with more than 1 million residents). Even after several years of declining plan participation, by 2002 some 78 percent of beneficiaries in large cities could choose from among at least two private health plans.<sup>40</sup> (Conversely, this means that 22 percent could not; 17 percent had one private plan option, 5 percent had none.) But outside of large cities (in which 41 percent of beneficiaries live) choice among private health plans was quite rare: available to 30 percent of those living in smaller cities and less than 5 percent of those living outside cities. Put slightly differently, the majority of beneficiaries who had access to private health plans outside of large cities had only one plan that they could select. The importance of this finding depends on whether M+C is supposed to produce some choice, or competitive choices. Outside of large cities, it is at best a limited success at the former. It fails at the latter.

It is also much more difficult to establish and sustain managed care plans outside of cities and suburban areas. Even with repeated Congressional attempts to encourage their involvement in Medicare+Choice, plans remain scarce in rural areas and are far more likely to withdraw from the program over time. Given the history of M+C, the study panel does not believe that it is realistic to expect HMOs or other more traditional forms of managed care to be viable in rural areas.

**Finding 4: Private fee-for-service (PFFS) plans are currently providing beneficiaries with some additional benefits not covered by Medicare, but fewer than those provided by coordinated care plans. However, because PFFS plans operate primarily in low-cost areas that receive “floor” payments, Medicare payments to PFFS plans are well in excess of the costs of Medicare-covered services.**

Congress has also been ambiguous about whether the purpose of providing beneficiaries with a choice of private health plans in Medicare is to coordinate their health care, or simply to make available any private insurance alternative to original Medicare. Initially, many proponents of private health plans envisioned managed care plans that would improve health care by coordinating services provided to beneficiaries. Given the difficulty of sustaining managed care plans in rural areas, Congress and the Administration have turned instead to insurance models that offer little, if any, care management. These alternative forms of private insurance include PFFS plans and the PPO demonstration project.

Because we know relatively little about these “less-managed” forms of private insurance, it is difficult to assess their impact. As we discuss in Chapter Three, early experience suggests that plans like Sterling offer less financial security than M+C coordinated care plans. While no data are yet available regarding enrollee satisfaction with these plans, experience from employer-based insurance has found lower levels of satisfaction in these less managed insurance plans; performance of these plans is particularly problematic for people with more serious or chronic health problems (Druss et al. 2000). Since these sicker enrollees have health needs more like those of the Medicare population, and since they were twice as likely to be dissatisfied with more open-ended forms of managed care than they were in more conventional HMOs, this may not bode well for the expected performance of comparable plans in Medicare+Choice.

At this point, it is still too early to gauge how beneficiaries will judge PFFS plans and the PPO demonstrations. To date, only about 20,000 beneficiaries are enrolled in a PFFS plan and approximately 56,000 are enrolled in the PPO demonstration (Data furnished by CMS for NASI). In Sterling, the only PFFS plan that currently has enrollees, beneficiaries mainly reside in areas where they do not have access to a coordinated care plan. Although they are receiving few additional benefits beyond those covered by original Medicare, a PFFS plan may be a less

costly alternative than Medigap. And some PFFS plans may be particularly advantageous for beneficiaries in poor health, who cannot afford Medigap premiums. Further, should they decide to disenroll from Sterling, they have access to a community-rated Medigap plan offered by Sterling.

While PFFS plans may be advantageous for some beneficiaries, Medicare payments to PFFS plans are considerably higher than they would be if beneficiaries stayed in original Medicare. This is because Sterling operates primarily in “floor” counties where the M+C payment rate exceeds the cost of providing Medicare-covered services to beneficiaries. In addition, Sterling has received bonus payment of 5 percent in the first year and three percent bonus in the second year for offering a plan in an area not served by another M+C plan.

**Finding 5: Even with unstable participation, caused in part by constrained Medicare payment rates, the participation of private health plans in Medicare has brought certain benefits to the program as a whole.**

The study panel believes that private health plans have an important place in Medicare. But there is a real need to clarify the benefits that can be realistically achieved through their involvement. We document some of the benefits for individual enrollees in the next two chapters of this report. Other benefits accrue to the program as a whole. The historical record demonstrates at least two of these programmatic benefits. Both involve the role that private health plans have played in “signaling” problems that had long been a part of original Medicare, but have been consistently overlooked by policy-makers.

The first involved the gaps in coverage. Medicare benefits were originally modeled on the types of health care paid by private insurers in the mid-1960s. As prevailing medical practices have changed, services covered by private insurers have adapted to these changes. But original Medicare has lagged behind. As M+C offered supplemental benefits, their appeal to Medicare beneficiaries was dramatically illustrated. Coverage of prescription drugs provides one clear example. Until 1990, virtually no Medicare plans offered prescription drugs as a supplemental benefit. As drug costs and use rose for the elderly, this coverage became more attractive and much more common among M+C plans. It was found in about half the plans by 1995 (see Table 2.2) and peaked at 84% of all plans in 1999 (See Table 2.7). This dramatic growth captured policy-makers’ attention and was instrumental in stimulating the ongoing debate about the need for these benefits in original Medicare. The subsequent reductions in availability and depth of coverage further illustrate some of the challenges of managing this benefit in a cost-effective, but equitable manner. In this way, M+C plans provide an important “laboratory” in which one can identify important ongoing changes in service needs.<sup>41</sup>

The second programmatic benefit involved geographic disparities in spending on health care. These have long been evident in original Medicare (and the health care system as a whole) and are of substantial magnitude. Health care spending on beneficiaries living in some parts of the country is, on average, two to three times as high as spending in other parts of the country, with no apparent difference in health outcomes (Wennberg, Fisher, and Skinner 2002). As we'll discuss in chapter three, these spending differences have important implications for Medicare, as well as the financial security of beneficiaries. But they tended to go unnoticed in original Medicare. However, when translated into large differences in payments to health plans, these geographic differences became matters of considerable controversy. Although the appropriate resolution remains a matter of intense debate, we consider it a valuable consequence of M+C that it has illuminated these geographic disparities and led policy-makers to consider how they ought to be addressed.

**Finding 6: The way M+C plans are currently paid does not rely on market forces. The payment structure established by Congress is an administered-pricing system, not a market-based system.**

The study panel believes that way Congress has set payments for private health plans in law is fundamentally flawed and counterproductive. Payments to plans have rarely reflected the actual costs of providing Medicare-covered services. In the years when payments were set at 95 percent of FFS payments, private health plans were paid more than it cost them to provide Medicare-covered services. When Congress responded to these overpayments by limiting updates to plans in the BBA, the end result was a decline in participation in private health plans, the exact opposite of what Congress intended. As the Center for Studying Health System Change has pointed out, Congress put the brakes on Medicare payments to private health plans in the BBA just as their costs began to rise rapidly. Twice since the passage of the BBA, Congress increased payment rates in unsuccessful attempts to reverse declining plan participation and enrollment.

Although Congress clearly intended to make the Medicare managed care program responsive to changes in the market for managed care services, it has not worked out that way, and seems unlikely to do so in the future. Institutionally, Congress was designed to be a deliberative body, and changes in law are not made easily. Congress cannot respond to rapidly changing market conditions or fully anticipate emerging changes in the market. The lesson the study panel draws from these experiences is not that Congress erred in setting payment rates, but that setting payments in law is an inherently faulty strategy when market forces are involved. Therefore, if Congress wants market forces to work in Medicare, then it must allow the market to set the prices, rather than setting payment rates in law. Later in this report, the study panel will suggest ways this might be accomplished.

The study panel wishes to caution, however, that injecting market forces in Medicare might not necessarily result in lower Medicare spending for private health plans than in original Medicare, depending on the level of FFS payments. For example, the BBA constrained Medicare FFS payment rates to the point that actual Medicare spending fell in 1999. Payments to plans were based on FFS payment rates, with an update. At that point, Medicare payments to plans were lower than their cost experiences in the private sector. If market forces had been used to set the rates then, payments to plans would likely have been higher than the payment rates Congress established. The same situation might occur now. Health care spending is still rising rapidly, and many plans have withdrawn from Medicare because of its low payment rates. Therefore, market-based payments might be higher than those paid in original Medicare.

**Finding 7: The entrance and exit of private health plans in Medicare, whatever the cause, results inevitably in disruptions in access to care and continuity of care, as well as changes in coverage of extra benefits.**

In its review of the managed care marketplace, the study panel was struck by both its volatility and cyclical nature. In both the late-1980s and late-1990s, the Medicare managed care program was roiled by volatility in the private insurance market. In the 1980s, the volatility was less obvious because continuing growth in Medicare managed care enrollment masked it. There was no mistaking its effects on Medicare in the late 1990s. The fledgling M+C program was buffeted by withdrawals and instability just as it was launched. While a good measure of the initial instability was probably attributable to the BBA spending reductions, analyses have also shown that market forces factored in plans' decisions about M+C participation. Factors totally outside the government's control, such underlying increases in health care costs, plans' inability to build and sustain provider networks, business strategies, and both the private and Medicare penetration in local markets, weighed in their decisions about whether to remain in M+C.

Similarly, turnover of physicians affiliated with M+C plans does not appear to be much affected by the level of Medicare payments to health plans. Physician turnover, for example, is above the national average in both Florida and Massachusetts, two states in which M+C payments to plans tend to be quite high. But clearly local market conditions and managed care practices matter greatly for physician turnover: there is a nine-fold difference in turnover rates between the state with the lowest average (Minnesota) and the states with the highest (Nevada and Wisconsin). And these are state averages — there is even more variance among health plans within given states.

Another factor clearly outside the government's control is the commercial underwriting cycle. In particularly inauspicious timing, just after the M+C program became operational, the commercial insurance underwriting cycle led plans to retreat from their strategy of the mid-

1990s of increasing market share. Instead, they retrenched and focused on increasing profitability, which led to widespread withdrawals from M+C for the next few years.

Congress reacted to unstable participation by private health plans by trying to shore up the M+C program through increased payments and regulatory flexibility. These efforts proved unsuccessful and, in hindsight, probably never had much chance of succeeding. Analyses of the determinants of plan withdrawals suggest that payment rates and regulatory demands were only two of many factors that undermined participation. And even if plan participation had been completely stable, there would still have been substantial turnover of physicians affiliated with given health plans.

In the study panel's view, the key lesson is that considerable volatility is inevitable with private health plans. Although the panel expects that moving to a more market-based pricing would increase the probability that there will be some continued managed care involvement in any given community, it offers no guarantees at all that particular plans will continue to participate. We considered at some length additional policies that might bring greater stability to Medicare+Choice. But we rejected each as being either impractical or potentially counterproductive.

For example, studies suggest that non-profit health plans or those that are locally controlled (as opposed to being owned by a large national corporation) have far more stable involvement with the Medicare program. But it seemed infeasible to restrict Medicare contracting to these types of plans, because they represent a declining share of the managed care industry. Similarly, plans that have a large local market share also have more stable participation. If the goal of M+C is simply to offer one private plan as an alternative to original Medicare, one could stabilize the program by contracting with a single private plan in each community. But this reduces beneficiaries' choice among plans and obviates any chance for competition to improve plan performance.

The study panel also explored regulatory requirements that might increase the stability of private health plan involvement. Long-term contracts between Medicare and the health plans were considered, but rejected, on the grounds that requiring plans that were losing money on Medicare beneficiaries to continue participating might only lead to potentially dangerous reductions in quality of care.

Given our inability to identify any policies that could realistically reduce the volatility of private plan involvement with Medicare, we concluded that this instability was a fundamental feature of

markets among health plans. This conclusion was reinforced by the experience of private employers, who often report considerable flux in the managed care market.

But it is essential to recognize that the Medicare population is crucially different from the employed population. With a much higher level of chronic illness (particularly among the oldest-old and disabled beneficiaries), continuity is an essential attribute of good quality medical care (Eichner and Blumenthal 2003). But this is seriously threatened by the instability of private insurance plans. As reported earlier, when a plan drops out of the program, half of the beneficiaries who had been seeing a specialist were forced to discontinue care. Almost a quarter were forced to change their primary care provider; the same number delayed care that they needed because they were concerned about medical costs. Similarly, when plans drop a beneficiary's personal physician, the enrollee may be unable to follow their doctor back to original Medicare without jeopardizing their access to affordable supplemental insurance. Given the choice between continuity of care and adequate coverage, the former is likely to suffer.

## NOTES

<sup>1</sup> The name of the agency that runs Medicare was changed from the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS) in 2001; in this report, the agency is referred to as HCFA or CMS, depending on the date.

<sup>2</sup> Medicare Part B covers physician and other outpatient services. Part A covers inpatient hospital and other institutional services.

<sup>3</sup> The historical discussion of the Medicare risk contracting program is distilled from several sources: (GAO 1989a, Merlis 1995, Merlis 2001).

<sup>4</sup> Known as the 50/50 rule, its purpose was to ensure that Medicare and Medicaid beneficiaries were not segregated into plans inferior to those available to privately insured individuals.

<sup>5</sup> This ultimately proved to be a less reliable source of savings than envisioned.

<sup>6</sup> The 19 states were: Alaska, Arkansas, Delaware, Georgia, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, Tennessee, Utah, Vermont, West Virginia, and Wyoming.

<sup>7</sup> In 1995, payment rates ranged from \$177.32 to \$678.90.

<sup>8</sup> The Financial Accounting Standards Board (FASB) adopted new standards in 1992 that required employers with 500 or more employees to treat obligations for retiree health insurance as a one-time expense. Prior to the release of these standards, most employers had treated these expenses on a pay as you go basis. Following the release of the FASB standards, many employers took a one-time write off of retiree health obligations. The new standards probably contributed to the decline in the percentage of employers offering retiree health coverage, while other employers turned more to managed care to help control the costs of retiree health care.

<sup>9</sup> The federal budget had not been balanced since 1969.

<sup>10</sup> This projection is based on the intermediate assumptions of the Trustees.

<sup>11</sup> In the budget resolution, Congress sets forth its recommended budget for the next year, and directs the committees with jurisdiction over programs to report back legislation that meets the spending targets established in the budget resolution. After the committees report legislation, the Budget Committee combines the bills into one, which is typically referred to an omnibus budget reconciliation bill. When the House of Representatives and the Senate have each passed budget bills, the two sides confer to negotiate over the differences in the bills. The end result of that is the conference agreement, which is voted on by both chambers and then sent to the President.

<sup>12</sup> This discussion is derived from a 1997 Congressional Research Service Report, *Medicare: The Restructuring Debate in the 104<sup>th</sup> Congress*.

<sup>13</sup> Congressional Record, October 19, 1995.

<sup>14</sup> Congressional Record, November 17, 1995.

<sup>15</sup> Following the terms of the bipartisan budget agreement, reconciliation instructions called for inclusion of these elements regarding managed care: creation of new health plan choices for beneficiaries, including PSOs and PPOS; an education campaign to give beneficiaries comparative information about health plan choices, and changes in managed care payment methodology to reduce geographic disparities in payments. Although the instructions called for these elements, the committees were legally bound only by the budget reduction target, and were therefore free to design their own methods of meeting the target.

<sup>16</sup> Other changes in law reduced the net savings from \$115 billion to \$112 billion.

<sup>17</sup> This section of the report focuses on the BBA's provision on private health plans. For more information about other Medicare provisions of the BBA, see the 1997 Congressional Research Service Report, *Medicare Provisions in the Balanced Budget Act of 1997*.

<sup>18</sup> Total reductions to M+C plans were \$27.5 billion, but they were offset by some increases in spending. For example, spending was projected to increase by \$2.2 billion as a result of provisions designed to reduce geographic payment disparities.

<sup>19</sup> Coordinated care plans are defined as those that provide a full range of services through a network of providers; an HMO is the most typical form of coordinate care plan.

<sup>20</sup> It also eliminated the "50/50" rule established in TEFRA.

<sup>21</sup> See the NASI report: (King et al. 2002)

<sup>22</sup> However, CBO acknowledged that some factors could mitigate against rising enrollment. Reductions in the capitation rates would cause managed care rates to rise more slowly than FFS rates, potentially eroding the additional benefits provided by many plans. The new preventive services in FFS might also encourage some beneficiaries, who otherwise might have chosen managed care, to remain in fee-for-service.

<sup>23</sup> The payment provisions of M+C took effect in 1998, but most of the other M+C provisions did not take effect until 1999.

<sup>24</sup> A 1998 GAO analysis of plan withdrawals found that withdrawals were not limited to counties with low payments. In fact, they found that 91 percent of high payment counties experienced a withdrawal, compared to 34 percent of low payment counties. GAO suggested that a portion of withdrawals may have resulted from plans' decisions that they could not compete effectively in that area, and other withdrawals may have occurred because they were unable to establish effective provider networks (GAO 1999a).

<sup>25</sup> This was evidenced by the fact that most M+C plans did not charge a monthly premium and only a small co-payment. Further, most plans were providing additional benefits such as prescription drugs, and routine physical, eye, and hearing exams.

<sup>26</sup> CBO estimated that it would increase Medicare spending by \$15 billion from FY 2000 to 2004. Of that amount, \$1.9 billion went directly to M+C, with another \$2.9 billion flowing indirectly to M+C plans through increases to FFS providers.

<sup>27</sup> The BBA stipulated that plans could not enter into an M+C contract if they had terminated an M+C contract in that county within five years.

<sup>28</sup> GAO said, "Some industry representatives have suggested that the BBA's payment reforms were too severe. They point to the recent plan withdrawals to support their claims that the Medicare+Choice payment is in danger...the seeming paradox between our findings and the industry's position is resolvable. Medicare+Choice plans are being paid too much for what was originally intended — providing beneficiaries the package of Medicare-covered benefits at less cost than the traditional FFS program. However, Medicare+Choice plans may not be paid enough for what they have been offering to attract beneficiaries—a more comprehensive benefit package beyond that covered for FFS beneficiaries for only modest or no premiums" (GAO 2000c).

<sup>29</sup> CBO estimated that it would increase Medicare spending by \$32.3 billion from FY 2001 to—2005, with one-third of that, \$11.2 billion, for M+C plans.

<sup>30</sup> Different minimum payment amounts were set for areas outside the fifty states and the District of Columbia.

<sup>31</sup> This requirement only applies if the plan uses model language specified by the Secretary.

<sup>32</sup> Unpublished CMS data provided to NASI.

<sup>33</sup> Original Medicare places limits on the amount that some providers may bill beneficiaries in excess of the Medicare payment amount (referred to as balance billing), and totally prohibits Part A providers and some other providers from balance billing.

<sup>34</sup> Sterling has three plan options, but most beneficiaries are enrolled in option one. For purposes of simplifying the discussion, that is the option described here.

<sup>35</sup> Unpublished CMS data provided to NASI.

<sup>36</sup> Unpublished CMS data provided to NASI.

<sup>37</sup> This discussion is derived from several studies: Gold and McCoy 2002; Grossman, Strunk, and Hurley 2002; and Stuber, Dallek, and Biles 2001).

<sup>38</sup> A CMS analysis, CMS 2001, comes to a similar conclusion about the underwriting cycle.

<sup>39</sup> This discussion focuses only on the differences between the House and the Senate bills regarding the use of private health plans in Medicare.

<sup>40</sup> Marsha Gold and John McCoy, "Choice Continues to Erode in 2002". Monitoring Medicare+Choice: Number 7 Mathematica Policy Research, January 2002.

<sup>41</sup> This benefit carries with it one important caveat. M+C plans are not likely to offer supplemental benefits that attract disproportionately unhealthy enrollees. Consequently, while services like enriched home care may prove most valuable to Medicare beneficiaries, they will typically not be incorporated as supplemental benefits (Shaughnessy, Schlenker, and Hittle 1994). The bottom line is that policy-makers can use markets to help identify certain service needs, but other measures should be used as well.



# Chapter 3:

## Private Health Plans and the Conventional Goals of Medicare

As chapter two revealed, efforts to incorporate private health plans into Medicare have had a turbulent history. Amid continuing shifts in market conditions, plan characteristics, and program requirements, it has been difficult to assess the contribution of private health plans to meeting the program's goals. In this chapter, we evaluate the potential for private health plans to enhance Medicare's capacity to provide beneficiaries with access to, and choice among, a financially affordable set of health care services. More specifically, we consider the track record of both original Medicare and M+C in meeting four objectives: (1) ensuring financial security for beneficiaries, (2) promoting timely access to needed medical care, (3) providing beneficiaries with desired choices, and (4) achieving these three goals in a cost-efficient manner. We also assess whether private health plans could mitigate some of the shortcomings in the performance of FFS Medicare.

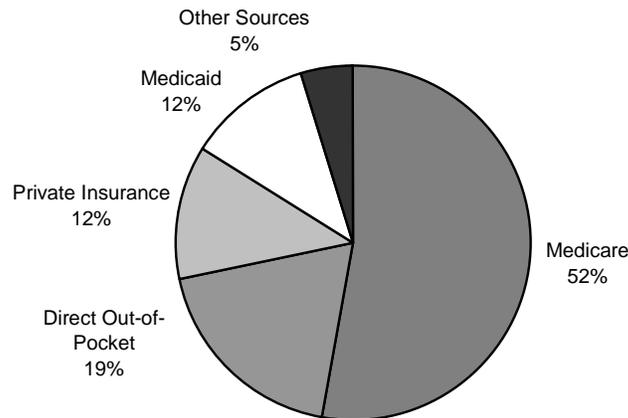
### THE GOAL OF FINANCIAL SECURITY

Protecting beneficiaries from the potentially ruinous costs of medical care is perhaps the most fundamental mission of the Medicare program. When Medicare was enacted, its purpose was to provide elderly people with health coverage comparable to that of working age Americans. When eligibility was extended to disabled people in 1972, so too was its promise to provide them with comparable financial security. Original Medicare, however, has fallen short of its promise. From its inception, it has never paid for a sufficient range of services and, over time, the gap between Medicare coverage and private health insurance coverage has widened. It has required beneficiaries with chronic and severe conditions to shoulder a significant percentage of their medical expenses.

As shown in Figure 3.1, overall health care spending per Medicare beneficiary was \$9,573 in 1999, with Medicare paying slightly more than half (\$5,043) (CMS 2003). Beneficiaries paid 19 percent out-of-pocket, with Medicaid and private health insurance (including Medigap) each paying 12 percent, and other sources paying the remaining 5 percent. Of the \$115 billion in out-of-pocket spending by beneficiaries, 21 percent was for private health insurance premiums, 15 percent for the Medicare Part B premium, and the remaining 64 percent in direct out-of-pocket spending. Of direct out-of-pocket expense, 27 percent was for Medicare cost sharing,

**Figure 3.1**

**Sources of Payment for Medicare Beneficiaries' Medical Services, 1999**



Overall Medical Expenses per Medicare Beneficiary = \$9,573

Source: CMS 2003.

and 73 percent was for services not covered by Medicare, including long-term care (41 percent), prescription drugs (21 percent), dental care (10 percent), and home health care (1 percent).

**The Scope and Limits of Medicare Coverage**

Beneficiaries pay a considerable portion of their own health care expenses because Medicare does not cover all the services Medicare beneficiaries need, and because Medicare does not have an annual limit on out-of-pocket spending. In general, Medicare covers health care services needed for the diagnosis or treatment of illness or injury. Most preventive services are not covered, although Congress has added some preventive benefits in the last decade. Table 3.1 shows services not covered by Medicare.

Two important benefits Medicare does not cover are long-term care (except in limited amounts) and outpatient prescription drugs. Long-term care services are very expensive, with relatively few beneficiaries able to afford them from their own resources. Some beneficiaries using long-term care services become Medicaid eligible after depleting their own resources, while a relatively small percentage of beneficiaries receive benefits through private long-term care insurance.

**Table 3.1**

**Products and Services Traditional Medicare Does Not Cover**

Outpatient prescription drugs (with limited exceptions)
Routine or annual physical exams
Hearing exams and hearing aids
Routine eye care and most eyeglasses
Dental care and dentures (in most cases)
Screening tests (except for those specifically identified by Medicare)
Routine foot care (with limited exceptions)
Orthopedic shoes
Vaccinations (except for those specifically identified by Medicare)
Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home
Acupuncture
Cosmetic surgery
Health care received while traveling outside of the United States (except in limited cases)

Note: Medicare provides drugs not usually self-administered, oral anti-cancer drugs, drugs used following an organ transplant, erythropoietin for beneficiaries on dialysis, and injectable drugs used for treatment of postmenopausal osteoporosis. Screening tests covered by Medicare include bone mass measurement for some at-risk beneficiaries; colorectal cancer screening; glucose monitors, test strips, and lancets for all diabetics; diabetes self-management training for at-risk diabetics; glaucoma screening for at-risk enrollees; mammograms; Pap tests for pelvic exams (including clinical breast exams) for all women; and prostate cancer screening for all men age 50 and over. Vaccinations covered by Medicare include those for flu, pneumococcal pneumonia, and hepatitis B (for those at medium to high risk).

Source: MedPAC 2002.

Lack of prescription drug coverage poses serious problems for Medicare beneficiaries. More than a third of Medicare beneficiaries without any source of drug coverage from another source reported that they skipped doses or did not have prescriptions filled because of cost concerns

(The Commonwealth Fund 2002). Low-income seniors without other drug coverage are particularly hard hit, with 42 percent reporting skipped doses or unfilled prescriptions.<sup>1</sup>

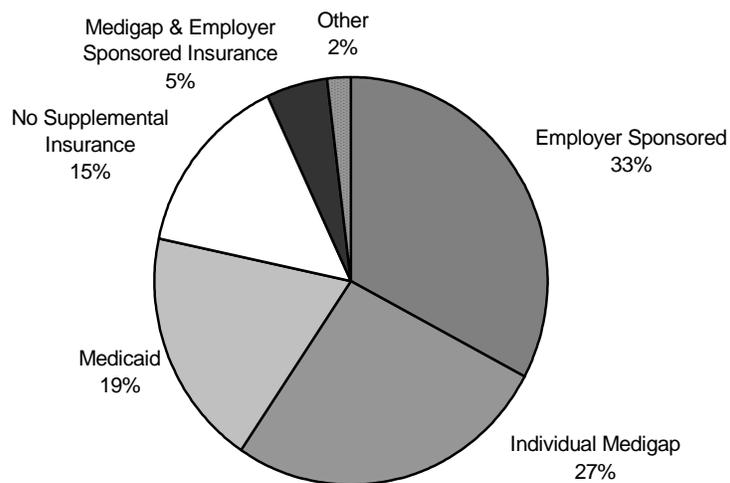
### Supplements to Medicare

Given the inadequacy of Medicare benefits, most beneficiaries have insurance that supplements Medicare coverage, as shown in Figure 3.2. In 2000, the most common form of supplemental insurance was employer-based retiree coverage, which 33 percent of beneficiaries had (CMS 2003). Twenty-seven percent of beneficiaries had Medicare supplemental (commonly referred to as Medigap) insurance, with 5 percent of beneficiaries having both employer-sponsored and individual Medigap insurance. Medicaid served as supplemental insurer to 19 percent of beneficiaries, and 15 percent of beneficiaries had no supplemental insurance at all.

**Employer-Sponsored Coverage.** In 2002, 34 percent of all firms with at least 200 workers offered health insurance to retirees (Kaiser Family Foundation and Health Research and Educational Trust 2002).<sup>2</sup> However, coverage for retirees varies greatly by firm size, with only 5 percent of small firms (3-199 employees) providing coverage, compared to 30 percent of

Figure 3.2

Types of Supplemental Health Insurance Held by Fee-for-Service Medicare Beneficiaries, 2000



Note: Medicaid (shown above) includes both Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs).

Source: CMS 2003.

midsize firms (200-999 employees) and approximately 50 percent of firms with 1,000 or more employees. Coverage also varies widely by industry type, with retirees from financial firms; state and local governments, and the transportation, communication, and utility sectors far more likely to provide coverage than the mining, construction, wholesale firms, or retail and manufacturing sectors.

Over time, retiree health coverage has eroded slowly. In 1988, 66 percent of all large firms (at least 200 employees) offered retiree health benefits, compared to 34 percent in 2002. The percentage of all large firms offering coverage to Medicare eligible retirees fell from 80 percent in 1999 to 72 percent in 2001, with further declines likely (Kaiser Family Foundation and Health Research and Educational Trust 2002). In the 2002 Annual Survey of Employer Health Benefits, 14 percent of all firms said they were likely to eliminate retiree health benefits for new employees or employees who have not yet retired in the next two years (Kaiser Family Foundation and Health Research and Educational Trust 2002).

Retirees who have employer-sponsored coverage tend to have fairly comprehensive benefits, although there are harbingers of retrenchment. Currently, coverage generally includes payment for Medicare coinsurance and deductibles, outpatient prescription drugs, and vision and dental benefits. In 2001, 99 percent of Medicare-eligible retirees had coverage for prescription drugs, although the level of benefits varies by the firms' size, region and industry (Kaiser Family Foundation and Health Research and Educational Trust 2000 and Commonwealth Fund 2002).

In the last couple of years, employers have reduced health insurance benefits offered to retirees. For example, more than one-half of employers said they increased retirees' share of premiums, nearly one-third increased cost sharing for prescription drugs, and almost 20 percent introduced three-tiered cost-sharing formulas for drugs in the last two years. In 2002, nearly 40 percent of employers said they were likely to increase retirees' share of premiums in the next two years, one third said they were likely to increase co-payments for prescription drugs, and 16 percent said they would introduce three-tiered cost-sharing for drugs (Kaiser Family Foundation and Health Research and Educational Trust 2002).

**Medigap Policies.** Medigap insurance is private insurance designed to wrap around Medicare coverage.<sup>3</sup> Individuals purchase most Medigap policies, but approximately 25 percent are group policies obtained through an employer or an association, such as AARP. In 1990, Congress passed legislation that required new Medigap policies to conform to one of ten standards, which are referred to as policies A through J.<sup>4</sup> Policies A through G generally cover Medicare cost-sharing and deductibles, but little in the way of additional benefits, as shown in Table 3.2. The most popular plan, Plan F, enrolls 35 percent of those with Medigap insurance; it covers few

additional benefits, compared to Plan C. Policies H, I, and J offer limited prescription drug coverage, subject to a \$250 annual deductible; 50 percent coinsurance; and an annual out-of-pocket limit of \$1,250 for Plans H and I and \$3,000 for Plan J. Together, Plans H, and I, and J cover about 9 percent of enrollees.

Beneficiaries who purchase Medigap policies tend to be older, female, white, more educated, and wealthier than beneficiaries without policies. Medigap is more prevalent in rural areas, where beneficiaries have less access to other forms of supplemental insurance. For example, in 1999, 39 percent of beneficiaries in rural areas had Medigap, compared to 23 percent of beneficiaries in urban areas.

Medigap insurers are required to enroll any aged Medicare beneficiary, regardless of health status, who applies for a policy within six months of becoming eligible for Medicare, which is referred to as open enrollment or guaranteed issue. Congress has also required insurers to guarantee the issue of Plans A, B, C, or F to Medicare beneficiaries under certain limited circumstances, including the following:

- They were disenrolled when an M+C plan leaves their service area;
  - They lose employer-sponsored coverage;
  - They are enrolled in a Medigap policy that goes bankrupt;
  - They are forced to disenroll from an M+C plan because the plan goes out of business, commits fraud, or they leave the plan's service area; and
  - They voluntarily disenroll from an M+C plan within a year of enrollment.
- Beneficiaries who joined an M+C plan for the first time and want to leave within a year must also be readmitted to their original Medigap plan, if available, or have the right to purchase Plans A, B, C, or F.

After age 65, very few insurers guarantee issue plans to aged Medicare beneficiaries. In 1999, only 18 percent of Medigap policy-holders were in standard plans that guarantee issue. Notably, disabled beneficiaries have no federal rights to guaranteed issue of Medigap plans, and most disabled beneficiaries experience difficulty obtaining a Medigap policy. In 1999, only 11 percent of policy-holders were in plans that accepted disabled beneficiaries.

Table 3.2

**Benefits, Enrollment, and Average Premiums in Standardized Medigap Plans, 2000**

Benefits, enrollment, and premiums	Standardized Medigap Plan									
	A	B	C	D	E	F	G	H	I	J
Cost Sharing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Part A hospital coinsurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
365 additional hospital days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Part B coinsurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Part A deductible		<input type="checkbox"/>								
Part B deductible			<input type="checkbox"/>			<input type="checkbox"/>				<input type="checkbox"/>
Skilled nursing facility co-payments			<input type="checkbox"/>							
Part B balance billing						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Additional benefits										
Foreign travel			<input type="checkbox"/>							
Home health care				<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Preventive medical care					<input type="checkbox"/>					<input type="checkbox"/>
Prescription drugs								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enrollment	10%	10%	26%	6%	2%	35%	3%	2%	3%	4%
Average Monthly Premium	\$87	\$88	\$106	\$98	\$95	\$110	\$87	\$109	\$159	\$176

Note: Percentages do not sum to 100 because of rounding.

Source: MedPAC 2002.

Medigap premiums vary widely for several different reasons: geographic differences in health care costs; state access and consumer protection laws and regulations; and underwriting practices. For example, Medigap policy-holders in California, Florida, and Indiana paid more than \$1,600 per year, compared to policy-holders in New Hampshire, Pennsylvania, and Utah, who paid less than \$900 per year. Policy-holders in Montana paid an average annual premium of just \$244 (Chollet and Kirk 2001).

In Medigap, insurers are permitted to underwrite policies or charge different rates based on the health status and age of beneficiaries. Medigap insurers generally use two kinds of age rating: issue age rating and attained age rating. Under issue age rating, insurers set premiums based on the age of the beneficiary when the policy is issued, which makes it difficult for older beneficiaries to buy a policy for the first time.<sup>5</sup> Under attained age rating, insurers base premiums on the current age of the beneficiary, which also makes premiums considerably more expensive for older beneficiaries. Under community rating, which AARP uses in most of its Medigap policies, all beneficiaries are charged the same amount in a market area, regardless of their age or health status.<sup>6</sup> Six states have prohibited issue age rating, and 8 have required community rating. However, some opponents of community rating have argued that younger beneficiaries subsidize older beneficiaries, making community rated premiums less affordable for younger beneficiaries.

Medigap policies are subject to varied criticisms. They may not be accessible to disabled beneficiaries, or to aged beneficiaries once they pass their first year of enrollment. Underwriting practices in Medigap lock most policy-holders into both a specific carrier and a specific policy essentially for life, without a viable option to change either carriers or policies. While Medicare beneficiaries whose plan quits the program are guaranteed some access to Medigap policies, underwriting practices may make the purchase of a plan prohibitively expensive. Some experts have also said that Medigap insurance is of questionable value because the premium (net of administrative costs) closely approximates the benefit that most Medicare beneficiaries receive from policies.<sup>7</sup> However, the benefits may be of psychic value to risk-averse beneficiaries.

