The Changing Face Of Managed Care

Managed care plans face the challenge of satisfying marketplace preferences for less restrictive care while holding down costs.

by Debra A. Draper, Robert E. Hurley, Cara S. Lesser, and Bradley C. Strunk

ABSTRACT: Managed care plans—pressured by a variety of marketplace forces that have been intensifying over the past two years—are making important shifts in their overall business strategy. Plans are moving to offer less restrictive managed care products and product features that respond to consumers’ and purchasers’ demands for more choice and flexibility. In addition, because consumers and purchasers prefer broad and stable networks that require plans to include rather than exclude providers, plans are seeking less contentious contractual relationships with physicians and hospitals. Finally, to the extent that these changes erode their ability to control costs, plans are shifting from an emphasis only on increasing market share to a renewed emphasis on protecting profitability. Consequently, purchasers and consumers face escalating health care costs under these changing conditions.

On multiple fronts—consumer, purchaser, provider, and regulatory—managed care plans are facing mounting pressures to change.\(^1\) Consumers are becoming more active health care participants and are demanding more choice, greater flexibility, and fewer restrictions on access and service delivery. Employers (purchasers) are demanding less restrictive managed care to appease employees and at least so far have been willing to absorb most of the higher ensuing costs. Consumers’ and purchasers’ preferences for broad and stable networks give providers the upper hand in contract negotiations with plans. Also tipping the scales in favor of providers is consolidation among both physicians and hospitals and the reappearance of capacity constraints for many hospitals. With their new clout, these providers are pressuring plans to pay more and reduce the scope of risk in risk-contracting arrangements; others are pressuring plans to replace risk payment

Debra Draper is a health researcher at Mathematica Policy Research in Washington, D.C. Bob Hurley is an associate professor in the Department of Health Administration, Medical College of Virginia, Virginia Commonwealth University, in Richmond. Cara Lesser is a senior health researcher and director of site visits at the Center for Studying Health System Change (HSC) in Washington. Bradley Strunk is a health analyst at HSC.
with fee-for-service (FFS) payments (for physicians) or per diem and case-rate payments (for hospitals). Federal and state regulations sought by consumers and providers in response to perceived problems with health maintenance organizations (HMOs) are prompting additional changes. Also, declining HMO enrollment is pressuring plans further.\(^2\)

Based on data from markets around the country, this paper examines how managed care plans are responding to these evolving marketplace pressures. It first examines the shifts in business strategy that plans are making. It then discusses various implications of these changing managed care strategies for health care costs, the affordability of health insurance, and other important matters. The paper concludes with some speculation on the durability of the strategies that plans have recently adopted.

**Data And Methods**

The data on which this paper is based are from the Community Tracking Study (CTS), a longitudinal study conducted by the Center for Studying Health System Change (HSC). That study uses multiple data sources, including site visits to twelve nationally representative communities—Boston; Cleveland; Greenville, South Carolina; Indianapolis; Lansing; Little Rock; Miami; northern New Jersey; Orange County, California; Phoenix; Seattle; and Syracuse—to examine changes in local health care systems.\(^3\) These communities are geographically diverse and vary in size and health system characteristics, including experience with managed care, and all areas have seen major changes take place (Exhibit 1).

This paper draws most heavily on the round of site visits conducted between June 2000 and March 2001; it also draws on the two previous rounds conducted in 1996–1997 and 1998–1999. Research teams conducted 895 interviews with key participants in the local health care markets during the latest round of site visits, including approximately 220 managed care plan interviews representing more than fifty plans. For each of the twelve communities, five plans were targeted for study: a large national plan, a large Blue Cross Blue Shield plan, a large local or regional plan, and two additional plans. Structured interviews using standardized protocols were conducted with top officials at each plan, including the chief executive officer; the medical director; and executives responsible for marketing, network operations, Medicare, utilization management, care management, and pharmacy. Researchers also interviewed employers and other health benefit purchasers, insurance brokers, benefit consultants, providers, and policymakers.\(^4\)
Managed Care Plans' Changing Strategies

Managed care plans historically have relied on two key strategies to enable them to offer expanded benefits with limited financial responsibility for consumers and cost containment for employers and other purchasers. One is to use traditional managed care technology—limited provider networks, primary care gatekeeping of access to specialty services, medical necessity authorizations, and negotiated payments including provider risk sharing—to aggressively control health care costs. The second is to grow plan membership to gain leverage in provider negotiations and achieve economies of scale. Plans have pursued this strategy, at times forgoing near-term profitability, through low pricing, adding new product lines, and market expansion.

