Medicare+Choice: An Interim Report Card

In mid-2001, the program must be graded a “D” if not an “F.”

by Marsha Gold

PROLOGUE: Strong bipartisan agreement undergirded the effort made in the 1997 Balanced Budget Act to increase beneficiary choice and harness the potential of private health plans in the Medicare+Choice program. Subsequent proposals to restructure Medicare, which continue in the current Congress, also have built on widespread agreement that competing private plans would be the key to reinvigorating the nation’s largest health insurance program.

Remarkably, the policy community’s faith in the competitive model has persisted despite the acutely disappointing performance of Medicare+Choice. Congress has amended the program and enhanced payment levels, but enrollment and plan participation continue to decline. Nor has any alternative approach to restructuring Medicare emerged. As the retirement of the baby-boom generation creeps closer, Congress looks more and more like a besieged garrison running out of powder, with no help on the way. The suspense becomes excruciating.

Under the circumstances, understanding what has gone wrong with Medicare+Choice is no academic exercise. To what extent have design flaws contributed to the program’s shortcomings? Is underfunding the root of the problem? How have changes in the environment affected the performance of the Medicare risk plans? In an analysis that combines empirical and qualitative approaches, Marsha Gold brings her considerable experience and acumen to bear on the problems facing Medicare+Choice, with particular attention to the crucial interaction of market factors with the policy judgments on which the program is based. Gold, who holds a doctoral degree from Harvard University’s School of Public Health, is a senior fellow at Mathematica Policy Research in Washington, D.C.
ABSTRACT: While the aim of Medicare+Choice (M+C) was to expand choice, the choices available to Medicare beneficiaries have diminished since its inception: Existing plans have withdrawn from M+C, few new plans have entered the program from among the newly authorized plan types, greater choice has not developed in areas that lacked choice, and the inequities in benefits and offerings between higher- and lower-paid areas of the country have widened rather than narrowed. Operational constraints probably explain the most immediate declines in M+C enrollment, but Congress’s ability to foster success for M+C will ultimately depend on the way in which historical tensions related to competing goals and ideologies for the Medicare program are resolved.

The Balanced Budget Act (BBA) of 1997 integrated the existing Medicare managed care program to create Medicare+Choice (M+C).1 M+C aimed to expand the health plan options available to Medicare beneficiaries and to encourage beneficiaries to become more actively involved in considering their choices. For some BBA sponsors, expanded choice was a prelude to what they hoped would be a more privatized and market-based Medicare program. Even those not so inclined still voted for the bill, hoping that expanded choice would provide an important source of supplemental coverage, particularly for beneficiaries with moderate incomes and no access to other subsidized coverage.2 Especially in recent years, the program also has been a relatively affordable source of coverage for outpatient prescription drugs, a benefit excluded from traditional Medicare.3

All signs point to continued debate over the future of the M+C program. Participating plans rushed to withdraw between 1999 and 2001, despite a last-minute effort by Congress in late 2000 to increase payments to plans as part of the Benefits Improvement and Protection Act (BIPA).4 The current Congress is likely to address the issues of “reasonable payments” under M+C and what “choice” does and should mean in Medicare.

In this paper I examine the available data to determine how M+C has fared to date, with respect to several of its important goals: expanded choice, growth in choice in areas with previously little or no choice, enhanced equity in payments to managed care plans around the country, and growth in quality and performance measurements to promote competition and informed choice. I then consider what the findings might mean for future public policy.

Other observers have commented on the M+C program and its thorny issues, but few have attempted to consider the issues’ implications as a whole within the M+C context.5 Thus, even though this analysis depends largely on evidence-backed commentary by a researcher who has monitored Medicare managed care for many years rather than on “pure research,” I believe that the issues raised here
merit consideration by policymakers concerned with interpreting the implications of recent M+C experience for the M+C program itself and for the ongoing debate over the fundamental restructuring of Medicare.

**Findings: Experience In Relation To M+C Goals**

Four choice-related M+C goals are inherent in the BBA: continued and expanded types of choices; more choice in areas previously lacking or having only limited M+C choice; enhanced equity in payments to promote more equitable offerings nationwide; and an expanded focus on quality and performance measurement to promote competition and informed choice. I assess the evidence in terms of the accomplishments associated with each goal and, most crucially, the reasons for success or failure. The analysis is empirical where the data so lend themselves and more qualitative or speculative where they do not.

- **Continued and expanded choice.** Experience under M+C demonstrates that enrollment in Medicare managed care—which had been growing rapidly before the BBA was passed in 1997—slowed after the law took effect and most recently reversed (Exhibit 1). The decline in enrollment has been accompanied by a sharp reduction in participating plans. In 1999 ninety-seven plans either withdrew or reduced their service areas, directly affecting 407,000 enrollees. In 2000 ninety-nine plans withdrew, affecting 327,000 enrollees.

