CHAPTER 5

Health insurance choices for Medicare beneficiaries

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Since the Medicare program began, beneficiaries have been able to make limited choices about their health coverage. Policymakers have sought to broaden these choices; some want to use choice as a platform for a system of competition among Medicare and private plans. Many Medicare beneficiaries now have available to them an increasingly complex array of options beyond traditional Medicare fee-for-service and varying forms of supplemental coverage. How and when beneficiaries choose among these options depends on a number of factors, including specific market conditions and the circumstances of individual beneficiaries.

The determinants of how supply and demand for health insurance meet in the marketplace are both national and local. They reflect the tension between Medicare as a national program and the reality that it is only at the local level that medical care is organized and delivered, beneficiaries choose insurance options and delivery systems, and decisions to enter the insurance market are made. In this chapter we review the entire spectrum of options as a first step in MedPAC's larger effort to better understand beneficiaries' choices and market conditions.

Medicare beneficiaries face a complex array of health insurance options, including the traditional Medicare fee-for-service (FFS) program; various forms of insurance that supplement the traditional program; and alternatives to the traditional program such as managed care, private fee-for-service (PFFS), and preferred provider organization (PPO) plans. Which of these options, other than the nationally-available FFS program, are available to beneficiaries depends on local market conditions. Which they choose—or whether they decide to choose at all—depends on the circumstances and motivations of individual beneficiaries and the information available to them.

Although supplemental insurance and options for receiving care in managed care plans have been available to beneficiaries since the Medicare program began, the array of choices for receiving Medicare and supplemental coverage has become increasingly important both for beneficiaries and for Medicare program spending. Policymakers have sought to expand Medicare beneficiaries' health insurance options for a variety of reasons. Some sought to offer Medicare beneficiaries a wider choice of plans that might better meet their perceived need for health insurance and provide access to health care delivery system options that are popular among the employed population. Some sought to build a platform for a system of competition among plans that might provide better management of care, market-determined rates for providers, and better quality.[1] The theory is that if plans compete on the basis of product, quality, and price, and if markets work well, beneficiaries and providers will have the incentive to take the costs and quality of health care into account, which could help control Medicare spending in the long run.

Choice has evolved over the years from health maintenance organizations (HMOs) paid on a cost basis, to HMOs paid on a risk basis, to the current Medicare+Choice (M+C) program, to newly developed demonstration programs. The M+C program was established by the Balanced Budget Act of 1997 (BBA). When the program became effective January 1, 1999, it allowed private plans to offer Medicare beneficiaries options beyond the traditional FFS Medicare program, including HMOs and other managed care plans, private fee-for-service plans, and Medical Savings Accounts. However, during the last five years, many plans left the M+C program, and few new non-HMO options materialized. Enrollment declined sharply as private plans withdrew, and beneficiaries were upset by the instability in plan choices and reductions in benefits offered by plans. There have been concerns that the program has failed.

In response, the Congress and the Centers for Medicare & Medicaid Services (CMS) have been trying several approaches to encourage greater plan participation. Plans' regulatory concerns have been addressed; the Congress extended the life of Medicare HMOs that are paid on a cost basis; and CMS undertook a demonstration program to encourage PPOs to participate in M+C.

In this chapter, MedPAC examines the status of the Medicare program with respect to health insurance options for Medicare beneficiaries on a national level, including not just M+C options but all forms of supplemental insurance. The chapter begins by describing the health insurance options available to some Medicare beneficiaries, as well as the way the options have evolved over the last few years. The second section of the chapter describes constraints on Medicare beneficiaries' choices in the health insurance market and examines Medicare beneficiaries' actual choices and satisfaction, as well as the perspective of health insurers, highlighting changes insurers might like to see in order to stimulate participation.

In the final section of the chapter, we analyze how potentially conflicting preferences might play out in the health insurance marketplace. The products available to beneficiaries vary considerably across regions and states and even within metropolitan areas. Further, competition between options is not limited to M+C versus traditional fee-for-service Medicare alone. There is also competition between comprehensive plans and traditional Medicare plus supplemental policies that are available to many Medicare beneficiaries. The availability of options, their costs, plus variations in M+C benefits and premiums can create very different market dynamics in local markets across the nation. Further research is needed to help understand more about how local markets are structured and how they might work for Medicare.

What health insurance options do Medicare beneficiaries have?

Although most of the concern and debate about the availability of health insurance choices for Medicare beneficiaries have revolved around the participation of private managed care plans—predominantly HMOs—in the Medicare+Choice program, beneficiaries also make choices about other Medicare-related insurance products available to them. Therefore the discussion here covers the broad range of health insurance options available to Medicare beneficiaries. We describe two general types of insurance products:

- **Insurance products that replace the traditional Medicare FFS benefit package**. Such products include M+C managed care plans, called coordinated care plans (CCPs); M+C private fee-for-service plans; Medicare demonstration PPO plans; and Medicare cost plans.

1 The Institute of Medicine (IOM) report, Crossing the quality chasm, points out that the fragmented nature of Medicare's traditional fee-for-service program makes the implementation of some quality improvements more difficult (IOM 2001).