Between 1999 and 2001, plans departed sharply from these two strategies, through three strategic shifts: offering less restrictive products and product features; reconstituting their often adversarial, friction-ridden contracting relationships with providers in order to establish a more peaceful coexistence; and focusing more clearly on profitability than on growth in market share.

**Offering less restrictive managed care products.** Virtually all of the more than fifty plans interviewed are adding less restrictive products to their product mix and revamping existing products to relax restrictive features. Some of this repositioning is a response to regulatory impositions prompted by consumers and providers who

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**EXHIBIT 1**
Population And Managed Care Characteristics Of Community Tracking Study Sites, 1996–2000

<table>
<thead>
<tr>
<th>Study site</th>
<th>2000 population</th>
<th>HMO penetration</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston*</td>
<td>4,536,430</td>
<td>36.9%</td>
<td>47.7%</td>
</tr>
<tr>
<td>Cleveland</td>
<td>2,250,871</td>
<td>19.8</td>
<td>28.9</td>
</tr>
<tr>
<td>Greenville</td>
<td>862,441</td>
<td>5.6</td>
<td>11.1</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>1,607,486</td>
<td>20.2</td>
<td>24.4</td>
</tr>
<tr>
<td>Lansing</td>
<td>447,728</td>
<td>39.5</td>
<td>41.1</td>
</tr>
<tr>
<td>Little Rock</td>
<td>583,845</td>
<td>18.1</td>
<td>26.2</td>
</tr>
<tr>
<td>Miami</td>
<td>2,253,362</td>
<td>52.9</td>
<td>61.1</td>
</tr>
<tr>
<td>Northern New Jersey</td>
<td>2,032,989</td>
<td>21.1</td>
<td>23.9</td>
</tr>
<tr>
<td>Orange County</td>
<td>2,846,289</td>
<td>40.5</td>
<td>45.3</td>
</tr>
<tr>
<td>Phoenix</td>
<td>3,251,876</td>
<td>33.1</td>
<td>34.2</td>
</tr>
<tr>
<td>Seattle</td>
<td>2,414,616</td>
<td>20.8</td>
<td>25.9</td>
</tr>
<tr>
<td>Syracuse</td>
<td>732,117</td>
<td>18.0</td>
<td>19.4</td>
</tr>
</tbody>
</table>

**SOURCES:** Population data are from U.S. Census Bureau (as of 1 April 2000), <www.census.gov/dmd/www/databank.html> (July 2001). Health maintenance organization (HMO) penetration rates are from InterStudy Competitive Edge, 7.1, Part III: Regional Market Analysis (St Paul: InterStudy, 1997); Competitive Edge 9.1, Part III: Regional Market Analysis (1999); and Competitive Edge 11.1, Part III: Regional Market Analysis (2001).

* HMO penetration data were adjusted to better reflect the geographic definition of Boston in the Community Tracking Study.
are unhappy with certain aspects of managed care. By offering consumers greater flexibility and choice and providers more autonomy and control, plans hope to reduce dissatisfaction with managed care.

New products. In the first two rounds of site visits, managed care plans in several communities were beginning to move toward offering products that gave consumers fewer restrictions, more choice, and enhanced flexibility. In the latest round of site visits, the movement toward such products was even more apparent, as all but one of the communities saw the addition of HMO products that did not require a gatekeeper.

The drive to offer new, less restrictive products is especially noteworthy in markets with high HMO penetration rates (Exhibit 1). In Phoenix, for example, United Healthcare’s direct-access product reportedly accounts for the majority of its membership; four of the market’s other largest plans introduced similar direct-access products during the past two years. In Miami the success of United Healthcare’s direct-access HMO in attracting new business has prompted other plans in the market to introduce similar products during the past two years; several plan executives in Miami note that offering direct-access products was important because of high market demand, especially in acquiring new accounts.

The distinction between HMO and preferred provider organization (PPO) products is becoming less clear as HMOs increasingly offer broad provider networks and no gatekeeper. Premium differences between HMOs and PPOs are shrinking as well. In Seattle, plans report that prices in HMOs have increased more rapidly than prices in PPOs. Similar price convergence between HMOs and PPOs, which some respondents attribute to a disproportionate regulatory burden on HMOs, has been reported by plans in Greenville, Indianapolis, Lansing, Little Rock, Phoenix, Seattle, and Syracuse.