**Medicaid Programs.** Medicaid supplements Medicare for low-income beneficiaries. To be fully eligible for all Medicaid benefits, Medicare beneficiaries must fit in one of these three eligibility categories:

- A recipient of Supplemental Security Income (SSI);

- A Medicaid beneficiary whose eligibility stems from enrollment in the state’s optional “medically needy” program or whose income is less than 300 percent of the SSI income eligibility level; or
- A Medicaid beneficiary enrolled in a home and community-based services demonstration waiver, or enrolled in Medicaid through state options that allow more generous income and resource limits.<sup>8</sup>

Medicare beneficiaries who meet one of these criteria (referred to as dual eligibles) are entitled to the full range of Medicaid benefits offered in the state where they live. Medicaid is the payer of last resort and is responsible for all Medicare premiums, coinsurance, and deductibles. States may only require Medicaid beneficiaries to make nominal co-payments for services. Federal law requires states to cover certain services, such as hospital and physician services and long-term care, and permits states to cover a broader range of services. Most Medicaid programs are an important source of long-term care coverage for Medicare beneficiaries. Although they are not required to do so, most Medicaid programs also cover outpatient prescription drugs, subject to restrictions.

Medicare beneficiaries who meet one of the Medicaid categorical eligibility requirements and whose incomes are higher than Medicaid eligibility levels, but still limited, may also qualify to have Medicaid pay for some of their premium or cost-sharing requirements. Over time, Congress has gradually increased the income levels at which Medicare beneficiaries can receive some Medicaid assistance. The current standards provide for the following:

- Beneficiaries whose incomes do not exceed 100 percent of the federal poverty level and whose assets do not exceed twice the SSI limit are eligible to have Medicaid pay their Medicare premiums, deductibles, and coinsurance;
- Beneficiaries whose incomes are between 100 and 120 percent of the federal poverty level are eligible to have Medicaid pay their Medicare Part B premium;
- Beneficiaries whose incomes are between 120 and 135 percent of the federal poverty level are eligible for payment of the Part B premium; and
- Beneficiaries whose incomes are between 135 and 175 percent of the federal poverty level are eligible for some subsidy of their Part B premium.<sup>9</sup>

Medicare beneficiaries who are fully eligible for all Medicaid benefits have the most comprehensive supplemental coverage possible, including coverage for all Medicare out-of-

pocket payments and premiums, and access to a very comprehensive health insurance program, which includes both long-term care and prescription drugs.

Although a substantial number of low-income beneficiaries are eligible for Medicaid coverage of Medicare's cost sharing requirements or premiums, a relatively small proportion take advantage of these benefits. The take-up rates (proportion of eligible people who actually get benefits) range from 3 percent to 57 percent, depending on the program. Many of those who are eligible but not enrolled are not aware that they are eligible, or do not enroll because the application process is too complicated or cumbersome. But low enrollment also reflects other barriers. A survey of low-income beneficiaries who would have qualified but who had not enrolled for Medicaid benefits found that:

- 88 percent had not heard of the programs for which they were eligible;
- 42 percent had contacted a Medicaid office, but only 12 percent were told about the programs;
- Of the 12 percent informed about the programs, only 2 percent had actually applied for benefits. Many of those who did not were ashamed of needing a program for poor people, put off by the intrusive eligibility questions, or felt mistreated by the staff at the welfare office (Medicare Rights Center 2000).

### **Financial (In)Security for Beneficiaries Under Medicare's FFS Program**

The issue of financial security can be seen as two related questions: (1) What is a fair amount to expect a Medicare beneficiary in average health to pay on an annual basis? and (2) If beneficiaries experience serious health problems, how much will their financial liability increase? Even when average spending is relatively predictable, it can become a source of insecurity for beneficiaries if they simply do not have the resources to pay for medical care and other basic needs. But the greatest source of insecurity, obviously, is the threat of serious illness and correspondingly substantial out-of-pocket liabilities.

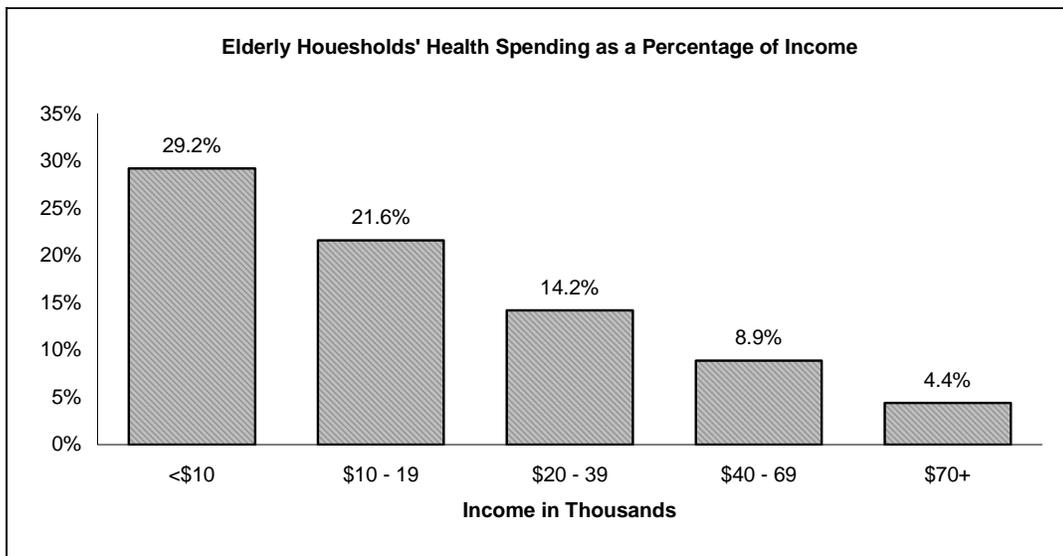
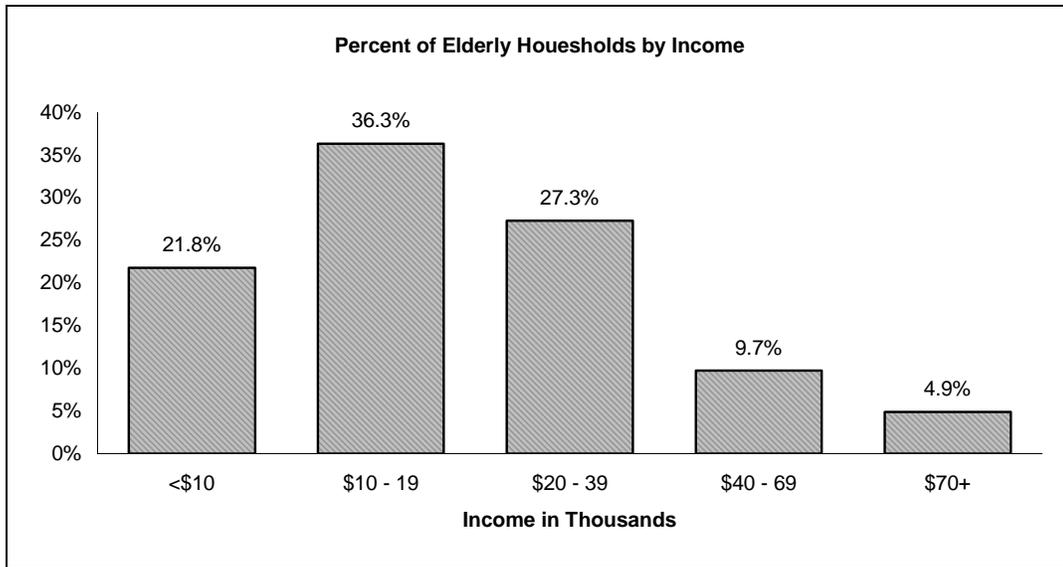
### **Average Spending for Medical Care For Different Groups of Beneficiaries**

In 2000, the average elderly beneficiary spent \$3,124 out-of-pocket for medical care. The average disabled beneficiary (of middle age) spent \$3,870. This spending represented 21 percent and 27 percent of their respective average incomes (Maxwell, Moon, and Storeygard, 2001). These financial burdens represent a proportionately larger share for beneficiaries with limited income, as shown in Figure 3.3. Elderly beneficiaries with annual incomes less than \$10,000 spent almost 30 percent of those incomes on health care (CMS 2003). One-fifth of all elderly Americans have incomes in this range.

Supplemental policies offer only limited assistance. Those who are eligible and enrolled in Medicaid had average out-of-pocket spending of only \$1,628 (Maxwell, Moon, and Storeygard, 2001). But since Medicaid eligibility is limited to low-income households, these expenses still represented more than 20 percent of their annual incomes. For those unable to

**Figure 3.3**

**Elderly Health Spending as a Percentage of Income, 2000**



Source: CMS 2003.

qualify for Medicaid, Medigap policies offer more predictable spending, but no reduction in out-of-pocket spending for the average beneficiary. Because these policies have large administrative overhead, their purchase actually increases the average out-of-pocket expenses for the typical beneficiary.<sup>10</sup>

### **The Impact of Poor Health**

The purpose of health insurance is to ensure that beneficiaries do not face ruinous expenses when they are seriously ill. Original Medicare fails to provide this sort of security for some beneficiaries, in part because they need services Medicare does not cover, most notably outpatient prescription drugs. One study estimated that elderly beneficiaries in poor health have out-of-pocket spending 50 percent higher than the average beneficiary, representing more than a third of their annual income (Maxwell, Moon, and Storeygard 2001). And if medical needs are particularly severe, the resulting financial liability can be calamitous. Ten percent of older Americans in poor health had to pay more than \$9,000 out-of-pocket for their medical care in the prior year (Maxwell, Moon, and Storeygard, 2001).

Medicare beneficiaries are more vulnerable to large medical bills because original Medicare does not have an annual out-of-pocket limit, which has become standard in employer-based insurance over the past twenty years.<sup>11</sup> As of 1997, 79 percent of all employer-based policies had annual limits, with the most frequent policy capped between \$1,000 and \$1,500 (Maxwell, Storeygard, and Moon 2002). Supplemental policies can help limit financial liability, but they cover primarily cost-sharing requirements, which represent only about a quarter of the spending for beneficiaries in poor health.

The most severe financial burdens fall on the most disadvantaged — those who are both seriously ill and living in low-income households. Among the elderly, this is most common among oldest beneficiaries, who are disproportionately women. One study estimated that the typical 85 year-old woman in poor health and in a low-income household faced out-of-pocket costs for medical care that were more than half of her annual income (\$5,969 in 2000).

### **The Consequences for Beneficiaries' Sense of Financial Insecurity**

Under these arrangements, beneficiaries can hardly feel financially secure, and many do not. A survey conducted by the Commonwealth Fund found that 21 percent of Medicare beneficiaries worry that they would not be able to afford needed medical care (Schoen et al. 2000b). And supplemental policies are themselves becoming so expensive that they become an added source of concern. Among beneficiaries age 65-70, who are younger and healthier than the average beneficiary, 28 percent reported being very worried that they would not be able to afford to pay for their insurance in the future (Schoen et al., 2000a). But the insecurity is clearly felt most by

disabled beneficiaries, who are more likely to have serious and chronic health problems. Thirty-nine percent reported being unable to pay their medical bills; 33 percent reported that they had to change their way of life to pay those bills (Davis et al. 2002).

### **The Potential for Private Health Plans to Enhance Financial Security**

Greater financial security has long been a strong motivation for beneficiaries to enroll in Medicare managed care plans. Surveys conducted in the mid-1990s found that almost half (47 percent) of those joining a private health plan cited reduced medical costs as their primary reason (Nelson et al. 1996). Even though M+C plans have reduced supplemental benefits and increased premiums and cost-sharing requirements in recent years, they still represent a way for the average beneficiary to reduce out-of-pocket spending. The most recent estimates suggest that the out-of-pocket expenses of beneficiaries in a coordinated care plan in 2003 are 25 percent lower than the expenses of beneficiaries in original Medicare (without supplemental insurance) (Achman and Gold 2003).

However, out-of-pocket spending for other types of plans is higher. In PFFS plans and the new PPO demonstrations, out-of-pocket expenses are estimated to be 10 percent higher in 2003 than for beneficiaries in original Medicare (Achman and Gold 2003).

Between 1999 and 2003, the cost-saving advantages offered by coordinated care plans have been eroding. As discussed in chapter two, out-of-pocket spending doubled between 1999 and 2003 (Achman and Gold 2003). Premiums and cost sharing have increased while coverage of supplemental benefits has declined. It is impossible to determine how much of this erosion is a consequence of changes in law in M+C payments, and how much is in response to growing market pressures on M+C plans. Consequently, it is difficult to predict whether coordinated care plans will continue to retain their advantage in reducing financial liabilities for the average beneficiary.

Beneficiaries in poor health (most often, the disabled and the oldest old) do not enjoy the same level of financial protection as healthier enrollees in coordinated care plans. In the late 1990s, M+C coordinated care plans were particularly good financial choices for these beneficiaries, because the plans made limited use of cost-sharing requirements (accounting for roughly 80 percent of the savings in out-of-pocket spending). But this too has changed. Cost sharing for hospital and physician services in M+C coordinated care plans increased by 127 percent between 1999 and 2002. As a result, out-of-pocket spending for enrollees who were in poor health grew much faster (292 percent over these same four years) than for those in good health (62 percent). One study estimates that the 2003 out-of-pocket expenses of beneficiaries in poor health will be about 3.4 times higher than for those in good health (Achman and Gold 2003).

In sum, M+C coordinated care plans still retain some important advantages for beneficiaries in reducing out-of-pocket spending on medical care. Not surprisingly, M+C plans have been most attractive to beneficiaries with limited incomes. But these benefits were a consequence both of the fact that Medicare payments to M+C plans were higher than costs (through 1999) and plans' use of managed care techniques to control costs, both of which enabled them to keep cost-sharing low. Complaints from both providers and consumers led plans to relax restrictions on access to care at the same time that growth in Medicare payments to plans has been restricted. As a result, plans seem to be losing their advantage. Although it is difficult to predict how far this trend will progress, it is already the case that coordinated care plans no longer offer a safe financial haven for beneficiaries in poor health. Nor do other forms of private insurance promise much better protection. Financial insecurity remains a problem throughout the Medicare program.

### **THE GOAL OF (PLAN) CHOICE**

The inclusion of private health plans in Medicare adds new dimensions of choice — the ability to choose not just a physician, but a plan and a set of benefits, a network of providers, and a set of administrative practices that affect the care provided. But enrollment in an M+C plan both enhances and constricts choices of health care providers. Physicians and hospitals affiliated with a plan's network become more accessible to the beneficiary, while those who are not become less accessible

Greater choice of plans, one of the goals of the BBA, raises three questions: First, do beneficiaries value the ability to choose among health plans? Second, are beneficiaries willing and able to collect the information necessary to choose among plans in a reasonably well-informed manner? Third, how do choices among M+C plans relate to choices made in supplemental insurance markets?

### **The Salience of Plan Choice For Medicare Beneficiaries**

Several surveys have assessed beneficiaries' interest in plan choice. Their findings suggest limited interest, but considerably higher salience among the groups less satisfied with original Medicare. In 2000, one study estimated that only 15 percent of beneficiaries had given choice of plans any "serious thought" (Gold and et al. 2001). A second study concluded that about a quarter of all beneficiaries had some interest in obtaining information about private health plans, but that less than half of these were sufficiently motivated to actually think seriously about these choices (Levesque et al. 2000). Although interest was higher in communities in which M+C plans were available, even in these settings, only 16 percent of beneficiaries had given serious thought to their choices.

The most common reason for not considering a private health plan was satisfaction with original Medicare and supplemental policies (65 percent of all respondents), though other beneficiaries didn't consider the choice worth the effort (11 percent), were too confused about their options to even consider choosing (5 percent), or actively disliked HMOs (5 percent) (Gold et al. 2001). It thus appears that plan choice is not particularly important to most beneficiaries.

But these broad findings mask more intense interest among some groups of beneficiaries. Those whose are least well protected by existing insurance are far more likely to consider: 25 percent of those without a supplemental policy and 26 percent of disabled beneficiaries had given the choice some serious thought.<sup>12</sup> Beneficiaries with annual incomes under \$10,000 were a third more likely to give private health plans serious consideration than those with incomes over \$20,000. The option of considering a private plan thus provides a potentially important safety valve for those whose needs differ from the typical enrollee in FFS.

### **The Willingness and Ability to Make Informed Choices Among Health Plans**

If and when beneficiaries are motivated to consider a private health plan, they must be sufficiently informed to choose wisely between their M+C options and original Medicare. A number of studies have assessed beneficiaries' knowledge, as well as their confidence in making well-informed choices about health insurance. These studies demonstrate a pervasive lack of understanding and misinformation about even the most basic elements of original Medicare, let alone the more nuanced features of M+C plans.

Of course, one would not expect beneficiaries who haven't considered a private plan to spend much time learning about their options. More relevant is the level of knowledge among those who want to know about private alternatives to FFS Medicare. But findings from this group look equally problematic. Lack of understanding and confusion are not simply the result of beneficiary apathy, but emerge from the complexity of the choices, coupled with the limited cognitive and sensory capacities of some beneficiaries, particularly those whose health is most frail (Farley et al. 2002). While many beneficiaries are clearly capable and competent of choosing among health plans, others cannot be expected to make informed choices because of the consequences of aging and chronic illness.

### **Beneficiary Understanding of Medicare**

Each year, the Medicare Current Beneficiary Survey (MCBS) asks Medicare beneficiaries some questions about their understanding of Medicare. In 1999, the latest year for which data are available, nearly one third of beneficiaries reported that they knew all or most of the Medicare program information they needed to know (CMS 1999). But more than the third of

beneficiaries said they knew little or none of the information they needed. Beneficiaries over age 85, and those under 65 were the most likely to say that they knew little or none of the information they needed. Higher income beneficiaries (those with incomes over \$40,000) were twice as likely as those with incomes below \$10,000 to report having enough information. Similarly, more educated beneficiaries (those with some college education) felt they were better informed; 42 percent of this group said they had enough information, compared to 16 percent of beneficiaries with less than nine years of schooling.

In the MCBS, beneficiaries assess their own knowledge of Medicare. Other studies have tested that knowledge. A 1998 Kaiser Family Foundation/Harvard School of Public Health survey found high levels of basic understanding of Medicare. Of those over age 65, 66 percent knew that Medicare provides insurance to all those eligible, regardless of income; 86 percent knew that Medicare paid for hospital bills; 84 percent knew that Medicare covers doctor bills; and 63 percent knew that Medicare does not pay for prescription drugs. However, only 44 percent knew that Medicare does not pay for nursing home care (Kaiser Family Foundation and Harvard School of Public Health 1998). Similar findings were revealed in earlier studies (Mebane 2000).

In 1997, another survey, conducted before the advent of the M+C program, tested beneficiaries' knowledge of both FFS and managed care (Hibbard et al. 1998). Half of the sample was enrolled in FFS and half in risk-based HMOs. The survey consisted of two steps. The first (screening) assessment separated respondents into those who know almost nothing at all about managed care (those who failed the screening test) and those who passed the screening test by demonstrating some minimal knowledge of the difference between FFS and managed care. Thirty percent of all respondents failed the screening test, including 31 percent of respondents enrolled in managed care. Beneficiaries who failed the screening test were older, had lower incomes, lower education, more nights in the hospital, and fewer doctor visits.

Respondents who passed the screening test then participated in a knowledge test designed to assess whether respondents could distinguish the characteristics of managed care from FFS. The test takers got an average of 56 percent correct, but only 16 percent were judged to have adequate knowledge (at least 76 percent correct) to make an informed choice. More than 41 percent scored in the inadequate range (less than 50 percent correct) and 35 percent scored in the lowest quartile (equal to or worse than guessing). Compared to those who scored in the highest quartile, those in the lowest quartile were more often women, enrolled in an HMO, used fewer information sources, had less education, and lower incomes. These findings made the authors question whether beneficiaries would be able to cope with the impending implementation of M+C, and its wide range of choices.

Since the implementation of M+C, HCFA has attempted to determine how well both those enrolled in original Medicare and M+C understand their choices. Under contract to HCFA, Mathematica Policy Research, Inc. surveyed three groups of beneficiaries in the spring and summer of 2000: new members of a Medicare managed care plan; those who switched from one managed care plan to another; and a reference group of FFS beneficiaries (Mathematica Policy Research, Inc. 2001). They found that only 23 percent of new enrollees, and 26 percent of switchers and those in FFS reported that they knew just about everything they needed to know. About half in each group reporting knowing some or a little of what they needed to know, and about 25 percent reported knowing almost nothing.

As far as actual knowledge, a much larger proportion of switchers and new enrollees demonstrated a basic understanding of the program compared to FFS enrollees. About 75 percent of switchers and 70 percent of new enrollees know that if they leave a Medicare HMO, Medicare would still cover them. Only 41 percent of FFS enrollees understand this. Beneficiaries who read the Medicare handbook, *Medicare and You*, understand more than those who do not read it.

The question about whether they would be covered by Medicare after leaving an HMO was one of six used to ascertain basic knowledge of original Medicare and M+C. About 60 percent of the switchers, 56 percent of new managed care enrollees, but only a third of FFS beneficiaries answered 5 or 6 questions correctly.<sup>13</sup> In all three groups, older, less educated beneficiaries, and lower income beneficiaries were less likely than others to answer the questions correctly.

**Factors Limiting Beneficiaries' Understanding of Medicare.** A number of factors inhibit some beneficiaries' ability to understand Medicare. A 2000 Mathematica Policy Research survey of Medicare beneficiaries reported that 12 percent of beneficiaries are blind or have poor vision, even with correction. Another 19 percent said that their vision is only fair. Similarly, 9 percent of beneficiaries said that they are deaf, while another 15 percent reported fair hearing. About 4 percent speak a language other than English at home, with Spanish being most common (Gold et al. 2001).

Literacy problems also impair beneficiaries' ability to understand Medicare. The Mathematica study found that, among beneficiaries who graduated from high school and did not report vision problems, 17 percent said they had difficulty reading three or more of the following: newspapers, directions for taking medicine, health care forms, food package labels, recipes, and books. Forty one percent said they had problems with at least one of these activities. Another study of health literacy in Medicare managed care organizations found that a third of English-speaking beneficiaries, and more than half of Spanish-speaking had inadequate or marginal

health literacy.<sup>14</sup> Beneficiaries with inadequate health literacy were more likely to be black, older, less educated, and worked in a “blue collar” industry. Researchers found health literacy problems increasing with age. The prevalence of inadequate health literacy increased from 15.6 percent of beneficiaries between the ages of 65 and 69-years-old to 58 percent of those ages 85 and older (Gazmararian et al. 1999).

### **Assessing the Prospects for Better Informing Choice Among Health Plans**

It is important to emphasize that the widespread lack of information and misinformation identified in these studies was not simply a consequence of the issues not being salient for the beneficiaries in question. Those who are actually in M+C plans appear to be equally—and in some cases more—misinformed. The University of Oregon study found that Medicare beneficiaries currently enrolled in Medicare HMOs were actually less informed about plan choice than those who covered under original Medicare (Hibbard et al. 1998)

Nor can it be attributed solely to a lack of available information about M+C plans. The fundamental challenge rests neither in lack of interest nor lack of information, but in beneficiaries’ capacities to assess and interpret information relevant to complex choices. This is the crucial difference between some Medicare beneficiaries and working aged Americans: the former are simply more often unable to process the information needed to make informed choices among plans. One recent study found that Medicare beneficiaries made almost three times as many errors as younger people in interpreting comparative information on the performance of health plans (Hibbard et al. 2001). These limitations are compounded among the beneficiaries who are most vulnerable:

- Disabled beneficiaries: 72 percent have some problems reading; 45 percent have substantial problems (Gold et al. 2001). More than a third have cognitive limitations (Moon and Storeygard 2001).
- The oldest old (85 and older): 58 percent have some problems reading; 24 percent have substantial problems (Gold et al. 2001). More than 50 percent have cognitive limitations (Moon and Storeygard, 2001). Error rates in comprehending health plan features exceed 40 percent for beneficiaries over the age of 80 (Hibbard et al. 2001).

Beneficiaries may be assisted in these decisions. About 40 percent of all beneficiaries, for instance, are reported by their adult children to routinely need assistance in handling “paperwork or bills” (Kaiser Family Foundation and Family Circle 2000). But not all beneficiaries have family members to assist them with choices; – about 60 percent of elderly people report making decisions about health insurance on their own. Only 19 percent of Medicare beneficiaries report knowing of an unbiased source of counseling to help them with

choice about health plans (Gold and Stevens 2001). And even when family members are available, they often feel uncomfortable intervening (Kaiser Family Foundation and Family Circle 2000).<sup>15</sup>

The implications of limitations of knowledge and cognitive and sensory abilities, particularly among beneficiaries who are old and frail, are very different for M+C plans compared to original Medicare. As noted in chapter two, the benefits and administrative requirements of original Medicare have remained relatively stable over time. Although this stability may be a liability when health needs or technology change, it does ensure that beneficiaries who learn about the FFS program when they first become eligible can look forward to a roughly similar program as they age.

Private health plans, by their very nature, are less static. Plans sometimes withdraw from the program, requiring beneficiaries to switch to an alternative source of coverage, learn a new set of administrative procedures, and sometimes find a new physician. But even when plans maintain their participation, Medicare beneficiaries must often cope with changes. As noted earlier, physicians regularly leave — or are dropped — by M+C plans. On average, M+C plans experience about a 14 percent annual turnover in primary care physicians, with turnover exceeding 25 percent on average in the four states with the greatest instability. In addition, benefits and administrative requirements are in flux. Between 2001 and 2002, for example, 45 percent of M+C plans added hospital co-payment requirements, 32 percent reduced coverage for prescription drugs, and 27 percent changed generic drug requirements (Achman and Gold 2002b).

Because M+C plans are in flux, Medicare beneficiaries cannot simply make one choice about health plans. They must be prepared to regularly reassess that choice, to decide if the plan that once was most appropriate for them still retains its appeal. This, of course, is the sort of active consumer choice that seems so appealing to proponents of private insurance. But it may be unrealistic to expect the average 85-year-old beneficiary to adapt to these changing circumstances. This assessment is not meant to reinforce negative stereotypes about the capacities of the elderly or disabled. Many Medicare beneficiaries are willing and able to assess health plans and choose among them. But it is essential to recognize that some are not. While it is one thing to make a one-time choice among health plans, it is quite another to effectively sign-up for a lifetime of choices, choices that don't stop even if the capacity for choice has diminished.

### **Some Perverse Interactions with Markets for Medigap Coverage**

As first observed in chapter two, there is an open enrollment period for Medigap policies only

when older Americans first become eligible for Medicare (and no guaranteed issue for disabled beneficiaries). This creates a set of perverse incentives for beneficiaries considering enrollment in an M+C plan. If the plan later goes out of business or withdraws from the Medicare program, beneficiaries can re-enroll in certain Medigap policies without medical underwriting.<sup>16</sup> But no such guarantee exists if enrollees wish to disenroll voluntarily.

These Medigap policies create barriers between original Medicare and M+C. Most beneficiaries consider private plan options when they are relatively healthy, typically when first eligible for Medicare. These beneficiaries can join a plan without disrupting care with their regular providers.<sup>17</sup> They consider the features of health plans most salient for them at that point: reduced paperwork, a good array of supplemental benefits, and a broad network of health care providers. What they cannot do is evaluate the ability of the plan to meet future health care needs, since this information is not available for most health care problems, and has limited salience to people who have not yet experienced the problem themselves (Edgeman-Levitan and Cleary 1996).

At some later date, the beneficiary develops a health problem and becomes dissatisfied with the care their health plan is providing for that condition. Now the beneficiary wants to go back to FFS Medicare. But Medigap policy may be unaffordable, particularly for beneficiaries with limited incomes (who are, of course, more likely to consider private health plans in the first place). In the many communities in which there is only one M+C option, beneficiaries who become dissatisfied with the health care they are receiving, with reduced benefits, or with rising premiums are either locked into the private health plan with which they are dissatisfied or forced to “go bare” — that is, return to original Medicare without supplemental coverage.

As a consequence, those who consider a private plan face the prospect of being locked into a plan they no longer want or stripped of adequate financial protection. Neither of these options ought to be encouraged. Beneficiaries who are sufficiently foresighted to recognize these risks might avoid considering M+C plans at all, foreclosing options that could have provided them with better health care or greater financial security.

These problems could be ameliorated. AARP currently offers a community-rated policy, though it limits enrollee choices among types of Medigap policies. Moreover, if only one organization offers such a policy, it is likely to attract a disproportionate number of beneficiaries with high health care costs, which will result in increased premiums over time. If all insurers were required to offer policies with no underwriting (as they currently are in a handful of states) supplemental policies would remain affordable and beneficiaries could move freely between M+C plans and original Medicare. However, because such requirements might result in

adverse selection, restrictions may be required on the number of times beneficiaries can switch between FFS Medicare and M+C plans, or on the number of plans that are available on a community-rated basis.

## **THE GOAL OF ACCESS TO HEALTH CARE**

By promoting inclusion to mainstream American medical care, Medicare has lessened barriers that had existed in obtaining timely medical care (Davis and Schoen 1978, Blumenthal et al. 1988). But some fear that these historic gains have been threatened by two of the trends reported earlier in this report. First, rising out-of-pocket expenditures may deter some beneficiaries from using services when they need them. Second, constraints on Medicare payments to physicians in the last several years may be making physicians less willing to see Medicare patients. Have these trends seriously degraded access for older patients?

### **Medicare's Track Record: Strong, But With Some Troubling Signs**

This question has been addressed in two recent studies, which compared beneficiaries in original Medicare to a different group of non-beneficiaries. The first study, conducted for the Commonwealth Fund in 2001, surveyed access to care for elderly and disabled Medicare beneficiaries, as well as working-age Americans<sup>18</sup> (Davis et al. 2002). Because Medicare's original goal was to provide access to elderly Americans equivalent to that available to workers, these younger age groups (particularly those with employer-based insurance) provide a useful initial comparison. However, younger people tend to be healthier than either the disabled or the elderly.<sup>19</sup>

The results suggest that, despite the potential threats to access that have emerged in recent years; FFS Medicare provides significantly better access than that available to Americans with employer-based insurance. Retired beneficiaries reported only one-third as many problems getting access to medical care as those insured through their employer, after taking into account differences in medical needs (Davis et al. 2002).<sup>20</sup> Disabled beneficiaries reported about the same number of access problems as those covered by employer-based insurance.<sup>21</sup> Elderly beneficiaries were more than twice as likely (again taking into account differences in health) as those with employer-based insurance to be very confident in their future ability to get medical care when needed (Davis et al. 2002).

These findings suggest that Medicare retains its capacity to provide access to care. But the findings do indicate that further study is needed regarding disabled beneficiaries. A survey fielded in the mid-1990s found that 14.1 percent of disabled beneficiaries had difficulties obtaining needed medical care and 26.1 percent reporting delays in seeking care due to concerns about cost (Nelson et al. 1996). The comparable numbers for elderly respondents were

2.8 percent and 8.5 percent, respectively. Disabled beneficiaries also reported significantly reduced access to preventive services, such as immunizations (Nelson et al. 1996).

A second study, recently completed by researchers at the Center for Studying Health System Change (HSC) examined access trends over time through three waves of surveys fielded in 1997, 1999, and 2001 (Trude and Ginsburg 2002). The study measured access through three questions: (1) whether patients delayed or failed to obtain needed medical care, (2) whether patients could get appointments in a timely fashion and (3) how readily patients could obtain medical advice over the phone.

Access for the elderly had significantly worsened on all three measures between 1999 and 2001 (though not between 1997 and 1999) (Table 3.3). By 2001, 11 percent of beneficiaries had delayed or foregone treatment in the past year, 23.6 percent had trouble getting an appointment with a physician, and 11.3 percent had difficulty getting medical advice over the telephone (Trude and Ginsburg 2002). To understand the causes of these changes, the researchers compared the reported experience of elderly beneficiaries to Americans of middle-age (50-64).

**Table 3.3**

<b>People Who Had Problems Obtaining Care, by Reason</b>			
	1997	1999	2001*
<b>Delayed or Put Off Care, Any Reason</b>			
Medicare Seniors	9.1%	9.8%	11.0%
Privately Insured Near-Elderly	15.2%	17.6%	18.4%
<b>Reasons for Delaying or Putting Off Care</b>			
<b>Could Not Get Appointment Soon Enough</b>			
Medicare Seniors	13.9%	16.3%	23.6%
Privately Insured Near-Elderly	21.8%	20.8%	25.1%
<b>Could Not Get Through on Phone</b>			
Medicare Seniors	7.1%	4.8%	11.3%
Privately Insured Near-Elderly	7.2%	7.6%	9.1%

\* Change from 1997 to 2001 is statistically significant at  $p < .05$ .

Source: Trude and Ginsburg 2002.

This comparison group was used because their health care needs are more similar to the elderly than younger adults. They found the same trend of worsening access among the middle-aged. For some measures (appointments and phone access), the declines in access for Medicare beneficiaries were more pronounced than for the privately insured, for other measures (delayed or foregone care) the declines were larger among the privately insured.

HSC also found that fewer surgeons were willing to accept new Medicare beneficiaries. In 1997, 81.5 percent of surgeons were willing to accept new Medicare patients, but that declined in 2001 to 73 percent, partly due to changes in the BBA that reduced payments by 14 percent for cardiac surgeons and 10 percent for thoracic surgeons between 1997 and 2001. Congress took action in early 2003 to ameliorate these reductions, although a payment reduction of 4.2 percent is slated for 2004 as an unintended consequence of the payment formula in law. However, since HSC's survey also shows declines in access for non-Medicare beneficiaries, other factors, not related to Medicare, including growing patient demand for services, changes in private health insurance, the number and type of available physicians, and local market factors, are also probably affecting the situation.

### **Potential Benefits and Risks from Expanding the Role of Private Health Plans**

The introduction of private health plans has the potential to enhance access for Medicare beneficiaries. To a certain extent, beneficiaries can select plans whose benefits best match their health care needs. Coordinated benefit plans should have additional advantages, above and beyond fee-for-service insurance. Because they impose fewer (or lower) co-payments, financial access to care is improved. Indeed, for at least some forms of preventive care, such as immunizations, coordinated care plans might have financial incentives to implement outreach programs and encourage beneficiaries to obtain treatment. This might be particularly helpful for disabled beneficiaries.