- **Insurance products that supplement the traditional Medicare FFS benefit package.** Products designed to fill in or "wrap around" the basic Medicare FFS benefit package include Medigap plans, Medicare Select plans, employer-sponsored retiree plans, and Medicaid.

The availability and attractiveness of these products varies by geographic area and by beneficiaries' individual circumstances. Products that replace the traditional Medicare FFS benefit packages, for example, are available only in some areas of the country. Further, the cost to the beneficiary and the benefits provided vary significantly—even among areas where these replacement products are available—depending on factors such as Medicare payment, market characteristics, and beneficiaries' need for services. Though generally more widely available, even some products that supplement the Medicare benefit package are available only to certain beneficiaries. For example, retiree supplemental coverage is limited to beneficiaries who have worked for the employers or unions that offer this coverage. Medicaid coverage is available only to beneficiaries who meet the low-income and other standards set by the state in which they live. Finally, even supplemental products available to almost all beneficiaries have premiums that can vary by market and beneficiary age.

Insurance products that replace the traditional Medicare FFS benefit package

Medicare beneficiaries can enroll in some insurance products which serve as alternatives to the traditional Medicare program. When beneficiaries enroll in most of these alternatives, they must give up their traditional benefits (though they can disenroll at the end of any month and return to FFS Medicare). In addition to providing beneficiaries with Medicare benefits, most of these alternatives offer some supplemental benefits.

M+C coordinated care plans

Under M+C, Medicare beneficiaries have the option of joining a private CCP, which then receives payment from Medicare for providing all Medicare-covered services. Generally, members of M+C CCPs must use plan providers to get their care. These private plans are allowed to provide additional benefits and to charge beneficiaries an additional premium for them. However, if a plan's projected costs for Medicare benefits are lower than its Medicare payments, the plan is required by law to either return the difference to enrollees in the form of additional benefits (or lower premiums) or contribute the money to a reserve fund for future use (few plans choose this option). Historically, beneficiaries have been able to join these plans and receive extra benefits at no additional premium.

M+C CCPs have been the core of the M+C program, but they are not available everywhere and their benefit packages vary considerably. Currently, M+C CCPs are available to about 58 percent of the Medicare population, down from 74 percent availability at the peak in 1998. However, less than 20 percent of rural beneficiaries have a plan available. Currently about 5 million beneficiaries are enrolled in an M+C CCP, down from about 6 million in 1998. In explaining M+C plan participation trends, it is important to note that the CCP model is dominated by HMOs, which have been withdrawing in the private sector as well.

Medicare payments for M+C CCPs Medicare pays M+C CCPs a monthly capitated rate for each enrolled Medicare beneficiary based on the beneficiary's county of residence and relative health cost risk. (See Appendix A.)

As a result of this payment system, Medicare has paid more to M+C plans, on average, than it would have paid to insure demographically similar beneficiaries under the traditional FFS program for the basic benefit package. MedPAC has calculated that in 2001, Medicare's payments were about 104 percent of average FFS costs. This calculation assumes there are no risk selection differences (other than those such as age, sex, and Medicaid status that are included in the rate-setting model) between the M+C plans and traditional Medicare. For 2003, we project the rate will also be 104 percent.

Benefits and costs to beneficiaries of M+C CCPs The benefit packages and beneficiary premiums for the packages vary quite a bit. Almost 30 percent of Medicare beneficiaries have a plan available in their county in 2003 that charges no premium. In fact, about 4 percent of beneficiaries have access to a plan that will, in essence, pay them to join.[2] At the other end of the spectrum, some plans charge premiums in excess of $200 per month. Premiums reaching that level result, at least partially, from the plan providing benefits in addition to the basic Medicare benefits. The data do not allow us to calculate the average premium paid, but the lowest premium available to beneficiaries averages $40 per month across all M+C markets.[3]

The additional benefits offered and co-payments required also vary considerably. Plans can and do charge deductibles, flat copayments, and percentage coinsurance on days, stays, or benefit periods. Because of the complexity of the benefit offerings, we focus on a few indicators to compare across packages. We looked at three supplemental benefits sometimes offered by plans:

- some coverage for outpatient prescription drugs,

2 The actual transaction will involve the plan paying some or all of the beneficiary's Part B premium.

3 The Centers for Medicare & Medicaid Services (CMS) reports the number of beneficiaries enrolled under a managed care organization's (MCO) contract. An MCO may have several different plans (each with different benefit packages and premiums) under a single contract, but CMS has not reported the number of enrollees in each plan. CMS has begun collecting the plan-level enrollment information.

- inpatient hospital services covered without any cost-sharing, and
- physician office visits covered without any cost-sharing.

Almost half of all Medicare beneficiaries have an M+C CCP available that covers some prescription drugs. Almost 30 percent of beneficiaries have a plan available that does not charge any cost-sharing for inpatient hospital services. About 10 percent of beneficiaries have a plan available without any cost-sharing for physician services.