As health plan enrollment migrates toward less restrictive products, the market position of traditional HMOs such as Kaiser and PacifiCare becomes less clear. Some traditional HMO companies report diversifying their product mix in response to changing preferences. In a number of markets, for example, PacifiCare is actively developing a PPO product to offer employers as an alternative to its traditional HMO product (and to reduce its reliance on Medicare+Choice). The challenges of product diversification by traditional HMO companies are noteworthy, however, because many of
these companies delegated major administrative functions and responsibilities to their network providers and never developed the infrastructure to operate a traditional insurance business.

*Existing products revamped.* Evidence from the latest round of site visits in 2000–2001 compared with the earlier site visits indicates that managed care plans are also increasingly moving to eliminate or relax many of the controls associated with the heavily managed products, such as the traditional HMO. In all twelve communities, plans report moving away from requiring preauthorization for health care services to a prenotification process, although the level to which this has occurred varies both within and between markets. Plans in several communities have relaxed their preauthorization requirements in response to new legislation. In Boston, for example, new state regulations require plans to send detailed letters to members and physicians for each utilization management decision made, whether favorable or unfavorable. Respondents say that some plans in Boston have relaxed their preauthorization requirements to avoid the administrative burden and costs associated with these new communication rules.

Plans also are relaxing restrictions by streamlining the referral process, and some plans report having eliminated the process altogether. In Lansing, where plans say that the greatest source of member dissatisfaction is the referral requirement, several plans are moving to an electronic system that should simplify and speed up the process. Plans in Miami and Seattle report similar movement toward a simplified referral process.

Managed care plans in the twelve communities are looking for other innovative ways to loosen controls. In Orange County, for example, Blue Cross of California is attempting to reposition the gatekeeper function as a “medical concierge” to fill a more facilitative and coordinative role rather than being an impediment to members seeking care.

Aside from relaxing their cost control practices, some plans are also pursuing other, “softer” approaches to consumers that feature direct interaction with members. Several plans are promoting electronic information exchange and communication. Others report increased use of condition-specific case management and disease management programs during the past two years. Some plan respondents were skeptical that such initiatives could contain costs and improve clinical outcomes for members with chronic conditions such as asthma and diabetes. But other plan respondents appreciated the opportunities that case management and disease management programs created for plans to work directly with their members.

**Seeking less contentious contractual relationships with**
Managed care plans are seeking to rebuild damaged relationships with providers, which have become increasingly fractious. Plan executives acknowledge that contentious relationships with providers are costly for plans because they increase the cost of contract negotiations, consume a large amount of resources trying to mediate, and often result in considerably higher payment concessions than may have occurred otherwise. Various respondents say that these disputes also foster distrust between plans and providers, which, although less tangible, is difficult to dispel and sows disharmony in negotiations and other dealings. These ill feelings also may get passed along to consumers, who then become less satisfied with their managed care plan.

Providers' pushback on plans. It was evident during the second round of site visits that providers were pushing back against managed care plans and their practices; this "pushback" had gained considerable momentum in all twelve communities in the recent round. Across markets, providers cite various reasons for their dissatisfaction with managed care, including low payment rates and loss of autonomy. Also, providers say that plans' poor business practices, such as their failure to pay claims promptly and their seemingly arbitrary service authorization denials, also contribute to providers' dissatisfaction.

Conflicts arising from these issues have led to deteriorating relationships between plans and providers, often resulting in contract terminations and network instability. In Orange County, for example, St. Joseph's Health System cancelled its contract with PacifiCare in the fall of 2000, affecting nearly a third of the plan's local enrollment. In Seattle more than 150 specialists cancelled their contracts with Regence Blue Shield in December 1999; the situation prompted several large employers to seek performance guarantees from the plan, holding the plan financially accountable for providing a broad and stable provider network. Additional evidence from the recent site visits indicates major tensions and flare-ups in plan-provider relationships in Boston, Greenville, Miami, northern New Jersey, and Phoenix. In some instances, leverage gained by providers because of consolidation also has helped to fuel tensions.