The ongoing Consumer Assessment of Health Plans Survey (CAHPS) survey conducted under CMS' auspices contains questions designed to compare beneficiaries' access to care in both original Medicare and M+C.<sup>22</sup> In the 2001 survey, few differences were found at the national level. Ninety percent of original Medicare and 91 percent of M+C beneficiaries had seen a health care provider within the last year. Fifty-eight percent of original Medicare and 59 percent of M+C beneficiaries said that they always got care when they needed it, without long waits.<sup>23</sup> Eighty-seven percent of original Medicare beneficiaries and 85 percent of M+C beneficiaries said they had no problem getting the medical care that they needed.<sup>24</sup> Beneficiaries in M+C plans were also asked whether they had problems getting referrals to specialists.<sup>25</sup> Seventy-nine percent said it was not a problem.

Although CAHPS can not separately measure the experiences of disabled beneficiaries, beneficiaries under the age of 65 were more likely than beneficiaries age 70–74 to report having problems with all aspects of obtaining needed care, including finding a personal doctor or nurse, seeing a specialist, getting necessary medical care, and obtaining care without delay. In addition a lower percentage of beneficiaries in poor or fair health than those in very good or excellent health reported that it is “not a problem” to get access to needed care (Bernard et al. 2003).<sup>26</sup>

These studies suggest that access to care is not a significant problem for Medicare beneficiaries, in either absolute terms or compared to the performance of private insurance. Still, there are warning signs that suggest that the performance of the program could be improved, and other potential problems that should be forestalled through appropriate intervention. By 2001, more than 10 percent of elderly beneficiaries were reporting access problems, while further study is needed to discern the extent to which disabled beneficiaries are experiencing access problems.

Overall, this evidence also suggests that private health plans do not have either significant advantages or disadvantages in terms of access over original Medicare.<sup>27</sup> But the relatively large proportion of enrollees (21 percent) who reported that access to specialists was a problem in the past year may be a warning sign that coordinated care plans are functioning less well for beneficiaries with greater health care needs.

## **THE GOAL OF COST CONTAINMENT**

The costs of the Medicare program have been a concern for policy-makers since the late-1960s. Given the growing share of the federal budget devoted to health care and the impending costs of the baby boom generation, these are very legitimate concerns. But policy discourse about Medicare spending and the potential savings from competing private health plans has been muddled by simplistic assumptions, confusion about the sorts of cost savings anticipated, and flawed comparisons between Medicare and employer-based insurance.

### **Clarifying The Goals for Cost Containment**

Perhaps the most common misperception involves the presumed advantages of competitive markets to reduce the rate of growth in health care spending. Because we live in a largely market economy, there is a strong presumption that markets generally promote societal well-being. And there is an equally strong predisposition to question the ability of government programs and political decision-makers to achieve those same ends. But in health care, the relative performance of markets and government programs are not simple to predict. For example, when asked about the sources of rising health care costs, 70 percent attribute these increases to “poor management” by government (Kaiser Family Foundation 1998).

Competitive markets promote a more efficient allocation of resources by providing individual consumers with incentives to make choices in a cost-conscious manner. In FFS Medicare, many beneficiaries do not have this incentive, since the combination of Medicare and supplemental policies make use of covered medical services essentially free. This may lead beneficiaries to use more Medicare-covered services than they otherwise would have (Wilensky and Newhouse 1999).<sup>28</sup> Some private health plan arrangements could clearly enhance consumers' sensitivity to costs, compared to those that now exist in original Medicare and the M+C program.

It might therefore seem to follow that competing private health plans must reduce costs, compared to a single program like original Medicare. But consumer choices are not the only ones relevant to health care spending. Health insurers must negotiate with doctors and hospitals. The larger their share of the local market for medical services, the greater their capacity to negotiate discounts, holding down costs. Because FFS Medicare accounts for such a large share of national health spending, it can bargain for lower prices than those that can be negotiated by private insurers. It may also be better able to control practices that would otherwise drive up spending over time, such as the diffusion of expensive new medical technologies. Comparing the experience of the United States and other advanced democracies in terms of cost containment, evidence suggests that countries with more centralized purchasing authority have been better able to contain the growth of health care costs over time (Anderson and Hussey 2001).

The potential for cost containment in health care is thus more complicated than often assumed. Market-oriented policies may achieve cost savings, if they can provide sufficiently powerful incentives for individual consumers to make choices in a cost-conscious manner. By so doing, policies may reduce costs for treatment that is otherwise unnecessary or of limited value. But market-oriented policies also fragment the purchasing of medical care, reducing bargaining power in negotiations with health care providers. To judge the track record of the FFS Medicare program, and to assess the future cost saving potential of greater competition among private health plans, we need to consider separately these different sources of excessive spending.

### **Medicare's Track Record With Respect to Cost Containment**

Following on the distinctions introduced above, we will separately assess experience with original Medicare in terms of excessive utilization of services, and containing the growth of health care spending over time. We will also explore one other related aspect: the administrative costs associated with providing Medicare benefits.

**Use of Medical Care.** Beneficiaries with supplemental insurance policies (either purchased by their employers or individual Medigap policies) typically have first-dollar coverage for health care. Although this can reduce financial barriers to access, it also encourages more use of health care services. Because the costs of additional treatment are borne in part by Medicare, it is essentially subsidizing the cost of these supplemental policies. This leads to more coverage, even less incentive to contain costs, and potentially excessive medical spending.

Studies that have examined the treatment-seeking behavior of the elderly, however, do not find large amounts of inappropriate utilization being initiated by patients. For example, when clinicians are asked to evaluate beneficiaries' responses to symptoms, they are as likely to find cases in which they should have sought treatment, but did not, as they are to document cases in which beneficiaries went to the doctor unnecessarily (Hurwicz 1995).

More persuasive evidence of excessive treatment under Medicare comes from a different set of studies. Researchers have documented large regional differences in the average annual spending for Medicare beneficiaries (Wennberg, Fisher, and Skinner 2002). Spending in high cost areas averages 250 percent more than in low-cost areas, with only about 20 to 30 percent of the variation explained by differences in average health status of beneficiaries.<sup>29</sup> It is important to recognize that the regional differences documented by Wennberg and colleagues do not, primarily, reflect differences in the care-seeking behavior of beneficiaries. Instead, they reflect differences in prevailing clinical practices. In other words, they are primarily the product of physicians' decisions, not those made by beneficiaries. Nor are these differences in regional spending unique to Medicare. They are deeply rooted in practice patterns that shape treatment for all Americans.

**Containing the Growth in Medical Costs Over Time.** Given ongoing concerns about the rate of growth in Medicare spending, one might think that Medicare spending was growing much faster than that of private insurance. And for a brief period in the 1990s, this appeared to be the case, a difference that many observers attributed to the greater role of competition and managed care in private insurance.

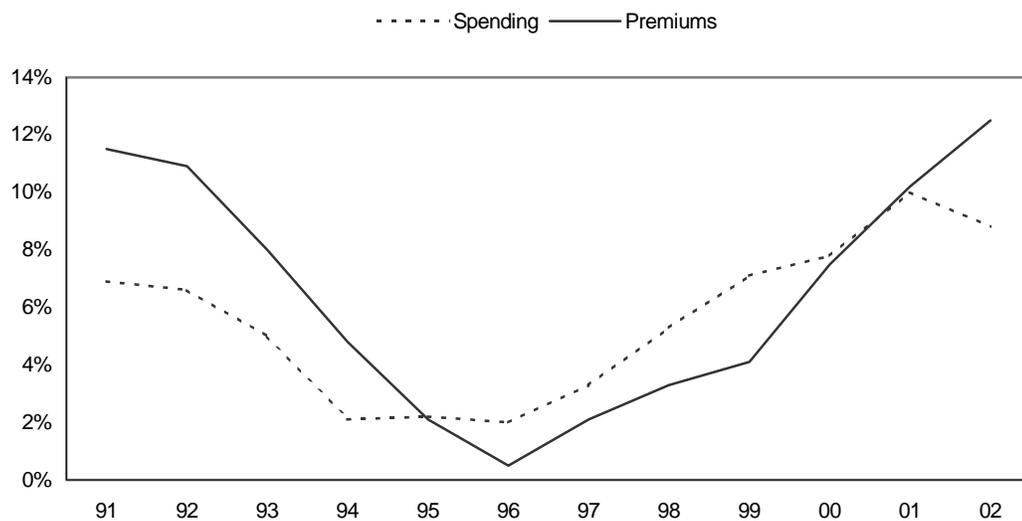
In the 1980s, employers gradually moved away from FFS to more managed care delivery systems. In the 1990s, the trend toward managed care accelerated rapidly. By 1998, only 14 percent of employees in firms with more than 200 employees were enrolled in FFS (Kaiser Family Foundation and Health Research and Educational Trust 2002). Because the shift toward managed care occurred as the rate of increase in health care spending and premiums slowed dramatically, as shown in Figure 3.4, many attributed the slow-down to the success of managed care in controlling costs. Writing in 1996, Etheredge, Jones, and Lewin said, "Employers now have a firm conviction that enormous savings are possible in health care spending without reducing quality of care. They now expect (and demand) that rather than the annual

double-digit premium increases of the insurance era, managed care premiums should fall, or rise only modestly. This strategy has succeeded in slowing the rise of national health care costs to the lowest rate in three decades” (Etheredge, Jones, and Lewin 1996).

The euphoria about record low rates of increases in health care spending and about the power of managed care practices to control costs was relatively short-lived, because health care spending and premiums began to rise again. It is difficult to determine what role managed care played in these trends. Although the evidence about whether managed care really saves money is decidedly mixed, most analysts attribute the slower rate of growth in the 1990s at least in part to the effects of managed care (Hogan, Ginsburg, and Gabel 2000). Confounding the analysis is the fact that both providers and consumers rebelled against managed care tactics in the mid-1990s, including restrictive networks, tight gatekeepers, and low payment levels. This led many

**Figure 3.4**

**Annual Percent Change, Cost of All Health Care Services and Premiums,  
Large Firms, 1991-2002**



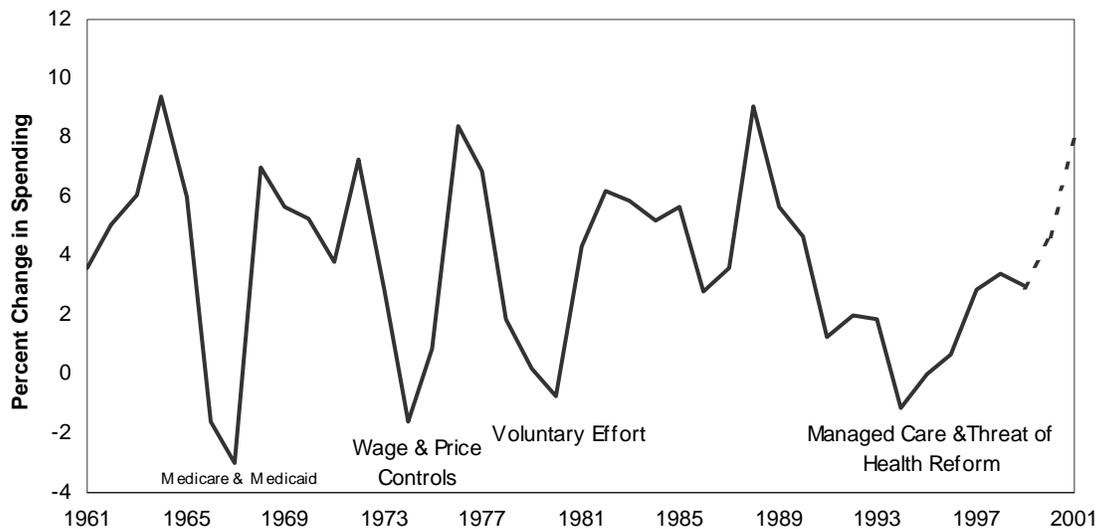
Source: Struck, Ginsburg, and Gabel 2002.

managed care organizations to loosen their requirements, which could have accounted for a portion of the cost growth after 1996. A second study examined cost containment efforts in the private sector over the last forty years. The data show that no cost containment effort, including wage and price controls, the voluntary price constraints of the early-1980s, managed care, or the threat of health care reform in the 1990s, has ever had a lasting effect (Altman and Levitt 2002).

Given this inconsistent track record of cost-containment in the private sector, it is not surprising to find that the comparative performance of original Medicare depends on the time period in which the comparison is made. Figure 3.6 compares the rate of growth between private sector and Medicare spending between 1970 and 2000. In general, Medicare and private sector spending rates have been roughly comparable, although it is extremely difficult to make direct comparisons between Medicare and private health spending because the benefits, coinsurance, and premiums differ.<sup>30</sup> One study found that Medicare spending was somewhat lower than private sector spending from 1984 through the early-1990s, and then higher in the mid-1990s until the effects of the BBA reductions sharply lowered Medicare spending in the late-1990s. Throughout the entire period, private spending grew at a slightly faster annual rate (11.1 percent) than Medicare, at 9.6 percent (Boccuti and Moon 2003). Although there are limitations to the data, they do not provide convincing evidence that either Medicare or the private sector is superior at controlling costs.

**Figure 3.5**

**Annual Change in Private Health Spending Per Capita, Adjusted for Inflation, 1961–2001**



Source: Altman and Levitt 2002.

**Administrative Costs in the Medicare Program.** It is sometimes assumed that because Medicare is administered by a government agency, it must be excessively bureaucratic and administratively costly. In fact, administrative costs for Medicare average about 2 percent of benefit payments. This is far lower than administrative costs of employer-based insurance, which range from about 10 percent for larger firms to 25 percent for smaller firms, or up to 35-40 percent for individual policies (GAO 2001; Blumberg 2001). However, Medicare's administrative budget is lower than necessary to meet all the program's administrative obligations because it has been constrained by Congress (King and Burke 2002).

Medicare does have some economies of scale. Offering a single plan throughout the country is much less expensive than offering a variety of different insurance products in different communities, each of which must be marketed and separately administered. Nor does Medicare have to recruit enrollees, which all private health plans must do, or to achieve a profit, which proprietary health plans must if they are to survive in the long term.

### **Private Health Plans Competing for Medicare Beneficiaries**

Contemporary policy debates often confuse two potential benefits of a larger role for private health plans. The first involves the introduction of coordinated care plans to save money by controlling potentially excessive use of medical care. Because most excessive spending appears linked to clinicians' decisions, it makes sense to consider whether various ways of "managing" these practices might reduce Medicare spending. Here the evidence for Medicare beneficiaries is relatively clear: there is potential for some modest cost saving, though this is partially offset by the higher administrative costs of managed care plans. In the past, these savings have been completely offset by the enrollment of relatively healthy beneficiaries in Medicare+Choice plans.

The second potential advantage requires a new approach to Medicare's arrangements with private health plans. Medicare competitive models would provide beneficiaries with greater incentive to select lower cost plans in their community. These claims are necessarily more speculative, because we have no experience with these models in Medicare. Extrapolating from the experience of similar models for working age Americans, the potential for cost containment appears rather modest. But there is a larger potential for costs to be shifted from the government's budget to individual beneficiaries. Whether this is an asset or a liability of competition depends on a judgment about the appropriate share of health care costs that should be borne by the elderly, compared to younger taxpayers.

### **Coordinated Care Plans**

Coordinated care (i.e. "managed care") plans were once seen as an effective policy instrument

for reducing spending throughout the American health care system. Early studies suggested that these plans significantly reduced health care spending, particularly in inpatient settings (Luft 1981). However, the clinical practices that were associated with managed care soon diffused to the system more generally. By the 1990s, it was no longer clear that managed care could achieve further cost reductions (Miller and Luft 2002; Sullivan 2000), at least without creating such a “backlash” that its policies proved unsustainable.<sup>31</sup> Competition depends on a judgment about the appropriate share of health care costs that should be borne by the elderly, compared to younger taxpayers.

Moreover, there had never been much evidence that managed care plans were able to alter the growth rate of health care spending over time, as opposed to achieving a one-time reduction in costs (Marquis and Long 1999). Increases in health care spending are attributable to the following factors: population growth (less than 1 percent a year); general inflation; health care inflation in excess of general inflation; increases in the per capita use of health care services; and increasing intensity of treatment (Smith et al. 1998).

Advances in medical technology appear to play a significant role in increasing intensity, not just when they are introduced, but also over time, as new treatments are refined and diffused more broadly (Fuchs 1999). Although some hoped that managed care plans would slow the rate of diffusion of new technology, the evidence is mixed. One study from the mid-1990s showed a lower rate of use of magnetic resonance imaging (MRI) in areas with higher managed care penetration (Baker and Wheeler 1998). But another study showed little difference between the rate of diffusion in minimally invasive gallbladder surgery between FFS and managed care, suggesting that managed care plans find it difficult to control the diffusion of new technology (Chernew, Fedrick, and Hirth 1997). In the long run, most experts think that Americans will not be dissuaded from their “love affair with medical innovation” and will demand access to new services and technology (Iglehart 2001).

The cost containment potential of coordinated care plans in Medicare has been roughly similar to the private sector’s experience. Plans serving Medicare beneficiaries appear to achieve one-time cost savings, largely by reducing the costs of inpatient treatment. Assessments by actuaries in CMS suggest that M+C coordinated care plans can provide the same benefits as FFS Medicare at roughly 80 percent of the costs of average spending in FFS Medicare (Thorpe and Atherly 2002). But these benefits have not translated into savings for Medicare. Some of the savings were consumed by higher administrative costs in M+C plans. These average about 15 percent of spending, which is substantially higher than for FFS Medicare. In addition, M+C enrollees tend to be healthier than average, so that the program essentially has overpaid private health plans for their care. The combination of higher administrative costs and favorable risk

selection means that the Medicare program has actually lost money, on average, on M+C enrollees (MedPAC 2000).

Nor is there any evidence that M+C plans have been better at containing the growth of health spending over time. We noted earlier that original Medicare has averaged slightly lower cost increases than those charged by private insurers. Between 1994 and 2001, annual increases in spending in the private health plans that contract with Medicare have exceeded premium increases in private insurance in three years, been lower in three years, and been roughly equal in the two other years (Grossman, Strunk and Hurley 2002). To summarize, health care spending in M+C plans, private insurance, and original Medicare has tracked roughly equally over this time period.

### **Market-Oriented Strategies**

Proponents of a greater role for markets in Medicare have argued that the potential for cost containment would be increased if the program shifted from administered pricing to more market-based solutions.<sup>32</sup> Some of these solutions include competitive bidding, negotiation, and premium support, and combinations of these strategies.

**Competitive Bidding.** As discussed in chapter two, the Clinton administration attempted to test competitive bidding in Medicare managed care, first in Baltimore and then Denver. Critics charged, among other things, that HCFA had taken little account of the views of local communities in selecting the demonstration sites. The industry also urged that fee-for-service be included in the demonstration and that HCFA announce how the Medicare contribution would be determined prior to bidding. HCFA's attempts in both Baltimore and Denver met stiff resistance from both national and local elected officials. Some local beneficiary groups also opposed the demonstrations, partly in response to assertions by the industry that they would be harmed, and would likely lose benefits. Ultimately, both demonstration sites were thwarted by both political and legal means.

After these failures, the administration sought and received explicit legislative authority to conduct similar competitive pricing demonstrations. The BBA instructed HCFA to conduct at least four (and up to seven) competitive pricing demonstrations of managed care.<sup>33</sup> In response to criticism that HCFA had not appropriately consulted with local communities in the failed sites, Congress created two oversight bodies: a national Competitive Pricing Advisory Committee (CPAC) to design the demonstrations and select the sites; and an Area Advisory Committee (AAC) to assist in implementing the demonstration and adapting it to local circumstances. Creation of these advisory committees was intended to address the complaint that HCFA had been insensitive to local concerns. In response to earlier demands that FFS be

included in the demonstrations, CPAC examined the issue and determined that it did not have authority to include FFS in the demonstration, but urged HCFA to consider including it in future demonstrations. CPAC addressed the industry's request that the government contribution be known in advance by establishing the government contribution at either the median bid, or the enrollment-weighted average bid, which the AACs would determine. In response to beneficiary concerns that they would be adversely affected, CPAC also established a standard benefit package for which plans would submit bids. These benefits were set at the statutory Medicare benefit package plus a prescription drug benefit with an actuarial value of \$500. The AACs were given latitude to determine which other benefits should be part of the package on which plans would bid; supplements would be allowed if they were priced and offered separately.

Despite CPAC's efforts to address many of the complaints about the structure of the demonstrations in Baltimore and Denver, opposition soon arose in the new sites selected for the demonstration, Kansas City and Phoenix. The AACs in both cities requested a one-year delay of the demonstration, and industry opposition was fierce. Members of the relevant Congressional delegations ultimately intervened by seeking a moratorium on the demonstrations. Congress subsequently prohibited HCFA from spending any funds on the demonstrations, and passed a moratorium on the demonstrations until 2002. Since that time, CMS has not tried to resurrect the demonstrations. The explicit legislative authority for these demonstrations expires in 2003 although CMS could still conduct this type of demonstration using its existing authority.

What went wrong? To some, the failure of the demonstrations was not surprising because health care providers, including managed care plans, durable medical equipment (DME) suppliers, clinical laboratories, and others have long resisted having to compete on the basis of price. Since the late-1980s, only two competitive pricing demonstrations, both for durable medical equipment, have gotten off the ground, and only after attempts were made to block them in the courts and in Congress (Dowd, Coulam, and Feldman 2000). As one review noted, "Although all businesses like to purchase their inputs in highly competitive markets with low prices, most would prefer to sell their outputs in a monopolistic market or one with an administered price well above their costs. In short, it was not in the (industry's) interest to have HCFA learn how to become an effective purchaser" (Nichols and Reischauer 2000). More succinctly, one former HCFA administrator and a colleague involved in the demonstrations wrote, "Everyone wants market competition until they don't like the results. Real markets have losers. Without them, it is difficult to achieve much efficiency. In a democratic political system, losers, potential losers, and even those who feel that they might someday be losers often seek redress from their elected officials" (Cooper and Vladeck 2000).

The lesson the study panel draws from these demonstration efforts is that they have real potential to produce savings for the program. Indeed, the results of the Florida DME competitive bidding demonstration resulted in aggregate savings of 17 percent, without a reduction in access or quality of services (DeParle and Berenson 2000). However, the difficulties in implementing these demonstrations also suggests that intense political and industry opposition clearly remain formidable barriers to more widespread adoption of this form of market-based competition. In view of the potential benefits and the barriers to implementation, the study panel believes that further pursuit of competitive pricing strategies is desirable.

**Negotiated Pricing Models.** The Federal Health Employees Benefit Program (FEHBP) is frequently cited as an alternative model for introducing price-based competition to the Medicare program. FEHBP is structured in a way that requires far less government intervention, its benefits are more generous than Medicare's, enrollees appear to be quite satisfied with it, and its ability to contain costs has been well regarded.<sup>34</sup>

Unlike Medicare, FEHBP is not a defined benefit plan, but more like a defined contribution plan, although not exactly so.<sup>35</sup> The FEHBP has three generic types of plans:

- a national fee-for-service plan, with a PPO option, available throughout the country, that charges everyone the same premium;
- fee-for-service plans offered by employee organizations; of which six are open to all employees, and six are available only to specific groups; and
- comprehensive medical plans available only to employees residing in specific areas.

Overall, about 70 percent of FEHBP participants are enrolled in FFS plans (GAO 2002a). All FFS plans charge every enrollee the same amount, based on prior claims experience. Most of the comprehensive medical plans vary premiums by service area, although premiums must be community-rated. None of the plans, unlike M+C, are risk-adjusted to account for any differences in characteristics among enrollees.

In the FEHBP, the federal government pays 75 percent of any plan premium, up to a maximum.<sup>36</sup> Federal employees pay 100 percent of the premium over the 75 percent level, which creates incentives both for plans to set their premiums near the 75 percent level and for employees to choose plans at or below the level of the maximum federal contribution. Each year, the federal Office of Personnel Management (OPM) issues a "call letter" to health plans that outlines changes from the previous year, and invites plans to participate. Then OPM

begins “negotiation” with the plans, although that term should be understood loosely. OPM sets minimum standards for plans to participate (lower than those set by Medicare) and minimum benefits lower than Medicare’s, although plans are generally expected to provide more generous benefits comparable to those in the private sector. Instead of aggressive negotiating style preferred by some major purchasers such as General Motors, OPM relies more on enrollee choice among competing plans to control costs, along with its suggestions for ways costs might be constrained. There is no formal bidding in the FEHBP, and OPM does not have authority to contract selectively with some plans on the basis of price or quality.

During the 1990s, the FEHBP was often viewed as an attractive alternative to Medicare because its structure required much less Congressional involvement and intervention than Medicare coverage and reimbursement policies, and its apparent success in containing costs. From 1991 to 1996, premium increases in FEHBP were below those of major private insurers. And in 1995 and 1996, premiums in FEHBP actually declined by 3.8 percent and .3 percent respectively, while Medicare spending per beneficiary grew 7.7 percent per year.<sup>37</sup> However, from 1997 through 2002, premium increases in FEHBP were larger than for other large purchasers. The 11 percent average annual premium increase for 2003 is both lower than the 2002 increase of 13.3 percent, and lower than the average expected for other large purchasers. According to GAO, premiums in 2003 would have been higher, but for some increases in enrollee cost-sharing and enrollee shifts in enrollment to lower cost plans.

Based on the last few years, it appears that FEHBP is not inherently more successful in controlling costs than either the private sector or Medicare. Between 1996 and 2003, premiums and health care spending under FEHBP grew considerably faster (7.2 percent and 5.3 percent annually) than Medicare spending (4.3 percent annually) (Merlis 2003). No feature of the FEHBP automatically restrains growth in costs, and absent Congressional intervention, government costs for FEHBP could rise freely with the costs of benefits (Merlis 1999b). Moreover, OPM cannot do what CMS can: aggregate all of its potential purchasing power. Instead, its purchasing power is scattered all across the private sector (Cain 1999). And higher administrative costs under FEHBP have largely offset any savings from asking enrollees to pay out-of-pocket for more expensive health plans. Overall administrative costs for HMOs run about 15 percent under FEHBP. Administrative costs for PPOs tend to be lower (about 7 percent), but these plans have less capacity to hold down costs through managed care techniques (Merlis 2003).

There is another reason for caution in thinking about the FEHBP as a model for Medicare. Because premiums are not risk-adjusted, there is a danger that higher-risk people will enroll in higher benefit, higher premium plans, and lower-risk people will congregate in cheaper, lower

benefit plans. This can eventually lead to a “death spiral” in the higher cost plans, as relatively healthier enrollees flee high cost plans for lower cost plans, ultimately increasing premiums in the high cost plans to the point where they are unsustainable. In the late 1980s, such a spiral led to rapid price increases in the high option fee-for-service plans, precipitating the withdrawal of the Aetna indemnity plan from FEHBP (Merlis 1999b). Despite the fact that a recent study did not find a great deal of risk segmentation in current FEHBP plans for individuals, experts continue to think that risk segmentation poses substantial issues.<sup>38</sup>

Some have found the FEHBP model attractive for Medicare because it would relieve Congress from the burden of making very detailed determinations about coverage and reimbursement policies. However attractive this might seem, others have argued that Medicare spending represents so large a portion of the federal budget compared to the FEHBP, and plays such a key role in providing support to health providers and local communities, that neither the Congress nor health providers, who have long been accustomed to appealing to Congress, would be likely to accede to such a fundamental change (Cain 1999; Merlis 1999b).

**Premium Support.** Aaron and Reischauer first proposed premium support as an alternative to Medicare’s defined benefit model in 1995 (Aaron and Reischauer 1995). Under premium support, Medicare would pay a defined sum toward the purchase of a defined set of benefits. (The key distinction between the FEHBP and premium support models is that premium support is based on a defined benefit package.) The underlying theory of premium support is that it would encourage beneficiaries to select lower-cost plans, and would drive down aggregate health spending over time (Vladeck 1999).

Under premium support reforms, services could be delivered on a FFS basis, through a PPO, or a managed care plan. Plans would bid to provide the defined benefit package in a market area for an “average” Medicare beneficiary. The federal Medicare reimbursement amount in each area would be the same regardless of which plan a beneficiary chooses. If the beneficiary chooses a plan above the premium support level provided by Medicare, the beneficiary would be responsible for the full cost of the premium above Medicare’s contribution. Medicare payments to plans would be risk-adjusted to reduce risk segmentation.<sup>39</sup>

Whether premium support would actually generate savings is a matter of speculation. Studies that have evaluated comparable premium support models for private insurance have documented cost savings of between 5 and 20 percent (Buchmueller 1998; Cutler and Reber 1998; Feldman and Dowd 1993). But again, the timing of the evaluation appears to be a significant issue. For example, between 1993 and 1998, the cost saving experience in the California Public Employees’ Retirement System (CalPERS), a premium-support arrangement,

looked promising. Costs increased during this period at less than 3 percent annually, compared to 6.6 percent for the Medicare program. However, after 1998, costs in CalPERS grew 10 percent per year compared to increases in Medicare of under 2 percent (Rice and Desmond 2002; Oberlander 2000).

Could comparable savings be expected for the Medicare program? This depends on several factors. First, how strongly would Medicare beneficiaries respond to premium cost differences in choosing among health plans? Although there is only a smattering of evidence on this question, it suggests that older people are much less sensitive to price differences in making choices among health plans (Buchmueller 2000). This is quite understandable — enrollees with more chronic health problems prefer to maintain relationships with current physicians, even if they're dissatisfied with the costs of the plan (Schlesinger, Druss, and Thomas 1999). This suggests that the cost saving potential of a premium support model would be lower for Medicare.

The second open question involves how effectively a premium support model could attract private health plans into more markets than the current M+C program serves. Cost savings documented in the private sector were all from urban markets with extensive competition among health plans. Given Medicare's difficulty in attracting stable participation by plans under M+C, could competition among plans really be sustained?

This depends on the way in which the federal government's premium contribution is calculated. If based on bids received nationwide, the contribution is likely to be seen as inadequate by plans in high-cost regions and rural areas, making them unwilling to participate. On the other hand, if the premium is set based on local bids, there is likely to be a substantial increase in participation by private health plans. But in local areas with limited competition (particularly rural areas), these bids might be substantially above what Medicare currently pays under M+C. Hence one is likely to see enhanced potential for cost containment in urban areas, but possibly higher costs in less competitive rural areas.

On balance, the reduced price-sensitivity of beneficiaries, compared to working-age Americans, and the challenges of uneven competition across geographic areas are likely to limit the cost reducing potential of a premium support model, though it may still produce some real savings. The HCEA Chief Actuary estimated that one premium support model considered by the Medicare Commission would reduce Medicare spending by 2.5 percent over 30 years (Vladeck 1999).

### **Concerns About the Side-Effects of Market-Based Choice**

Implicit in most proposals for increasing the role of private health plans in Medicare is the notion that competition can squeeze greater efficiency out of the health care system. The documented patterns of seemingly unnecessary spending makes this potential seem very appealing. However, in practice it has proven rather difficult for private insurers to change clinical practices without engendering a strong resistance from clinicians and the general public. Indeed, in recent years insurers have switched to marketing their plans as not unduly affecting medical practice. In addition, many plans have had trouble maintaining adequate provider networks and have been forced to make concessions to providers to get or retain them (Strunk, Devers, and Hurley 2001).

Under these circumstances, premium support models may produce a very different outcome. If costs for medical care in a given community rise faster than the federal government's willingness to support premiums, the ones who must ultimately pay the difference are beneficiaries. This is cost shifting, not cost saving. The magnitude of the shift will again depend on the details of how the premium support level is calculated. But evaluations of existing reform plans suggest most of the savings for the federal government under premium support come from cost shifting, rather than cost saving. The HCFA actuary attributed most of the 2.5 percent savings associated with premium support from shifting costs to beneficiaries (Vladeck 1999). In their evaluation of premium support proposals, Thorpe and Atherly (2002) concluded that these proposals could reduce federal spending on Medicare by as much as 8 percent, but only by transferring substantial costs to beneficiaries.

A second set of concerns relates to the effects of competition on the long-term viability of FFS Medicare. As mentioned in the discussion on FEHBP, concerns about risk segmentation and a potential death spiral apply equally to premium support models. Depending on the design structure of a premium support model, two additional issues could have adverse effects on beneficiaries: determining the level of the government contribution, and whether FFS is included or excluded.

Some economists have advocated setting the government contribution at the lowest bid submitted by a qualified plan. This has the greatest potential for producing savings, since beneficiaries would have incentives to choose the plan for which they could get a full subsidy. While the lowest cost plan could indicate a highly efficient plan, that is not necessarily so. It could also reflect an unusually Spartan delivery system or a low quality plan. It could also reduce the choices of low-income beneficiaries, since many would feel compelled to choose plans for which they do not have to pay a supplemental premium (Aaron and Reischauer 1995).

Another key issue is whether FFS is considered one of the plans in a premium support model. Some have argued that leaving FFS out of premium support gives FFS an unfair advantage. However, under a premium support model proposed a few years ago, the HCFA actuary estimated that the premiums for FFS Medicare would cost more than the average premium price, with Part B premiums for those remaining in FFS 47 percent higher than Part B premiums under current law (CRS 2001c). If enrollment in private health plans grew over time, FFS Medicare premiums would increase further (Oberlander 2000). Cost shifting to beneficiaries could be reduced by increasing the government's contribution level (which was between 88 and 90 percent in this model) or by pegging the government contribution to FFS costs. However, either approach would reduce savings from a premium support model.

## **FINDINGS AND RECOMMENDATIONS: MARKETS, PRIVATE HEALTH PLANS, AND MEDICARE'S TRADITIONAL GOALS**

We summarize here our key findings and introduce our recommendations for each of the four core goals that have been traditionally addressed by the Medicare program.

### **Financial Security**

**Finding 8: Original Medicare provides inadequate financial security to beneficiaries, particularly those with limited incomes and chronic health problems. Many low-income beneficiaries eligible for additional federal assistance are not enrolled in the means-tested programs intended to help them pay for health care because they are not informed about programs, or are reluctant to apply for them.**

**Finding 9: Private health plans have provided greater financial security for some beneficiaries. However, greater financial security is associated only enrollment in some coordinated care plans, not PFFS plans. For beneficiaries in frail health, ongoing reductions in coverage in coordinated care plans are exposing them to substantially greater financial risk than in previous years.**

Original Medicare is no longer adequate for ensuring that America's elderly and disabled will remain financially secure in the face of substantial health care needs. Unlike Medicare, most employer-based insurance now has annual out-of-pocket limits to protect enrollees against catastrophic expenses. Given the limited earnings potential of Medicare beneficiaries, they are even more in need of these protections than working-age adults. Consequently, we believe that annual limits on out-of-pocket spending should be incorporated into both original Medicare and Medicare+Choice. Further, given the rising costs and use of pharmaceuticals among the elderly, paying for prescription drugs has also become a serious threat to financial security. Consequently, we believe that Medicare should keep pace with employer-based insurance by adding a prescription drug benefit to both original Medicare and Medicare+Choice.