*EXHIBIT 1*

**Medicare Risk/Medicare+Choice Enrollment, 1985–2001**

<table>
<thead>
<tr>
<th>Enrollment (thousands)</th>
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<tbody>
<tr>
<td>6,000</td>
</tr>
<tr>
<td>5,000</td>
</tr>
<tr>
<td>4,000</td>
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<tr>
<td>3,000</td>
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<tr>
<td>2,000</td>
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<tr>
<td>1,000</td>
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<td>0</td>
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*1985 1987 1989 1991 1993 1995 1997 1999 2001*

**SOURCE:** Health Care Financing Administration/Center for Health Plans and Providers data; Mathematica Policy Research analysis for Robert Wood Johnson Foundation.

**NOTES:** All data are as of December of the year indicated except for 2001, for which data are for April. Data for 1999, 2000, and 2001 are for enrollees in coordinated care plans (CCPs). Data for prior years are for enrollees in Medicare risk contracts. Exact figures are available from the author.
enrollees. In 2001 withdrawals and service area reductions affected an estimated 934,000 enrollees. Not only did beneficiaries have fewer options for Medicare managed care (called coordinated care plans, or CCPs, under M+C), but few of the new choices authorized under the BBA had materialized, as discussed later. One reason may be that despite the attempt to foster a market-based strategy, the legislation paid insufficient attention to market dynamics.

- **Continued choice in managed care.** In any industry, exit and entry are essential features of a functioning market. After a period of growth, some consolidation is likely as new entrants review their experience and assess their strategy. Such consolidation took place early in the Medicare managed care program when, between 1987 and 1990, 101 contractors—44 percent of those holding a contract at that time—terminated their participation. But total enrollment continued to grow, albeit slowly, from 0.8 million in 1986 to 1.3 million at year-end 1990, and the number of persons affected by the terminations was relatively small. However, current terminations affect many more beneficiaries; as a result, the impact of withdrawals on beneficiaries is now more obvious.

The dominant effect of exits from the Medicare program since enactment of the BBA has been a reduction by more than half in the share of beneficiaries with five or more health plan choices and an increase in the share of beneficiaries with two to four (or fewer) choices (Exhibit 2). Many of the M+C plans that withdrew from the program in 1999 and 2000 registered much lower enrollments than did those that stayed. Withdrawers also had participated in the program for a shorter average period than plans that remained.

### Exhibit 2

**Trends In Number Of Health Plan Choices Available To Medicare Beneficiaries, By County Of Residence, 1997–2001**

<table>
<thead>
<tr>
<th>Percent of beneficiaries</th>
<th>1997</th>
<th>1999</th>
<th>2001</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–4 plans</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5 or more plans</td>
<td></td>
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</tbody>
</table>

**SOURCE:** Mathematica Policy Research analysis of Health Care Financing Administration (HCFA) data, excluding data on two nonrenewals with 9,028 enrollees.

**NOTES:** Data are for December of each year from HCFA’s State County Plan Penetration and Geographic Service Area file. Data for 2001 are from a HCFA file of submitted 2001 nonrenewals and service area reductions.
2001 saw a noticeable increase in the number of beneficiaries with one or no available plans. Undoubtedly, some withdrawals since the passage of the BBA represent healthy market behavior, as new entrants learn that they are either too small to function economically or not well positioned to provide a competitive product in a new market. Unfortunately, while such market behavior is expected, it can make insurance arrangements unstable for beneficiaries and generate controversy for political leaders who are unprepared for the political response to market behavior.

While Medicare managed care remains a good deal financially for beneficiaries whose only alternative is a Medigap policy (typically costing $1,000 or more annually), Medicare managed care plans are less attractive today than they were several years ago. Historically, Medicare beneficiaries were drawn to managed care plans not so much because of the coordinated care they offered, at least in concept, but because products provided an attractive alternative to Medigap coverage. Indeed, the program grew most rapidly during the mid-1990s, when rising government payments (capitation rates) for Medicare managed care allowed plans to reduce the beneficiary premium—often to zero—and to expand benefits, including coverage of outpatient prescription drugs (Exhibit 3). However, since 2000, beneficiaries who continued to have choices (even the same ones) faced higher premiums or reduced benefits (Exhibit 4).