M+C private fee-for-service plans

M+C PFFS non-network plans operate like traditional FFS insurance plans in the commercial sector. They allow beneficiaries to use any provider who will accept the plan's reimbursement rates. (Although allowed by law, there are currently no network PFFS plans.) Medicare pays these plans the same rates as it pays other M+C plans. They are subject to most of the same conditions of participation as other M+C plans, but some quality data reporting requirements are less stringent.[4] As is the case with other M+C plans, PFFS plans may alter the cost-sharing arrangements for Medicare benefits, subject to approval by CMS. CMS reviews the structure in an attempt to ensure that selection bias will not occur.[5] It is unclear how a non-network plan would compete financially with the traditional Medicare program except in areas where the payment rates are above FFS spending. The Medicare program currently pays approximately 102 percent of what it would be expected to pay to insure demographically similar enrollees under the traditional program.

There are currently three M+C PFFS plans: One of them is a demonstration plan that operates in only one county; another, established in 2000, operates in most of 25 states and is available to about one-third of all Medicare beneficiaries, and the third has just been approved and will operate in six states. Enrollment in the established multi-state plan is low (about 20,000 enrollees) but has been growing steadily since its inception in 2000. However, the plan has pulled out of some areas in each of the last two years.

Benefits and costs to beneficiaries of the M+C PFFS plan The established multistate M+C PFFS plan sets a standard benefit package across its entire service area. For 2003, this M+C PFFS plan charges a monthly premium of $88. The plan does not cover outpatient prescription drugs. For inpatient hospital services, the beneficiary has a copayment of $100 per day, up to a maximum of $500 per stay. (There is no limit to the number of days in a stay under this plan.) The beneficiary must notify the plan before a planned admission; otherwise there is an additional copayment of $50 per day, up to a maximum of another $500 per stay. For physician services, the beneficiary's copayment is $15 per primary care visit and $30 per specialist visit.

The newly approved plan charges a monthly premium of $19 and provides some coverage for outpatient prescription drugs.

Medicare preferred provider organization (PPO) demonstration plans

Although the statutory language that established the M+C program specifically mentioned PPOs as examples of CCPs, only a few PPOs have ever participated in the program. CMS wants to encourage PPOs to enter the M+C program, for at least two reasons: (1) to enhance competition in the Medicare marketplace and (2) to make the most popular form of insurance in the commercial sector more readily available to Medicare beneficiaries.

CMS identified several barriers to PPOs' participation in the M+C program (Centers for Medicare & Medicaid Services April 2002):

- **Low M+C payment rates in some areas.** M+C payment rates were too low in some areas for PPOs to recruit providers into networks.
- **PPOs' reluctance to participate in a fully capitated program.** Another barrier to PPOs' participation in M+C has been their wariness about entering the fully capitated M+C program. In the commercial world, PPOs often share the risk on medical costs with the employers who offer the PPOs to their employees. In many cases, the PPOs carry no medical risk and offer administrative-services-only contracts to self-insured employers.
- **The M+C limit on premiums and cost-sharing.** The M+C limit on cost sharing (designed to protect beneficiaries from paying higher cost-sharing in M+C than under the traditional program) hinders benefit design in some geographic areas. The actuarial value of all cost-sharing, including premiums and copayments related to basic Medicare services, cannot exceed the national average cost-sharing amount for the traditional fee-for-service Medicare program, which is about $102 per month for 2003. Because this cap is based on a national average, it has been troublesome for HMOs in higher-than-average cost areas, and would be even more of a problem for PPOs, which often include substantial out-of-network cost sharing.[6]

4 Because non-network PFFS plans do not have a network, their control over provider behavior is limited. Therefore, the plans are not required to report some of the quality measures or participate in quality improvement projects that relate to provider practices.

5 CMS does not review or approve PFFS plans' premiums, as it must with CCP premiums.

6 Beneficiary cost sharing is correlated with Medicare payments: the more Medicare pays for services, the higher beneficiary cost sharing. For Part B services, cost sharing is generally 20 percent of Medicare-allowable charges. Thus, in areas where Medicare spending is higher than average, it can be expected that beneficiary cost sharing would be higher than average.

CMS has initiated a Medicare demonstration program for PPOs in order to encourage plans to enter M+C. The Medicare PPO demonstration program is scheduled to run for three years beginning in January 2003. CMS has approved demonstration waivers for 33 plans in 23 states. The plans will be available to 11 million Medicare beneficiaries (Department of Health and Human Services 2002). Under the demonstration program, payment rates will be higher than M+C rates in some areas, the limit on cost sharing will be waived, and the Medicare program will offer to share some of the cost risk with the plans.

While the PPO demonstration program may provide an additional option to many beneficiaries, it is not likely to increase the choices available to beneficiaries who do not already have other alternatives to Medicare FFS. Of the more than 11 million beneficiaries who will have a PPO available, only about a half million do not already have a CCP available. Generally, demonstration plans are going into urban areas, but a couple of the plans are targeted to rural areas. As a result, out of approximately 10 million rural beneficiaries, about 600,000 will have access to PPOs, but 450,000 of them already have a CCP available. It remains to be seen whether those who enroll in PPOs will come from the coordinated care plans, or have fee-for-service coverage only, or have FFS plus Medigap.