**Recommendation 1: The Medicare program should include an annual limit on out-of-pocket spending for Medicare covered services.**

**Recommendation 2: The Medicare program should include an outpatient prescription drug program to protect beneficiaries against large out-of-pocket expenses.**

## **Plan Choice**

**Finding 10: Some Medicare beneficiaries are willing and able to choose among competing health plans. However, it is not realistic to expect the oldest and most frail beneficiaries to do so, especially those with multiple chronic conditions or cognitive impairments. For these beneficiaries, policies that require annual reconsideration of their insurance options, or switching health plans, can be very disruptive to continuity of care or a source of confusion.**

**Finding 11: Failures in the market for Medicare supplemental policies are preventing some Medicare beneficiaries from trying M+C plans, and involuntarily locking other beneficiaries into M+C plans. Medigap premiums that are adjusted for health status or denied entirely to beneficiaries who are disabled trap less healthy beneficiaries, who are unable to disenroll without having to either forgo supplemental coverage or pay much higher premiums. Beneficiaries with moderate incomes are most likely to become trapped in this manner.**

Choice of private health plans can be an attractive option for beneficiaries. But it is unrealistic to ignore the very real constraints on cognition and sensory capacity that can be a by-product of old age and frail health. Most panel members believe that Medicare beneficiaries should be assured of a health insurance option that does not require them to constantly reassess their health benefits, frequently change health care providers, or learn to deal with new administrative requirements. In other words, they should have the option to remain in FFS Medicare. The very qualities of change and flexibility that can make private health plans an attractive alternative to original Medicare become at some point disadvantages to beneficiaries who place the highest priority on security and stability.

Conversely, beneficiaries who would like to explore private health insurance options ought to be able to do so without sacrificing their health care benefits if they subsequently discover that their private health plan is not addressing their medical needs adequately. Beneficiaries enrolled in plans that withdraw from Medicare are already assured some access to supplemental benefit plans. We believe that it is unfair to deny these options to enrollees who are dissatisfied with their plans. Providing for open enrollment and community-rated benefits for supplemental plans would assure that the market for private health plans functions more equitably and extends access to disabled beneficiaries, who are currently disadvantaged with respect to both financial protection and access. Experience with states that have adopted comparable regulations has been positive (Lutsky et al. 2001). Because these provisions may increase the potential for adverse risk selection in original Medicare, restrictions may be required on the

number of times beneficiaries can switch between FFS Medicare and M+C plans, or the number of plans that are available on a community-rated basis.

**Recommendation 3: Beneficiaries must be assured that original Medicare is available in all areas and will remain so over time. Most panel members believe that keeping original Medicare premiums affordable should be a priority, but that view was not unanimous.**

Most panel members believe that keeping original Medicare affordable, particularly for those with limited incomes, should be a priority. They note that out-of-pocket spending already consumes more than twenty percent of the typical elderly beneficiary's income. In their view, requiring beneficiaries to pay a larger share of their health care expenses, as could happen in a competitive model, could undermine access to health care and unduly burden beneficiaries. If original Medicare becomes unaffordable in a competitive model, beneficiaries may not have an affordable alternative, which would undermine the universality of Medicare.

A few panelists disagree with this view. They believe that it is unrealistic to guarantee the affordability of original Medicare in the future, particularly if new benefits are added. They think that the combination of demographic shifts and real growth in costly medical technology means that Medicare will surely be more budget-constrained in the future than it has been in the past. These panel members are not optimistic that there will be infusions of substantial new revenues or that large amounts of waste and abuse can be eliminated to fund improvements in the performance of Medicare FFS.

**Recommendation 4: Medicare supplemental policies should be community-rated, with greater freedom to switch among plans. To prevent adverse selection, restrictions may be required on the number of times beneficiaries can switch between FFS Medicare and M+C plans, or on the number of plans that are available on a community-rated basis.**

## Access to Medical Care

**Finding 12: Both original Medicare and M+C have provided good access to care so far, with original Medicare performing better than employer-based insurance for aged beneficiaries. However, access to care is better for aged beneficiaries than disabled beneficiaries, regardless of whether they are enrolled in original Medicare or M+C.**

Disabled beneficiaries have systematically less favorable experiences in Medicare than the elderly. This is of concern for several reasons. First, it seems unfair that one class of beneficiaries has consistently less positive outcomes. Second, the experience of disabled beneficiaries likely illustrates problems that are experienced by a broader group of beneficiaries: those who have chronic health care problems. We believe that our first and third recommendations presented

above may help to ameliorate these problems. But we also believe that the well-being of beneficiaries with chronic health problems in both original Medicare and M+C merits additional attention, as recommended by the NASI study panel on Medicare chronic care.<sup>40</sup>

**Recommendation 5: The performance monitoring systems (CAHPS, HEDIS) used by CMS to measure access to care under original Medicare and M+C should include new measures related to chronic illness, as well as increased sample sizes of disabled enrollees.**

### Cost Containment and Market Forces

**Finding 13: Private health plans have the as-yet unrealized potential to achieve modest one-time cost savings for the Medicare program, on the order of 5 to 7 percent for coordinated care plans and 2 to 3 percent for premium support programs. However, under current price-setting practices, these savings depend, respectively, on more effective risk-adjustment and national premium setting that have, to date, proven technically difficult and politically infeasible. The savings associated with coordinated care plans may not apply to private fee-for-service plans because of the higher payments they receive in “floor counties.”**

**Finding 14: There is little evidence that private insurance, which relies on market forces, has reduced the rate of growth in private health spending over the long term, compared to either the historical trend or the rate of increase in Medicare spending.**

These potential cost-savings make competitive price setting an attractive alternative to Medicare’s current administered pricing system. It is also possible that competitive price setting would increase the stability of plan participation in the program, depending on how prices are determined.

It is equally important for policy-makers to recognize that market-based approaches have shown little potential for affecting the rate at which health spending will grow in the future. If the rate of increase is of concern to policy-makers, it should be addressed through explicit political choices about the share of the federal budget devoted to the Medicare program. Although making these choices is indisputably difficult, they cannot be “delegated” to market forces.

It is not the charge of this panel to determine how much beneficiaries should be collectively expected to pay for their care. But we do believe that (a) for beneficiaries with moderate incomes, the current levels of out-of-pocket spending are already at (if not above) an acceptable upper limit and (b) that choices about the appropriate share of beneficiaries’ collective contributions to health care ought to be made openly and publicly, not disguised by the intricacies of some technical formula. These issues may be difficult to address openly, without

political consequences. But that is precisely why they need to be dealt with in as open and transparent a manner as possible. With these caveats in mind the Panel concluded that:

**Recommendation 6: Medicare should conduct competitive pricing demonstrations to pay private health plans. Most panel members think that original Medicare should be excluded from these demonstrations, although a few panel members believe that original Medicare should be included. These demonstrations should test both competitive bidding and Federal Employees Health Benefits Program (FEHBP) models.**

Most panel members favor exempting original Medicare from these competitive pricing arrangements for several reasons. Experience with private sector competitive models provides examples of plans that experience a financial “death spiral” in which their premiums become progressively more expensive, because enrollees with higher health expenses tend to remain in these plans, while healthier enrollees migrate to less expensive plans. Most panel members believe that adverse selection poses a significant risk to original Medicare, because sicker enrollees have gravitated to it for a variety of reasons. Given the current inadequate methods of risk adjusting payments, they believe that Medicare’s fee-for-service program would be disadvantaged in a competitive pricing demonstration.

It is precisely because there are a substantial number of beneficiaries who are in relatively frail health or of limited cognitive capacity that most members of the Study Panel concluded that they should, in every locality, be assured of a stable array of insurance arrangements and provider choices. In their view, this sort of security cannot be maintained if Medicare FFS is made a part of a competitive pricing model. Excluding original Medicare from competitive pricing would reduce the cost-saving potential of these arrangements. But experience over the past several decades has established that the growth of costs in original Medicare can be constrained at least as well as cost growth in markets for private insurance, so that the costs of this exclusion do not, in their assessment, seem unduly large.

A few panel members do not share this view. They believe that, although the ideal of a plan that is both stable and affordable is attractive, it is impossible to provide such a guarantee, offer choices of other plans, and still control program costs. Fundamentally, the guarantee of a traditional Medicare program with current benefits and with premiums in the (inflation adjusted) “affordable” range would require that original Medicare be provided, no matter how high its costs turned out to be. In their view, original Medicare lacks both constraints and accountability, the exact problem that competitive bidding models are intended to remedy.

Therefore, they disagree with the view that original Medicare should be exempted from direct price competition with private health plans. Their concern is that exempting Medicare FFS

from competition would discourage private health plans from participating in Medicare, which would in turn deny beneficiaries the benefits of plan choice, the possibility of getting additional benefits at no cost or a lower cost to them, and greater potential for coordination of care. Fundamentally, they believe that exempting FFS Medicare from competition would remove an important incentive for FFS to improve its own performance with respect to costs and quality.

However, they are mindful that direct price competition between FFS and M+C could be both disruptive and costly for some beneficiaries, particularly those with cognitive impairments or serious illnesses. To address these issues, they endorse full risk adjustment of premiums and propose that payment for some of Medicare's broader functions be removed from the bidding process and paid separately.<sup>41</sup> They also propose special treatment, in the form of "premium stability insurance" for vulnerable beneficiaries, to prevent them from facing dramatic changes in premiums and from having to change from their preferred health plan (either FFS or a private health plan) because of increased premiums. Premium stability insurance would hold vulnerable beneficiaries harmless from dramatic increases in premiums above a pre-determined amount.

Beneficiaries not categorized as vulnerable due to cognitive impairment or serious illness would not be eligible for premium stability insurance (although they might qualify for existing premium subsidies (the Medicare Savings Program) for low-income beneficiaries. They could therefore experience increased premiums as the result of direct price competition between original Medicare and M+C. Either the public or private sector could run the premium stability insurance program. The cost of this insurance could be paid by either the beneficiary or the government.

The majority of the panel viewed these efforts to make competition "safe" for vulnerable beneficiaries to be inadequate in several ways. There is no evidence that any feasible method of risk adjustment can protect either beneficiaries or the Medicare program from the consequences of selective enrollment of healthier beneficiaries in private health plans. Premium insurance offers no safeguard for vulnerable beneficiaries against the unexpected cuts in coverage, discontinuities of care, disrupted relationships with doctors, and rising out-of-pocket costs that have resulted from unstable participation by private plans in the M+C program.

## NOTES

<sup>1</sup> Both the House of Representatives and the Senate passed bills in June 2003 to provide outpatient prescription drug benefits to Medicare beneficiaries. As of this writing, a conference committee is working to reconcile differences between the two bills.

<sup>2</sup> Retirees include those under age 65 (who are not eligible for Medicare unless they are disabled) and those age 65 and older who are eligible for Medicare.

<sup>3</sup> The discussion in this section is derived from MedPac 2002; Chollet and Kirk 2001.

- <sup>4</sup> Pre-existing policies were generally allowed to continue, and three states (Massachusetts, Minnesota, and Wisconsin) already had laws requiring standard policies. About 30 percent of the policies in 2000 were “pre-standard” plans, meaning that they were in effect prior to the 1992 effective date of the law.
- <sup>5</sup> In addition, many insurers “front load” issue age premiums by charging higher premiums initially, so policy-holders who cancel a premium forfeit excess premiums already paid.
- <sup>6</sup> AARP does not community rate Medigap policies with drug coverage. It also provides some discounts to long-term subscribers.
- <sup>7</sup> Peter Fox, presentation at the National Health Policy Forum session, *Medigap: Prevalence, Premiums, and Opportunities for Reform*, October 2, 2002.
- <sup>8</sup> For a more complete explanation of Medicare/Medicaid dual eligibility categories, see MedPAC’s report, *Assessing Medicare Benefits*.
- <sup>9</sup> Medicaid assistance for those between 120 and 175 percent of the federal poverty level is limited by a federal appropriation, and is provided on a first-come, first-serve basis.
- <sup>10</sup> For example, a recent study from Mathematica Policy Research (Gold and Achman 2002) estimated that elderly beneficiaries who had purchased Medigap policies C, E, and J had out-of-pocket spending 11 percent, 13 percent and 19 percent higher, respectively, than beneficiaries covered only by original Medicare with no supplemental policy.
- <sup>11</sup> These are also referred to as stop loss provisions because they cap the amount of cost sharing required of enrollees who are very sick and thus have large medical bills.
- <sup>12</sup> Although the salience was roughly equal for the two groups, their conclusions were quite different. Forty percent of those with supplemental benefits who considered a private plan actually joined one. The disabled were much less enthusiastic about their options in the private sector: only a quarter of those who considered an M+C plan actually enrolled in one.
- <sup>13</sup> For example, 85 percent of switchers and 79 percent of new enrollees understand that their choice of physicians is limited in managed care, compared to 62 percent of FFS beneficiaries.
- <sup>14</sup> Those with inadequate functional health literacy often misread simple prescription instructions, information regarding the results of blood sugar tests, and the simplest reading comprehension test for a gastro-intestinal test. Those with marginal health literacy performed better on these tests, but showed poor comprehension of blood glucose tests, and instructions for taking medicine on an empty stomach, for example.
- <sup>15</sup> And of those that do help, more than half report feeling ill-informed about health insurance decisions; many adult children score poorly on even the most simple questions about Medicare benefits. (For example, less than a third knew that Medicare did not cover long-term care services.)
- <sup>16</sup> Only Medigap policies A, B, C, and F must be offered on a guaranteed issue basis to enrollees whose plan has left the market.
- <sup>17</sup> Roughly half of those who enroll in coordinated care plans under Medicare report having to change their primary care physician (Nelson et al. 1996).
- <sup>18</sup> The survey of working aged Americans included those covered by employer-based insurance, individually purchased insurance, Medicaid, or uninsured.
- <sup>19</sup> In making the comparisons, the researchers estimated statistical models to control for differences in health status as well as number of chronic medical conditions.
- <sup>20</sup> This measure was constructed as a composite of questions about not filling prescriptions, not getting needed specialist care, skipping a recommended or follow-up visit and having a medical problem without seeing a health care provider.
- <sup>21</sup> However, no conclusions about disabled beneficiaries can be drawn from this survey because the sample size was too small.
- <sup>22</sup> National level data are presented here, but ZIP code level data are available for specific M+C plans on Medicare Compare on the CMS web site. CAHPS measures for beneficiaries in original Medicare include only those residing in areas where M+C plans are available.
- <sup>23</sup> Subsumed in these results are responses to questions that asked them, within the last six months, how often they: (a) got the help or advice they needed when they called the doctors office during regular business hours; (b) got treatment as soon as they wanted when they needed to be seen right away for an

illness or injury; (c) got an appointment as soon as they wanted for regular or routine health care; and (d) waited only 15 minutes or less past their appointment time to see the person they wanted to see.

<sup>24</sup> This battery of questions measured, within the past six months, whether they had any problems with: (a) Finding a personal doctor or nurse; (b) Getting a referral to a specialist they wanted to see; (c) Getting the care they and their doctor believed necessary; and (d) Getting care approved by the health plan without delays

<sup>25</sup> Beneficiaries in original Medicare were not asked this question because they may self-refer to specialists.

<sup>26</sup> Disabled beneficiaries cannot be measured separately because the data do not capture disabled beneficiaries over the age of 65.

<sup>27</sup> Some low-income beneficiaries living in areas with high Medicare payments to private health plans may choose an M+C plan with no or low premiums over Medicaid.

<sup>28</sup> According to a 2002 report of the Medicare Payment Advisory Commission, beneficiaries with supplemental insurance cost the program more than those without such coverage. However, researchers have been unable to isolate the extent to which beneficiaries with supplemental insurance are getting unnecessary care or those without supplemental insurance are forgoing needed care because of the cost-sharing requirements (MedPAC 2002).

<sup>29</sup> There is also a growing body of evidence that documents under-use of needed health care services. For example, only half the population receives needed preventive care, and only 60 percent of those with a chronic illness such as diabetes or hypertension get the care they need ((McGlynn and Brook 2001).

<sup>30</sup> This figure includes managed care spending, which is projected to account for approximately 14 percent of Medicare benefit payments in 2003.

<sup>31</sup> Two researchers, Luft and Miller, have systematically reviewed managed care studies since the early-1990s. In 1994, they found that HMOs reduced use of medical services below those provided in FFS. However, they could find no reliable studies showing that managed care actually reduced health care spending. In 1997, they reported that between 1993 and 1997, five studies measured managed care spending against FFS spending in the private sector. Three showed substantially lower total expenditures, ranging from 16 to 34 percent less, while the other two studies showed little difference or mixed results (Miller and Luft 1997). Between 1997 and 2001, studies focused more on quality issues than cost containment, and no studies directly addressed the issue of whether managed care was more cost effective than FFS. Instead, studies seemed to focus on whether there were differences in use of discrete services between managed care enrollees and those in FFS. Little difference was observed in the number of inpatient hospital admissions between the two groups, although five studies showed significantly shorter lengths of stay, while five other studies showed no discernable differences in length of stay. Other studies showed that the number of ambulatory visits were comparable between the two groups. Several studies showed lower use of expensive resources, such as rehabilitation hospitals (instead of nursing homes), neurology consultations, emergency departments, cataract surgery, ambulances and services in an intensive care unit (ICU). However, less intensive resource use was not linked to lower costs overall (Miller and Luft 2002).

<sup>32</sup> Although payments to M+C plans are set administratively, plans are free to determine their own methods and rates of payment for plan providers.

<sup>33</sup> This discussion is derived from several articles that appeared in a special section of the September/October 2000 issue of *Health Affairs*, Dowd et al "A Tale of Four Cities: Medicare Reform and Competitive Pricing;" Nichols and Reischauer, "Who Really Wants Price Competition in Medicare Managed Care;" and Cooper and Vladeck, "Bringing Competitive Pricing to Medicare."

<sup>34</sup> The discussion in this section is largely derived from two sources: Merlis 1999a and GAO 2002a.

<sup>35</sup> The government contribution is not fixed in advance, but is determined by a formula that takes account participant choices from among options with different benefits, delivery systems and prices. OPM can indirectly affect costs by negotiating different benefits with plans, and affecting which plans may participate (Merlis 1999b).

<sup>36</sup> The BBA established the maximum at 72 percent of the enrollment-weighted average of all premiums.

<sup>37</sup> Comparisons of premium increases in FEHBP and Medicare should be made with caution, for two reasons. Much of the growth in Medicare spending during those years was due to increased use of skilled nursing facility and home health services, which are sharply limited in FEHBP. In addition, premiums in

the FEHBP are not always directly related to costs. In some years, premiums are above a cost, which leads to a build-up in the reserve fund, while in other years, costs exceed premiums and reserve funds are drawn down to meet expenses (Merlis 1999b).

<sup>38</sup> In a session sponsored by the Heritage Foundation on March 12, 2003, former HCFA Administrator Gail Wilensky commented on the findings of this study and cautioned that its findings of little risk segmentation ought not to be taken as a sign that risk selection is not a significant issue in the FEHBP. In testimony before the Health Subcommittee of the House Ways and Means Committee on March 2, 2002, Marilyn Moon also cautioned that risk selection would be a major issue if Medicare adopted an FEHBP model.

<sup>39</sup> Because of the magnitude of change, Aaron and Reischauer also recommended that their approach be phased in gradually and reevaluated every few years, and that federal payments be initially based on a blend of costs and capitation.

<sup>40</sup> See the recommendations of the NASI study panel on Medicare Chronic Care, *Medicare in the 21<sup>st</sup> Century: Building a Better Chronic Care System*, 2003.

<sup>41</sup> These functions include payment for graduate medical education and payments to disproportionate share hospitals.

# Chapter 4:

## Private Health Plans and Quality Disparities

Since Medicare was enacted, its original goals of financial security and increased access to health care have been expanded to include other missions. In this chapter, we explore the effects of private health plans for two goals. The first is improving the quality of care, which has emerged as a program goal within the last decade. The second is Medicare's role in reducing disparities in the health care of Medicare beneficiaries, which is gaining increased attention as a goal that should be pursued.

### **PRIVATE HEALTH PLANS AND IMPROVING THE QUALITY OF CARE FOR BENEFICIARIES**

When Medicare was enacted, it was designed to pay for health care costs incurred by beneficiaries in accordance with prevailing medical practices. The 1965 law required that all providers meet “conditions of participation” to ensure that care was rendered in facilities that met safety and health standards, and that care was provided by licensed providers. At the time, these requirements were considered to be all that was necessary to ensure quality of care.

During Medicare's first two decades, its emphasis was largely on assuring that services were provided by qualified providers in licensed facilities and in monitoring use of services to spot overuse or underuse. Beginning in the mid-1990s, evidence began to emerge about shortfalls in quality throughout the health care system. Reports from the Institute of Medicine (2001, 1999) found “a health care system that frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately... It may be exemplary, but often is not, and millions of Americans fail to receive effective care” (IOM 2001). These reports served to heighten policy-makers' and CMS' growing concerns about the quality of care in the American health care system.

### **QUALITY SHORTFALLS IN MEDICARE**

A parallel body of research suggested that Medicare beneficiaries in FFS face many of these same problems. Like other Americans, their primary care was often fragmented, treatment was frequently provided at sites ill equipped to provide appropriate care, and they were sometimes treated in inappropriate ways. The magnitude of these problems for Medicare beneficiaries was on par with problems faced by other Americans. However, because Medicare beneficiaries are older or disabled, they have more chronic conditions, and tend to be frailer than the general

population. This exacerbates particular types of quality problems, leading to less adequate coordination of care, and more frequent errors in medical practice than the general population.

### **Shared Quality Problems**

**Treatment At the “Wrong” Sites.** A growing body of research suggests that patients who are treated at hospitals with limited experience with particular health problems experience more frequent problems with medical care. A handful of recent studies have documented similar patterns for Medicare beneficiaries. For example, one study of Medicare beneficiaries who had one of fourteen high-risk cardiovascular or cancer operations in hospitals that performed a high volume of those procedures showed higher survival rates than patients in hospitals with low volumes of those procedures. Hospital volume was most important for patients undergoing cancer of the pancreas; only 4 percent of the high volume patients died, compared to 16 percent at lowest-volume hospitals. Hospital volume was also important for patients undergoing surgery for cancer of the esophagus, heart valve replacement, abdominal aneurysm repair, and surgery for lung, stomach, or bladder cancer. For each of these procedures, death rates at high-volume hospitals were between 2 and 5 percent lower than at lowest volume hospitals (Birkmeyer et al. 2002).

Another study of hospital-based care showed that Medicare beneficiaries being treated for heart attack are more likely to be alive two years later and receive better care if they are treated at teaching hospitals than those treated at hospitals that do not train physicians. Patients at teaching hospitals are also more likely to be given aspirin while hospitalized, which helps prevent blood clots, and to be given beta-blockers and ACE inhibitors upon discharge<sup>1</sup> (Allison, Kiefe, and Weissman 2000).

**Excessive Use of Certain Therapies.** Researchers began documenting overuse of health care services in the 1980s. The seminal study, the RAND Health Services Utilization Study, found that 17 percent of coronary angiographies, 32 percent of carotid endarterectomies, and 17 percent of upper gastrointestinal endoscopies were performed inappropriately on Medicare beneficiaries (Chassin 1997). Subsequent studies have documented persisting levels of inappropriate utilization under Medicare FFS, despite various utilization review arrangements to limit the extent of unnecessary medical procedures (Schneider et al. 2001b).

Overuse has also been documented in the use of psychotropic medications for the elderly. One review identified twelve studies showing that between 7 and 51 percent of sedatives, hypnotics, antidepressants, and anti-psychotics were overused (Chassin 1997).

Inadequate Preventive Care and Follow-up Care: There is considerable documentation that Americans continue to receive too few screening exams for preventable medical conditions (IOM 1999). This same pattern persists for Medicare beneficiaries. Table 4.1 shows increases in the percentage of beneficiaries receiving immunizations for influenza and pneumonia; pap smears for cervical cancers, and mammograms for breast cancer in the late 1990s. Immunization for pneumonia rose from 38 percent in 1995 to 55 percent in 1999. Rates of increase were more modest for other services. While use of preventive services has been rising, it is still well below optimal levels. Further, while each preventive service was used by a majority of beneficiaries, fewer beneficiaries received multiple preventive services. For example, in 1999, 91 percent of female beneficiaries received at least one preventive service; only 10 percent of beneficiaries were screened for cervical, breast, and colon cancer, as well as immunized against flu and pneumonia (GAO 2002b).

Another GAO study found very low rates of use for services to detect colorectal cancer. In 1999, 14 percent of beneficiaries received one or more of the Medicare covered preventive services (fecal occult blood test, flexible sigmoidoscopy, or double contrast barium enema). Of these three, the most common and least invasive is the fecal occult blood test, used by only 9 percent of beneficiaries, well below the recommended rate of once a year for every beneficiary. The use rate for flexible sigmoidoscopy, which Medicare covers once every four years, was 1.9 percent, while 3.8 percent of beneficiaries received a colonoscopy<sup>2</sup> (GAO 2000a).

Follow-up care after an acute illness also remains troublingly inconsistent. Although there is considerable variation across procedures, for Medicare beneficiaries the reported levels of care average between 35 and 80 percent of appropriate levels, whether measured in terms of physician visits after hospitalization for heart attack (83 percent), hemoglobin test after a diagnosis of anemia (54 percent), radiographs after congestive heart failure has been diagnosed (68 percent), or timely eye exams after a diagnosis of diabetes (42 percent) (Asch et al. 2000). Another study found that only 21 percent of Medicare beneficiaries who were eligible for beta-blocker therapy after a heart attack actually received it, even though patients who receive beta-blockers are 43 percent less likely to die in the first two years following the heart attack than those who did not receive beta-blockers (Soumerai et al. 1997). Unlike the trends for preventive screenings, the provision of follow-up care was not improving over time, although these studies were conducted before CMS' interventions to improve quality of care (Masters and Eng 2001).

**Table 4.1**

**Percentage of Medicare Beneficiaries Age 65 and Older Using Preventive Services in 1995, 1997, and 1999**

**National Usage Rate**

Service and Frequency	Year first covered under Medicare	1995a	1997	1999
Immunizations				
Pneumococcal-ever	1981	38	46	55
Influenza-within previous year	1993	60	66	68
Screening Services				
Cervical cancer-pap smear w/in previous 3 years	1990	70	71	72
Breast cancer-mammogram w/in previous 2 years	1991	66	72	75

\*For 1995 only, values obtained from CDC's BRFSSD web site data. These 1995 data includes Puerto Rico, and may include some survey respondents not enrolled in Medicare.

Source: GAO 2002b.

**PROBLEMS STEMMING FROM THE COMPLEX HEALTH CARE NEEDS OF MEDICARE BENEFICIARIES**

Because Medicare serves elderly and disabled people, its beneficiaries have health needs that are more complex than those of other Americans. Most strikingly, Medicare beneficiaries are more likely to have at least one chronic health problem and much more likely to have multiple chronic conditions. (These distinctive health needs are discussed at greater length in a companion report from NASI, *Medicare in the 21<sup>st</sup> Century: Building a Better Chronic Care System.*) Based on most recent estimates, 88 percent of those over 65 and 82 percent of the disabled have at least one

chronic health problem. Roughly two-thirds of both groups have multiple chronic conditions. And 20 percent of aged beneficiaries (14 percent of the disabled) have five or more chronic conditions.

The multiplicity of health problems and the numbers of health providers involved complicates the provision of appropriate care. For example, beneficiaries with no chronic problems typically see a single physician during the course of the year. In contrast, those with two chronic conditions see on average five physicians a year; those with five chronic conditions see more than a dozen different physicians. Beneficiaries with no chronic conditions fill, on average, four prescriptions a year; those with two chronic conditions average eighteen prescriptions a year; and those with five chronic conditions fill almost fifty prescriptions in a typical year (Eichner and Blumenthal 2003). Equally important, the combination of health problems leaves these beneficiaries in much frailer health and more vulnerable to negative repercussions if their care is not of the highest quality.

### **Errors in Medical Practice**

The widespread attention generated by the Institute of Medicine reports raised public concern about the prevalence and consequences of errors in clinical practice. A survey conducted in 2002 by the Harvard School of Public Health and the Henry Kaiser Family Foundation revealed that 35 percent of physicians and 42 percent of the public reported that they had experienced an error in their own care or that of a family member.<sup>3</sup> Eighteen percent of physicians and 24 percent of the public reported an error that had serious health consequences, including death (reported by 7 percent of physicians and 10 percent of the public), long-term disability (6 percent and 11 percent) and severe pain (11 percent and 16 percent) (Blendon et al. 2002).

Although less publicized, there is also evidence that the frequency of adverse events and medical errors increases with the age of the patient. The Harvard Medical Practice Study found that among hospitalized patients, the probability of an adverse event (about two-thirds of which were judged to be preventable) rose from 2.6 percent for patients age 16-44, to 4.7 percent among patients age 45-64, and to 5.9 percent for patients over the age of 65 (Brennan et al. 1991). Rothschild and Leape (2000) reanalyzed these data (collected in New York), as well as data from a follow-up study from Utah and Colorado. They found that every type of medical error was significantly more common for elderly patients than for younger patients (Table 4.2).

Several factors account for more frequent errors in older patients. Because they have more complex conditions and multiple co-morbidities, effective treatment is simply more difficult.<sup>4</sup>

This is reflected in findings that several types of adverse events are even more common among patients over the age of 85 (1.66 percent for medical treatment errors, 4.81 percent for operative complications), since this oldest group of patients has even more co morbidities and is, on average, in even frailer health. Other problems result from physicians who are inadequately trained to recognize the different presentation of illness in older patients, or who view older patients through negative stereotypes.

**Table 4.2**

**Frequencies of Different Types of Medical Errors, By Age of Hospitalized Patient**

Types of Medical Error	New York State		Colorado and Utah	
	Under 65	Over 65	Under 65	Over 65
Diagnostic Errors	0.27 %	0.48 %	0.22 %	0.27 %
Medical Treatment Errors	0.15 %	0.63 %	0.29 %	0.98 %
Drug Complication Rates	0.52 %	1.22 %	0.41 %	1.43 %
Operative Complication Rates	1.36 %	3.05 %	1.44 %	2.11 %

Source: Rothschild and Leape 2000.

**Failures of Coordination**

With multiple providers and therapies, there is a greater risk that treatment of older and disabled patients may be mismanaged. Many of the adverse drug reactions experienced by beneficiaries living in the community, for example, involve multiple drug interactions, which have been shown to account for a substantial number of hospitalizations and adverse drug reactions among older patients (Cooper 1996; Col, Fanale, Kronholm 1990). Other problems of coordinating care involve services that extend beyond the acute medical care required by younger patients to include more supportive and rehabilitative services. About two-thirds of all physicians consider themselves to be inadequately trained to effectively coordinate in-home and community services for patients with chronic conditions (Eichner and Blumenthal 2003).

**Inadequate Primary Care**

When patients have serious chronic conditions, their regular source of medical care is often specialists, not primary care physicians. Although this may have some advantages for the

treatment of a particular chronic condition, it probably undermines the quality of their primary care. In a 1994-95 sample in Washington State, Medicare FFS beneficiaries had an average of 7.5 outpatient visits per year; 14.7 percent of those surveyed saw only specialists. As one measure of adequacy of primary care, the study included immunization rates for influenza. Patients of who saw primary care physicians for the majority of visits had the best immunization rates, 55 percent, compared to 48 percent of medical specialists, and 40 percent of surgical specialists. Overall, the study found that specialists play an enormous role in providing ambulatory care to beneficiaries, but they tend to focus on the interrelated diagnoses that define their specialty, and “probably only rarely provide substantial amounts of care beyond their specialty” (Rosenblatt et al. 1998).

A second challenge for effective primary care is that older patients may have illnesses that present in atypical ways, or a multiplicity of health problems that makes it difficult to identify and manage emerging or worsening conditions. Physiological differences can lead to inappropriately high dosages of medications, which account for as much as three-quarters of the adverse drug events in hospitalized elderly patients (Gray et al. 1998). Adequate training in geriatric medicine can equip clinicians to deal with these challenges, but few physicians receive this training. As a result, “studies comparing geriatric assessments by geriatricians with those made by primary care or nongeriatric specialists find the latter miss many diagnoses, particularly gait disorders, metabolic problems, early cancers, presence of untreated infections, and reversible causes of incontinence and dementia” (Rothschild and Leape 2000).

### **THE EMERGENCE OF QUALITY IMPROVEMENT AS A GOAL FOR THE PROGRAM**

Beginning in the 1990s, CMS began to take more proactive efforts to measure and improve quality, and Congressional attention to quality issues has also increased. Perhaps most significantly, in 1992 CMS changed the mission of Peer Review Organizations (PROs) from detecting individual instances of inappropriate or poor quality care to changing and improving patterns of care.<sup>5</sup> Within this new framework, CMS has pursued a number of strategies, including setting measurement and performance goals; developing a database to measure FFS quality; establishing service-specific quality measures; conducting patient satisfaction, quality, and health status surveys; conducting demonstrations to improve quality; and encouraging physicians to focus on quality improvement.

#### **Establishing Quality Improvement Targets**

The PROs are responsible for improving quality for beneficiaries in original Medicare. Their first initiative under the new framework, the Cooperative Cardiovascular Project, was designed to help providers improve systems of care for beneficiaries who suffered a heart attack. In 1999, the focus was expanded to include heart attack, breast cancer, diabetes, heart failure, pneumonia,

and stroke. In addition, CMS also adopted a number of performance goals to encourage PROs to:

- reduce one-year mortality rates following hospitalization for heart attack;
- increase mammography rates;
- increase immunization rates for flu and pneumococcal vaccines; and
- improve the rate of biennial diabetic eye exams.<sup>6</sup>

In M+C, each coordinated care plan must develop and implement a quality improvement assessment plan as a contracting requirement. While plans are given a fair amount of latitude about the design and implementation of such plans, their purpose is to measure and achieve sustained improvement in quality over time. Since 1999, when this requirement was implemented, CMS has specified national quality improvement projects for each year. They are: diabetes (1999); pneumonia (2000); congestive heart failure (2001); breast cancer screening (2002); and disparities or culturally and linguistically appropriate services (2003).