The result is that beneficiaries are likely to experience increasing difficulty in finding affordable alternatives. Analysis of the 1999

| EXHIBIT 3 |
| Zero-Premium Products And Outpatient Prescription Drug Coverage In Medicare Risk/Medicare+Choice Contracts, 1993–2001 |

<table>
<thead>
<tr>
<th>Percent</th>
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<tbody>
<tr>
<td>75</td>
</tr>
<tr>
<td>60</td>
</tr>
<tr>
<td>45</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Zero premium</th>
<th>Drug coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>1994</td>
<td>17%</td>
<td>32%</td>
</tr>
<tr>
<td>1995</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>1996</td>
<td>25%</td>
<td>40%</td>
</tr>
<tr>
<td>1997</td>
<td>30%</td>
<td>45%</td>
</tr>
<tr>
<td>1998</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>1999</td>
<td>40%</td>
<td>55%</td>
</tr>
<tr>
<td>2000</td>
<td>45%</td>
<td>60%</td>
</tr>
<tr>
<td>2001</td>
<td>50%</td>
<td>65%</td>
</tr>
</tbody>
</table>


**NOTES:** Data are for basic plans and are not weighted by enrollment. Data for 2001 are for March and reflect changes submitted in response to the Benefits Improvement and Protection Act (BIPA).
withdrawals shows that most beneficiaries were able to obtain other coverage (two-thirds through other M+C plans), although 8 percent had no other coverage beyond Medicare. Four in ten, however, paid higher premiums for their choice, 22 percent had to seek out a new doctor, and 47 percent said that they would pay more out of pocket for prescription drugs. A recent study suggests that the adverse effects on beneficiaries may have been greater in 2000 than in 1999, with an estimated 27 percent of those in terminated plans lacking any other coverage beyond Medicare. Presumably, the disruption will be greater in 2001, as many more beneficiaries are affected and alternative choices are more limited and expensive.

**Expanded managed care choice.** Under the BBA, existing managed care options (such as the Medicare risk and cost programs) are folded into a CCP option. Unlike traditional managed care plans, which restrict coverage to a designated network of providers, CCPs are authorized to offer open-ended point-of-service (POS) plan options that provide some coverage for the self-referred use of out-of-network providers. The BBA also authorizes preferred provider organizations (PPOs) and provider-sponsored organizations (PSOs) to offer CCP products. To encourage plan participation, the BBA eliminated the requirement that Medicare and Medicaid not account for more than half of an organization’s total enrollment and relaxed the minimum enrollment requirements in the first three years.

Despite these provisions, M+C makes available to Medicare beneficiaries most of the same, though renamed, choices offered under

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**EXHIBIT 4**

**Premiums And Benefits In Medicare+Choice Plans, 1999–2001**

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent with zero premium</td>
<td>80%</td>
<td>56%</td>
<td>46%</td>
</tr>
<tr>
<td>Mean premium</td>
<td>$6</td>
<td>$14</td>
<td>$23</td>
</tr>
<tr>
<td>Mean premium among beneficiaries paying any premium</td>
<td>$32</td>
<td>$36</td>
<td>$43</td>
</tr>
<tr>
<td>Primary care physician copay over $5</td>
<td>32%</td>
<td>57%</td>
<td>73%</td>
</tr>
<tr>
<td>Hospital copay</td>
<td>4</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>Laboratory copay</td>
<td>4</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Radiology copay</td>
<td>8</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Prescription drug coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cap of $500 or less</td>
<td>84%</td>
<td>78%</td>
<td>70%</td>
</tr>
<tr>
<td>Cap of $1,500 or more or unlimited</td>
<td>11%</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Brand-name copay of $20 or more</td>
<td>44%</td>
<td>39%</td>
<td>38%</td>
</tr>
</tbody>
</table>

**SOURCE:** Mathematica Policy Research analysis of a data file created for the Health Care Financing Administration’s Medicare Compare for the Commonwealth Fund.

**NOTES:** Data are based on enrollment as of March of the indicated year; the 2001 figures reflect benefits in March 2001. All data are weighted by enrollment.

a Among beneficiaries with a drug benefit.
Medicare. A PSO plan (offered in Albuquerque) that expected to withdraw in 2001 reversed course after Congress raised minimum payment rates in late 2000. Several PPO applications are pending at the Health Care Financing Administration (HCFA). At the same time, the only currently operational PPO was launched under the authority of the Medicare Choices demonstration, which began before the BBA; the demonstration also included PSO products, many of which had relatively unsuccessful experiences.13

The absence of new options led Congress to retrench on other changes sought by the BBA. For example, the Balanced Budget Refinement Act (BBRA) of 1999 extended until year-end 2004 all cost contracts scheduled for phase-out by year-end 2002 in favor of risk-based arrangements. The BBRA also lowered the five-year reentry bar for terminating plans to two years and provided exceptions to allow reentry if payments are raised or diverse products offered. In addition, the BBRA established a “new-entry bonus” of 5 percent for the first year and 3 percent for the second year when organizations enter a previously underserved area.