Medicare payments for PPO demonstration plans Under the Medicare PPO demonstration program, plans will be paid the higher of the M+C rate in the county or 99 percent of the average risk-adjusted per capita spending under the traditional FFS Medicare program. Demonstration plans will also have the opportunity to individually negotiate risk-sharing arrangements with Medicare. If beneficiaries enroll in the PPOs at the same rate in each county where they are offered (e.g., if 1 percent of beneficiaries in each county enroll), PPO spending will average 109 percent of the cost of insuring the enrollees in the FFS Medicare program.[7] The reason that the Medicare costs would be so high is that the PPOs are going into many counties where M+C payment rates exceed fee-for-service spending.

Benefits and costs to beneficiaries in PPO demonstration plans Almost all of the PPO demonstration plans will charge premiums, ranging from $32 to $184 per month. All but one of the PPOs will offer some coverage for outpatient prescription drugs. About one-fifth of beneficiaries who have a demonstration PPO available will have one that charges no cost-sharing for inpatient hospital services in network hospitals. Plans that cover physician visits without any cost-sharing will be available to only about 2 percent of beneficiaries who have a PPO available.

Medicare cost plans

Cost HMOs have been authorized to participate in the Medicare program since 1972 (National Academy of Social Insurance 1998). They were designed to allow Medicare beneficiaries who were in HMOs before they became eligible for Medicare to stay in those HMOs. Medicare pays the HMOs their cost, as determined by a cost report, for providing Medicare benefits for their members, less the actuarial value of traditional Medicare cost sharing. The beneficiaries in cost HMOs generally cover this cost sharing through monthly premiums rather than payments as services are delivered. In addition, members are free to seek Medicare-covered services outside of the HMO's network. If a beneficiary goes to a non-network provider, Medicare pays the provider the same as if the beneficiary were in the traditional FFS program, and the beneficiary is responsible for the usual Medicare FFS cost sharing. To the beneficiary, this structure is similar to being in a point-of-service (POS) HMO.

Although Medicare cost plans have been attractive to some beneficiaries, past studies have shown that this option costs the Medicare program significantly more than serving beneficiaries in the traditional fee-for-service program (Sing et al. 1998). However, those studies are based on old data and compared costs only relative to the traditional program. Though that comparison may be the best one to examine, it may also be relevant to compare cost plan performance to the performance of M+C plans, because in areas where the M+C plans are paid more than FFS costs, the cost plans might result in Medicare spending less than for the M+C plans. The cost plan program is set to expire at the end of 2004, but the program has already been extended several times, and there has been congressional interest in extending it further.

Currently, 30 Medicare cost plans are in operation, with a total of 290,000 members. Those numbers should rise because two M+C CCPs are shifting their membership to Medicare cost plans that they also operate.

Benefits and costs to beneficiaries in Medicare cost plans Premiums generally range from $29 per month to $326 per month (there is one zero-premium plan). Half of the cost plan offerings have monthly premiums between $72 and $116. While less than half of the plans include coverage for outpatient prescription drugs, some of the ones that do not provide coverage offer high-option choices that do include drug coverage. Most of the plans charge no cost-sharing for inpatient hospital services in a plan hospital, and about one-third do not charge cost-sharing for visits to plan physicians.

7 The 109 percent figure was calculated by comparing the projected per capita FFS spending in each participating county with the rate the PPO would be paid in each county. Those county-level comparisons were then aggregated and weighted by the number of Medicare beneficiaries in each county. The calculation assumes that there is the same level of health risk in the PPO and non-PPO populations and that the risk-sharing arrangements have no aggregate net effect.

National and local availability of alternatives to Medicare's traditional FFS program

About 80 percent of Medicare beneficiaries nationwide live in counties where an alternative to Medicare's traditional FFS program—an M+C coordinated care plan, an M+C private fee-for-service plan, a PPO demonstration plan, or a Medicare cost plan—is available to them (Table 5-1). These alternatives are available to 85 percent of urban beneficiaries but only 61 percent of rural beneficiaries. Furthermore, while urban beneficiaries may have a range of plans to choose from, the only option for rural beneficiaries is generally the PFFS plan. Looking at availability of alternatives to the traditional Medicare FFS program in terms of M+C county payment rates, we find that 86 percent of beneficiaries who live in counties with payment rates above the floors[8] (as determined in 2002) have a plan available, while 74 percent of beneficiaries in floor counties have a plan available. In addition to these alternatives, which are open to all Medicare beneficiaries,[9] there are some specialized plans that offer benefits attractive to the frail elderly which are sometimes available only to categories of frail beneficiaries. (See text box.)

TABLE 5-1

Availability of alternatives to the traditional Medicare fee-for-service program, 2003

		Percent of beneficiaries with plans available, by type of county of residence, 2003				
	Percent of beneficiaries	M+C CCP	PFFS	PPO demo	Cost contracts	Any plan
National	100%	58%	36%	23%	23%	80%
County payment rate						
Floor	55	40	50	15	16	74
Large urban floor	31	61	43	24	19	82
Other floor	23	12	58	3	12	63
Non-floor	45	80	20	32	30	86
Rural areas	23	13	56	4	9	61
Urban areas	77	72	30	28	25	85

Note: CCP (coordinated care plan), M+C (Medicare+Choice), PFFS (private fee-for-service), PPO (preferred provider organization). For 2003, the large urban floor is $564.10 and other floor is $510.38.