Recently, CMS also initiated quality improvement projects in hospitals to identify patient safety issues and reduce medical errors that occur in hospitals.<sup>7</sup> In January 2003, CMS published a final rule that requires hospitals to develop and maintain a quality assessment and performance improvement (QAPI) program as a condition of participating in Medicare. QAPI programs identify and verify quality-related problems and their underlying causes; design and implement corrective action activities to address deficiencies; and follow up to determine the degree of success of a corrective intervention and to detect new problems and opportunities for improvement.

### **Measuring Care Provided to Beneficiaries**

CMS collects separate measures of performance for M+C plans and for original Medicare. The Health Plan Employer Data and Information Set (HEDIS) consists of a set of standardized performance measures that assess the quality and services provided by managed care plans.<sup>8</sup> Since 1997, CMS has collected HEDIS measures for all managed care plans. The quality portion of HEDIS is comprised of thirteen measures, of which six measure patient satisfaction, six whether beneficiaries received preventive health care services, and one whether the plan has enrolled Medicare beneficiaries for at least one year.<sup>9</sup>

In 2000, as the next stage of the Health Care Quality Improvement Project, CMS announced the creation of the first national database of process measures of the quality of care provided to

FFS beneficiaries. Twenty-four quality of care measures were chosen, based on professionally developed, widely accepted practice guidelines that were translated into measures as part of a larger public-private partnership, a public health surveillance effort, or by CMS staff in consultation with experts. The measures cover six conditions: heart attack, breast cancer, diabetes mellitus, heart failure, pneumonia, and stroke. The data are collected by abstracting medical records for randomly selected beneficiaries.

While creation of the database represents a significant achievement in quality measurement for FFS, it over-represents inpatient and preventive services, under represents ambulatory care, and includes very few interventional procedures. It also does not include information on individual practitioners and providers, because that would have required a much more voluminous database. Thus, its principal use is measuring quality at the state level, which CMS will use to help determine the effectiveness of the QIOs.<sup>10,11</sup>

CMS has also developed and implemented several quality measures for specific services and settings including nursing homes and home health care.<sup>12</sup> In addition, in December 2002, a number of hospital and consumer organizations announced a joint agreement to allow some standardized hospital quality measures to be posted on a public website hosted by CMS.<sup>13</sup> These measures, which focus on the process of care rather than the outcome, are currently collected by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as part of the accreditation process, but have not been made public. The ten measures to be reported on the website include treatments for heart attack, heart failure, and pneumonia. (Participation at this point is voluntary, although CMS will identify participating hospitals, and Administrator Tom Scully has said that mandatory reporting of quality measures is on the horizon, likely within two years.)

### **Measures of Health Care Outcomes**

CMS also oversees several ongoing surveys intended to measure outcomes of care in both FFS and M+C. The Consumer Assessment of Health Plans (CAHPS) is part of a group of consumer surveys developed by a consortium of researchers.<sup>14</sup> Since 1998, CMS has used the CAHPS in an annual, nationwide survey of Medicare beneficiaries.<sup>15</sup> Initially, only enrollees of managed care plans were surveyed, but the survey now includes FFS beneficiaries and beneficiaries who disenroll from a plan.

The surveys contain core items that ask beneficiaries for four overall ratings of their doctor (or specialist, if one is used), overall health care, and health care plan. CMS has also funded the development of a special version of CAHPS for Medicare to capture the experiences of

beneficiaries with chronic conditions or limitations in the activities of daily living (Goldstein et al. 2001).

A second survey, the Health Outcomes Survey (HOS), was developed in 1997 to assess a health plan's ability to maintain or improve the functional status of Medicare beneficiaries over time. A part of HEDIS, HOS is designed to measure the physical and mental health functioning of the Medicare population and the beginning and end of a two-year period using a survey instrument known as the 36-item Short Form Health Survey, or SF 36.<sup>16</sup> CMS requires all M+C plans to participate in HOS, and CMS is also conducting the HOS survey among FFS beneficiaries.

CMS and the AHRQ are also planning to collaborate on the development of a patient satisfaction survey for hospital patients, and mandate reporting of its results as soon as the survey instrument is validated. The survey will be tested and validated in a three state reporting pilot in 2003 in Arizona, Maryland, and New York (*Medicine and Health* 2002).

### **Demonstration Projects to Improve Quality of Care**

Since the 1970s, Medicare has authorized demonstrations to test new ideas in Medicare. The Program of All-Inclusive Care for the Elderly (PACE) has been one of the most successful. Currently, approximately forty sites participate in PACE, which is designed to keep frail beneficiaries with chronic conditions in their communities by coordinating a wide array of services, including adult day care services on site, prescription drugs, home health and personal care, respite care, and hospital and nursing care when necessary. The average beneficiary participating in PACE today is an 80 year-old female with 8 chronic conditions who needs assistance with three activities of daily living (ADLs) ([www.natlpacessn.org](http://www.natlpacessn.org)). In order to be eligible to participate in PACE, beneficiaries must be at least 55-years-old, live in the PACE service area, and be certified as eligible for nursing home care. PACE participants must agree to use PACE as the sole source of their care.

PACE providers are paid on a capitated basis from both Medicare and Medicaid. An interdisciplinary team, consisting of both professional and paraprofessional staff, assesses participants' needs, develops care plans, and provides all necessary services, including long term care. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the interdisciplinary care team. Medicare payments to PACE providers are significantly higher than payments to M+C organizations; for community-based individuals, PACE programs are paid 2.39 times more than the average Medicare costs for the elderly population (Federal Register 1999).

In recent years, CMS has also established several initiatives to develop new approaches for improving quality. For example, to test the efficacy of using HOS for quality improvement, CMS established a national pilot project using HOS data to improve the recognition and treatment of depression in primary care settings. In the project, which began in 2000 in five states, health plans are collaborating with QIOs to design and implement interventions for beneficiaries identified as being at risk for depression.<sup>17</sup> Using a subsequent HOS survey, post-intervention results will be compared to baseline to determine whether the interventions are having an effect (Stevic et. al. 2000).

In addition to the quality improvement demonstrations initiated by CMS, Congress has also directed the agency to conduct specific types of demonstrations to improve quality. Over the past five years:

- The BBA directed CMS to test whether providing coordinated care services to Medicare FFS beneficiaries with complex chronic conditions can yield better outcomes without increasing Medicare spending. CMS awarded fifteen proposals to test a wide range of programs, including a mix of case management and disease management models operating in urban and rural settings. The projects, which were chosen 2001, will run for four years.
- BIPA directed CMS to conduct demonstration projects to test the impact on costs and health outcomes of applying disease management services, supplemented with prescription drug coverage, for Medicare beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary artery disease. The projects may include up to three organizations, each serving up to 30,000 beneficiaries for a period of three years
- BIPA directed CMS to implement a demonstration to test physician groups' responses to financial incentives for improving care coordination; delivery processes and patient outcomes; and the effect on access, cost, and quality of care to Medicare beneficiaries. The demonstration, which is open only to physician groups being paid by Medicare on a FFS basis, will run for three years. Performance on both process and outcome quality measures, together with cost savings, will be used to calculate bonus payments. The targets for quality measures will be based either on demonstrating improvement over time or achieving a predetermined threshold for: (1) influenza vaccination; (2) hemoglobin A1c tests for diabetics; (3) mammograms; (4) chest radiograph and electrocardiogram for congestive heart failure (CHF); (5) left ventricular ejection fraction testing for beneficiaries with CHF; (6) physician visits for beneficiaries with chronic stable angina, chronic obstructive pulmonary disease (COPD), CHF, or diabetes; and (7) rate of ambulatory care sensitive conditions (ACSC) admissions per 1,000 beneficiaries.

### **Efforts with Physicians**

In an effort to engage physicians in quality improvement efforts, CMS announced a pilot project in April 2003 that will award continuing medical education credits (CME) to physicians who participate in quality improvement projects with a QIO. Under the pilot, physicians can earn up to ten CME credits a year for working with a QIO to improve the quality of care provided in offices and outpatient settings. Initially, three clinical areas, including diabetes/influenza/pneumococcal immunizations and breast cancer screening will be part of the project. CMS will cover the costs of thirty CME credits for the first one hundred physicians participating in each state.

### **Success in Improving Quality of Care**

Because many of these quality improvement initiatives were begun recently, we still know relatively little about their effectiveness. The best evidence is available for the revised mission of the QIOs. According to CMS, the Cooperative Cardiovascular pilot project increased the use of beta-blockers for heart attack patients from 47 to 68 percent in Alabama, Connecticut, Iowa, and Wisconsin (HCFA 2000c).

In January 2002, CMS reported that it had surpassed its goal of increasing both flu immunizations and mammography rates to 60 percent in 2000, was making progress on the increasing the rate of biennial diabetic eye exams to 68 percent, but would not meet its goal to reduce the one-year mortality rate to following heart attack<sup>18</sup> (NCHS 2002).

With respect to process of care measures at the state level for beneficiaries in FFS, researchers found a marked improvement between 1998 - 1999 and 2000 - 2001. For the median state, performance increased on twenty of the twenty-two indicators, with the percentage of beneficiaries receiving appropriate care increasing from 69.5 percent to 73.4 percent, a 12.8 percent relative improvement. The average relative improvement was nearly 20 percent for outpatient indicators, and almost 12 percent for inpatient indicators. While improvement was associated with increased QIO activities, data limitations did not allow researchers to directly attribute improvement to QIO actions. Despite these improvements, researchers found a “much larger opportunity for future improvement” (Jencks, Huff, and Cuerdon 2003).

### **Private Health Plans and Their Potential Consequences for Quality of Care**

Private health plans can affect quality for Medicare beneficiaries in two ways. First, the structure of some private plans — more specifically, coordinated care plans — may have consequences for quality of care. Second, competition among private plans may, depending on the circumstances, either encourage private plans to improve quality, or discourage them from pursuing quality enhancements. There is a small body of evidence on the impact of coordinated care plans on

quality for older enrollees. But there has been no experience with Medicare+Choice plans in a more competitive environment. Consequently, predictions about quality of care must again be based on experience with comparable models for working aged Americans.

### **The Impact of Coordinated Care on Medicare Quality**

Compared to FFS Medicare, where beneficiaries frequently obtain care from multiple providers, who have no means of knowing about other sources of care unless beneficiaries inform them, coordinated care plans have the ability to track all care provided to beneficiaries by plan providers.. They can also monitor the practice patterns of affiliated physicians to ensure that care provided is appropriate and in accordance with clinical guidelines. In addition, many plans require beneficiaries to obtain approval from their primary care physicians to see specialists, which should improve both coordination of care and enhance the quality of the primary care relationship.

Coordinated care plans also have an advantage over FFS in reimbursement practices. Although plans are paid a fixed price by Medicare, they can choose the method of payment for providers in the plan. Through these payment methods, particularly capitation, plans can encourage greater coordination of care. By contrast, FFS reimbursement methods, which reimburse providers only for billable services provided, create disincentives for providers to coordinate care through a team approach or through telephone consultations.

The track record of managed care plans for younger enrollees suggests that this potential for quality improvement is, at best, only inconsistently realized. The most recent review of research comparing the quality of care in managed care plans to that in more conventional insurance found that both provide roughly comparable quality of care, while HMOs reduce somewhat the use of hospital care and expensive resources. However, managed care enrollees report worse results on many measures of access to care and lower levels of satisfaction compared to FFS enrollees. Quality results are mixed, "...which suggests that quality is not uniform — that it varies widely among providers, plans (HMO and non-HMO), and geographic areas" (Miller and Luft 2002).

The evidence on quality for older enrollees is also mixed. After reviewing the entire body of research comparing managed care and fee-for-service quality under Medicare, Miller and Luft concluded that HMOs enrolling Medicare beneficiaries had "comparatively negative findings" relative to FFS Medicare.

Compared to the findings on quality for privately-insured individuals, the evidence for Medicare beneficiaries appears to fall into a somewhat more consistent pattern. Medicare beneficiaries

enrolled in coordinated care plans tend to have stronger connections to primary care providers and reduced errors in the diagnosis of serious illness. Conversely, follow-up care does not appear to be improved for the average Medicare enrollee. And for those with more complex and chronic health problems, quality appears to be worse for those enrolled in coordinated care plans.

On the positive side of the ledger, the proportion of Medicare beneficiaries who report that they have an established relationship with a regular medical provider is higher for those enrolled in managed care plans (Nelson et al. 1996). Enrollment in M+C plans is associated with an increase in immunization rates (from 65 percent to 71 percent), widely used as a marker of the quality of primary care (Schneider et al. 2001a). Various cancers appear to be identified at an earlier stage and treated with greater success in M+C plans than in FFS Medicare (Merrill et al. 1999; Riley et al. 1999).

Evidence on the quality of follow-up care is mixed. Studies of treatment patterns using similar performance measures for FFS Medicare (Asch et al. 2000) and Medicare+Choice plans (Schneider, Zaslavsky, and Epstein 2002) have documented that some treatment is better in private health plans, some in original Medicare. For example, beneficiaries in M+C plans are more likely to receive timely eye exams following a diagnosis of diabetes (49 percent vs. 42 percent). They are much less likely, however, to have a follow-up outpatient visit following a hospitalization for a mental health problem (53 percent vs. 95 percent).

On the negative side of the ledger, M+C plans are associated with less continuity of care, impaired physician-patient communication, or worsened overall quality for beneficiaries with chronic health problems. A 1998 survey of Medicare beneficiaries compared quality for those enrolled in HMOs in thirteen states with mature, substantial HMO markets to those in FFS Medicare.<sup>19</sup> The survey found that FFS Medicare performed significantly better in terms of duration of primary care relationships, visit-based continuity, and all scales relating to the quality of the physician-patient interaction (Safran et al. 2002).

M+C appears to perform less effectively for older enrollees with more serious and chronic health problems. Miller and Luft reviewed the relevant literature at two different points over the past ten years. Based on studies from the end of 1993 through early 1997, they found a pattern of worse care for frail elders and the chronically ill, based on three findings negative to HMOs (Miller and Luft 1997). In 2002, they reported that, of the four findings for stroke and frail elders, two were unfavorable to HMOs and none were favorable, although the studies showing negative findings were not as comprehensive as findings in the past (Miller and Luft 2002).

One must interpret these results with caution because the evidence is inconclusive. Although existing research reveals some suggestive patterns, these are based on the limited number of studies, which are imperfectly adjusted for differences in the health status of respondents. Constrained Medicare payment rates may have also undermined the performance of M+C plans.

### **Promoting More Effective Coordinated Care**

Evidence from the PACE demonstration suggests that it is possible for coordinated care plans to perform more effectively. Evaluations have documented that PACE sites are associated with improved quality of care for beneficiaries in frail health, compared to FFS Medicare (Chatterji et al. 1998). More strikingly, the improvements are most substantial among beneficiaries who are the most impaired, precisely the group for which M+C plans appear to perform least well. But the positive PACE track record remains the exception, not the rule. Five years after moving from a demonstration to a core Medicare benefit, there are still only forty PACE sites in the country. Why haven't M+C plans been more ready to adopt PACE programs, or at least adapt their lessons about how to effectively manage the care of frail elders?

Several factors appear to be at work. First, implementing PACE models requires considerable investment in infrastructure, both within the health plan and the communities in which they operate. Given the instability of plan participation in M+C, it makes little sense for most plans to make these longer-term investments. Second, the sorts of care coordination that have been adopted by most managed care plans involve the use of case managers and disease management protocols designed to improve care for particular illnesses (Boult et al. 2000). Although these show promise for working-aged patients, who tend to have only a single serious health problem, they cannot deal with the more complex needs of older and disabled patients. Third, the sorts of change in clinical practice embodied in the PACE model require high levels of commitment to change among affiliated physicians. In contrast, many M+C plans have large networks of clinicians, each of whom may have only a handful of patients from a given plan. Under these circumstances, few clinicians are likely to make the commitment to make the sorts of changes in practice patterns required by the PACE model.

Finally, PACE Medicare payment levels are 2.39 times higher than for the average elderly Medicare beneficiary. Providing such a comprehensive service package in PACE has been possible only by pooling Medicare and Medicaid funds, which limits the populations to which this sort of enhanced managed care can be applied. And efforts to blend PACE into the M+C program with a common capitation rate threaten to so reduce revenues that the PACE plans that have been established will be starved of essential support (Masters and Eng 2001).

## **THE IMPACT OF PRIVATE HEALTH PLANS ON MEDICARE QUALITY**

To date, the track record for private plans in Medicare has been shaped by the terms under which these plans contract with the program. These M+C payment rates established in law have limited the extent of competition in many parts of the country, provided only a limited financial incentive for enrollees to choose carefully among private health plans, and only recently provided beneficiaries with the sort of information that would allow them to identify plans that were offering higher quality care. Were Medicare to encourage more effective competition, could one expect any improvements in quality?

Because we have no direct experience with competitive pricing arrangements under Medicare, predicting their impact is necessarily speculative. But one can draw some useful inferences from the experience of similar contracting arrangements in employer-based insurance. One striking example emerged from a consortium of employers who were among the first to embrace a competitive choice model, provide fixed premium support for employees' health benefits, and survey employees to assess their experiences with health plans (Allen et al. 1994). The results from these surveys (Table 4.3) suggest that although managed care plans were viewed as clearly superior in terms of costs and paperwork requirements, and although there were no significant differences among health plans in terms of quality problems among healthy employees and employees with chronic conditions, problems related to various aspects of quality were significantly more common in managed care plans than with FFS insurance (Druss et al. 2000).

## **PRIVATE HEALTH PLANS AND DISPARITIES IN HEALTH CARE EXPERIENCED BY MEDICARE BENEFICIARIES**

Prior to the enactment of Medicare, access to health care was a major issue for many elderly Americans, particularly minority Americans. Only about 50 percent of the elderly had hospital insurance. Elderly African Americans and those with the lowest incomes had fewer physician visits and were admitted to the hospital at lower rates than white Americans and those with higher incomes (Davis and Schoen 1978).

Medicare's primary goal was eliminating barriers to health care for all elderly people. Although not designed explicitly to reduce disparities among different groups of beneficiaries, in conjunction with the Civil Rights Act of 1964, Medicare made major contributions in improving access to care for minorities, both by providing them with access to health care and by prohibiting segregation in health care facilities (Smith et al. 1998; Davis and Schoen 1978). After Medicare's implementation, the number of physician visits and hospital admissions for minorities increased sharply and approached the rates for whites and higher income groups. By the mid-1980s, hospitalization rates for blacks began to exceed the rate for whites (Gornick, Eggers, and Riley 2001).

**Table 4.3**

<b>Frequencies of Poor Performance Ratings Reported by Employees Enrolled In Various Types of Health Plans Under Competitive Choice Models</b>						
Measure of Plan Performance	Healthy Enrollees			Chronically Ill Enrollees		
	FFS*	IPA*	PGP*	FFS	IPA	PGP
<i>Cost and Paperwork</i>						
Cost Sharing and Premiums	37.4 %	12.3 %	9.3 %	40.5 %	14.1 %	9.4 %
Paperwork Requirements	22.0 %	8.1 %	6.2 %	24.4 %	10.6 %	8.2 %
<i>Quality of Medical Care</i>						
Technical Quality of Care	8.9 %	8.7 %	11.3 %	9.8 %	12.7 %	17.8 %
Communications	12.3 %	10.1 %	12.2 %	13.4 %	15.5 %	16.7 %
Physician-Patient Interaction	11.9 %	10.0 %	13.2 %	11.3 %	14.2 %	18.3 %
Outcomes from Treatment	7.8 %	7.0 %	8.2 %	10.5 %	12.2 %	16.7 %

Notes: FFS: Fee-for-service plans; IPAs: Managed Care, Independent Practice Associations; PGPs: Managed Care: Group and Staff Model.

Source: Druss et al. 2000.

Medicare was thus responsible for closing the gaps in access to care that previously existed among different groups of American elderly people. But it did not entirely eliminate these gaps. And policy-makers would later discover that getting beneficiaries through the door of a doctor's office (or hospital admitting room) was not, in itself, sufficient to ensure equal treatment.

The full import of these unequal experiences, their relationship to the involvement of private health plans in Medicare, and their implications for future Medicare reform, remain matters of considerable debate. But as the American public becomes increasingly aware of, and concerned about, disparities in access to care, treatment, and outcomes, it is likely that the salience of these issues for judging Medicare's performance will grow as well.

### **Identifying Policy-Relevant Disparities in Care Among Medicare Beneficiaries**

Medicare has systematically collected data on the race and ethnicity of beneficiaries, and has far greater ability to examine the extent of disparities than any private health insurer. As a result of Medicare's rich data, researchers have been able to document a plethora of differences in health

care and health outcomes among different subsets of Medicare beneficiaries. But the import of these differences for assessing Medicare's performance is not always clear. Some differences are not necessarily inappropriate or unfair. Other differences may have little to do with Medicare policies and practices, and thus lie outside the scope of debates over Medicare's effectiveness.

### **The Meaning of "Disparities"**

To label a difference a "disparity" is to assert that the differences violate some accepted norm of fairness. Clearly not all differences do this. Evidence that 85-year-old beneficiaries have higher mortality rates than 65-year-olds ought to evoke little alarm. Evidence that the former see the doctor more often than the latter would also be considered neither surprising nor cause for concern. Evidence that 85-year-old beneficiaries were consistently treated less aggressively by physicians than were 65-year-old patients might also be viewed as perfectly acceptable, though people may disagree as to the how large a difference in treatment they would consider acceptable. Evidence that the average 85 year-old has less discretionary income than the average 65 year-old, and can thus purchase fewer discretionary medical procedures might also be given guarded acceptance, if one were convinced that the treatments in question are truly discretionary.

It was not this panel's mandate to explore the ethical underpinnings of the Medicare program. Nonetheless, one cannot meaningfully assess the import of differences among beneficiaries, cannot determine when a difference constitutes a "disparity," without being clear about the norms of fairness that are being invoked. For the purposes of this study, the panel considered the following standard of equity: that all beneficiaries should have an equal chance of receiving the treatments considered medically necessary for their health problems. This standard has several important implications for defining disparities. First, differences in health care use would be treated as disparities only if the group with lower levels of treatment could be shown to have measurably benefited from treatment they did not receive. Second, groups receiving equal levels of treatment may still embody disparities, if those groups have very different levels of health needs. Third, this standard focuses attention more on differences in treatment than on differences in health outcomes. This is not to suggest that differences in health outcomes do not exist or are not important. At age 65, women have a significantly longer life expectancy than men; whites and Hispanics have a longer life expectancy than African Americans (NCHS 2002). High-income beneficiaries live longer than those with more limited financial means. Assessed in terms of morbidity, the different set of "disparities" emerges. By these standards, Hispanic and African American beneficiaries have more health problems than whites: for example, about 25 percent of whites perceive their health status as poor, compared to over 40 percent of blacks and Hispanics (Murray 2000). Elderly women have more chronic health problems than elderly men (79 percent have two or more chronic conditions, compared to 60

percent for men) more arthritis (63 percent vs. 42 percent) and are more often limited in activities of daily living (33 percent vs. 27 percent) (Kaiser Family Foundation 2001a). Elderly black women are more likely than their white counterparts to have at least three chronic conditions, including hypertension, diabetes, cardiovascular disease, and cerebrovascular disease (NIH 2002).

Many of these differences may be important for creating a more just society. But they are not, we would argue, appropriate standards for judging Medicare's performance. Some of these differences would not even be appropriately labeled disparities. Women have more chronic conditions than men because they outlive men. This hardly counts as a failure or inequity, let alone one for which Medicare should be held responsible. Other differences, such as the increased prevalence of chronic illness and low health status among ethnic and racial minorities, are more sensibly seen as disparities. These may well merit the attention of policy-makers. But they are not sensible criteria for judging Medicare. Health status and life expectancy are influenced far more by social determinants of health than by medical care. To the extent that they are shaped by medical care, it will often be from treatment received (or foregone) long before someone becomes eligible for Medicare. Consequently, to hold Medicare responsible for differences in health status and life expectancy among the elderly and disabled is to suggest that Medicare be responsible for every American's well-being throughout his or her life. No program should be charged with a mandate this broad.

Differences in health outcomes are not entirely irrelevant for discussions of disparities in Medicare, even when those disparities are defined in the narrower fashion that we favor. Some disparities in health outcomes can be directly linked to the different treatment experiences of particular groups of beneficiaries. For example, five-year survival rates from cancer are much lower for black than white beneficiaries, attributable in part to the fact that blacks are also far less likely than whites to have cancer diagnosed when it is still localized (rather than metastasized) (Gornick 2000). Differences in health status among groups are also important for interpreting differences in treatment patterns, in ways discussed below.

### **Identifying Groups for Assessing Disparities**

Earlier sections of this report emphasized the different experiences between beneficiaries who are relatively healthy compared with those who have serious and chronic health problems. These differences in health status correlate with other group identifications: disabled versus aged beneficiaries, old-old (85+) versus younger cohorts of beneficiaries, as well as gender and racial groupings. Because differences related to health status are explored elsewhere in this report, they are excluded here.

Previous research on the health care experiences of working-age Americans has documented significant disparities by racial/ethnic group and by socio-economic status, indicating that disparities are pervasive in the health care system, and not unique to Medicare (IOM 2002). In the literature on Medicare, unfortunately, there has been a sufficiently large body of research to effectively document disparate treatment only for particular subsets of disadvantaged groups. There is a fairly accurate picture of the differential health care experiences of black beneficiaries compared to whites, but much less is known about the experiences of Latinos, or other ethnic or racial minority groups. On the socio-economic front, we have relatively complete information comparing beneficiaries from high and low-income households, but little information related to other measures of financial well-being.

Due to these limitations in data regarding other racial and ethnic groups, the panel focused primarily on disparities between black and white beneficiaries, and between beneficiaries from high- and low-income households.<sup>20</sup> Even within this limited purview, there are some challenges in assessing the magnitude and origins of disparities. Minority beneficiaries are much more likely than their white counterparts to live in poverty. Only 10 percent of whites over the age of 65 have incomes below 100 percent of the federal poverty standard, compared to 33 percent of African Americans and 30 percent of Latinos (Figure 4.1). African American and Latino women were also much more likely than white women to have incomes below \$10,000, with 56 percent of African American women and 58 percent of Latino women with incomes below \$10,000 compared to 24 percent of white women (Kaiser Family Foundation 2001a). These correlations make it more difficult to sort out the distinctive experiences of each group.

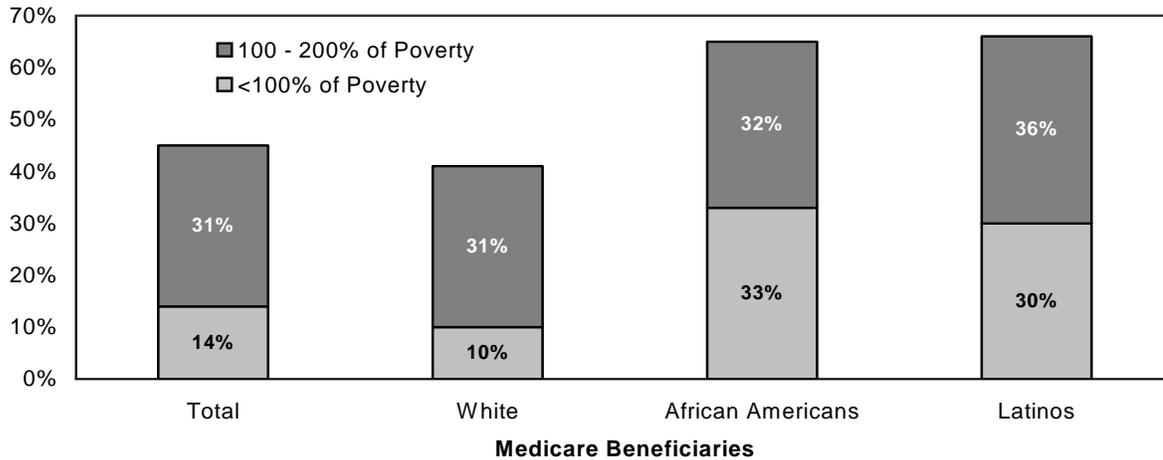
Evidence on gender-based disparities is also considered here. In this case, the correlation of age (and frail health) with women's health care experiences complicates the task of assessing disparities. And the task is further complicated by correlations with income. Female beneficiaries are much more likely than male beneficiaries to live in poverty. In 2001, 67 percent of beneficiaries living in poverty were women (Kaiser Family Foundation 2001a). Although gender differences are given somewhat less attention in this report because evidence is lacking, we believe it is important to examine these differences in utilization and expenditures because important questions of potential disparities in access to care and health outcomes are at stake.

### **DISPARITIES AMONG BENEFICIARIES IN ORIGINAL MEDICARE**

Data from original Medicare show systematic and sustained differences in the use of health care services and the quality of medical care between whites and blacks, as well as between low-income and high-income beneficiaries. Persisting disparities are evident in (a) use of preventive

**Figure 4.1**

**Minority Medicare Beneficiaries Have Higher Poverty Rates Than Whites, 1997**



Note: Latinos refers to U.S. residents self-describing as being of Hispanic origin, regardless of country of birth or citizenship. Excludes other races (Asian-Pacific Islanders, American Indians, Eskimos, and Aleuts).

Source: Kaiser Family Foundation 1999a.

services, (b) quality of primary care, and (c) utilization of surgical procedures and follow-up care.

**Experience of Racial Minorities**

Racial gaps in preventive care and screenings have been widely documented (Asch et al. 2000). Tables 4.4 and 4.5 capture these differences for two common procedures: mammography and influenza immunization. These differences appear to be distinctly related to race. After controlling for income differences, black beneficiaries remain significantly less likely to receive preventive services (Gornick, Eggers, and Riley 2001). Indeed, statistically controlling for an even larger set of socio-demographic characteristics, co-morbidities and attitudes towards medical care, the magnitude of the racial differences is actually larger than those presented in Tables 4.4 and 4.5 (Schneider et al. 2001a).

The quality of primary care has been measured in two ways: first, based on their own assessment of the thoroughness of their physicians, and second, based on the frequency of avoidable complications associated with particular chronic conditions. Among beneficiaries in original Medicare, African Americans are significantly less likely (26.1 percent vs. 31.7 percent) than whites to report that their “physician checks everything” during a medical exam (Nelson et

**Table 4.4**

**Influenza Immunization Rates for Medicare Enrollees Age 65 and Older, By Race, 1993-1997**

Year	Black (per 100)	White (per 100)	Ratio (Black: White)
1993	17.3	36.5	0.47
1994	20.6	41.9	0.49
1995	21.6	43.2	0.50
1996	23.4	45.5	0.51
1997	24.3	46.1	0.53

Source: Gornick, Eggers, and Riley 2001.

**Table 4.5**

**Biennial Mammography Rates for Female Medicare Enrollees Age 65 and Older, By Race, 1992-1998.**

Period	Black (per 100)	White (per 100)	Ratio (Black: White)
1992-1993	28.1	38.2	0.74
1994-1995	30.9	40.4	0.77
1996-1997	33.7	42.5	0.79
1997-1998	35.1	46.1	0.76

Source: Gornick, Eggers, and Riley 2001.

al. 1996). Racial differences are even more striking in terms of avoidable medical complications. African American beneficiaries are 60 percent more likely to be treated for retinal lesions (Eggers 2000), more than twice as likely to be admitted to a hospital for a hyperosmolar or ketotic coma (Asch et al. 2000), and more than three times as likely to experience a lower limb amputation (Eggers 2000), all indicators of inadequate care for diabetes. Among beneficiaries with known angina, blacks are 60 percent more likely to have multiple emergency visits for cardiovascular problems, and 44 percent more likely to have a non-elective hospital admission for congestive heart failure (Asch et al. 2000).

Although these racial differences in the quality of primary and preventive care are striking, the disparities that have captured public attention involve the treatment of particular health

conditions. Most striking are the differences related to care of cardiovascular disease. Black beneficiaries are much less likely to receive aggressive treatment for these problems, with angioplasty rates at about 60 percent of white counterparts and bypass surgery rates 50 percent lower (Gillum et al. 1997; Kaiser Family Foundation 2002b). Strikingly, these differences persist if one takes into account income (Gornick et al. 1996) and the prognosis from the benefits of the surgery (Peterson et al. 1997).<sup>21</sup> The quality of follow-up care after hospitalization for a cardiac problem is also worse for black beneficiaries, typically averaging about 80 percent of the rate for white patients (Asch et al. 2000; Ayanian et al. 1999). Black beneficiaries were significantly less likely to receive reperfusion therapy following heart attack (Canto et al. 2000)<sup>22</sup>

### **Trends Over Time in the Magnitude of Disparities**

Despite growing attention to health care disparities in the medical profession, media and among health policy analysts, there is no evidence that these racial disparities have diminished over time. As illustrated in Tables 4.4 and 4.5, there has been a very modest narrowing of the racial gap in use of preventive services. Racial differences in some cardiac procedures show some convergence, but for others show divergence (Gillum et al. 1997). The higher levels of avoidable medical complications experienced by black beneficiaries remained roughly stable between 1990 and 1998 (Eggers 2000).

Access barriers may have been exacerbated by growth in the number of minority beneficiaries without supplemental coverage. In 1995, 27 percent of African American beneficiaries and 15 percent of Latinos had no supplemental coverage, compared to 9 percent of white beneficiaries (Pourat et al. 2000). By 2000, 38 percent of elderly black beneficiaries and 23 percent of elderly Latino beneficiaries had no supplemental coverage, compared to 14 percent for whites (Gold and Stevens 2001).

### **Differences Among Minority Groups**

The only other minority group among the elderly that has been consistently identified in empirical research is Latinos. Although evidence is far more limited than studies of the African-American experience, it suggests that Latino beneficiaries generally experience disparities in access and quality of care compared to elderly whites, but that these gaps are considerably smaller than those experienced by black beneficiaries in original Medicare.<sup>23</sup> For influenza immunizations, the gap between white and black beneficiaries was 21.2 percentage points, but only 8.1 percentage points for Hispanics (Schneider et al. 2001a).<sup>24</sup> More Latino beneficiaries (6 percent) reported more difficulty accessing specialists than white beneficiaries (2 percent), but fewer than African-American beneficiaries (8 percent) (Kaiser Family Foundation 1999b). Latinos are less likely to report being very satisfied with the quality of their medical care under

original Medicare (29.7 percent) than whites (37.9 percent), but more so than are African Americans (26.3 percent) (Nelson et al. 1996).