Why did more managed care choice not materialize? The answer lies in the market. By allowing provider-sponsored options, policymakers assumed that providers would want to sponsor health plans. Yet history shows that successful provider-sponsored managed care poses a challenge because of conflicting incentives epitomized by hospitals’ desire to “fill beds” and managed care’s emphasis on reduced utilization, especially of costly and potentially inappropriate inpatient services. Costs are high, and the marketing and administrative functions typically carried out by health maintenance organizations (HMOs) prove extremely burdensome.

A recent survey of PSOs that had entered into substantial risk-based contracts with managed care organizations suggests that few PSOs perceive the PSO option in M+C as an advantage. PSOs already had the option of assuming risk without taking on the administrative challenges of serving as the primary insuring organization and potentially competing with the very organizations that provide them with business.14 Although some organizations perceived that M+C program changes dealing with rates, financial solvency, or administrative requirements might make them more interested in offering products, others saw fundamental incompatibilities between what the legislation sought and what they believed the marketplace and their capabilities would support.

Expanded choice was also premised on the assumption that managed care companies would wish to offer PPOs to the Medicare population. Although little study of Medicare PPOs exists, some argue that more PPO products would have emerged in the market if
the same quality requirements imposed on other CCPs had not been imposed on PPOs. PPOs do not have the same control over care systems and often do not regard themselves as managing care. On the other hand, it could be difficult within the structure of Medicare to create PPO products that appeal to beneficiaries who want both cost protection and provider choice.

**Expanded private insurance options.** One of the most fundamental, and controversial, changes introduced in M+C was the grant of authority for private insurance options to compete with Medicare without requiring beneficiaries to limit their choice of providers (as required under Medicare managed care). The BBA authorizes private fee-for-service (FFS) plans that include all legally authorized providers who agree to the plan’s terms and conditions, with providers paid fee-for-service.

The BBA also authorized a nationwide demonstration of medical savings account (MSA) plans beginning in January 1999 and expiring in 2002. The demonstration is limited to 390,000 beneficiaries. To date, HCFA has received no applications for MSAs. After a congressionally mandated study, the Medicare Payment Advisory Commission (MedPAC) concluded that the private sector will not offer Medicare MSAs because of two basic market characteristics: little demand from risk-averse Medicare beneficiaries, and the expense and difficulty of marketing a complex product to a fragmented and scarce set of customers.\(^\text{15}\) MedPAC also concluded that the market constraints on the MSAs’ success would hold sway even if Congress amended program features such as the limit on the number of participants and duration of the demonstration, encounter and quality data requirements, payment method, and the current exclusion of balance-billing protections for beneficiaries in the demonstration.

Sterling Life Insurance Company gained approval for its offering of the first private FFS option in July 2000, eighteen months after M+C took effect. The plan first was offered in all or portions of seventeen states, most without existing M+C options. The company later expanded the plan to an additional eight states. Those electing the option may see any provider, with providers receiving FFS payments. In addition to Medicare benefits, the Sterling product offers expanded inpatient coverage and worldwide emergency care, but no pharmacy coverage. In the individual market, the plan is the first to offer beneficiaries access to an FFS product with open provider choice that combines Medicare and supplemental benefits.

If the Sterling option captures enough enrollees, the private FFS option could provide the nation’s first FFS competition for traditional Medicare benefits. The issue is whether beneficiaries will find the product attractive and who will be drawn to it. Open access and
consolidated coverage could appeal to beneficiaries if the price were attractive, but, in view of recent M+C withdrawals, beneficiaries also may question the continued availability of a private market product. Whether Sterling or other private plans find it feasible to offer a cost-competitive product that appeals to many beneficiaries—particularly on an open-access basis—remains to be seen.

In April 2001 just 13,000 beneficiaries had enrolled in the Sterling plan, but enrollment is growing. Much of Sterling’s service area includes counties that benefited from the new-entry bonus and the rate increase authorized by BIPA. Sterling thus has a strong incentive to market the plan aggressively. Sterling also has benefited from M+C withdrawals. As a result of BIPA, Congress is paying more for private FFS plans than its estimated cost of traditional Medicare benefits.