Providers' resistance to risk-contracting arrangements. When the first round of site visits was conducted in 1996–1997, health plans and providers were anticipating rapid enrollment growth in HMOs. They were actively preparing for—and in some markets, such as Orange County, already engaged in—risk-contracting arrangements. Two years later, as risk-contracting organizations began to fail, costs such as those for pharmaceuticals started to soar, backlash against managed care grew, and regulatory scrutiny of risk relationships increased, plans and providers were growing more cautious of...
risk-contracting arrangements.11

By the most recent round of site visits in 2000–2001, some providers in markets where risk arrangements were common, including markets with high HMO penetration such as Boston, Miami, Orange County, and Phoenix, report aggressively resisting risk-contracting arrangements with plans and demanding major changes. Plans and providers in other markets, including Greenville, Lansing, Little Rock, northern New Jersey, and Syracuse, say that they have essentially rejected risk contracting and have little, if any, interest in pursuing these types of arrangements in the future.12

In some markets changes in risk-contracting arrangements between plans and providers are expected to defuse or forestall some provider pushback brought about by providers’ displeasure with low and often declining reimbursement levels. In Orange County, for example, risk arrangements continue, but plans report paying providers much higher rates, taking back pharmacy risk, and weakening the impact of government mandates on provider risk-bearing organizations. Although risk contracting also remains prevalent in Boston, there has been some decline in the number of these arrangements, with plans paying much higher rates to providers to ensure network stability. In Miami, United Healthcare began converting its full-risk physician contracts to individual FFS arrangements during the past two years. In Phoenix, respondents report that FFS arrangements for physicians and per diems and case rates for hospitals also have been rapidly replacing risk arrangements.

**Shifting emphasis to safeguarding profitability.** The noted shifts in managed care strategies have created significant cost pressures for plans, and they continue to do so. These trends coincide with the turn in the underwriting cycle, as financial losses from years of underpricing to gain market share led plans to focus on restoring profitability. By 2000–2001 plans were responding by raising premiums, eliminating marginal lines of business, and retreating from unprofitable markets to alleviate or avert eroding profitability.

Large premium increases. In the first two rounds of site visits in 1996–1997 and 1998–1999, plans in the twelve communities reported intense price competition, particularly among new market entrants and existing plans launching new products.13 By the most recent round of site visits in 2000–2001, managed care plans, struggling to keep pace with rapidly rising medical cost trends, were levying large premium increases on purchasers—increases averaging 11 percent across employer groups nationally.14 In many communities employers find that plans are no longer willing to use pricing strategies to attract new members. Small employers have been hardest hit. In Miami, for example, employers with fifty or fewer employees are
reportedly facing premium increases in excess of 20 percent—more than double the increases for larger employers. Similar premium spreads are also reported in Greenville, Little Rock, and Seattle. Many plans report emphasizing features other than price—including broad and stable networks, responsive customer service, high quality, and firm reputation—to sell their products.

*Higher consumer cost sharing.* To mitigate large premium increases, managed care plans had begun to implement higher consumer cost sharing for some services, and this trend was widely expected by plan respondents to increase as the labor market softened. In all twelve communities, three-tier pharmacy benefit structures have been implemented for commercial products. Both between and within markets, however, the level of consumer cost sharing varies greatly among the tiers. Plans also have adopted market- and plan-specific changes in consumer cost-sharing arrangements, often with major customization by the individual purchaser. In Lansing, for example, Blue Cross and Blue Shield of Michigan recently implemented a fivefold increase in the physician office copayment for General Motors employees (raising it to $10 from $2). In Miami, United Healthcare nearly tripled its emergency room copayment. In Orange County, Kaiser instituted for the first time a copayment for emergency room visits, which the plan reports many employers opted out of by paying higher premiums.

*Reduced rate guarantees and premium caps.* Managed care plans also are reducing—and, in some cases, eliminating altogether—multiyear rate guarantees and premium caps for purchasers, which had been prevalent in some markets since 1996. In Seattle, as multiyear contracts have expired during the past two years, plans report moving away from these types of arrangements. Plans in Boston, northern New Jersey, and Phoenix report taking similar steps.

*Fewer unprofitable lines of business.* In 1996–1997 managed care plans in the twelve communities were actively developing new lines of business—including Medicare risk, Medicaid, small-group, and individual insurance products—in an effort to increase their market share. By 1998–1999 plans had begun to lose optimism about some of these products. By 2000–2001 there was a definite shift among plans in some markets to retreat from or eliminate lines of business deemed unprofitable.