### **Experience of Beneficiaries From Low-Income Households**

Researchers have documented disparities related to income for the same three categories of medical care: preventive services, primary care, and the use of surgical and follow-up procedures. In this case, some of the studies compare beneficiaries' experiences based on household income, in other cases based on the income of the neighborhood in which they live. In both cases, extensive disparities have been documented.

The magnitude of disparities for preventive care related to household income appears to be on par with those associated with black-white differences. Gornick and colleagues examined use of an index of preventive services, and found that those from high-income households were about 5-15 percentage points more likely to receive extensive preventive care (Gornick et al. 2001). For a few services, such as immunizations, the income gap appears smaller than the gap between African American and white beneficiaries (less than 10 percentage points vs. greater than 20 percentage points), though still potentially significant (Schneider et al. 2001a). Beneficiaries who lived in a federally designated poverty area were 84 percent as likely as beneficiaries in other communities to have a regular eye exam; women living in poverty areas were 72 percent as likely as other female beneficiaries to have had a mammogram every two years (Asch et al. 2000).

There are also evident differences in the quality of primary care related to income. Those from low-income households were less likely to rate their medical exams as thorough (26.3 percent vs. 35.6 percent) and were almost four times as likely to report that they had trouble getting necessary medical care (Nelson et al. 1996). Avoidable complications of medical conditions were also more prevalent among lower income beneficiaries. Those from low-income households were 25 to 50 percent (depending on race) more likely to have had a lower limb amputated (Gornick et al. 2001). Those living in poverty areas had between 50 and 100 percent more complications related to diabetes and cardiovascular disease (Asch et al. 2000).

Income-related differences associated with surgical procedures have been identified, but appear to be less dramatic than those associated with race. Indeed, much of the income-related effect appears to be limited to African-American beneficiaries (Gornick et al. 1996). The quality of follow-up care following an acute cardiac episode is somewhat lower (5-10 percent) for beneficiaries who live in poverty areas, compared to those who do not (Asch et al. 2000).

### **Limited Evidence of Gender Differences**

There is no evidence of substantial differences between male and female beneficiaries in terms of either preventive care or the quality of primary care. Those differences that do exist are small: for example, female beneficiaries are slightly less likely to rate their medical exams as thorough (30.3 percent vs. 32.1 percent).

The accessibility of surgical procedures presents a more complicated story. Several studies have documented differences in the treatment of coronary disease (Seils, Friedman, and Schulman 2001). The American Heart Association has reported that 42 percent of women who have a heart attack die within one year, compared to 24 percent of men. Women are 12 percent more likely to experience a second heart attack within six years following the first one, yet multiple studies have shown that women are less likely than men to be referred for invasive cardiac procedures. Studies have reported that the odds of undergoing cardiac catheterization are 25 to 50 percent less for women than for men.

Many explanations have been offered for the sex differences. Women are typically 10 to 20 years older than men when they first experience symptoms of heart disease, and they are referred later in the course of their disease for invasive surgery. Treatment differences may thus reflect clinicians' perceptions of the expected benefits from invasive procedures. But these perceptions may themselves be negatively biased, due to assumptions of subtle combinations of age and gender bias (Ganz et al. 1999). Several studies suggest that the disparity cannot be explained entirely by clinical factors. And while studies have identified that individuals' preferences affect catheterization rates, there is no evidence suggesting that women prefer less aggressive care.

Two studies have examined the combined effects of race and sex on the quality of cardiac care. In the first, researchers looked at race and sex differences associated with reperfusion therapy following heart attack.<sup>25</sup> White men received reperfusion therapy with the highest frequency (59 percent), followed by white women (56 percent), black men (50 percent), and black women (44 percent). After adjusting for demographic and clinical characteristics, the differentials between the sexes were minimal, but the differences between blacks and whites remained (Canto et al. 2000).

The second study examined quality of care differences in Medicare beneficiaries hospitalized for heart failure or pneumonia in three states. Black beneficiaries received poorer care than whites overall for basic hospital services, such as physical exams, simple diagnostic tests, standard drug therapies, and patient history taking. Researchers also found that only 32 percent of black pneumonia patients were given antibiotics within six hours of admission, compared to 53

percent of other Medicare beneficiaries treated for the same condition. Care for men and women was roughly equivalent, although men received better care than women from doctors, and women received better care than men from nurses (Ayanian et al. 1999).

### **CMS' EFFORTS TO REDUCE DISPARITIES**

CMS has charged the QIOs with designing interventions to reduce disparities in the provision of health care among FFS beneficiaries. Beginning in 1999, QIOs initiated local quality improvement projects to reduce disparities in six targeted clinical conditions: heart attack, breast cancer, congestive heart failure, diabetes, stroke/transient ischemic attack/atrial fibrillation, and pneumonia/influenza. Each QIO is working on projects to help explain the causes of disparities or to reduce disparities, and one QIO has been designated to identify disadvantaged populations, develop data standards, and test the cost effectiveness of different interventions. In BIPA, Congress amended the quality improvement requirements for M+C plans to include a separate focus on racial and ethnic minorities. CMS implemented this provision by requiring that M+C plans implement a quality improvement plan in 2003 that focuses on either clinical health care disparities among racial and ethnic minorities or culturally or linguistically appropriate services.

CMS also provides plans with feedback on ratings from CAHPS, subdivided by different types of enrollees. But for many plans, sample sizes from these surveys are too small to provide reliable estimates of the experiences of potentially disadvantaged groups. And CAHPS ratings are not appropriate for trying to identify disparities in procedures, though they may have some value in identifying gaps in follow-up care for beneficiaries with serious illnesses. In M+C, coordinated care plans are required, as part of the QAPI plans, to develop projects that address clinical health care disparities or culturally or linguistically appropriate services.

### **THE IMPACT OF PRIVATE HEALTH PLANS ON DISPARITIES**

Ideally, one would assess the impact of both coordinated care plans and competitive markets on the nature and magnitude of disparities. There is a modest body of empirical research that can be used for the first task, though it has some important limitations. About the second question, very little can be said, because there has been virtually no research on the impact of markets on disparities among working-age Americans. This makes it impossible to even attempt to extrapolate from the experience of employed Americans to predict the consequences for the elderly and disabled.

#### **Coordinated Care Plans and the Magnitude of Disparities**

There has been only a single study that has compared disparities between M+C plans and original Medicare using a common data set. Other studies have constructed comparisons, but

made use of different sources of data, often with questions or measures constructed in inconsistent ways. In still other cases, we can compare across studies that purported to use similar measures (though they may not have used those measures in entirely consistent ways). With these caveats in mind, patterns do seem to appear in this literature. Enrollment in a coordinated care plan appears to be associated with a reduction, though not elimination, of the magnitude of racial disparities in prevention and primary care. But there do not appear to be comparable reductions in disparities related to the accessibility or quality of medical procedures. Although the evidence is even less adequate for assessing income-related disparities, a similar pattern seems to hold.

The one study using a consistent data set to compare the experiences of beneficiaries in both original Medicare and M+C compared the frequency of influenza immunizations between black and white enrollees (Schneider et al. 2001a). The simple comparisons indicated no change in the magnitude of racial disparities. In FFS, the difference in immunization rates was 21.6 percentage points (67.1 percent for whites vs. 45.5 percent for blacks). Those enrolled in M+C plans were slightly more likely to have been immunized, but the differential remained 21.6 percentage points (72.8 percent for whites vs. 51.2 percent for blacks). This simple comparison, however, did not account for the fact that M+C plans were enrolling more low-income beneficiaries, who would have previously been even less likely to be immunized. Taking these socio-demographic and attitudinal differences into account, the racial gap in M+C plans declines to 18.6 percentage points. An earlier study found that the racial gap in immunizations was reduced from 22.6 percentage points to 15.8 percentage points when beneficiaries enrolled in managed care plans (Nelson et al. 1996).

By looking across studies, one can piece together evidence showing a similar pattern for other types of prevention. For example, studies that compare breast cancer screening rates in M+C plans generally find the racial gap to be smaller than in FFS. Black women enrolled in M+C plans are screened at a rate between 84 (Virnig et al. 2002) and 89 percent (Schneider, Zaslavsky, and Epstein 2002) of their white counterparts. In original Medicare, screening rates for blacks have been estimated to be between 73 percent (Asch et al. 2000) and 79 percent (Gornick et al. 2001) of those of whites.

A similar pattern appears to hold for income-related disparities, though here we could construct a comparison only for breast cancer screenings. Low-income beneficiaries in FFS are screened at about 80 percent the rate of the average beneficiary (76.4 percent for whites vs. 80.4 percent for blacks) (Gornick et al. 2001). When enrolled in M+C plans, low-income beneficiaries are screened at 88.4 percent the rate of the average beneficiary in those plans (Schneider, Zaslavsky, and Epstein 2002).

A somewhat different picture emerges from beneficiaries' assessments of their care. Racial and income disparities in access are smaller under M+C plans than in FFS (Table 4.6). By contrast, enrollment in M+C plans does not appear to decrease, and may actually increase the racial gaps in quality that beneficiaries perceive.<sup>26</sup>

Although measures of performance for follow-up care that can be compared across the two parts of the program are equally sparse, they suggest no obvious consistent reductions in disparities for these aspects of medical care.

The impact of coordinated care on racial disparities in follow-up care after a diagnosis of serious illness appears mixed. Disparities in eye exams for diabetics appear to be slightly smaller in magnitude under M+C plans than under FFS, but the differences are small: 5.8-6.8 percentage points under M+C (Schneider, Zaslavsky, and Epstein 2002, Virnig et al. 2002), compared to 7.2 percentage points in FFS (Asch et al. 2000). Racial gaps in the frequency of regular physician visits for beneficiaries diagnosed with serious illnesses (heart problems, cancer, or diabetes) are about as large within M+C plans (Barents Group 2002) as the disparities identified under Medicare FFS (Asch et al. 2000). And racial disparities in follow-up care after psychiatric hospitalizations appear to be much larger under M+C plans: 20.8 percentage points (Schneider, Zaslavsky, and Epstein 2002) compared to 7.6 percentage points (Asch et al. 2000).

### **Adding Up the Pieces: Do Private Health Plans Affect Disparities?**

Taken together, these results suggest that the enrollment of Medicare beneficiaries in coordinated care plans reduces some disparities in care, but not all. More specifically, coordinated care plans produce a demonstrable reduction in disparities in preventive and (perhaps) primary care, benefits that extend to both racial minorities and beneficiaries from low-income households. However, while disparities in prevention and primary care are reduced, they are not eliminated. Substantial gaps remain between white and non-white beneficiaries, as well as between those from low- and high-income households. And no comparable gains appear for the quality of medical care, as measured by follow-up care following diagnosis/treatment of a serious illness. But we know much less about this last category of disparities, many of which have not been studied in managed care settings.

We know very little about why coordinated care plans reduce some disparities, while not affecting others. Although necessarily speculative, we can offer several possible explanations. Because coordinated care plans have historically relied less on beneficiary co-payments than original Medicare, low-income beneficiaries face fewer financial barriers to seeking care. Second, coordinated care plans have a greater capacity to notify enrollees about the need for

**Table 4.6**

<b>Comparing Disparities in Original Medicare and M+C Plans Beneficiaries' Assessments of Their Medical Care</b>			
Ratio of Disadvantaged Groups to Entire Enrollee Population	Performance Measures		
	Problems Related to Access in Past Year	Very Thorough Medical Exams	Highest Rating for Overall Quality of Care
<i>Medicare FFS</i>			
African-Americans	2.05	0.68	0.84
Low-Income	1.75	0.69	0.84
<i>Coordinated Care Plans</i>			
African-American	1.13	0.66	0.61
Low-Income	1.38	0.96	0.91

Source: Nelson et al., 1996.

regular screening exams or other preventive care, and thus encouraging higher rates of participation by groups that are otherwise less strongly connected to health care providers.

To the extent that these are the factors accounting for reduction in disparities, they represent important advantages for coordinated care plans. However, since coordinated care plans have increased their cost-sharing requirements in recent years (see Chapter 2), this historical advantage may be deteriorating.

Disparities in the frequency of particular procedures or the reliability of follow-up care are more difficult for coordinated care plans to address, because they call for a more detailed monitoring of clinical practices. But it was exactly this sort of oversight that has produced the “backlash” against managed care among health care professionals and consumers. To the extent that plans are “backing off” their oversight of treatment patterns, they will have even less capacity to address disparities in medical care.

## FINDINGS AND RECOMMENDATIONS

The study panel believes that improving quality of care and reducing disparities are important goals that should be pursued in both original Medicare and M+C.

### Findings and Recommendations Related to Quality of Care

**Finding 15: Despite aggressive new policies by CMS to improve quality, low quality remains an important concern for Medicare. Most strikingly, none of the current mechanisms for monitoring quality under either original Medicare or M+C can measure certain crucial dimensions of practice, such as errors in treatment, selection of appropriate venues for treatment, or adequate coordination of care for beneficiaries with multiple chronic conditions.**

Various initiatives have led to striking improvements in some aspects of the quality of care for Medicare beneficiaries. But even where quality has improved, there remains a large gap between appropriate and actual clinical practices. And there are other aspects of quality that remain outside the purview of quality monitoring and improvement programs. We know little, for example, about the frequency with which beneficiaries receive care at low-volume facilities, when that care would have been predictably better at a high-volume site. Perhaps even more distressing, we know that the rate of adverse medical events for Medicare beneficiaries is higher than that for working-aged Americans, yet we have no capacity to monitor those error rates in either FFS or M+C.

Obviously, one needs to be realistic about the potential for quality improvement. No amount of oversight, training, or incentives will restore frail elderly or disabled people to the vitality of someone who is relatively healthy. With complex health care needs, some errors are inevitable, some adverse events unavoidable. But there is substantial evidence that many errors in the care of beneficiaries can be reduced, or their consequences mitigated. Delirium among hospitalized elder patients can be reduced by a third (Inouye et al. 1999). Hospital readmissions for frail elders discharged in unstable medical condition can be reduced by 45 percent (Naylor et al. 1999). At least a quarter of the cases of problematic geriatric medication can be eliminated with appropriate monitoring (Monane et al. 1998).

**Recommendation 7: CMS should modify the hospital conditions of participation to require mandatory reporting of adverse events that result in death or serious harm. CMS should also develop the capacity to identify beneficiaries admitted to low-volume hospitals for procedures where outcomes are sensitive to the volume of procedures performed. CMS should be encouraged to consider a system that could prospectively screen such admissions.**

A number of large employers have taken an aggressive role in identifying and rewarding good quality care (Maxwell and Temin 2002). They have implemented strategies that reward plans and providers that perform well on quality indices, entered into selective contracting arrangements to “weed out” plans that are consistently poor performers, and gotten employees more involved in selecting high quality health plans and providers.<sup>27</sup>

The Study Panel believes that incentive programs and selective contracting could both, in theory, be used by CMS, but it is also mindful of the powerful constraints that limit the implementation of certain policies. More specifically, the panel believes that selective contracting is likely to prove so controversial that it makes more sense, in at least the immediate future, to rely on incentives as a means of improving the quality of care received by Medicare beneficiaries.

**Recommendation 8: CMS should develop and implement a payment system for health plans that incorporates explicit incentives for improving quality of care. Parallel incentives should be established for FFS providers. In the short-run, these may be limited to physicians in group practice, but should eventually be extended to all physicians.**

However effective our systems of monitoring clinical practice or powerful the financial incentives for improved clinical practice, these sorts of targeted rewards will inevitably capture only a few dimensions of what health care professionals would judge to be optimal clinical practice. There is much about good quality care that simply cannot be reliably measured or consistently reported by beneficiaries. And incentive systems that focus attention on only a small set of dimensions of quality may cause providers to neglect other, equally vital, aspects of care. Consequently, the Study Panel sees a need for other quality improvement approaches that could complement the sort of incentive systems described above. A companion report on chronic illness discusses a number of these strategies (Eichner and Blumenthal 2003). The consistent theme that connects them all involves the need for CMS to develop the administrative capacity and financial resources to stimulate improvements in the infrastructure of the medical care system.

These changes in infrastructure might take a variety of forms. In some cases, they involve aspects of the health care system (e.g., medical education) that have long been treated by policy-makers as a public good (more on this in chapter five). In other cases, the market may generate insufficiently strong incentives to induce investment needed to expand the capacity to provide certain types of care, as in the case of the PACE program. In still other cases, government authority is required to counteract certain incentives produced by the market, which tends to promote a fragmentation of treatment capacity among multiple sites of care.<sup>28</sup>

**Recommendation 9: Congress should give CMS the necessary resources and authority to stimulate infrastructure changes that will improve quality of care for beneficiaries. This should include, at a minimum: expanded requirements for geriatric training for clinicians treating Medicare patients, and capacity to promote regionalization of care for procedures shown to have a relationship between volume and quality.**

### **Findings and Recommendations Related to Disparities in Medical Care**

**Finding 16: Racial, ethnic, and income-related disparities exist in preventive care, primary care, and essential medical and surgical treatments. These are of a magnitude that merits immediate redress.**

Disparities in health care for racial minorities and low-income beneficiaries have been a persistent part of Medicare. While not unique to Medicare, the panel believes that they need to be addressed. The differences in health care use documented here involve treatments of known efficacy.

These disparities are of a magnitude that makes them as problematic as many of the quality problems identified. But disparities have produced much less pressure for Medicare reform. CMS has, over the past decade, established a number of creative and effective initiatives to improve quality, both in original Medicare and M+C. The agency has devoted much less time, energy, and resources to addressing and reducing disparities among Medicare beneficiaries. Congress has instigated a number of the demonstration projects intended to enhance Medicare's quality of care, and has encouraged a number of other initiatives instigated by CMS. But Congress has done little to encourage effective responses to the problems posed by disparities in medical care. The study panel believes that a more proactive stance on these issues is necessary.

**Finding 17: Racial, ethnic, and income-related disparities in preventive care are reduced by beneficiaries' enrollment in coordinated care plans. Evidence is mixed in terms of the quality of primary care, and there is no evidence that coordinated care plans reduce racial or income-related disparities in essential medical and surgical treatments.**

Enrollment in coordinated care plans has moderated disparities in preventive care related to race and income. It appears to have reduced disparities in primary care, at least for beneficiaries from low-income households. But beneficiaries are not, at this point, informed about these advantages of coordinated care plans. These plans need to be encouraged to not only maintain their current performance but also expand their purview into clinical practices known to have disparate consequences for racial minorities and low-income beneficiaries.

The Study panel concludes that effective policies to redress disparities cannot be identified at this time, given the limits of understanding about the causes of these disparities. But we believe

that it is essential to develop an ongoing capacity for monitoring the nature and magnitude of disparities, in both original Medicare and M+C. In addition, it is important to develop measures of disparities that can be constructed for specific plans (or particular regions of the country for Medicare FFS). Because many M+C plans have a modest level of minority enrollment (Barents Group 2002), sampling for surveys like CAHPS would need to be redesigned to collect a sufficient sample of low-income and minority respondents. Moreover, because existing evidence suggests that the nature and magnitude of disparities differs among different disadvantaged populations (Virnig et al. 2002), it is essential to collect an adequate sample of experience for each of these groups.<sup>29</sup>

**Recommendation 10: CMS should measure and assess disparities in preventive care, primary care, essential medical and surgical procedures, and follow-up treatment on a regular basis. Disparities based on race, ethnicity, socio-economic status, and gender should be studied in both original Medicare and M+C. Aggregate measures should be reported on an annual basis. Plan-specific measures should be used whenever possible to encourage improvement at the local level.**

In order to encourage appropriate accountability to address disparities, the study panel favors a reporting requirement for measures of disparities because these aspects of the program have important social consequences and that merit public scrutiny and discussion. Although there are greater technical problems with developing reliable measures on the plan-level, these are also essential. Over the longer term, they might be incorporated into report cards for beneficiaries, or the sort of incentive payment arrangements proposed earlier for improving quality of care.

## NOTES

<sup>1</sup> Beta-blockers slow the heart rate and reduce contractions of the heart muscle; ACE inhibitors reduce constriction of blood vessels.

<sup>2</sup> These data are only for FFS beneficiaries. Colonoscopy is included here because Medicare covers it, even though the U.S. Task Force on Preventive Services has not recommended its use.

<sup>3</sup> Medical errors were explained as follows: “Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be.”

<sup>4</sup> A recent study of medical errors in hospitalized children found that error rates for children with special medical needs or dependence on medical technology were higher than for other children, lending credence to the theory that complexity leads to greater incidence of error (Slonim et al. 2003).

<sup>5</sup> Peer Review Organizations were initially called Professional Standards Review Organizations. Created by the 1972 amendments to the Social Security Act, their original mission was reviewing medical records to determine whether services provided were medically necessary, provided in accordance with professional standards, and in the case of institutional services, rendered in appropriate settings. Congress substantially revamped their mission in 1983 when it enacted the prospective payment system for inpatient hospital services. In response to concerns that hospitals would discharge patients “quicker and sicker,” Congress charged the PROs with monitoring hospital discharges to ensure that Medicare beneficiaries were not discharged from hospitals before it was clinically appropriate. In 1992, CMS revised their mission again, this time to focus on detecting systemic problems and improving patterns of

care. In 2002, the agency changed the name of the PROs to Quality Improvement Organizations (QIOs).

<sup>6</sup> The Government Performance and Results Act (GPRA) requires each agency to set specific performance goals and track progress toward them. CMS chose these targets for GPRA.

<sup>7</sup> The majority of hospitals, which are privately accredited, are already using a QAPI approach. This rule extends the QAPI requirement to hospitals that are certified by the states on behalf of Medicare.

<sup>8</sup> The National Committee for Quality Assurance (NCQA) developed HEDIS in conjunction with public and private purchasers.

<sup>9</sup> CMS maintains a website, Medicare Health Plan Compare on *www.Medicare.gov* for use in beneficiaries in selecting an M+C plan, or comparing their plan to others available to them. Data are maintained to the zip code level, and the website allows beneficiaries to see the scores of FFS Medicare and all the plans in their area.

<sup>10</sup> These measures are: use of appropriate antibiotics to prevent surgical infection, appropriate timing of the administration of these antibiotics, and appropriate discontinuation after surgery.

<sup>11</sup> CMS remeasured the data in 2000-2001 and plans to use the information to become a more informed and better purchaser. CMS also plans to remove stroke from the data, because further systemic improvement seems unlikely and to add three new indicators related to patient safety in inpatient hospitals. It also plans to collect a continuous sample large enough to provide accurate trending of national data every few months (for measures based on medical record abstraction), to collect enough data to make accurate state-level estimates every three years to use in evaluating the performance of QIOs, and to extend the system to include other settings such as nursing homes and home health agencies. (Jencks et al. 2000; Jencks, Huff, and Cuerdon 2003).

<sup>12</sup> The nursing home quality indicator system uses patient assessment data from the Minimum Data Set to evaluate the quality of nursing home care. Comparative nursing home information is available through Nursing Home Compare, posted on the *www.Medicare.gov* website. In 2002, CMS also began a multimedia campaign, using both television and newspapers, to inform beneficiaries about the availability of quality information for nursing home care. Quality improvement measures have also been developed for home health care through the Outcome and Assessment Information Set (OASIS) (Docteur 2001).

<sup>13</sup> Data for Medicare beneficiaries are included in the measures, which cover all hospital patients.

<sup>14</sup> In cooperation with the Agency for Healthcare Research and Quality (AHRQ), the Research Triangle Institute, the RAND Corporation, and the Harvard Medical School developed the survey.

<sup>15</sup> In 1999, more than 160,000 beneficiaries were surveyed.

<sup>16</sup> Because the functional status of Medicare beneficiaries is expected to decline over a two-year period, HOS is adjusted to take the expected decline into account, and then looks at whether the decline is better or worse than expected

<sup>17</sup> The states are Arizona, Florida, Maryland, Minnesota, and New York.

<sup>18</sup> These goals were set to meet requirements of the Government Performance and Results Act. Determining whether target rates were met has been complicated by a change in the measurement instrument. Results are not available for pneumococcal vaccines because it was added as a goal in 2001. The goal of lowering the one-year mortality rate following a heart attack to 27 percent was not met; actual performance was between 31 and 33 percent.

<sup>19</sup> The study compared FFS and HMO performance on eleven summary scales measuring seven defining characteristics of primary care: access, continuity, integration, comprehensiveness, "whole-person" orientation, clinical interaction, and sustained clinician-patient partnership. Overall, performance favored FFS over HMO care on nine of the eleven scales in analyses that did not differentiate between different types of HMOs.

<sup>20</sup> Where evidence exists, data on other ethnic and racial minority groups is included.

<sup>21</sup> A portion of the higher rates of angioplasty among whites can be accounted for by excessive treatment, but there are no differences between black and white elderly beneficiaries in the rate of inappropriate use of bypass graft surgery (Schneider et al. 2001b).

<sup>22</sup> The study does not identify whether beneficiaries were enrolled in FFS or managed care. Because the study was conducted in 1994 and 1995, before managed care enrollment began to increase sharply, this

analysis assumes that vast majority of beneficiaries in this study were receiving FFS care.

<sup>23</sup> One exception involves the thoroughness of their medical exams, which Latinos rate significantly better than either whites or African Americans (Nelson et al. 1996).

<sup>24</sup> A study using earlier years of the same data source (the Medicare Current Beneficiary Survey) found an identical difference between whites and African Americans in the frequency of flu shots, but are larger gap between whites and Latinos: 19.2 percentage points (Nelson et al. 1996). But the same pattern still holds, with the gap between whites and Latinos smaller than that between whites and African-Americans.

<sup>25</sup> The study does not identify whether beneficiaries were enrolled in FFS or managed care. Because the study was conducted in 1994 and 1995, before managed care enrollment began to increase sharply, this analysis assumes that vast majority of beneficiaries in this study were receiving FFS care.

<sup>26</sup> A similar pattern exists for Latino respondents, who report relatively worse experiences (compared to other beneficiaries) in Medicare managed care plans than in the conventional program (Nelson et al. 1996).

<sup>27</sup> Initiatives to involve employees more in choosing health plans and providers (“consumer-directed” health care) are still in the early stages, and the evidence about employees’ ability to understand the complexity of the information provided to them and their interest in choosing on the basis of quality is mixed. Nevertheless, the Study Panel believes that consumer involvement in assessing quality is a useful complement to purchasers’ efforts on this front.

<sup>28</sup> For a discussion of the benefits of regionalization that the state of New York achieved for cardiac care, see Chassin 1997.

<sup>29</sup> Given relatively small numbers of different minority groups enrolled in some plans, these measures may require pooling responses over several years.



# Chapter 5:

## Beyond the Individual Beneficiary: Medicare's Impact on Health Politics and the Health Care System

Medicare's performance is typically assessed in terms of the health care it pays for, measured through the health outcomes and financial security of beneficiaries, or the societal costs of paying for their treatment. To this point, the Study Panel's assessment of the role of private health plans in Medicare has been cast in these same terms. From the beginning of our deliberations, however, the panel has been mindful of the broader role that the Medicare program plays in shaping the politics and policies affecting our country's health care system. This broader perspective harkens back to an admonition offered by an earlier NASI study panel, which concluded that:

“Decisions about Medicare's future, including its ability to deal with health care utilization and costs, will not (and cannot) be made on purely economic or medical criteria. Medicare has become part of America's infrastructure. It reflects deeply held social and political values (and value conflicts) and reform policies must recognize these if they are to be successful” (Bernstein and Stevens 1999).

Beginning with this chapter, we widen the scope of our inquiry. We first consider the implications of private health plan participation on the political stability of the Medicare program. Few previous assessments have considered their political implications. But as a social insurance program, Medicare needs to be assessed differently from many other public policies. The program, at its core, is a contract among generations. Those who pay into the program during their working years support the medical care of their parents' and grandparents' cohorts (Kingson, Hirshorn, and Cornman 1986). And by so doing, they can anticipate future support for their health care needs when they retire or become disabled.

For these expectations to be realized, people must be confident that Medicare will be there for them and fellow citizens in the future. To ensure this, there must be a broad base of political support for the program, resilient in the face of hard economic times or partisan bickering. These considerations led the earlier study panel to make “political sustainability” one of their seven criteria for assessing program reform. They argued that reforms should be judged in part on their effect on “the degree to which the Medicare program enjoys the support of the

American population, regardless of the state of the economy, political climate, or social atmosphere” (Bernstein and Stevens 1999).

Public support cannot be taken for granted. Medicare remains an extremely popular program; citizens have repeatedly given its fiscal health priority over cutting taxes, balancing the budget, or other societal needs (Bernstein and Stevens 1999). Yet many younger Americans doubt that the program will retain sufficient support to adequately finance their own benefits (Reno and Friedland 1997). Although pundits have somewhat overstated these public concerns (Cook and Jacobs 2002), it remains important to consider how reforms designed to achieve short-term programmatic gains may affect Medicare’s long-term political future.

The second set of broader implications that we will consider in this chapter involves Medicare’s “collateral functions” (Gusmano and Schlesinger 2001). In a variety of ways, Medicare’s policies and operating practices shape the broader public and private arrangements through which American health care is financed and delivered. These effects include establishing quality and safety standards for health care facilities, the form and functions of medical education, the financial viability of health care facilities essential to their local communities, and the ability of Americans to assess the performance of their health care providers. These ancillary effects of the program have often been overlooked in past discussions of market reforms, since they typically involve only modest program expenditures. Nonetheless, we believe that the consequences for the health care system can be substantial. And they carry with them implications for Medicare’s future, which are essential to examine in order to fully assess the effects of private health plans and market reforms.

## **THE CONSEQUENCES OF PRIVATE PLAN PARTICIPATION FOR MEDICARE POLITICAL FUTURE**

As with all government-funded programs, Medicare’s form, performance, and future prospects are inevitably shaped by political considerations. These can complicate program administration. They are frequently criticized as distractions or impediments to improving program performance. But political influences can also play an important positive role, by focusing attention on program objectives that might otherwise have been neglected. Indeed, a number of the goals identified in earlier chapters, including concerns about cost containment, disparities in medical outcomes, or broad patterns of quality shortfalls, have been elevated to the center of debates over Medicare largely through political considerations.

We will refer to these potential improvements in Medicare’s performance as the “political accountability” of the program. In Chapter six, we explore in more detail the relationship between political and other forms of program accountability. In this chapter, we consider the

ways in which market reforms and private plan involvement may affect these political influences, by altering the ways in which Medicare beneficiaries relate to the program in political terms.

**The Challenges of Balancing Political Influences over the Medicare Program.** Appropriate political accountability requires that all parties with legitimate interests in Medicare have effective political voice, and that the program is shaped by their concerns in a balanced manner. These interests include taxpayers' concerned about the program's costs, health care professionals whose livelihood depends on fair reimbursement practices, and, of course, the beneficiaries who health care and financial security are profoundly affected Medicare's performance.

Social scientists have long recognized that political debates often become imbalanced, with concentrated economic interests exerting more influence than do the diffuse interests of individual citizens (Scholz and Wei 1986; Moe 1985; Olson 1965). For similar reasons, analysts worry that Medicare politics have become more responsive to the concerns of health care providers than those of beneficiaries or the general public, a concern that has extended to efforts to introduce private health plans and market reforms to the Medicare program (Cooper and Vladeck 2000; Dowd et al. 2000). The expanded role of private insurers in Medicare introduced another set of economically powerful interests, in the form of the health plans that now contract with the program. As we documented in Chapter two, following the creation of Medicare+Choice, Congress repeatedly responded to the concerns of M+C plans in revising their terms of participation. But there is little evidence, to date, of how these reforms have influenced the ways in which beneficiaries relate to the program in political terms.

**The Role of Medicare's Beneficiaries as A Political Influence.** The political resilience of the Medicare program rests on a broad base of support among Americans of all ages (Bernstein and Stevens 1999). Nonetheless, a crucial linchpin involves support for the program among beneficiaries. Beneficiaries are far more likely than the general public to follow media coverage of Medicare (Kaiser Family Foundation and Harvard School of Public Health 2003) and to become engaged in political activities related to the programs that provide them with benefits (Campbell 2002, Mebane 2000). Private health plans have the potential to transform how beneficiaries understand Medicare, relate to the program, and assess its goals.

**The Potential Impact of Private Health Plan Involvement on Beneficiaries' Political Attitudes**

An expanded role for private health plans may alter beneficiaries' political attitudes in two distinct ways. First, it may weaken beneficiaries' sense of personal identification with the program, reducing their sense that their own well-being depends on the program's performance. Alternatively, the spread of private health plans may weaken beneficiaries' sense of

collective identification and thereby reduce their willingness to endorse policies that assist beneficiaries as a group, even if they do not expect to benefit personally. Either of these changes could reduce beneficiaries' support for the program or, more subtly, transform the goals toward which they think the program should be striving.

### **Private Health Plans and Beneficiaries' Personal Identification With the Medicare Program**

When a Medicare beneficiary enrolls in a private health plan, the accessibility and quality of their medical care depends in the first instance on the policies and practices adopted by that particular health plan. These practices may seem only loosely related to the funding or administration of the Medicare program as a whole. Under these circumstances, Medicare politics may seem less relevant to the self-interest of individual beneficiaries.

This sense of disconnection from Medicare appears to be exacerbated by beneficiaries' misunderstandings about their relationship to the program once they have enrolled in an M+C plan. In 1998, NASI conducted a series of focus groups among Medicare beneficiaries living in California to study how they chose among health plans. In the course of collecting this information, researchers discovered an unexpected pattern: a number of beneficiaries who were enrolled in private health plans thought that they were no longer Medicare beneficiaries at all. "They sometimes thought that they were not in Medicare... Because they thought that they were no longer in Medicare, some were convinced that they had to deal with the HMO entirely on their own" (Bernstein et al. 1999).

At about the same time, the Kaiser Family Foundation supported a study of counselors who worked for the Information Counseling and Assistance (ICA) program, a federally funded, state-administered program to help beneficiaries understand their insurance options. Focus groups from ten states revealed a pattern much like the NASI researchers had discovered in California. "Beneficiaries typically do not understand how a Medicare HMO works. Counselors in some states report that beneficiaries equate enrolling in an HMO as going off Medicare; or losing my Medicare" (Frederick Schneiders Research 1998).

### **Private Health Plans and Political Engagement Among American Elders**

Prior to Medicare, there was little evidence in public opinion surveys that elderly Americans had a distinct sense of political identity (Schiltz 1970). Proposed federal programs to provide health insurance to older Americans were no more likely to receive support from elderly people than from citizens of other ages. And beneficiaries' attitudes toward federal action were sharply divided by their own personal circumstances. Those with higher socio-economic status were much less supportive of government action than those in less advantaged circumstances. In the decades following Medicare's enactment, polls identified a growing political identification

among beneficiaries (Rhodebeck 1993). Although changes in support for particular policies were modest in magnitude (Ponza et al. 1988), there was a clearly emerging sense of beneficiary political identity (Campbell 2003).

