CMS (HCFA) implemented the Medicare Choices Demonstration to test the feasibility and desirability of new types of managed care plans for Medicare such as integrated delivery systems and preferred provider organizations. Many of the innovations being tested in the demonstration were subsequently included in the Medicare + Choice (M+C) program enacted under the Balanced Budget Act (BBA) of 1997. The evaluation by Mathematica Policy Research described the characteristics of the participating MCOs and the products they offered, and their operational experience, the direction and magnitude of biased selection and its implications for Medicare costs; and the effects of the demonstration on access to and satisfaction with care.

Evaluation Highlights:

- All but one of the 13 demonstration managed care organizations (MCOs) were sponsored by provider systems. The demonstration experience indicated that provider-sponsored organizations (PSOs) face important challenges in successfully contracting with Medicare. Their limited experience with some managed care functions (resulting in poor product design) and the inherent conflicts that arise when a provider system attempts to restructure provider incentives and modify practice patterns caused many sites to drop out of the demonstration. This suggested that relatively few PSOs are likely to enter M+C in the near future, and those that do may be less successful than health maintenance organizations (HMOs).

- The MCOs were not able to submit the required encounter data. The problems the MCOs faced in this area underscored the challenge of collecting complete encounter data from MCOs in the future. The demonstration showed the substantial challenges and delays involved in moving to a more complete encounter data system.

- Given the substantial start-up costs for a new product, all of the MCOs anticipated losing money in the first several years of operation. However, five MCOs withdrew from the demonstration because their losses were much higher than expected. The MCOs attributed the higher-than-expected losses to a variety of factors, including higher-than-expected utilization, low enrollment, and high administrative costs (including the costs of submitting encounter data). In addition, two MCOs acknowledged that poor product design contributed to their financial losses.

- Overall, the demonstration MCOs experienced favorable selection, although the demonstration MCOs attracted a more representative mix of enrollees than has been attracted to Medicare HMOs. This suggested that future participation by such MCOs could offer beneficiaries a more meaningful and desirable choice of health plans.

- Overall, the capitation payments HCFA made for demonstration enrollees did not differ significantly from the expenditures HCFA would have incurred for those individuals in the FFS sector.

- In addition, the demonstration MCOs provided access to care that is comparable to access in the FFS sector, and enrollees were more satisfied with the overall quality of care and with most aspects of care than were nonenrollees.

- Five percent of demonstration enrollees disenrolled within 3 months after joining their MCO, and 13 percent disenrolled within 12 months. The higher disenrollment among enrollees in a POS product may have been a result of not understanding, at the time of enrollment, the limitations on the POS benefit. Disenrollment rates were highest among nonwhites, the under 65 disabled, the oldest old, those on Medicaid, and those with high baseline expenditures. This suggests that these vulnerable subgroups were less satisfied with their care and/or had a poorer understanding of how to use their MCO.

- Enrollees in the demonstration often had a poor understanding of their coverage. Twenty-nine percent of enrollees reported knowing little or nothing about how their MCO works and how to get services paid for. Beneficiaries enrolled in MCOs with out-of-network coverage had the poorest understanding of their coverage.

- The lack of understanding about coverage was more prevalent among disenrollees and may have contributed to their decision to disenroll. Also, more vulnerable subgroups such as less educated beneficiaries, minorities, those with a low income, dual eligibles, and those in poor health did not understand the MCO as well as their counterparts. The evaluator predicted that beneficiary education will continue to be an important issue for HCFA and for MCOs participating in the Medicare program.