This retreat has been most dramatic in Medicaid and Medicare. In Cleveland, Greenville, northern New Jersey, and Seattle, plans have eliminated their Medicaid product lines, citing poor financial performance as the major reason. Historically, plans have expressed little interest in participating in the Medicare-risk business in low-payment markets such as Greenville, Indianapolis, Lansing, or
Syracuse. Now, interest in participating in this line of business is waning in other markets as well. Exceptions are Miami, Orange County, and Phoenix, where Medicare managed care penetration continues to exceed 40 percent and plan participation is more prevalent. Many plans remaining in the Medicare-risk line of business report having instituted premiums and reduced and/or eliminated pharmacy benefits in an effort to curb financial deterioration. Others have engaged in “silent withdrawals” by eliminating marketing efforts or freezing enrollment.

Although plan exits from public-sector programs such as Medicare have been more highly publicized, plans have also ceased or severely curtailed their participation in other lines of business deemed financially unsustainable. In Greenville and Little Rock, for example, some plans report eliminating their small-group product lines; and in Seattle all major plans serving the individual insurance market report closing enrollment to new members. In several markets, including Little Rock and Syracuse, CIGNA stopped offering an HMO product after failing to gain sufficient membership to ensure the product’s financial viability. Reportedly, many of the affected members moved to CIGNA’s PPO.

Retreat from market expansions. In both 1996–1997 and 1998–1999 plans in the twelve communities were actively pursuing market expansion strategies, often entering multiple states, to grow market share. A key component of these strategies was to enter markets with products offered at prices considerably below those of competitors. During the past two years these approaches have proved financially burdensome for some plans. In Boston, for instance, financial losses during the past several years have forced Harvard Pilgrim Health Care and Tufts Health Plan to greatly retreat from service areas in other New England states. An unsustainable pricing strategy in the expansion markets was a major factor cited in the financial difficulties for both plans. Following an unprofitable attempt to enter and build membership in California, United Healthcare is withdrawing from most markets in the state, including Orange County. In Seattle, QualMed Health Plan reportedly withdrew from the market for financial reasons as well.

Implications Of Plans’ Changing Strategies

For the nearly eight in ten privately insured consumers nationwide
who are enrolled in some form of managed care, including eighty million HMO enrollees, changes in managed care plans’ strategies have particularly important implications. As plans move to less restrictive managed care products, they lose their ability to control costs. This trend is likely to contribute to further premium increases, leading to fewer affordable insurance options for employees, particularly employees of small firms—a situation that is likely to raise uninsurance rates and increase pressure on public programs.

If employers’ health care costs return to rates of increase experienced in the early 1990s, they are likely to look for relief in a number of ways. Less expensive products are an option, including products with greater restrictions such as limited or tight provider networks. In the near term, however, greater financial responsibility on the part of employees is more likely, particularly when the preservation of choice and flexibility are important. The option of less expensive products is already evident in the use of cost-sharing tiers for pharmacy benefits, and the option is likely to be applied to provider network structures (such as tiered provider networks) and other benefits in the future. Some employers may drop coverage or raise employees’ premium contribution levels. More extreme versions of employee financial responsibility could include some type of defined-contribution strategy for employers, although widespread movement in this direction is not yet evident.

Plans’ movement toward less restrictive managed care, especially via non-HMO products such as PPOs, has additional implications. First, the less restrictive products typically do not offer comprehensive benefits, which is the hallmark of HMOs. Features such as disease management, preventive care, and wellness programs are usually not a part of non-HMO products, although employers have the option to pay extra for them. Second, less restrictive products make risk-based contracting between plans and providers less feasible, because plan members have more freedom to seek care from providers other than those in risk-bearing provider groups. Whatever influence risk contracting has in helping to control costs, therefore, could be eroded.

Third, shifting enrollment to more loosely managed non-HMO products is likely to result in an overall weakening of plan accountability. Industry performance standards, including the National Committee for Quality Assurance’s Health Plan Employer Data and Information Set (HEDIS), are primarily HMO-based, as are many states’ efforts to provide consumers with plan comparison data. In addition, state licensure and reporting requirements typically are applicable to or more stringent for HMO products than for non-HMO products. Consequently, consumers are likely to have less
information available to assess the performance of health plans when making decisions about insurance coverage and services.