The crystallization of a political identity among older Americans was paralleled by the growing influence of advocacy groups for the elderly. Although AARP (the organization formerly known as the American Association of Retired Persons) was formed in 1958, neither it nor other retiree membership groups had much influence on Congressional debates about health insurance for the elderly in the early-1960s (Lammers 1983). It was only after Medicare was enacted that beneficiary membership groups like AARP began to gain an effective political voice. Although their legislative accomplishments were quite modest, AARP, the National Council of Senior Citizens (NCSC), and other groups became increasingly visible in national politics (Hecl 1988). By the mid-1970s, political scientists were beginning to write about the “gray lobby” in Washington (Pratt 1976). Their political credentials were bolstered by their increasingly effective defense of Medicare and Social Security against cost-cutting pressures, combined with some modest expansions of benefits provided through these programs (Pierson and Smith 1994). By the late 1980s, political scientists were describing the political influence of membership advocacy groups for the elderly as approaching “the pinnacle of their organizational success” (Day 1990). Their perceived influence depended on the perceptions that beneficiaries shared a common political perspective and voice (Himelfarb 1995).

Since beneficiaries’ group political identity was in large measure a consequence of government policy, it seems plausible that changes in policy might well alter these attitudes. More specifically, enrollment might alter beneficiaries’ sense that they share a common program with other beneficiaries and people with disabilities. Past studies make clear that most beneficiaries have only a vague sense of the overall scope and function of the Medicare program (Mebane 2000; Bernstein and Stevens 1999). Most beneficiaries learn what they do understand about their health insurance largely by discussing these matters with their family and friends.

In the original Medicare program, all beneficiaries share the same coverage and administrative arrangements. (Those who have purchased supplemental insurance policies face somewhat different coverage, an issue discussed below.) As they learn from the experience of their peers in the community, they also build a sense of shared experience. What happens to Medicare affects not only them, but also their entire cohort. By contrast, in communities in which there are a number of M+C plans, beneficiaries’ experiences may be very different from that of their friends, who may be enrolled in a different plan, with a rather different set of benefits and administrative requirements. With less shared experience, there is less sense of common identity or shared concern for the status of the Medicare program. Under these circumstances, one

might expect beneficiaries to have less of a group-centric orientation toward elders' matters generally or Medicare in particular.

Political mobilization among the elderly can have negative as well as positive consequences. Although strong group political identity can protect Medicare from budget cutting pressures, it may also cause politicians to be fearful of changes needed for the program to remain effective (Schlesinger and Wetle 1988). Beneficiaries and their advocates may be seen as a threat to other age groups, motivated solely by self-interested concerns (Longman 1987). But if American elders reduce their concern about, and involvement in, debates over Medicare's future, pressures for political accountability may become imbalanced, giving excessive influence to groups whose economic well-being is affected by the shape of Medicare reforms. Consequently, it is important for us to understand how changes in Medicare's structure may affect political attitudes and engagement among its beneficiaries.

### **STUDYING THE EFFECTS OF PRIVATE PLANS ON BENEFICIARIES' ATTITUDES TOWARDS MEDICARE**

To date, there has been no careful study of the consequences of private plans on beneficiaries' perceptions of, and support for, the Medicare program. This study panel concluded that this issue merited further research. To this end, a subcommittee was delegated to develop and commission a survey of beneficiaries' political attitudes. To assess the impact of market reforms, the survey would draw respondents from communities in which private health plans had become a central feature of health insurance for beneficiaries and compare their attitudes to those of residents of areas in which private plans remained nothing more than a distant promise (or threat).

Because M+C participation is uneven across the country, some beneficiaries live in communities in which there have long been many participating HMOs. Others reside in areas in which M+C plans have never been available. This sort of geographic variation creates what social scientists term a "natural experiment." One can compare the attitudes of beneficiaries enrolled in Medicare HMOs to those who remain in original Medicare, as well as compare attitudes in communities with extensive M+C options to those in which original Medicare remains the primary source of health insurance. If the introduction of private health plans transforms the political attitudes of beneficiaries, it should be detectable in these variations. Because those who join M+C plans may be different in important ways from those who do not, and because communities with extensive M+C penetration may differ from those without, it is important to take these pre-existing differences into account when making these comparisons. Multi-variate statistical models can do this. By controlling for pre-existing differences in attitudes or socio-demographic circumstances, one can discern whether M+C involvement is associated with

changes in political attitudes, holding constant other characteristics of the beneficiaries. The remaining differences ought to be those associated with M+C.

The following section describes the methods used for studying the impact of private plans on political attitudes, beginning with the measures used to assess attitudes, then the methods used to collect the information from a cross-section of the beneficiary population. (To facilitate the presentation, the text provides only a broad overview of methods. Details are conveyed in Appendix B.)

### **Measuring Attitudes Toward the Medicare Program**

The survey assessed three types of political attitudes. The first category involved measures of support for the Medicare program. This was assessed by (a) respondents' willingness to favor additional tax funding for the program and (b) respondents' perceptions that paying for health insurance in retirement was a collective societal responsibility, as opposed to the responsibility of individual beneficiaries. As revealed in Table 5.1, slightly more than two-thirds of respondents endorsed each of these attitudes.

The second set of attitudes involve the extent to which the respondents' own medical care was seen to depend on various attributes of the Medicare program, including (a) the generosity of its funding, (b) the ways in which it monitored quality of care, and (c) the approaches used to respond to beneficiaries' complaints about their care. These self-interested considerations were linked by respondents most strongly to Medicare funding, least to its consumer protection policies (Table 5.1).

The third set of attitudes examined the priorities that respondents assigned to various goals for federal involvement in the health care of older Americans. Respondents were asked how important it was for the federal government to: (a) guarantee adequate health insurance, (b) ensure that all beneficiaries received medical care of equal quality, and (c) to make sure that minority beneficiaries were treated fairly when receiving medical care. In light of the apparent downplaying of the latter two goals in Congressional debates, it is interesting to note that both quality assurance and racial equity received slightly higher levels of public support than the more conventional goal of assuring adequate health insurance.

**Table 5.1**

**Beneficiaries' Attitudes Towards the Medicare Program,  
Its Impact and Its Goals**

Attribute of the Program	Percent of Respondents Reporting			
	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
<b>Support for Medicare</b>				
Favor More Tax Dollars	21.9%	45.6%	24.5%	8.2%
Favor Collective Responsibility for Elder Care	21.4%	50.6%	23.3%	4.8%
<b>Perceived Impact on Beneficiary's Medical Care</b>				
Funding	31.8%	39.7%	18.5%	10.1%
Quality Assurance	26.1%	43.9%	18.0%	12.1%
Consumer Protections	17.8%	47.6%	19.1%	15.5%
<b>Priorities for Federal Government for Elderly</b>				
Provide Medical Insurance	45.3%	39.6%	4.6%	10.4%
Assure Quality of Medical Care	50.2%	40.3%	3.1%	6.4%
End Racial Disparities in Medical Care	44.2%	43.4%	4.5%	7.8%

Source: Data collected in a NASI survey of beneficiary attitudes fielded in February 2001.

### **Assessing the Impact of M+C on Political Attitudes**

To assess the consequences of private health plans, the attitudes of beneficiaries enrolled in M+C plans were compared to those who are not, as well as the attitudes of beneficiaries in communities with high M+C penetration were compared to those where private plans are scarce. To ensure an adequate number of respondents enrolled in private health plans, the survey includes beneficiaries living in sixty largely urban areas from around the United States and the sample is stratified to draw more heavily from those communities in which there was a high level of M+C penetration. Overall, data were collected from 1,129 elderly beneficiaries:<sup>1</sup> two-thirds from high penetration communities (those in which M+C enrollment exceeded 30 percent at the end of 2000), 17.3 percent from moderate penetration communities (M+C penetration rate between 10 percent and 30 percent), and 16.1 percent from communities with penetration of less than 10 percent. Data were collected in February 2001.

Because communities with high M+C penetration may differ in certain ways from those in which there are few private plans, and because those who are inclined to enroll in a private health plan may be systematically different from those who stay in original Medicare, it was important to measure and statistically control for these other characteristics of the respondent and the community in which they live. Data collected included the respondent's age, political ideology, educational attainment, gender, race, ethnicity, health status, household income, and supplemental insurance coverage (e.g., Medigap policies, employer-purchased insurance, Medicaid, or some combination of the three). Information on the community included its average income, poverty rate, prevailing political affiliation, and whether HMOs were a recent or long-standing feature of the local health care system. Survey respondents had slightly higher levels of education than the overall population of older Americans, but were comparable in terms of age, race, gender, income, supplemental insurance coverage, and political ideology (See Table in Appendix B). In assessing the relationship of M+C involvement to political attitudes, we statistically controlled for these other characteristics of the respondents and their communities.

### **The Impact of Medicare+Choice Involvement on Attitudes Related to Medicare**

These associations are reported in Table 5.2. The impact of market reforms is measured by (a) whether the respondent is enrolled in a M+C plan,<sup>2</sup> and (b) whether the respondent lived in a community in which there was substantial or moderate penetration by M+C plans. The results are presented in the table as odds-ratios — that is, the probability that a respondent with a particular characteristic held that attitude, compared to respondents without this characteristic. Consider, for example, the results for favoring more tax dollars for Medicare (the left hand column of findings). Beneficiaries currently enrolled in a M+C plan are 1.28 times as likely to favor more tax dollars as those in original Medicare. But beneficiaries who live in high

penetration communities are only 0.49 as likely to support more funding, compared to those who live in low penetration communities.

If there is no measurable relationship between the attitude and M+C involvement, one finds an odds-ratio of about 1.00 (as, for example, with the relationship between M+C enrollment and the perception that the respondent's own medical care depends on the level of Medicare funding). But some fluctuation among respondents occurs by chance, as a result of other unmeasured attitudes or circumstances. So how large a difference would be considered a serious change in attitudes? Researchers conventionally assess this using a measure of "statistical significance," that is, a change that is sufficiently large that it is unlikely to have been produced by chance alone. In the results presented in Table 5.2, those that exceed conventional levels of statistical significance are presented in bold type.

As one can see from these results (top row), the enrollment of individual beneficiaries in M+C plans is not generally associated with either reduced support for the program or a reduced sense that the beneficiary's own medical care is affected by characteristics of the program as a whole. However, those enrolled in M+C plans are only 75-85 percent as likely to see health care-related goals as important priorities for federal policy. In particular, those enrolled in private plans are only 75 percent as likely to consider it an important priority for the federal government to guarantee adequate health insurance for retired Americans.

By contrast, there are more consistent and dramatic associations found at the community level. Compared to communities in which M+C plans are scarce, residents who live in high penetration areas are only half as likely to endorse more tax dollars for Medicare. They are 75-80 percent as likely to believe that their own medical care is affected by the performance of the Medicare program (though only for consumer protections is this relationship statistically significant, and then only at a 10 percent confidence level). Perhaps the most interesting findings relate to the perceived importance of different goals for federal policy. Those who live in communities with high M+C penetration are less likely to endorse all three health-related goals. But there is a much sharper decline in support for the goals of quality assurance and protecting minority beneficiaries. It thus appears that M+C expansion is associated, at the community-level, with the same shift in relative goals observed earlier among policy-makers. The more extensive the engagement with private insurance and market arrangements, the less important quality and equity are seen, relative to simply providing beneficiaries with adequate health insurance.

The community-level associations for areas with moderate M+C involvement (penetration rates of 10-30 percent) are less dramatic than for localities with high penetration. This second set of communities show no decline in support for tax financing of Medicare, or any reduction in the

Table 5.2

**Predicted Impact of Medicare+Choice on Beneficiaries' Perceived Connections to the Medicare Program**

<b>Predicted Impact (Odds-Ratio) of Medicare+Choice on Average Level of Beneficiary Support</b>	<b>Measures of Medicare+Choice Involvement</b>		
	Beneficiary is enrolled in a M+C Plan	High M+C Penetration (30%) in County of Residence	Moderate M+C Penetration (10-30%) in county of Residence
<b>Support for Medicare</b>			
Greater Tax Dollars	1.28	<b>0.49**</b>	0.92
Collective Responsibility for Elder Care	0.87	0.76	1.17
<b>Perceived Impact on Beneficiary's Medical Care</b>			
Funding	1.00	0.81	0.81
Quality Assurance	0.93	0.81	0.85
Consumer Protections	1.00	0.74#	1.00
<b>Priorities for Federal Government for Elderly</b>			
Provide Medical Insurance	<b>0.74*</b>	<b>0.67*</b>	1.06
Assure Quality of Medical Care	0.87	<b>0.39**</b>	0.68
End Racial Disparities in Medical Care	0.85	<b>0.38**</b>	0.76

Results Control For: Respondents age, political ideology, educational attainment, gender, race and ethnicity, health status, household income, and supplementary insurance coverage (Medi-gap, Employer sponsored insurance, Medicaid).

Statistical Significance: \*\* probability <0.01 \* probability<0.05 # probability <0.10.

Source: Data collected in a NASI survey of beneficiary attitudes fielded in February 2001.

priority placed on health insurance for the elderly as a goal of federal policymaking. There appears to be something of a threshold effect — it is only when M+C involvement is relatively extensive that it is associated with significant shifts in these aspects of support for the program. But there is one important exception to this pattern. Even communities with moderate M+C penetration display a reduced support for the goals of quality assurance and racial equity (though the reductions are less sharp than found in localities with higher M+C involvement).

### **The Political Consequences of Attitudinal Changes**

During the Medicare reform debate in the 1990s, political scientists frequently argued that the program in its original form remained an important source of common identity and experience for American beneficiaries (Skocpol 1998). The survey fielded by the study panel provides the first solid evidence that the transformation of the program through involvement of private health plans may be undermining beneficiaries' connection to the program and thus the political base from which it draws its legitimacy. The major source of these effects was not associated with individual enrollment in M+C plans. Instead, the primary source of transformation in attitudes appears to rest at the level of the community. This is consistent with previous research indicating that older Americans make sense of their health insurance through local social networks. In communities in which this network becomes fragmented among a diverse group of competing private insurance plans, there is no longer a cohesive set of experiences through which to evaluate the performance of the Medicare program.

In addition, the reduced sense of common experience may indirectly affect the relative importance of different goals for the program. When all beneficiaries are enrolled in a common government-funded program, there are likely to be strong norms of equal treatment. Such programs are clearly in the “public sphere,” in which norms of equality typically dominate (Kluegel and Smith 1986; Hochschild 1981). In contrast, when beneficiaries are enrolled in private health plans, variations in quality or treatment may reflect in part their own choices, not simply discrimination or other forms of inequitable treatment. Consequently, whatever impact market reforms have on the magnitude of racial or geographic disparities, these findings suggest that they will be associated with a reduction in the perceived importance of disparities generally.

It is not the charge of this panel to judge whether these attitudinal changes are necessarily desirable or undesirable. But it seems clear that if they are a consequence of private health plan participation in Medicare, that outcome needs to be clearly understood by policy-makers and the public. The study panel believes that it is important that the goals of Medicare be shaped during open debate and discourse. Changing goals should be a matter of collective choice, not the inadvertent consequence of a series of disconnected individual decisions.

## **THE CONSEQUENCES OF PRIVATE HEALTH PLAN INVOLVEMENT FOR THE COLLATERAL FUNCTIONS OF THE MEDICARE PROGRAM**

Since its enactment, Medicare has accumulated a variety of responsibilities that go beyond financing health care for beneficiaries or monitoring the quality of their medical care. These include involvement in:

Medical education, which Medicare has financed since the program's inception. These include payments to cover the direct costs incurred in training physicians, as well as indirect costs associated with treating more intense cases in academic medical centers.

Hospital payments for those facilities that treat a disproportionate share of low-income patients, known as "disproportionate share" hospital payments. This commitment was added to the program in the early 1980s.

Health and safety standards in health care facilities, which Medicare has set and enforced since its inception. Medicare establishes standards that health care facilities must meet to serve Medicare beneficiaries. Because Medicare beneficiaries use nearly every type of health care facility, Medicare is responsible for setting and overseeing standards for almost all health care facilities.

Subsidies to rural and sole-community hospitals, which Congress has enacted to help sustain viability and preserve access to care in rural and isolated areas.

Research related to health services and health care policy, either in the form of health services research, demonstration and evaluation projects that are supported from the CMS budget, sharing of data collected by CMS to facilitate research by independent investigators, or cooperative agreements with other federal agencies

Data collection activities that provide information on beneficiaries' experiences with health care and health plans, the performance of Medicare certified providers, the monitoring of treatment through the national network of QIOs. CMS maintains the largest health care information database in the United States, a role that has been gradually expanding over the past two decades.

Beneficiary education and information, emerged as part of the evolving mission of CMS to become a "beneficiary-centered, value-based purchaser" during the 1990s. As part of the M+C program, the agency provides beneficiaries (and any other interested parties) with information about the performance of health plans operating in different local markets. In 2002, CMS also began a multi-media campaign, using both television and newspapers, to inform beneficiaries

about the availability of quality information for nursing home care. As noted in Chapter Four, a new initiative is under development to provide beneficiaries with information about hospital performance.

Although it is difficult to obtain a complete accounting of spending on all of these collateral functions, their total cost exceeds \$15 billion annually (Gusmano and Schlesinger 2001). Though a small fraction of Medicare's total expenditures, these costs are not trivial compared to federal spending on other pressing social needs. Some functions are also becoming increasingly controversial, as Medicare's spending on these functions increases over time, while corresponding spending by private insurers has declined (Boccuti and Moon 2003).

These formal responsibilities are not the only ways in which Medicare policies and practices shape the rest of the health care system. In previous chapters, we identified a number of instances in which Medicare policies have changed practices among private insurers, state Medicaid programs, or health care providers. In some cases, these involve explicit collaborations among purchasers, or between purchasers and providers of medical services. Examples include the CAHPS and HEDIS measures of health plan performance, the new patient satisfaction survey for hospitalized patients, and making coverage determinations for new or health care services or devices.

In other cases, CMS (previously HCFA, or in the program's earliest years, the Social Security Administration) acted unilaterally, but with consequences that rippled through the entire health care system. As we noted in chapter four, the initial implementation of the Medicare program provided federal officials with the leverage to close down many of the formally segregated hospitals during the late-1960s (Quadagno 2000). Another example is the adoption of hospital prospective payment systems based on Diagnosis Related Groups (DRGs) in Medicare, which was soon emulated by a number of state Medicaid programs as well as private insurers. These changes had important consequences for the efficiency and equity of hospital-based treatment for all Americans.

### **THE IMPLICATIONS OF PRIVATE PLANS FOR MEDICARE'S COLLATERAL ACTIVITIES**

Experience with M+C program as well as with the role of markets in employer-based insurance suggests that some of these collateral goals may be fostered by a greater use of private plans, others undermined, and others largely unaffected. We would place the beneficiary education in the first category, subsidies to health care providers in the second, and data collection and research in the third.

### **Educating Beneficiaries**

On the positive side of the ledger, incorporating coordinated care plans into Medicare creates the potential for more effective outreach and education for beneficiaries. Indeed, evidence cited in Chapter four on reduced racial disparities related to preventive services provides concrete evidence of the potential for these plans to provide a more effective conduit for information. This conduit could be better exploited by more extensive collaborations between CMS and coordinated care plans, targeted at increasing beneficiaries' knowledge about health promoting activities and services.

It is also important to recognize that these potential advantages are a consequence of the infrastructure created by coordinated care plans, not the incentives for private insurers more generally. If Medicare expands the involvement of private fee-for-service plans, there is no reason to expect them to be more willing or able to engage in beneficiary education than original Medicare. Indeed, as markets become more competitive and enrollee turnover increases, private insurers have less incentive to invest in educating beneficiaries, because they become less likely to reap the long term cost savings resulting from enhanced health promotion.

### **Research and Information Collection**

The enrollment of Medicare beneficiaries in private health plans seems to hold no clear-cut positive or negative consequences for these collateral activities. On the one hand, private health plans could serve as partners in various forms of collaborative research or data gathering activities. Employers' experiences suggest, however, that while some health plans will be quite willing participants in these sorts of activities, others see them as outside the scope of their organizational mission (Schlesinger, Mitchell, and Gray 2003). Whether these varied motives will produce a net increase or decrease in the capacity to collect or analyze information cannot be determined at this time.

### **Maintaining a Broader Mandate for the Medicare Program**

Some of Medicare's collateral involvements remain controversial. Although we know little about how they affect support for the program, the limited evidence that exists suggests that they enhance support among the general public, at least those who are aware of these activities. Most strikingly, beneficiaries of the program are quite positive about these involvements, seeing in them a way in which the Medicare program can "give back" to the broader community, helping those other than the elderly and disabled (Gusmano and Schlesinger 2001). Policy analysts are divided in their assessment of these collateral functions, with strong cleavages in support along ideological lines.

It is not in the mandate of this panel to determine whether particular collateral involvements have a positive or negative effect on the health care system or the Medicare program. Nor do we take a stand on whether particular activities should be tied to the Medicare program, or made a responsibility of some separate program or government agency. But we do consider it relevant to this report to address a related, but broader question: should Medicare policies and practices be established to foster some broader set of societal goals, or should policy-makers and program administrators remain more narrowly focused on the health care of the program's titular beneficiaries?

We believe that the answer to this question is clear. Medicare cannot, and should not, be considered in a vacuum. As we have seen throughout this report, Medicare's performance is inevitably assessed in light of the performance of other parts of the health care system. And its practices will affect the rest of that system; whether or not administrators choose to explicitly consider these consequences. Moreover, it is essential for policy-makers and program administrators to recognize that the decisions of individual beneficiaries, however well-informed and thoughtfully made, will not necessarily respond to the full range of societal needs that could be addressed through the health care system. Some aspects of health care must be seen as public goods and pursued through collective, rather than individual choices. Certainly many of the collateral functions that Medicare has assumed could be placed in this category. And there are others that could conceivably be added (Gusmano and Schlesinger 2001). Whether the scope of Medicare's collateral functions should be expanded or contracted is not at issue here. What is at issue is the capacity to make these choices in a sensible manner. It is essential that CMS and the Congressional committees charged with oversight for the program pay attention to these broader social roles for Medicare and revisit them on a regular basis.

## **FINDINGS AND RECOMMENDATIONS**

Our review of the broader implications of private health plan involvement in Medicare has explored two quite different sets of consequences: those related to political sustainability, and those related to Medicare's collateral functions. We have identified one key finding and one recommendation in each of these two domains.

### **Medicare's Political Sustainability**

Based on our analysis of geographic variations in support for the Medicare program and its various goals, we identified some potentially troubling findings.

**Finding 18: Support for Medicare is significantly attenuated in communities in which there has been substantial enrollment of beneficiaries in private health plans. In areas in which private enrollment exceeds 30 percent of all elderly residents, support for taxes to finance Medicare in the future is at half the level found in other communities. Lower levels of**

**support for government involvement is most pronounced in promoting quality and preserving equity of treatment among beneficiaries.**

Several other aspects of our findings are noteworthy. First, these community-level effects on political attitudes appear to be more pronounced than individual enrollment in an M+C plan, though personal enrollment in a private health plan is associated with a 24 percent reduction in support for an active government role in providing health insurance to the elderly. Second, there appears to be a threshold for the political consequences of private health plan participation. Community enrollment in the range of 10 to 30 percent is not associated with significant reductions in support for Medicare, but a set of more striking attitudinal changes emerge where private plan enrollment exceeds 30 percent.

These apparent consequences of private health plan involvement have not, to date, dramatically reduced public support for Medicare, in part because enrollment above the 30 percent threshold has been limited to a small number of metropolitan areas. But they appear to be problematic harbingers for Medicare's future. If enrollment in private health plans expands greatly, as proposed, we believe that future support among the program's core constituency is at risk. This threat may be driven in large part by beneficiaries' misunderstandings about the extent to which their access and health benefits continues to depend on the level at which Medicare pays health plans, as well as the requirements that it establishes for their performance.

**Recommendation 11: CMS should help beneficiaries better understand that they are enrolled in Medicare, regardless of whether they are receive care through original Medicare or an M+C plan, and the conditions under which they can disenroll from M+C and return to original Medicare. This educational effort must be carefully designed to clarify the structure of the program, while not confusing beneficiaries about the terms under which they have enrolled in particular M+C plans.**

While increased information may ameliorate some of the decline in support for the program, we are not, however, optimistic that it will eliminate the apparent threat to the program's political sustainability. As was clear from Table 5.2, community-level effects on beneficiaries' personal well-being were relatively modest. The declines in support for the program, particularly for its role in assuring quality and equity, appear to be less driven by personal considerations than by changes in beneficiaries' broader understandings of the program and government's role in its performance. Given the disparities and quality shortfalls we documented above, this reduced support for an active government role threatens to lock into place some of the problems currently facing Medicare beneficiaries.

## NOTES

<sup>1</sup> In order to reduce the cost of the survey, disabled beneficiaries were not included. Lists of telephone numbers can be constructed by age, allowing surveyors to contact only households in which there was at least one member over the age of 65. To identify disabled beneficiaries, it would have been necessary to randomly call households and screen for those who are disabled. The costs of this sort of screening exceeded the resources available to the study panel.

<sup>2</sup> In supplementary analyses, the issue of whether they had formerly been enrolled in a plan was considered, as well as the length of time that they had been enrolled. These analyses did not differ significantly from those reported in the text.

# Chapter 6:

## Toward a More Dynamic Perspective on the Medicare Program

In this final chapter, we step back from the specific objectives discussed earlier to ask a broader question: how should one view the role of private plans and market-oriented reforms for enhancing Medicare’s performance over time? In previous chapters, the study panel identified a number of Medicare’s shortcomings in achieving particular programmatic goals. Some are more pronounced in original Medicare, others among private plans that provide health care to Medicare beneficiaries. Many pervade both parts of the program. We emphasize these shortcomings not because we believe that they can ever be fully eliminated. Medicare beneficiaries’ health care needs are costly and complex. Given limited resources, multiple goals, and the varied circumstances of beneficiaries, no program can ever ensure that all needs will be fully satisfied.

But Medicare can do better at addressing these goals. To ensure that program performance continues to improve, incentives and administrative mechanisms to foster improvement should be adopted. We will refer to these motivations for change and improvement as the need for increased “accountability” in program administration.<sup>1</sup> Given changing health needs, new technologies, and rapidly evolving delivery systems, Medicare needs to become more flexible and responsive to changing circumstances, and thus more accountable.

Yet change, if too frequent or too extensive, produces its own problems. Throughout this report, we have identified some unintended consequences of past efforts to change Medicare, or changes in the program’s environment that have affected its performance:

- Constrained payment rates and dramatic changes in market conditions have made it difficult for private health plans to sustain a stable business relationship with Medicare or beneficiaries.
- Changes in benefits and provider networks, as well as plan withdrawals from the Medicare program, have made it difficult for beneficiaries to retain coverage of needed medical services and have disrupted their relationships with health care providers.

- Some beneficiaries who decided to try private plans have been unable to return to FFS Medicare because they are unable to obtain or afford a Medigap policy. These problems have grown as employers have cut back on retiree health benefits.
- Congressional efforts to achieve new objectives for the program have at times worked at cross-purposes with other goals.
- The magnitude and extent of change since 1997 has been confusing for a number of beneficiaries. Change is challenging for us all. But it can be more threatening to those in frail health, with cognitive impairments, or with limited health literacy.

The inevitable tension between stability and flexibility is the focus of this final chapter. In preparing Medicare for an uncertain future, one that is sure to involve changes at least as pronounced as those of the recent past, we see this more dynamic perspective on the program as a crucial lens for understanding and improving Medicare. The optimal amount of change depends upon an appropriate balance between stability and flexibility. In the judgment of this study panel, achieving this balance depends on seeing Medicare as combining the strengths of a government social insurance program with the adaptability of private insurance that responds to market forces.

**Accountability for Improving Medicare’s Performance.** Both original Medicare and the M+C program incorporate distinctive, albeit largely implicit, models of accountability. At its inception, FFS Medicare was designed to rely on the norms of the medical profession to ensure appropriate, high-quality care, requiring only that providers meet accreditation and licensing requirements. To ease its acceptability to health care providers and to provide the broadest possible access to Medicare beneficiaries, requirements for provider entry into the program were deliberately kept low. However, over time, Congress has become more involved in the structure, management, and governance of original Medicare.<sup>2</sup>

In contrast, the M+C program was predicated on a notion of consumer accountability, with beneficiary choice among health plans providing incentives for better coverage, and protections against inadequate quality. Consumer choice was originally combined with a requirement that plans serving Medicare beneficiaries enroll at least half their covered population from working-age Americans, on the presumption that substantial private sector enrollment would ensure acceptable performance. Although the 50 percent rule was later dropped, it was replaced by quality assurance requirements for M+C plans, administered by CMS.

The track record for original Medicare and M+C can be seen as a scorecard for the strengths and weaknesses of these different accountability arrangements.

## DIFFERENT STRENGTHS AND WEAKNESSES IN EACH PART OF THE PROGRAM

Based on its review of a wide range of studies of Medicare performance, the study panel concludes that neither the FFS system nor M+C structure has produced clearly superior performance across the board. As shown in Table 6.1, original Medicare has produced better results in some areas, while M+C is better in others.

**Financial Security.** Beneficiaries enrolled in FFS have less financial security than those in M+C, because original Medicare has no limits on coinsurance or an annual limit on out-of-pocket payments. By comparison, beneficiaries in M+C are protected by an overall limit on out-of-pocket spending, and have not been generally required to make co-payments for most services. However, the financial advantages of M+C have eroded substantially in the last few years as benefits have been reduced and copayments increased. Moreover, those who enroll in an M+C plan and later decide to disenroll may be unable to afford a Medigap policy if they re-enroll in Medicare FFS, leaving them exposed to substantially higher financial risk.

**Access.** Access to care for enrollees in both original Medicare and M+C is quite good, with aged beneficiaries generally having better access than younger people in employment-sponsored plans. However, access problems have recently emerged in some geographic areas for beneficiaries in original Medicare.<sup>3</sup> Beneficiaries *enrolled* in M+C plans also have good access to care, but beneficiaries in many parts of the country do not have an opportunity to enroll. Access and continuity of care are typically disrupted for enrollees whose health plans discontinue participation with the program. In both original Medicare and M+C, access to care for disabled beneficiaries is not as good as for elderly beneficiaries.

**Cost Containment.** Over the long term, Medicare spending has not grown at a faster rate than private sector spending. From 1970 through 1998, overall Medicare spending grew at an annual rate of 10 percent, compared to 11.2 percent in the private sector. Studies have shown that Medicare managed care can produce one time savings of 5 to 7 percent, but that Medicare has not captured these savings because of inadequate risk adjustment and higher administrative spending. Instead, Medicare has actually spent more money, on average, for Medicare beneficiaries enrolled in M+C plans, who have received additional benefits not covered by Medicare. Moreover, after the initial implementation of managed care, subsequent spending grows at approximately the same rate as FFS. While true market based strategies such as negotiation, competitive bidding, and premium support models have not been instituted in Medicare, estimates of cost savings to Medicare are modest. For example, the Chief Medicare Actuary estimated that adoption of a premium support model under consideration by the Medicare Commission in 1999 would have produced savings of 2.5 percent over 30 years.

**Table 6.1**

**Summary Comparisons of Performance of Original Medicare and M+C**

	Fee-For-Service	M+C
Financial Security	Inadequate, particularly for poor beneficiaries and beneficiaries who are older and in frailer health.	Better than FFS, but eroding in past five years. More responsive to changing technologies, as illustrated by coverage of prescription drugs. But more risky for beneficiaries whose plans leave the program or who disenroll voluntarily.
Choice	Maximum choice of health care providers. Restricted choice among Medigap plans for the disabled and elderly beneficiaries who wish to change plans several years after retirement.	Plans concentrated in densely populated areas and not available in many parts of the country. Few areas have multiple choices. Less choice of providers than in FFS.
Access	Better than employer-based insurance, but emerging access problems in some geographic areas. Access for disabled not as good as for elderly.	For those enrolled, access to providers does not appear to be a problem. Access disrupted for beneficiaries when plans leave program. Access for disabled not as good as for elderly.
Quality	Achievements: Industry leader in access to cutting edge medical technologies; quality improvement initiatives on par with most progressive in employer-based insurance. Shortfalls: Treatment at "wrong" sites; excessive use of therapies; inadequate primary and preventive care and follow-up; medical errors; failures of coordination.	Similar quality problems as FFS, except: a higher percentage of beneficiaries have an established relationship with a primary care provider; higher immunization ratio; some cancers identified earlier. But continuity of care and communication tend to be worse than in FFS settings. Care seems to be less effective for older enrollees with more severe and chronic health conditions.
Cost Containment	From 1970-1998, Medicare performed slightly better than the private sector.	Introduction of coordinated care plans could produce one-time savings of 5-7 percent, but only if risk adjustment improved and implemented. Annual growth rates thereafter are similar to original Medicare.
Racial, Ethnic and Income-related Disparities	Systematic and sustained difference between whites and blacks, and between low and high-income beneficiaries, including: primary and preventive care, use of surgical and follow up. Limited evidence on disparities in care for Latinos and Asians. Gender disparities limited; largely related to age and income.	Only one study that compares disparities between FFS & M+C shows higher black immunization rates. Other studies suggest a reduction in disparities for primary and preventive care, but with no comparable reductions in disparities for follow-up care. Similar to FFS for disparities between low and high income. No evidence on other racial, ethnic, or gender disparities.

**Quality.** Both original Medicare and M+C suffer from some of the same quality shortfalls seen throughout the U.S. health care system, with evidence of treatment at inappropriate sites of care; excessive use of therapies; inadequate primary, preventive, and follow-up care; and considerable evidence of medical errors resulting in serious adverse events. Because Medicare beneficiaries are older and much more likely to suffer from a number of chronic conditions, they seem more likely to suffer from quality problems than younger people.

Medicare beneficiaries in M+C plans appear to have some advantages in terms of higher quality, with a higher percentage having an established relationship with a primary care provider, higher immunization rates, and earlier detection for some types of cancers. These benefits appear to be mitigated by less adequate *content* of primary care in M+C plans, with lower levels of continuity and less adequate communication. For older beneficiaries with more severe and chronic health conditions, care in M+C plans seems to be less effective than in original Medicare.