**Expanded choice in rural and other areas.** The minimum, or “floor,” for payments was intended to motivate plans to enter and remain in rural and other low-payment counties where beneficiaries had limited M+C choices before enactment of the BBA. The floor rate was $367 in 1998, rising to $415 in January 2001 (under BIPA, the floor is $525 as of 1 March 2001 in large urban areas and $475 elsewhere). While floor payments may have contributed to the entry of the Sterling plan, the payments appear to have had little effect on the availability of managed care (defined as CCPs under M+C).

Despite the floor, the nationwide share of Medicare beneficiaries with a choice of CCP options declined slightly from 1997 to 2000 (from 69 percent to 68 percent) and fell further to 63 percent in 2001 after withdrawals, assuming (as appears to be the case) that new entries will be limited in 2001 despite BIPA.16

Clearly, floor payments failed to expand M+C in rural areas. In 1997, 78 percent of beneficiaries in these areas had no M+C option. The percentage rose to 79 percent in 2000 and 85 percent in 2001. In 2000 fewer than 2 percent of rural beneficiaries were enrolled in CCPs; of these, 89 percent resided in rural counties that were adjacent to urban areas. But CCP penetration was only 3 percent in such counties.

One reason for the low CCP penetration rate is that the substantial payment increases still were insufficient to support the development of a CCP product in counties where the product was previously unsupportable. For example, industry experts convened in
August 1999 by MedPAC to provide insights into withdrawals argued that M+C is unsupportable at capitation rates lower than $450 per member per month. In 2001 only ninety-four counties in rural areas had an M+C option, accounting for enrollment of about 93,000. The number of counties is about the same as the number with a choice before M+C and represents a nationwide increase of only about 10,000 M+C enrollees since enactment of the BBA.

Payment is only one of the reasons for the difficulty in expanding managed care in rural areas. Many rural areas, which also tend to be low-payment counties, operate with single provider systems that make it more difficult for M+C plans to negotiate provider contracts. In fact, given that providers may be unduly powerful and resistant, it is questionable whether managed care is feasible or even reasonable in rural counties. Thus, while raising the minimum capitation payment to $475 may have some effect, experience suggests that an increase in rates is unlikely to be sufficient inducement to draw managed care to rural areas. Any growth in choice in rural areas will have to come through the growth of private insurance plans. However, it is unclear whether private plans are likely to be any more feasible than CCPs have been in these areas.

■ More equity in choice and benefits. The Medicare risk program paid organizations 95 percent of the expected amount for demographically similar beneficiaries in the same county (known as adjusted average per capita cost, or AAPCC). Risk-based plans estimated their cost for traditional Medicare benefits (the adjusted community rate, or ACR). The Medicare risk program required plans to use savings to fund supplemental benefits or reduce premiums, unless the plan opted to return savings to the government.

A critical change introduced by the BBA was to begin uncoupling the link to the county-based FFS arrangement. The link had come under criticism because it relied on outdated data and had the effect of penalizing beneficiaries in counties where FFS spending was lower, perhaps reflecting greater efficiency. Under the BBA, CCPs receive the greater of a phased-in blend of local and national rates, a national floor rate, or a minimum 2 percent update. The blend, however, is subject to budget-neutrality requirements, and no county received a blended rate in 1998, 1999, or 2001.

Because of the floor, the BBA narrowed the difference in payment rates between the highest- and lowest-paid counties. However, because the main vehicle for redistribution, “the blend,” was subject to budget-neutrality provisions, HCFA applied it in rate setting only in 2000. As a result, most M+C plans received the minimum 2 percent annual increase in at least three of the four years between 1998 and 2001, although they will receive 3 percent rather than 2 percent.
beginning in March 2001. \(^{18}\) In 2000, 40 percent of enrollees resided in counties that had received the minimum 2 percent annual increase in each of the four years, while another 28 percent resided in counties that had the equivalent of up to an extra 3 percent increase in the year when a blend was allowed.\(^ {19}\)

Because the blend was subject to budget-neutrality requirements, the disparities between higher- and lower-paid (often urban) counties have been ignored in three of the four years despite the intent of the BBA. The available evidence suggests that the increases associated with the blend in 2000 were not sufficient to offset the relatively low base rates to which they applied in terms of supporting expanded benefits. Despite receiving less of an increase in 2000 than plans in blend counties did, plans operating in high-payment areas were less likely to add a premium or increase an existing premium.\(^ {20}\) Similarly, drug benefits continued to be more available in high-payment counties than in blend counties, and the disparity in offerings between high- and low-payment counties (as measured in annual limits) increased rather than decreased in 2000.

The evidence suggests greater “slack” in rates for higher- versus lower-paid counties, a gap that BIPA aims to address. It remains to be seen whether expanded payments to lower-paid counties is sufficient over time to spur reconciliation of the disparities in offerings and benefits across the country (Exhibit 5). While the value of offerings declined in center-city counties between 1999 and 2001, coverage rates remained higher than in other urban or rural counties, and the latter tended to experience a greater decline.