Source: MedPAC analysis of data from CMS website, August 2002 and September 2002.

Insurance products that supplement the traditional Medicare FFS benefit package

In addition to choosing among insurance products just discussed which are intended as an alternative to (and sometimes add to) the traditional Medicare FFS benefit package, beneficiaries can also choose among products designed solely to wrap around, or supplement, the basic Medicare benefit package. All aged beneficiaries have the option of buying a Medigap plan when they first enroll in Medicare (this is not the case for disabled beneficiaries under age 65; see p. 199). Many beneficiaries can also choose to buy a Medicare Select plan. Some beneficiaries may be fortunate enough to have the option of participating in an employer-sponsored retiree plan. Other beneficiaries may be eligible to receive supplemental benefits from state Medicaid programs and other programs designed to assist low-income individuals.

Medigap plans

Medigap insurance is private coverage designed specifically to wrap around the Medicare benefit package. Most Medigap insurance is marketed directly to individual Medicare beneficiaries, although some employers and associations help enroll their retirees and members in these publicly available plans (Chollet and Kirk 2001).

Private supplemental insurance, similar to what we now call Medigap insurance, has existed since Medicare began, but the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) imposed some structure on the market, simplifying and clarifying offerings for beneficiaries.[10] Pursuant to OBRA 1990, the National Association of Insurance Commissioners (NAIC) created 10 standard plans, commonly labeled A through J, and states retained primary responsibility for regulating Medigap policies and insurers.[11]

For the most part, all standardized plans are available to all beneficiaries as they turn age 65, although not every plan is sold in every state. When beneficiaries turn age 65, they have a one-time open enrollment period during which Medigap insurers must allow the beneficiary to

8 The floor payment rates are described in the M+C section of Appendix A.

9 Beneficiaries who have end-stage renal disease (ESRD) and are being maintained by chronic dialysis may not enroll in an M+C plan, unless they were previously in a plan before developing ESRD.

10 Many beneficiaries had been subject to questionable sales practices and had purchased multiple policies that often duplicated existing coverage (Super 2002). The Congress found that the policy offerings needed to be standardized.

11 Insurers in three states (Massachusetts, Minnesota, and Wisconsin) are not subject to the standards for plans A–J. These states were granted waivers because they had preexisting standards which they continue to maintain.

Managed care programs for frail beneficiaries

Over the years, the Congress has created a variety of managed care programs to meet the needs of beneficiaries with impairments in activities of daily living. These programs generally have been available in relatively few locations. Three of the more long-lived examples are the Program of All-Inclusive Care for the Elderly (PACE), the Social Health Maintenance Organization (S/HMO) program, and EverCare.

Program of All-Inclusive Care for the Elderly

PACE is a permanent program under Medicare and a state option under Medicaid. Most PACE enrollees are eligible for both Medicare and Medicaid, and the program is targeted to enrollees with substantial functional impairments. A primary objective of PACE is to delay or prevent use of hospital and nursing home care. The program provides a comprehensive range of preventive, primary, acute, and long-term care, beyond what is available through Medicare and Medicaid. PACE service delivery and coordination are usually organized through adult day health centers. There are now 15 permanent PACE sites in 8 states, enrolling around 2,000 beneficiaries. Another group of PACE sites is still operating under demonstration authority while CMS considers their applications to join the permanent program.

Social Health Maintenance Organization

The S/HMO demonstration program has had two phases, called generations. Both generations have taken a traditional HMO model that enrolls a wide spectrum of beneficiaries, and added a limited long-term care benefit. The second generation program was started largely to address perceived shortcomings with the first. The two generations of S/HMO programs differ in the way that Medicare pays them, the degree to which they coordinate care across benefits and providers, and their targeting mechanisms for long-term care benefits. The demonstration project is slated to end on August 1, 2003. There are now 4 S/HMO sites in 4 states, enrolling around 112,000 beneficiaries; 37 percent of enrollees are in the single second generation S/HMO plan.

EverCare

The EverCare demonstration program enrolls permanent nursing home residents into managed care. The demonstration builds on the experience of the United Health Care EverCare company in subcontracting with Medicare HMOs to provide medical care for enrollees who live in nursing homes. Unlike PACE and S/HMO, EverCare does not expand the Medicare benefit package significantly; instead, it focuses primarily on providing more Medicare-covered outpatient services to reduce residents' use of hospital and emergency room care. The demonstration project is slated to end on December 31, 2003. Six EverCare demonstration sites now operate in 6 states, enrolling around 17,000 beneficiaries. ■

enroll in any open product. During this period insurers are prohibited from medically underwriting the beneficiary—meaning that they cannot consider the beneficiary's health and medical history in deciding whether to offer a policy and how much to charge. Medigap plans are often unavailable to disabled beneficiaries (under age 65) because these federal guaranteed-issue requirements are limited to beneficiaries turning 65 or in an M+C plan that no longer participates in the program. Except in the few states that require pure community rating, Medigap plans can be prohibitively expensive for older or sicker beneficiaries seeking coverage. (See text box, p.200, for age-rating methodologies.) After the six-month open enrollment period, Medigap insurers in most states can medically underwrite new applicants. This practice is common, particularly for Medigap plans that include prescription drug coverage. Once enrolled, however, beneficiaries can not be dropped from their Medigap plan, as the policies provide guaranteed-renewal protection.