**Disparities.** Studies of original Medicare have shown systematic and sustained differences between whites and blacks, between low- and high-income beneficiaries in use of primary, preventive, surgical, and follow-up care. There are limited data for Latinos and Asian Americans, and on gender differences. Only one study has compared M+C plans to original Medicare using identical data regarding racial, ethnic, gender, and income disparities. It showed higher rates of immunization for black beneficiaries in M+C than FFS. Other studies that rely on data from multiple sources indicate that M+C plans reduce disparities for primary and preventive care. But about two-thirds of the disparities in preventive service use that originally existed in FFS Medicare persist in M+C plans. And enrollment in coordinated care plans do not at all lessen disparities related to quality of care. Very little is known about the effects of M+C on disparities affecting Latinos and Asian Americans and low income beneficiaries.

### **ASSESSING THREE DIFFERENT APPROACHES TO MAINTAINING ACCOUNTABILITY**

Given the mixed performance of both parts of the program, it is clear that neither FFS nor M+C guarantee the best possible performance for all beneficiaries. Indeed, the distinctive strengths and weaknesses of each approach are likely to prove appealing to different subsets of Medicare beneficiaries. Although there is, as yet, little experience with the newer forms of private FFS plans and PPOs for Medicare beneficiaries, experience from working-age populations suggests that they will also have a distinctive set of strengths and weaknesses, which may well differ from those of either original Medicare or M+C coordinated care plans.

The study panel believes that additional lessons can be learned from experience with Medicare's performance and reform. To illustrate these lessons, we identify three distinctive mechanisms

for accountability that are embedded in both parts of the program, albeit to differing degrees and in different forms.

- Consumer Accountability: emphasizes the role of beneficiaries in assessing their own experiences and responding when they think that they can obtain better outcomes in other settings. In original Medicare, consumer choice involves the selection of doctors, hospitals, and other health care providers. In the M+C program, consumers are expected to assess and select among health plans, with information provided both by Medicare and by the plans.
- Political Accountability: involves the oversight provided by Congressional committees charged with the supervision of the program. Three authorizing committees (The House Committee on Ways and Means, the House Committee on Energy and Commerce, and the Senate Committee on Finance) have responsibility for the design, structure, and spending of the program; they are assisted with research and information from Congressional agencies, including the Congressional Research Service, the Congressional Budget Office, and the Medicare Payment Advisory Commission. Although experience with the M+C program to date has involved extensive Congressional intervention (See chapter two), proponents of premium support models expect that their adoption would reduce Congressional involvement.
- Managerial Accountability: is exercised by the federal agency that administers the program (CMS), the insurers and other organizations under contract to CMS, and the Secretary of the U.S. Department of Health and Human Services (DHHS). Other agencies, such as the General Accounting Office and the Office of the Inspector General in the DHHS, oversee many of the program's operations. Over past ten to fifteen years, CMS' administrative accountability has grown to include increased responsibilities for improving quality of care and conducting education campaigns for beneficiaries. Under the M+C program, the scope of quality enhancement activities has been quite similar to that in original Medicare, though the mechanisms for encouraging quality improvement have been somewhat different.

Each of these approaches to accountability has demonstrated its own distinct set of strengths and weaknesses, which are reflected in the track record comparing Medicare FFS and M+C over the past fifteen years. Consumer accountability has the great benefit of relying on individual choices. By so doing, it has the greatest capacity to reflect the diverse needs and changing preferences of Medicare beneficiaries. In original Medicare, individual beneficiaries make choices about which doctors and hospitals to use, or which supplemental policies to purchase. In M+C, entrepreneurs with promising ideas for new benefits can test their desirability by offering them to beneficiaries, allowing for flexibility and innovation in response

to changing needs, conditions, and technologies. The ability to choose different plans and benefits allows beneficiaries to signal their preferences for additional benefits, such as prescription drugs.

But the same features that make consumer accountability attractive also present certain shortcomings. In geographic areas with limited choice of providers or plans, consumer accountability can do little to safeguard or improve Medicare's performance. Consumer accountability also offers limited advantages to beneficiaries in persistently poor health because their need for continuity of care makes them reluctant to switch among plans or providers. Past research demonstrates that consumers are effective at assessing some aspects of their health care or health plan, but are less capable of judging other, equally important, dimensions. Consumers are effective judges of the quality of their relationships with health care providers, but less able to assess its technical quality (even with the assistance of report cards and other performance measures). Consumers can make sense of the differences among health plans in terms of coverage and costs, but have a much harder time interpreting complex measures of quality or preventive services. And some dimensions of performance, such as whether there are disparities across groups of beneficiaries, can only be judged in the aggregate and cannot be observed by individual beneficiaries.

In short, consumer accountability creates an important set of pressures for improved performance in both original Medicare and Medicare+Choice. But there are important dimensions of program performance, and substantial portions of the beneficiary population, for which consumer accountability is likely to have limited effectiveness. In a similar manner, both political and managerial accountability offer mechanisms for improving program performance that embody their own set of distinctive strengths and limitations.

The relative strengths of political accountability have been most evident in original Medicare. For example, Congress has, over time, enacted laws that have made Medicare the market leader in new payment methodologies. As documented in chapter three, Congress has been slightly more effective at controlling cost growth over the long-term than private employers and other purchasers. Political accountability has produced more of a mixed track record in terms of other goals. Although Congress has initiated a number of modest benefit expansions over the past 20 years, and is considering adding a prescription drug benefit to Medicare, Medicare's benefit package has generally lagged behind changes in the vast majority of employer-provided private insurance benefits. And although Congress has encouraged an increased role for Medicare at ensuring and improving the quality of medical care received by beneficiaries, political oversight for this goal has been limited.

As documented in chapter two, political oversight has also played an important role in modifying the M+C program, though with inconsistent results. Since 1997, Congress has twice changed the terms under which private plans contract with the Medicare program, intending to stabilize plan participation and reduce geographic inequities in the availability of choice. These efforts have achieved neither objective. But they illustrate that political oversight is necessary to assess whether the benefits of the program are being equitably provided among groups and across geographic areas. Political leadership is also needed to determine the appropriate level of Medicare spending and to establish the percentage to be paid by beneficiaries.

Most politicians and beneficiaries are not well equipped to assess certain aspects of program performance, such as the more technical aspects of quality of care, the extent to which treatment has been coordinated appropriately, or the prevalence of medical errors.

In the Medicare program, managerial accountability resides in CMS, the insurers and other organizations under contract to CMS to pay claims and perform other administrative duties, and ultimately the Secretary of HHS. The House and Senate Appropriations Committees have jurisdiction over administrative funds to operate the Medicare program and thus over Medicare administration and operations. The General Accounting Office performs studies and audits of Medicare performance at the request of Congress. The Office of the Inspector General in the Department of HHS has independent authority to oversee Medicare operations to detect waste, fraud, and abuse.

As documented in chapter four, over the past decade, CMS has taken a more active role in quality improvement, as well as in conveying to beneficiaries the information they need to make more effective choices among health care providers and health plans. As Medicare enrollment in private health plans grew during the 1990s, these roles of managerial accountability become more important for that part of the program as well.

The capacity for effective managerial accountability in Medicare has been constrained by inadequate administrative resources. As documented in a companion report from NASI (King and Burke 2002), Congress has not provided CMS with the resources necessary to manage the program effectively. Nonetheless, in the judgment of this study panel, CMS has pursued initiatives in the past decade to improve quality of care in Medicare that compare quite favorably with those adopted by the most pro-active employers. Indeed, CMS has been an active leader or partner in many quality-related initiatives, such as HEDIS and CAHPS.

But this same track record also illustrates the inadequacies of managerial discretion in Medicare. Apart from insufficient resources, perhaps the most striking limitation has been political constraints on managerial discretion. These have been evident in both original Medicare and M+C. These constraints have made it virtually impossible for Medicare FFS to adopt selective contracting to choose high quality providers or exclude poorly performing providers, although this technique for improving performance is actively used by large employers. Comparable constraints affect CMS' managerial discretion in M+C. Political pressures have gutted CMS' efforts to implement a competitive pricing demonstration for private plans, not once, but on four separate occasions over the past five years. In addition, pressures to make M+C more palatable to health plans have vitiated some of the administrative requirements intended to improve oversight of care for beneficiaries in private plans.

Over the last several years, Congress had also considered proposals that, in the panel's judgment, would seriously weaken CMS's managerial accountability. Proposals to split CMS apart, with one agency managing original Medicare and the other M+C, would weaken coordination between the two parts of the program, and cause considerable confusion for beneficiaries, particularly those who want to switch between original Medicare and M+C.

It is equally important, however, to recognize that not all management failures in Medicare can or should be attributed to political pressures. The track record of competitive contracting arrangements in the private sector demonstrates that achieving goals such as improving quality or reducing disparities has been extremely difficult, not just because they are politically contentious, but also because they require knowledge about the nature and determinants of medical outcomes that exceed current knowledge (Maxwell and Temin 2002; Hargraves and Trude 2002). These problems are compounded for Medicare beneficiaries. As documented in chapter four, the complexities of providing care to beneficiaries with multiple chronic illnesses create tremendous challenges for health care professionals, and even greater impediments for effective managerial oversight. Precisely because improving quality will remain a continuing challenge, it is important for Congress to emphasize its importance and to oversee CMS' quality improvement efforts. Consequently, efforts to "insulate" the Medicare program from politics do not, in themselves, appear to be the most promising approach to ensuring greater accountability for the program.

### **TOWARD A MORE ACCOUNTABLE MEDICARE PROGRAM**

The study panel believes that both original Medicare and Medicare private plans need to be more accountable. This will require a transformation of Medicare's governing culture. To achieve greater accountability, particularly in the dimensions of quality and disparities, this panel believes that the Medicare program needs greater managerial discretion. We believe that this

can be accomplished, even while being realistic about the political constraints under which the program operates. For example, we believe that it is feasible for CMS to pursue initiatives to improve quality by providing appropriate incentives to providers or beneficiaries. Similarly, although many private health plans have resisted additional CMS requirements for quality improvement, we believe that if payment rates to plans were more stable and equitable, quality improvement measures could be pursued more aggressively.

Equally important, we believe that it is essential for policy-makers to recognize that Medicare should rely upon a dynamic combination of consumer, political, and managerial accountability because no single approach, standing alone, can produce the best results. Proposals that favor any one at the expense of the others fail to realistically assess the strengths and limitations of each approach.

Making the health care system more accountable is critical to achieving maximum performance and efficiency if Medicare is to meet the challenges it faces in the future. We draw two broad conclusions for our assessment of program accountability.

Market oriented reforms cannot rely solely on consumer accountability. Whatever role is played by consumer choice among health plans, it will not prevent dramatic increases in Medicare spending for the baby boom generation, nor avoid difficult questions about how much this country is willing to pay for the health care of elderly and disabled Americans. These are inherently political choices and would remain salient even if every beneficiary were enrolled in private health plans. Similarly, market-oriented portions of Medicare need greater managerial accountability to encourage more long-term investments in quality improvement, and to address system-wide issues related to disparities and other aspects of health care that produce societal benefits, as well as improved health for individuals. As with all public programs, some decisions about Medicare's form and functions must take into account the consequences for its public acceptance and political legitimacy.

Second, it is precisely because the different parts of the Medicare program embody different combinations of accountability mechanisms, that each part of the program can serve as an important standard of performance for assessing and improving the performance of the other part. And because these different combinations of accountability arrangements produce a distinctive pattern of strengths and weakness, having both original Medicare and M+C as part of the program will provide the best potential for increased accountability. The differences between original Medicare and M+C ought to be viewed as assets for the program, not problems that ought to be eliminated by future reforms. To realize these benefits, accountability arrangements must encourage effective learning between the two parts of the program.

### **The Stability and Sustainability of the Medicare Program**

If one key aspect of a dynamic perspective on Medicare reflects the need for continual change and improvement, a second recognizes the need for the program to be reasonably stable and sustainable over time. Because Medicare serves elderly and disabled people, it should be seen as different from private health insurance for younger people. Medicare beneficiaries are far more impaired, and often more socially isolated, than many working-age Americans.

A second rationale for stability involves the long-term sustainability of the program. This too makes Medicare very different from private health insurance. When working-age Americans enroll in a private health plan, the expectation is typically that they will keep this coverage for the following year. When people join Medicare at age 65, they are joining a program for the rest of their lives, often for fifteen, twenty, or even thirty years. When people with disabilities qualify for Medicare coverage, this expected enrollment can be of even longer duration.

The choices that people make at time of retirement (or disability), in terms of benefits, insurance arrangements or even the decision about when to retire are contingent on their expectations for Medicare's future. Indeed, like Social Security, the availability of Medicare and the scope of its benefits alter choices that are made throughout one's working years, potentially involving choices of employment or selection of benefits (e.g. retiree health coverage).

Because Medicare, like Social Security, is primarily financed by current taxpayers, it confers to those taxpayers the general expectation that they, too, will reap the benefits of the program when they become eligible in years hence. The program was enacted with the expectation of long-term endurance and people have developed a sense of having earned its benefits as a result of many years of paying into the system. Despite these symbolic features of Medicare, there is no explicit contract among generations defining Medicare's precise character or roles. Its sustainability over time depends on its continued political resilience. Medicare typically enjoys broad popular support, but ongoing political endorsement requires that current and future (potential) beneficiaries continue to identify with the program.

Public policies are not based on some magical lens through which politicians read the minds of their constituents, and those constituents do not reside in isolation with ideas and attitudes derived from their genes. Policies are shaped by the articulation of political preferences by citizens, as an electorate and as represented by various organized interests. That articulation in turn depends on the means and pathways of political mobilization either facilitated or hindered by the existing political and policy-making institutions. As any reform of Medicare is considered, it is necessary to recognize how particular policy approaches affect the politics of the program itself and the nature of political mobilization on its behalf.

These political consequences require attention for several reasons. First, citizen preferences about Medicare and its particular features are not just givens that are then expressed. The preferences themselves are influenced by a combination of values, personal experience, the manner in which political leaders and the media frame policy options.

Second, political influence in the United States is unevenly distributed. Groups with concentrated economic interests can have a disproportionate influence over policymaking. In FFS Medicare, these economic interests involve health care providers and institutions. In the M+C program, they are found in the private plans that contract with the Medicare program. In either case, for political accountability to strike the appropriate balance among Medicare's various goals, it is essential that beneficiaries be effectively mobilized to mitigate the influence of groups with large economic stakes in the program's administration.

Public programs, however well conceived or effectively administered, will lose their legitimacy, if in this complex political system they cannot muster a continued base of political support. It is in this sense that the suggestive findings of chapter five about public attitudes toward Medicare should be interpreted. For policy-makers who share the original social insurance conceptualization of Medicare universality of coverage, risk sharing across the eligible population, and public financing, the results presented in chapter five could be seen as troubling, suggesting that an expanding role for private health plans in Medicare may undermine the long-term stability of the program. For other policy-makers, concerned that Medicare has created a block of voters committed to an increasingly expensive government program, the survey findings may show how increasing private plan participation potentially fragments interests among beneficiaries and creates new opportunities to redesign Medicare fundamentally and limit its financial commitments.

Although stability and sustainability are thus important features of the Medicare program, the pursuit of each carries potential risks. No one aspires to a Medicare program that is totally static. In the face of changing conditions, health needs, and technology, a program without change becomes stagnant, leaving its beneficiaries exposed to unexpected costs and unmet needs. We have documented the problems of excessive stability, such as the lack of prescription drug benefits and caps on out-of-pocket spending. Even since the panel began its work, the health care system has undergone rapid change, marked by the devolution of managed care toward less restrictive arrangements, rapid technology development and diffusion, and steep price escalation. It is likely to continue changing in ways that policy-makers cannot yet envision. Were Medicare to ignore these changes, or to fail to respond to them, it would not be serving effectively the interests of either beneficiaries or taxpayers.

## **MAINTAINING A BALANCE BETWEEN STABILITY AND ACCOUNTABILITY**

In the judgment of this study panel, the best way to achieve a balance between the flexibility needed to produce accountability, and the stability required to provide long-term security, is to think about Medicare as a “portfolio” of programs. The aspects of the program that involve the participation of private health plans offer the potential for greater innovation and responsiveness to individual needs and preferences. But this comes at the cost of greater risk of benefit changes, potentially unstable arrangements with doctors and other health care professionals, and the need to monitor closely the performance of one’s health plan, compared to other available options. FFS Medicare, conversely, can be seen as the “low-risk” alternative, slower to change and adopt new benefits, but also more typically reliable in ensuring access to particular providers and stability of health benefits. Much in the way that some people prefer to invest their savings in riskier but higher yield securities, while others favor the more stable returns offered by bonds and money market funds, so too Medicare can be seen as providing beneficiaries with the choice of a trade-off between flexibility and security.

This does not, of course, mean that either part of the Medicare program should be allowed to become too extreme in its embrace of change or stability. Even beneficiaries who choose an M+C plan fully aware of its more dynamic characteristics may face serious problems if provider networks are too unstable, or the plan confuses enrollees with overly rapid changes in its benefits or administrative requirements. This instability can be buffered by appropriate forms of managerial and political accountability. These forms of external oversight ought to be oriented at enhancing stability in the M+C program, not (as too often has been the case in recent years) producing instability in their own right.

Conversely, there is no magic in “preserving” original Medicare as if it were a basic provision in the American constitution. Original Medicare remains an important social program, meeting vital needs in American society. But the nature of that commitment, and its particular form of implementation, must constantly be tested against the reality of changing societal circumstances and competing needs. This pace of change can be slower than that among M+C plans, but the capacity for change must remain.

In striking this balance among the different attributes of Medicare FFS and M+C plans, the study panel believes that it is essential that beneficiaries choose the options that seem most appropriate to them, under their current circumstances. This suggests that there should not be systematic barriers or incentives favoring one portion of the program over the other. The American public appears to endorse this position. In a survey fielded in January 2001, 62 percent of respondents endorsed the notion of providing Medicare beneficiaries with a choice between original Medicare and private health plans (Kaiser Family Foundation 2001b). But

when asked if they continued to endorse choice if it meant those enrolled in “traditional Medicare” would be required to pay more “than they do today,” support fell to 39 percent of respondents. And when asked if they endorsed charging those who remained in FFS Medicare “higher copayments and deductibles,” support fell to 19 percent.

Based on similar principles, because beneficiaries’ circumstances change over time, it is essential that they have some opportunity to switch between original Medicare and M+C. The current rules governing premiums for supplemental policies violate this objective, for beneficiaries living in most states (except the handful that mandate community rating) and for virtually all beneficiaries who qualify based on disability. Proposals that would set Medicare FFS premium contributions in proportion to bids for private plans threaten, for at least some markets, to make original Medicare unaffordable for beneficiaries with modest incomes (but not so poor as to qualify for Medicaid).

Most importantly, we believe that it is essential that policy-makers see the different portions of the Medicare program as vital resources. Each approach, through its distinctive combination of accountability mechanisms, provides important feedback about how the program might be improved over time. Only by understanding the continuing promise of both Medicare FFS and M+C can policy-makers ensure that the program remains robust, politically legitimate, and effective at meeting the diverse needs of its beneficiaries.

## **FINDINGS AND RECOMMENDATIONS**

**Finding 19: Medicare lacks sufficient consumer, political, and managerial accountability in both original Medicare and M+C to assure optimal performance.**

**Recommendation 12: Mechanisms should be developed to ensure greater consumer, political, and managerial accountability in both original Medicare and M+C by more effectively connecting oversight for the two parts of the program. This would require (a) providing beneficiaries with comparable information on both parts of the programs, whether or not they are actively considering a switch between the two, (b) providing CMS with additional resources and allowing it to retain managerial oversight over both parts of the program, and (c) encouraging Congress to more effectively and consistently monitor the performance of both FFS Medicare and M+C plans with respect to the program’s core goals, without micromanaging the program’s operations.**

**Recommendation 13: Congress should create a more stable environment for the M+C program by refraining from legislating frequent changes in the program’s structure and payment rates.**

## NOTES

<sup>1</sup> The goal of accountability has been discussed in several previous NASI reports on Medicare (Bernstein and Stevens 1999; King and Burke 2002).

<sup>2</sup> Increased Congressional involvement in Medicare has resulted from a number of factors, including the increasing percentage of federal spending attributable to Medicare, the rate at which Medicare spending has grown, and Congressional budget rules that require Congress to identify, with great specificity, ways to reduce the rate of growth in Medicare spending.

<sup>3</sup> Access problems are not isolated to Medicare. As discussed in chapter three, access problems have also emerged in the private sector.



# Appendix A:

## M+C Payment Provisions

The annual capitation rate to plans was set at the highest of these three amounts for each county:

- a rate calculated as the blend of local and national rates;
- a minimum payment “floor”; and
- the minimum increase established in law.

### **BLENDED RATES**

Prior to the BBA, capitation rates were based solely on local rates. To reduce disparities between low and high payment areas, the BBA gradually blends local and national rates, so that the rates are based 50 percent on local prices and 50 percent on national prices in 2003, with adjustments for changes in input prices. The rates are updated annually by the national growth percentage, defined as the projected per capita increase in total Medicare expenditures minus a specific reduction set in law. For 1998, the reduction was set at .8 percentage points, and at .5 percentage points from 1999 through 2001.

The construction of the blended rate illustrates how Congress attempted to achieve several goals simultaneously. Reducing the annual update contributes to the goal of reducing the deficit. By including total Medicare expenditures (not just M+C expenditures) in the calculation of the rate, Congress also indicated its intention to maintain a link between M+C rates and FFS spending. Blending the rates over time so that national rates would gradually account for 50 percent of the rate reflected Congress’ desire to lessen the disparities between low and high cost areas without penalizing high cost areas.

### **MINIMUM (FLOOR) PAYMENTS**

In order to encourage plans to locate in low cost areas, the BBA established a minimum payment, known as the “floor” payment. The floor payment was set at \$367 for 1998, which would affect a substantial number of counties. In 1997, more than a third of counties had AAPPCs below \$367, and about 8 percent had AAPPCs below \$300 (Moon, Gagel, and Evans 1997).

### **MINIMUM PERCENT INCREASE**

Congress established a minimum percent increase to protect counties that would otherwise receive only a small or no increase. For 1997, the minimum percent increase was established at 102 percent of the 1997 AAPPC rate. For 1999 and 2000, the minimum increase is 102 percent of the M+C per capita rate for the preceding year.

### **EXCLUSION OF GRADUATE MEDICAL EDUCATION PAYMENTS**

Historically, payments to managed care plans included payments intended to compensate teaching hospitals for the indirect costs associated with teaching. In response to concerns from academic health centers that managed care plans were not compensating for these additional costs, Congress “carved out” these payments from the M+C rates, and stipulated that the payments be made directly to teaching institutions.

### **BUDGET NEUTRALITY**

The BBA includes a budget neutrality adjustment to assure that total M+C payments would not exceed what would have been paid if payments were based solely on local rates. The minimum floor payments and minimum increase payments are not subject to the budget neutrality adjustment, so budget neutrality only applies to payments made on the basis of the blend.

### **NATIONAL GROWTH PERCENTAGE**

The BBA limits the amount that the national per capita M+C growth percentage could increase each year. The sole purpose of this limitation is to reduce spending.

### **RISK ADJUSTMENT**

In response to research showing that Medicare risk plans typically enroll healthier people than those who remain in FFS, the BBA directed the Secretary to develop a risk adjustment methodology. Based on the Secretary’s recommendations, payments to M+C plans would be risk-adjusted starting in 2000. Risk adjustors are expected to result in lower payments to most M+C plans.

# Appendix B: Methodology for NASI Survey of Beneficiaries' Attitudes Towards Medicare

## SAMPLING METHOD

Enrollment in Medicare+Choice plans is distributed unevenly throughout the United States. To ensure that we had a sufficient sample of those enrolled in private plans, as well as those living in communities with high levels of penetration by private plans, the sampling scheme was constructed to select particular geographic areas in a weighted manner, then randomly sample beneficiaries within these communities. To take advantage of some substantial synergies with past research, we used as our community-level sample the 60 geographic areas that have been studied as part of Robert Wood Johnson Foundation's Community Tracking Study (CTS) (Ginsburg 1996).

The CTS has identified 60 sites, some metropolitan areas, others aggregations of counties in rural areas. Using data provided by the Health Care Financing Administration (now CMS) on Medicare HMO enrollment during 2000, we grouped the counties in the 60 CTS sites into three strata based on the enrollment in Medicare+Choice plans: those with high levels of managed care penetration (greater than 30 percent of Medicare beneficiaries in the county), those with moderate levels of penetration (10-29 percent penetration) and those with low levels of penetration (less than 10 percent of Medicare beneficiaries). We used a quota sample that was designed to draw two-thirds of our respondents from high penetration counties, one sixth from moderate penetration counties and one-sixth from low penetration counties.<sup>1</sup>

Ultimately, 1,129 beneficiaries were interviewed. Two-thirds lived in high penetration counties (752 respondents), 17.3 percent in moderate penetration markets (195 respondents) and 16.1 percent in low penetration counties (182 respondents). Respondents within each county were contacted through random-digit dialing based on a sampling frame of all households with at least one member over the age of 65. The overall response rate for the survey was 51.5 percent. Data were collected in February of 2001.<sup>2</sup>

## SPECIFICATION OF MEASURES

We identify three sets of measures that were collected in the survey. These include: (1) measures of political attitudes related to the Medicare program; these become the dependent variables in

our multi-variate models, (2) measures of Medicare+Choice involvement, which serve as our primary explanatory variables in predicting beneficiary attitudes towards the Medicare program, and (3) a set of additional explanatory variables to control for other characteristics of respondents that could be affecting attitudes toward the Medicare program.

### **Attitudes Toward the Medicare Program**

The survey assessed three types of attitudes: (1) support for Medicare spending, (2) support for an active role for the federal government in terms of two of Medicare's more contested goals: assuring equal quality of care for all beneficiaries and securing racial equity in health outcomes, and (3) the extent to which beneficiaries so their own well-being as depending on the performance of the Medicare program. This provides us with a half dozen-attitudinal measures.

Our measure of absolute support for the Medicare program was asked in a sequence of policy options, assessed after respondents had been told that the program faced a fiscal crisis. One proposed policy response involved "adding money to Medicare from new taxes or general government funds." Roughly two-thirds of beneficiaries endorsed this response; 21.6 percent indicated strong support.

Our measures of shifting program goals involved asking elderly respondents how important it was that the federal government play an active role in (a) "ensuring that all people enrolled in Medicare get medical care of the same quality, no matter where they live in the United States", and (b) determining "that elderly minorities are treated fairly when receiving medical care." Between 85 and 90 percent of respondents endorsed each of these roles.

The survey included three measures of beneficiaries' assessment whether the Medicare program affected their own self-interest. Respondents were asked the extent to which they saw "your own medical care being affected by" (a) "the amount of money Congress provides for the Medicare program", (b) "the way that Medicare monitors quality of care", and (c) "the amount of help that Medicare gives people when they try to resolve complaints about health care problems". Almost a third (31.8 percent) felt that their medical care depended "a great deal" on the generosity of Medicare funding. About a quarter (26.1 percent) felt equally affected by the program's monitoring of quality, while just 17.8 percent felt that assistance with grievances had a great deal of impact on their medical care.

### **Measures of Involvement With Medicare+Choice Plans**

As indicated above, we have measures of the market penetration by private insurers on the county level that corresponds to the residence of each of our respondents. To assess enrollees' individual exposure, we asked whether they were currently enrolled in a Medicare HMO and, if

so, for how many years they had been a member of that plan. Just over a third (35.5 percent) of our respondents were enrolled in a private plan. A quarter had been enrolled in the plan for more than 10 years, suggesting that a considerable number had long-term exposure.<sup>3</sup>

### **Controlling for Other Factors That Might Influence Medicare Support**

Past research is useful for identifying potentially confounding variables affecting support Medicare specifically or for a more generally expansive federal role in the health care of older Americans. Studies have found that beneficiaries are supportive of additional Medicare spending when they have lower incomes (Rhodebeck 1993; Schiltz 1970), or less education (Lake 1998; Schiltz 1970), are female (Mebane 2000; Lake and Brown 1998) and in older age groups (Lake and Brown 1998, Tropman 1987), or espouse a liberal ideology (Mebane 2000; Rhodebeck 1993). We measure socio-economic status using both educational attainment (42 percent of the sample had more than a high school education) and income (36.4 percent had annual household incomes of greater than \$30,000) (See Table B.1 for comparisons of the sample to the elderly population in the United States in these dimensions). We also controlled for age, ideology (39.9 percent of the sample labeled themselves “conservative”, 21.9 percent as “liberal”), sex (62.3 percent of respondents were women), and race (7.7 percent African-American, 4.1 percent “other”).

Although there has been little research linking political attitudes to supplementary insurance coverage or health status, one might expect that self-interested considerations would produce greater support for government among beneficiaries who (a) were less healthy than average or (b) did not have private insurance to supplement Medicare. We identified three types of supplementary insurance: Medi-gap policies purchased in the individual market (48.2 percent of respondents), policies purchased by former employers (20.0 percent) and coverage through Medicaid (9.5 percent). Finally, we measure perceived health needs by self-reported health status. Ten percent of our respondents reported themselves to be in “excellent” health, 26.7 percent in fair or poor health.

In addition to these individual characteristics, attitudes towards Medicare policy may also be shaped to the characteristics of the community within which respondents live. The literature suggests two factors that may be important: prevailing political ideology and local economic conditions. The prevailing ideology in a community will almost certainly affect attitudes about the appropriate allocation of responsibility for beneficiaries’ health care between individuals and society, as well as between public and private sectors. Even after one takes into account the self-reported ideological orientation of the respondent, these community level norms may subtly alter political attitudes. Because there exist no measures of prevailing ideology at the county

level, we will use the prevailing political ideology at the state-level as a proxy for these more local norms (Berry et al, 1998; Erickson et al., 1989).

Public support for an active federal role may also depend on local economic conditions. This is in part because communities in economic distress will be viewed by their residents as less capable of addressing the needs of older inhabitants, increasing the need for an active role for the federal government. In addition, citizens typically assess the state of the economy in light of their own experiences, which will depend in large part on the state of the local economy (Conover, Feldman, and Knight 1987). The more limited are economic opportunities, the less sensible it is to hold individuals responsible for their own needs, including health care in retirement (Iyengar 1991). Consequently, in depressed local economies we would expect to find greater support for federal initiatives and reduced emphasis on individual responsibility. These local economic conditions will be measured by the prevailing rates of poverty and unemployment in the county in which the respondent lives.

Finally, one might expect that the impact of privatization on beneficiaries' political attitudes will depend in part on the extent to which they are already familiar with the managed care plans that are contracting with the Medicare program. In communities in which these private health plans are familiar entities, their inclusion in Medicare represents a less dramatic transformation of the health care experienced by local residents. In contrast, when HMOs are unfamiliar to local residents, they represent a more dramatic break from prevailing experience and are likely to have more potential to transform prevailing attitudes and perceptions. To control for this effect, we assess the extent to which managed care plans have been a long-standing element in the local health care system. More specifically, the number of HMOs that were operating in the county in 1985, 15 years before the survey was fielded, measures this effect.

**Table B.1****Comparison of Sample and Population Characteristics**

Attributes of Respondents	Characteristics of the Study Sample	Characteristics of the U.S. Population, Age 65+
<b>Age Distribution [a]</b>		
65-74	53.8%	52.0%
75-84	37.0%	35.4%
85 and Above	9.2%	12.6%
<b>Educational Attainment [a]</b>		
Not High School Graduate	19.0%	31.9%
High School Graduate	38.9%	34.9%
Some College	20.9%	17.8%
College Graduate or Above	21.2%	15.3%
<b>Race [a]</b>		
White	88.2%	88.9%
African-American	7.7%	8.3%
Other	4.1%	2.8%
<b>Income (Annual Household) [a]</b>		
Under \$10,000	14.5%	17.7%
\$10,000-\$29,999	49.1%	45.7%
\$30,000-\$49,999	26.4%	17.5%
Over \$50,000	10.0%	17.1%
<b>Supplemental Insurance [b]</b>		
None	29.6%	27.1%
Self-Purchased (Medi-gap)	24.5%	26.9%
Employer Purchased*	31.1%	27.7%
Medicaid	9.5%	10.5%
Combination	5.3%	7.6%
<b>Gender [a]</b>		
Male	37.7%	41.5%
Female	62.3%	58.5%
<b>Political Ideology [c]</b>		
Liberal	21.9%	18.4%
Moderate	38.1%	40.9%
Conservative	39.9%	40.7%

Note: Of those covered by employer-based insurance in our study sample, 134 were enrolled in HMOs, 192 in other supplemental insurance plans.

Source: Data collected in a NASI survey of beneficiary attitudes fielded in February 2001, U.S. Census Bureau 2001, Merlis 1999a and University of California, Berkley 2002.

## NOTES

<sup>1</sup> It may be helpful to have some examples of sites in each strata. Syracuse, Knoxville, Shreveport and rural South Carolina were all sites in the low penetration strata. Baltimore, Cleveland, Milwaukee and Providence were all in the middle strata. Phoenix, Los Angeles, Miami and San Antonio were all in the highest strata. Because Medicare+Choice enrollment varies significantly within geographic areas, we had a number of CTS sites with counties in more than one strata, including Chicago (low and middle), Detroit (low and middle), Houston (high and middle) and New York City (high and middle). The Philadelphia MSA included counties from all three strata.

<sup>2</sup> The survey was fielded by REDA International, under contract from the National Academy of Social Insurance.

<sup>3</sup> We also collected information on whether respondents had been previously enrolled in a Medicare HMO, but were not currently enrolled (5.5 percent of respondents). Because this was a relatively small subset, we did not explore the implications of these experiences for beneficiaries' political attitudes.

# Appendix C:

## Acronyms

AAPPC	Average Adjusted Per Capita Cost
ACR	Adjusted Community Rate
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BIPA	Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000
CAHPS	Consumer Assessment of Health Plans
CBO	Congressional Budget Office
CMS	Centers for Medicare and Medicaid Services
DSH	Disproportionate Share Hospital
FEHBP	Federal Employees Health Benefits Program
FPL	Federal Poverty Level
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
IOM	Institute of Medicine
M+C	Medicare+Choice
MedPAC	Medicare Payment Advisory Commission
NCQA	National Committee for Quality Assurance
NIH	National Institutes of Health
OMB	Office of Management and Budget
ProPAC	Prospective Payment Assessment Commission
QAPI	Quality Assessment and Performance Improvement Program
QIO	Quality Improvement Organization
QISMC	Quality Improvement System for Managed Care
SSI	Supplemental Security Income
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982



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