**Quality and performance measurement.** The BBA provided for expanded quality assurance and improvement requirements as well as for performance reporting. More specifically, the BBA requires standardized reporting on Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Health Plans (CAHPS) measures, along with submission of results from annual, focused studies and any accreditation surveys and information on physician incentive plans. M+C plans also must submit encounter data for services provided to Medicare beneficiaries. HCFA interpreted the requirements for internal plan systems to mean compliance with Quality Improvement System for Managed Care (QISMC) standards and guidelines regarding quality assessment and performance improvement, enrollees’ rights, health services management, and delegation.

The BBA also emphasized beneficiary education in part to prepare beneficiaries for the phase-in implementation of open enrollment and lock-in. In particular, the BBA mandated a nationwide coordinated education campaign starting in November 1998, al-
though HCFA interpreted the initial year as a pilot and did not provide detailed market-specific information (beyond the five pilot sites) until November 1999. In addition, the M+C Helpline opened for Medicare beneficiaries in all states 15 March 1999.21

The BBA appears to have been relatively effective in encouraging a greater focus on quality of care and beneficiary information. HCFA has introduced HEDIS and CAHPS reporting in M+C, strengthened internal requirements for plan oversight, and initiated the collection of both encounter data and data on the health of seniors. Further, the practice of building in such systems has encouraged HCFA to consider where such mechanisms can be extended to the traditional Medicare program. HCFA is now fielding a CAHPS survey for beneficiaries in traditional Medicare and also is looking into how to introduce care management techniques from managed care into that program. HCFA’s Web site for beneficiary education, <www.medicare.gov>, now includes data on health plan performance.

While many of the initiatives required by the BBA originated in the commercial sector, their inclusion in Medicare has bolstered the program and resulted in some highly innovative efforts that build on Medicare’s strengths as a large public insurance system. Of course, whether beneficiaries are using the available information or find it responsive to their needs is still an open question.
One major downside of the BBA’s expanded requirements is the industry’s belief that the burden of compliance adds to administrative costs even as Congress is holding down payments, thus making plan participation less likely.\footnote{22} Congress and HCFA have since simplified some requirements to reduce their associated burden. For example, compliance is now reinterpreted as “best effort” instead of 100 percent compliance.

Requirements for M+C plans with open-access features (PPO plans) have been modified. The BBRA relaxed the quality requirements for PPOs to make the requirements comparable to those imposed on private FFS plans and MSAs. The BBA required M+C plans to contribute to funding the information campaign, but the BBRA reduced the requirements. The BBRA also formalized the change in reporting date for the yearly approval of rates and benefits (which provides key data for the information campaign) from 1 May to 1 July so that M+C plans could more confidently project costs. (Before enactment of the BBA, plans had to report in September for the next plan year.)

It is, of course, too early to discern whether these features will prove sufficient to address industry concerns. Arguably, there is an inherent tension between market-based approaches that thrive on relatively unconstrained entry and exit by competitors and public processes that aim to protect individuals through legislative and regulatory means. Particularly in today’s environment of managed care backlash, the legislative or regulatory process may make it overly easy to add requirements that make sense individually but cumulatively yield results that run counter to policymakers’ intent.\footnote{23}

Discussion And Policy Implications

By almost any measure, the interim grade for the M+C program as of the start of 2001 must be judged a “D” if not an “F.” In contrast to the goal of expanded choice, the M+C program has reduced the range of choice that once existed, with existing plans withdrawing, few new participants entering from among the newly authorized types of options, no geographic redistribution of participants to develop choice where none existed (except for the private FFS plan option, which is too new to assess), and an increase rather than decrease in the inequities in benefits and offerings between higher- and lower-paid areas of the country.

- **Operational factors.** In many ways, the experience under M+C was inevitable for a number of operational reasons. First, the M+C program had the misfortune of starting operations after a period of rapid growth in Medicare managed care enrollment. History with the Medicare risk program shows that after rapid growth, a
natural market shakeout occurs as many new entrants find that they cannot or do not want to compete effectively. Thus, some of the erosion in plan participation probably would have occurred with or without the launch of M+C.

Second, the M+C program began operation at the same time that Congress was reacting to a perceived explosion in Medicare costs. Indeed, the joint timing probably is no accident. The BBA reductions in FFS Medicare provider payments translated into lower premiums for M+C plans. The reversal in the growth of benefits in response to less rapidly increasing payments was destined to have a chilling effect on M+C enrollment. The reversal would have happened with or without the M+C program changes, although the BBA did alter the political environment, adding requirements and sending notice that payments would be constrained in the future both in the aggregate and in response to risk adjustment.