Over 10 million, or about 27 percent of Medicare beneficiaries living in the community in 2000 were enrolled in a Medigap plan.

Benefits and costs to beneficiaries in Medigap plans Medigap plans generally provide coverage of Medicare's cost-sharing requirements. All standardized plans (A through J) cover cost-sharing for physician and inpatient hospital services, except for the $100 Part B deductible and the $840 inpatient hospital stay deductible (Table 5-2, p. 201). Plans B through J cover the inpatient deductible, and plans C, F, and J cover the Part B deductible. Three of the standard plans (H, I, and J) offer limited coverage of outpatient prescription drugs, but all come with a $250 annual deductible, 50 percent coinsurance, and a cap on benefits of $1,250 per year (plans H and I) or $3,000 per year (plan J). Relatively few beneficiaries enroll in the three plans that offer prescription drug coverage, and most are in either plan C or plan F. About 25 percent of Medigap enrollees have stayed in their prestandardized plans that have been closed to new enrollment since 1992. The benefits in the nonstandardized plans tend to be similar to those found in the standardized plans.

Medigap age-rating

Generally, insurance companies use three different methods to determine the prices, or rates, for their plans, based on the age of the enrollee:

- **Pure community rating**: All enrollees in the same geographic area pay the same premium, regardless of age.
- **Issue-age rating**: Enrollees pay premiums based on their age when their policy was first issued to them.
- **Attained-age rating**: Enrollees pay premiums based on their current age.

State insurance rules regulate which method, or methods, insurers may use. The methods determine the relative levels of premiums beneficiaries will face as they age.

Under pure community rating, younger policyholders generally pay more than their expected costs while older policyholders pay less than their expected costs. This cross-subsidization may be desirable for older beneficiaries who may be less able to afford higher premiums tied to their expected costs. Insurers may face special challenges under community rating, however. In order to keep premiums low, insurers need to maintain an enrollee population that is balanced between older and younger policyholders as their original policyholders age. That means they need to attract a steady stream of younger beneficiaries, which usually requires keeping premiums low. If the premium is too high, younger beneficiaries may feel that they will not get good value from a policy, and they may wait until they are older to purchase a policy or purchase a policy that is rated differently. Such delaying behavior could lead to increases in the cost of the policies.

Under issue-age rating, beneficiaries have a stronger incentive to buy a policy without delay, because the premium is based on their age when they first buy the policy. For example, if a beneficiary buys a policy at age 65, the premium will continue to be the same as that offered to new 65-year-old beneficiaries. This rating structure also provides incentives for beneficiaries to stick with a plan because in many states some of their premiums are put into a reserve to fund their higher expected costs as they age.

Attained-age rating reduces cross-subsidies between groups of younger and older beneficiaries. The premiums for younger beneficiaries will generally be lower than under any other rating structure. However, the premiums for older policyholders will be higher than under any other structure and can become prohibitively expensive for many beneficiaries.

In addition to rating by age, insurers in some states can rate by other beneficiary variables, including sex, whether or not the beneficiary smokes, and the geographic area where the beneficiary lives. Finally, if beneficiaries want to enroll in plans outside of the time periods in which they have guaranteed-issue rights, plans in the majority of states may underwrite them, charging more for beneficiaries with certain health conditions or denying coverage. ■

The average premium for individual Medigap insurance across all plan types—standardized and nonstandardized—was $129 per month in 2001. The average premium for plan F, the most common standardized plan option, was $122 per month; premiums for standardized plans that include outpatient prescription drug coverage ranged from $119 for plan H to $196 for plan J. Medigap premiums vary considerably by state.[12] Premiums also vary substantially according to the age of the beneficiary and the rating methodology used (see text box at left). For example, policies for older beneficiaries in attained-age rated policies may cost considerably more than policies that use issue-age or pure community rating.

Medicare Select plans

The Medicare Select program began as a demonstration in the early 1990s and was made permanent in 1998. Medicare Select policies are Medigap policies that cover more of the cost-sharing when beneficiaries use network providers. From the beneficiaries' point of view, a Medicare Select policy is exactly the same as a Medigap policy when they use a network provider, but coverage is not as complete as with a comparable Medigap plan when they use non-network providers. In exchange for giving up some coverage for non-network providers, the Select policies usually have lower premiums than comparable Medigap policies.[13] Insurers are able to offer these less-expensive products because providers agree to accept rates lower than Medicare's in order to participate in the network. Because Medicare continues to pay its share of the claims from Select members, the reductions really are in the form of waiving all or part of the beneficiary cost-sharing.

Current Medicare regulations, however, have allowed these cost-sharing reductions only for hospital services. The Office of Inspector General (OIG) of the

12 For further discussion of Medigap products and reasons behind the variation in premiums, see Appendix B in MedPAC's Report to the Congress: Assessing Medicare Benefits, June 2002.

13 GAO found that in 1999 the average annual premium for a Select plan was more than $200 lower than the average premiums for non-Select plans (General Accounting Office July 2001).