Product line and market exits are likely to create major service disruptions for some consumers—notably, the seventeen million Medicaid and Medicare beneficiaries enrolled in managed care and the many persons who obtain health insurance from the small-group and individual insurance markets. From 1998 to 2000 the number of plans serving Medicaid beneficiaries dropped 15 percent nationally. In Medicare the two-year decrease was 20 percent. The withdrawal of plans from these public programs presents a formidable challenge for program administrators and policymakers, who must ensure adequate capacity to serve beneficiaries. Indeed, recent experience suggests that the underwriting cycle—and the associated cyclical nature of plans’ expansion and retreat activities—promises that this will be a recurring challenge for public programs that rely on the private health insurance market. Similarly, this phenomenon is likely to present enduring challenges for consumers in the small-group and individual insurance markets. For those affected by plan retreats in these markets, securing new, affordable coverage will be difficult, if not impossible, because plans’ participation in these lines of business is limited in most markets. Service disruptions are inconvenient and may have adverse health consequences for consumers.

Managed Care’s Future

Although evidence from the latest round of CTS site visits indicates that managed care is continuing to evolve, an important question is, What is the durability of managed care’s most recent strategic shifts? Much of this will depend on purchasers. Shifting strategies of health plans—moving to less restrictive managed care, rebuilding relationships with providers, and safeguarding profitability—were implemented at a time when national and local economies were particularly robust with tight labor markets and general prosperity. Should cost concerns lead purchasers to revert to their aggressive posture of the early 1990s, managed care plans may find that their recent strategy shifts will have to be reconsidered.

It does not appear, however, that an inflection point has been reached or that the pendulum has started to swing back yet. As medical inflation continues to increase and the economy weakens, a major challenge for plans will be to balance marketplace preferences for less restrictive care while at the same time holding down costs when purchasers finally conclude that they cannot or will not absorb large price increases. The end of managed care as we know it could be upon us, as some have suggested, but the search for afford-
able health care will continue. What role managed care plans will play in this search merits close tracking.

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NOTES
1. For additional details, see the special issue on the managed care backlash, *Journal of Health Politics, Policy and Law* (October 1999).
2. HMO enrollment declined by nearly 1 percent between 1999 and 2000. During this same period the number of HMOs in operation declined by nearly 9 percent, from 613 in 1999 to 560 in 2000. InterStudy *Competitive Edge 11.1, Part II: HMO Industry Report* (St. Paul: InterStudy, 2001).
8. Prenotification differs from precertification in that the former does not require a medical necessity review by the plan before care is authorized. Prenotification provides plans with a mechanism to identify, early on, potentially high-risk, high-cost members who may require more active care management.
“Update on the Nation's Health Care System.”

10. From the twelve study sites there are numerous examples of plan-provider confrontations. For further details, see B. Strunk, K. Devers, and R. Hurley, Health Plan-Provider Showdowns on the Rise, Issue Brief no. 40 (Washington: HSC, June 2001).


12. Ibid.


14. Throughout the early 1990s medical cost trends were decreasing, but in 1995 that trend reversed. Since then medical inflation has been increasing with the most dramatic changes occurring since 1998: Health care spending per person rose nearly 7 percent in both 1999 and 2000. See B.C. Strunk, P.B. Ginsburg, and J.R. Gabel, “Tracking Health Care Costs,” <www.healthaffairs.org>, 26 September 2001.


17. Across the twelve markets the number of plans participating in Medicare+Choice dropped from sixty-five to forty-six between the 1998–1999 site visits and the most recent round. In Miami, Orange County, and Phoenix the higher Medicare managed care penetration rates are not accounted for by payment rate alone. For example, the 2002 Medicare payment rates for these markets are $834 in Miami, $640 in Orange County, and $553 in Phoenix. For additional details, see R. Hurley, B. Strunk, and J. Grossman, “The Medicare Managed Care Lifecycle” (HSC Working Paper, August 2001).


19. These plans have renewed attempts to expand geographically by contracting with a national PPO to serve employers with out-of-state workers.


22. InterStudy Competitive Edge 11.1, Part II: HMO Industry Report. Of the seventeen million Medicaid and Medicare managed care consumers, eleven million are in Medicaid and six million are in Medicare.

23. Ibid. The number of plans participating in Medicaid decreased from 254 in 1998 to 215 in 2000, although not all plans participating in Medicaid are listed in the InterStudy report. The number of plans serving Medicare beneficiaries decreased from 273 in 1998 to 219 in 2000.