Third, bad timing or bad luck also applies to the market environment in which the M+C program was born. Both provider consolidation and the backlash against managed care strengthened the hand of providers in negotiating with plans. Entrenched providers made it hard for plans to negotiate favorable terms, making it more likely that plans would be forced to reduce benefits or, if an attractive product with an adequate provider network could not be formed, withdraw entirely from the program or county.

Fourth, the demands imposed on HCFA as a result of the full set of BBA provisions constrained the operational success of M+C. The provisions pertain not only to the M+C program itself but also to changes associated with payments under the original Medicare program. In addition, HCFA’s capacity to respond to the changes was diminished by both an overall funding shortage for administrative support and a complete reorganization of HCFA’s central office. As a result, HCFA experienced difficulty in coordinating efforts or expediting plan participation. The pressures of multiple demands on management distracted senior officials, while M+C’s lack of focus increased the likelihood that the agency would impose competing or duplicative requirements on plans.

Fifth, the decision to make the blend budget-neutral as a means of addressing cost concerns undercut opportunities to create more geographic equity. It prevented rates from rising more in lower-paid counties where managed care might be feasible and constrained
success by limiting the benefits that could be offered. The budget-
neutrality provision also converted potential “winners” under M+C into “losers,” thus expanding health plans’ opposition and unifying
the industry. Some degree of trade-off in budget-neutrality might
have been a reasonable strategy for reducing opposition to equitable
change, even in the face of arguments that because of favorable
selection, M+C plans were already overpaid. Besides, overpayments
presumably will be reduced as HCFA introduces risk adjustment to
deal with biased selection.

**Current dynamics.** For the most part, the negative incentives
militating against the growth of M+C remain in place today, par-
ticularly with respect to the managed care market. Withdrawals are
likely to cause beneficiaries to grow concerned over the long-run
viability of M+C products and to become more hesitant to enroll.
Even with BIPA, most plans now operate in areas where increases
are constrained to the minimum increase (2 percent, with 3 percent
in 2001), and these plans account for 75 percent of M+C enrollees.
The minimum increase is unlikely to cover the underlying growth of
medical costs, not to mention providers’ demands for increased pay-
ment. As risk adjustment is implemented and graduate medical edu-
cation payments are eliminated from rates, rate increases will be
further limited. If plans remain in M+C, premiums may continue to
rise even if benefits are reduced or cost sharing is added. While M+C
may remain a “bargain” compared with Medigap, it is unclear
whether beneficiaries will continue to find the program attractive.

The key question is whether BIPA will influence the dynamics in
counties receiving increased payments as a result of the new floors.
More than half of Medicare beneficiaries reside in counties benefit-
ing from the higher floor payments (32 percent are in counties paid
at $525, and 24 percent are in counties paid at $475). However, these
areas often have not been hospitable to Medicare managed care:
Only 23 percent of current M+C enrollees are in counties paid $525;
2 percent are in counties paid $475.\(^4\) The overarching question is
whether the increased payment will spur retention of participating
plans, help such plans expand their enrollment, and perhaps even
cause new plans to enter the market or expand their service areas to
include counties getting the floor.

The historical record suggests that the greatest potential for man-
aged care plans lies in urban areas whose previously low payment
rates benefited from the $525 floor. At the start of 2001, 67 percent of
beneficiaries in such counties already had at least one M+C plan
choice, and 11 percent actually were enrolled in an M+C plan, which
suggests that managed care has some appeal in these counties. That
is much less the case in counties receiving the lower floor of $475.
Although 24 percent of beneficiaries are in such counties, only 13 percent of them had a choice of managed care plans, and only 1 percent were enrolled in such a plan.

This suggests that growth in less urbanized areas would have to come from enrollment in the private FFS plan, which will receive a much higher payment in much of its service area as a result of the floor. Only time will tell whether floor payments and enhanced marketing make Sterling more attractive to beneficiaries.

**Normative considerations.** Both pragmatic and ideological concerns will be factors in the congressional debate over the future of M+C. From its beginnings, Medicare managed care was designed to provide an option for Medicare beneficiaries. The intent was to offer a product that cost no more than Medicare (and actually saved the government 5 percent) but was more efficient and thus could attract beneficiaries willing to forgo the flexibility in choice of providers in return for improved benefits, lower costs, and an acceptable delivery system. These incentives were relatively limited until the mid-1990s, when increases in payment rates, together with unplanned overpayments (as a result of favorable selection), allowed plans to greatly expand benefits, as shown in Exhibit 3.