TABLE 5-2

Benefits, enrollment, and average premiums in standardized Medigap plans, 2001

Benefits, enrollment, and premiums	Standardized Medigap plan									
	A	B	C	D	E	F	G	H	I	J
Cost sharing										
Part A hospital coinsurance	●	●	●	●	●	●	●	●	●	●
365 additional hospital days	●	●	●	●	●	●	●	●	●	●
Part B coinsurance	●	●	●	●	●	●	●	●	●	●
Blood products	●	●	●	●	●	●	●	●	●	●
Part A deductible		●	●	●	●	●	●	●	●	●
Part B deductible			●			●				●
Skilled nursing facility copayments			●	●	●	●	●	●	●	●
Part B balance billing						●	●		●	●
Additional benefits										
Foreign travel			●	●	●	●	●	●	●	●
Home health care				●			●		●	●
Preventive medical care					●					●
Prescription drugs								●	●	●
Enrollment	11%	9%	23%	6%	3%	37%	3%	2%	3%	4%
Average monthly premium	$91	$102	$117	$114	$108	$122	$121	$119	$170	$196

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

Source: Medicare Payment Advisory Commission analysis of 2001 Medicare Supplemental Exhibits from the National Association of Insurance Commissioners.

Department of Health and Human Services (HHS) had ruled that Part B providers could not waive cost-sharing without violating anti-kickback rules. Studies of Medicare Select found that the program was limited because plans could not include physicians in their networks, which kept them from any real possibility of saving money through managing care (Lee et al. 1997). The OIG has now proposed regulations that would allow physicians and suppliers to waive Part B cost-sharing if they participate in a network. If physicians are willing to accept lower total Medicare payments to participate, then insurers might be able to pass along savings in the form of lower premiums. Network creation may also allow plans to pursue managed care objectives within their networks. In any event, if this regulatory change allows insurers to lower premiums on Select plans, they may become a more attractive option for beneficiaries.

Benefits and costs to beneficiaries in Medicare Select plans Select benefits are the same as Medigap benefits except that beneficiaries may be limited in their choice of providers. For the most part, the premiums are lower because the insurers get lower rates from network providers. More than one million Medicare beneficiaries are enrolled in Select plans.

Employer-sponsored retiree plans

The most common form of supplemental coverage is employer-sponsored insurance, which covers 33 percent of noninstitutionalized Medicare beneficiaries. Some of these beneficiaries have access to employer-sponsored coverage in their current jobs or through a spouse's employer, but the majority receive coverage as part of their retiree benefit packages. While some employers enroll their retirees in M+C or other managed care plans, most of the plans wrap around the Medicare benefit package.

While employer-sponsored insurance has been the largest source of supplemental coverage, it has been declining. Over the past decade, the proportion of employers offering retiree health coverage has declined, even during the strong economy of the late 1990s.

A nationally representative survey of public and private employers with 500 or more employees found that 23 percent offered health coverage to Medicare-eligible retirees in 2001, down from 40 percent in 1994 (Mercer 2002). The declines have accelerated in recent years: The percentage of firms with 200 or more workers offering coverage to retirees over age 65 declined by 10 percentage points between 1999 and 2001. The same survey found that the percentage of small firms

Federal programs that provide supplemental coverage to retirees

Three Federal programs provide supplemental coverage to retirees.

Department of Defense supplemental health benefits

The National Defense Authorization Act for Fiscal Year 2001 created the program TRICARE For Life (effective October 1, 2001) to wrap around Medicare benefits. TRICARE For Life provides supplemental coverage for military personnel and retirees enrolled in Medicare. Approximately 1.5 million people are eligible for this benefit. The 2001 National Defense Authorization Act also created a new prescription drug benefit that provides eligible Medicare beneficiaries with the same pharmacy benefit enjoyed by military personnel not eligible for Medicare. Medicare beneficiaries who meet the eligibility criteria are automatically enrolled in TRICARE and in the pharmacy benefit program, with no application process.

TRICARE covers virtually all of Medicare's cost-sharing requirements, including deductibles and coinsurance for inpatient and outpatient services. It provides unlimited coverage for inpatient hospitalizations and skilled nursing facility stays, with beneficiaries responsible for 20 to 25 percent coinsurance for stays beyond the normal Medicare-covered allowance. The program also offers a comprehensive prescription drug benefit that gives beneficiaries the option of obtaining prescription drugs at no cost from military treatment facilities or with only nominal copays from any pharmacy. In general, for most Medicare-covered services, Medicare will pay first and TRICARE will pay the beneficiaries' remaining out-of-pocket expenses. If beneficiaries have other sources of coverage, TRICARE pays after the other sources have paid. The program includes a $3,000 annual out-of-pocket limit (Politi 2002).

To be eligible for TRICARE, beneficiaries must pay the Medicare Part B premium but are not required to pay any additional premium. Eligible beneficiaries include uniformed service retirees (including retired guard and reservists) who served at least 20 years in the military, family members of uniformed service retirees (including widows/widowers), and certain former spouses of uniformed service retirees, if they were eligible for TRICARE before age 65.