The expansion created an expectation that M+C could do more than it did, including serving as an important source of care in rural areas and providing a source of payment for expensive benefits, such as prescription drugs, not covered by Medicare. But achieving these outcomes at FFS equivalent pricing is unlikely to be possible, and the question for Congress is how much more it is willing to pay over what it pays for traditional Medicare to use M+C to achieve the desired outcomes. As illustrated by BIPA, experience suggests that payments likely will have to rise substantially to have any chance of succeeding. From a purely technical perspective, Congress may find much more efficient ways to improve care in rural areas or provide prescription drug benefits to all Medicare beneficiaries.

However, M+C decisions are unlikely to be made solely on technical grounds. As indicated at the outset, some of the momentum to develop M+C stemmed less from an interest in promoting choice for beneficiaries (many of whom are fundamentally concerned with comprehensive benefits, low premiums, and access to good doctors rather than choice per se) and more from an interest in creating a vehicle for shifting Medicare to a defined-contribution form of program with an extensive array of private-sector alternatives. Ideologically, some legislators favor such an approach, while others are committed to a defined-benefit approach in which Medicare beneficiaries always enjoy access to the traditional program without paying a higher price for the option if it proves more expensive.
“Congress is unlikely to succeed until it comes to terms with differences in ideology, values, and vision.”

The M+C program can be viewed as a compromise strategy; it creates options for choice without strong financial incentives to develop such options in the face of the continuing existence of the traditional Medicare program. Policymakers should have envisioned the result—limited enrollment and limited new choices. Whether this result represents a policy success or failure depends on the observer’s views of what Medicare should be.

In terms of the future, this analysis suggests that Congress is unlikely to succeed in addressing many issues plaguing the M+C program until it comes to terms with fundamental differences in ideology, values, and the vision for Medicare’s future. Experience to date suggests that promoting significant enrollment in M+C is not possible unless the traditional Medicare program becomes much less attractive. Congress took a first step in this direction when under BIPA it raised the floor and also authorized M+C plans to provide Medicare premium rebates starting in 2003. But, as the debate over the future of Medicare points out, Congress generally still does not favor strong steps that might jeopardize the traditional Medicare program. Even proponents of competitive solutions become less committed when the market leads to outcomes that conflict with the politics of their constituencies, as demonstrated when Congress authorized competitive pricing demonstrations (in the BBA) and then disallowed them (in the BBRA) when political resistance mounted.27

The bottom line for policymakers. M+C policy raises many of the same issues that arise in the context of Medicare reform. By paying attention to rates, limiting the requirements imposed on health plans, and other actions, Congress may be able to prevent the continued erosion of the M+C option and possibly even help managed care to expand in some urban areas, where it has historically been limited by low payment rates. However, the types of expanded choices envisioned under the BBA and the major shifts in enrollment are not likely to become feasible without more support than seems to exist today for fundamental reform of Medicare. In the meantime, policymakers may want to consider how much they are willing to pay to foster alternatives, especially FFS alternatives, that in essence will compete with traditional Medicare with a congressionally sanctioned price advantage.
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NOTES


4. BIPA authorized a minimum monthly payment of $525 in urban areas with 250,000 or more people and $475 elsewhere starting in March 2001. Plans also were granted a one-time-only minimum annual increase of 3 percent versus 2 percent otherwise. However, few of the plans exiting the program in 2001 returned and most of the increase so far went to providers rather than to expanded benefits. M. Gold and L. Achman, “Raising Payment Rates: Initial Effects of BIPA 2000,” Fast Facts #6 (Washington: Mathematica Policy Research, June 2001).


16. In February 2000 HCFA reported that four plans had reentered the program as a result of BIPA (Gold and Achman, “Raising Payment Rates”). A fifth plan may reenter (American Healthline, 9 February 2001).


18. Some plans received less than the 2 percent minimum, as risk adjustment was phased in starting in 2000. Although data are not available at the plan level, HCFA has reported that most plans will see their rates reduced as a result of risk adjustment. To minimize the impact, the BBRA directs HCFA to base only 10 percent of the payment accounting for risk in 2001 (versus 30 percent) and to limit it to no more than 20 percent in 2002 (versus 55 percent).

19. Only 12 percent of enrollees resided in counties that had a cumulative increase of more than 5 percent annually, although such areas account for 50 percent of counties and 28 percent of beneficiaries.


21. Under the BBA, there also is a lock-in that is to be phased in starting 1 January 2002, with beneficiaries allowed only one change in the first six months. Starting in 2003, change will be limited to the first three months of the year.