Department of Veterans Affairs health benefits

In 2003, an estimated 3.3 million beneficiaries will be enrolled in the Department of Veterans Affairs (VA) health care system (Congressional Budget Office 2002). For individuals who qualify, the VA program provides generous benefits at little or no charge to the beneficiaries, including broad coverage of most inpatient and outpatient services; preventive care; and prescription drug coverage. The VA program has become increasingly popular in recent years, with more than 1 million new enrollees in the past 5 years. The growth has been fueled largely by elderly veterans seeking prescription drug coverage (Simmons 2002).

To receive health care from the VA system, veterans generally must be enrolled with the VA. (Though disabled veterans do not have to enroll, the VA encourages them to enroll formally to help the agency's planning and resource allocation process.) Veterans are enrolled subject to available appropriated funds, based on a priority system of eligibility categories, with veterans with service-connected disabilities rated 50 percent or higher accepted first. Veterans deemed unable to make copayments for their treatment are given higher priority than others who do not have service-connected disabilities and who agree to pay copayments. To qualify based on inability to defray the costs of their care, veterans must supply the VA with income and net worth information, which is compared to a financial threshold. Enrollment is reviewed each year. Those in the lowest priority group pay the Medicare hospital deductible for the first 90 days of care during any 365-day period, and one-half of the Medicare deductible for each additional 90 days of hospital care, as well as a $10 per day charge for each hospital day. This group is also responsible for copayments for most outpatient care.

Outpatient pharmacy services are provided free to eight categories of veterans (subject to available VA funds), based on service-connected disability and other special needs criteria; others pay a fixed copayment ($7 per prescription in 2002). For most priority groups, there is also an annual cap on copayments for drugs, including both prescription and over-the counter medications and supplies dispensed by a VA pharmacy ($840 in 2002); those in the lowest priority group who are responsible for copayments for other health services are not protected by the cap (Department of Veterans Affairs 2002).

The Federal Employees Health Benefits Program (FEHBP)

In addition to providing employment-based group insurance to active federal workers, FEHBP provides group

(continued next page)

Federal programs that provide supplemental coverage to retirees (continued)

insurance to federal retirees. About 31 percent of the 8.3 million people covered by FEHBP are retired, and 1.8 million (21 percent) are enrolled in Medicare (Quayle, 2003). FEHBP offers retirees a range of commercial health plans, including both national and local fee-for-service plans, preferred provider organizations, point-of-service plans, and managed care plans. The benefits included in the plans, when coordinated with Medicare FFS, are generally comparable to those offered by other large public- and private-sector employers—i.e., they generally fill in Medicare cost-sharing, plus offer some additional coverage for preventive care, routine physicals, and prescription drugs. ■

(those employing 3–199 workers) offering retiree health coverage fell from 9 percent in 2000 to 3 percent in 2001 (Henry J. Kaiser Family Foundation, Commonwealth, HRET 2002). Few, if any, employers have added health coverage for Medicare-eligible retirees (Mercer 2002).

These declines generally affect future, rather than current, retirees. In 2001, 5 percent of large employers had plans that covered only current retirees, or those hired before a certain year (Mercer 2002). Employers also have increased the number of years of service required to qualify for retiree health benefits (Watson Wyatt Worldwide, 2002). Most of the impact of this change has yet to be felt. It is not apparent in current coverage trends, but will appear gradually over time as today's workers, who have less-generous employer contributions or no retiree health benefits at all, begin to retire (General Accounting Office May 2001).

Not only has the number of firms offering coverage to their retirees declined, but those firms that offer coverage have been scaling back on drug benefits and increasing retirees' premium contributions. Among firms that offer retiree health benefits, 32 percent increased cost-sharing for prescription drugs, and 53 percent increased retirees' share of the premium between 1999 and 2001. About 36 percent of large employers have capped their contributions towards retiree coverage for either current or future retirees (Hewitt Associates, LLC 2001).[14]

Special attention is often paid to federal retiree health programs, but they are essentially employer-sponsored plans.[15] (See text box at left.)

Benefits and costs to beneficiaries in employer-sponsored retiree plans

The average premium paid for employer-sponsored health insurance by new retirees over age 65 was $79 per month in 2002, up 20 percent from 2001 (Henry J. Kaiser Family Foundation, Hewitt Associates 2002). About 20 percent of employers providing coverage do not require new retirees to pay a premium. Currently, benefits provided by employer-sponsored plans tend to be comprehensive. Almost all retiree plans (96 percent of those issued by large firms) provide some coverage for prescription drugs (Henry J. Kaiser Family Foundation, Hewitt Associates 2002). Further, about 90 percent of the plans that cover prescription drugs have no upper limit on that coverage. Although we do not have specific information on required cost-sharing for hospital or physician services, the average retiree with coverage has an out-of-pocket cap of $1,500 per year for all covered service (Henry J. Kaiser Family Foundation, Hewitt Associates 2002).

Medicaid

In 2000, about 11 percent of beneficiaries living in the community were enrolled in the federal/state Medicaid program which supplemented their Medicare coverage. Medicaid offers several levels of supplemental coverage to eligible low-income beneficiaries. In addition, some low-income individuals who do not meet all of the requirements for dual eligibility receive Medicaid coverage for part or all of their Medicare premiums or cost-sharing requirements.[16]

14 These caps were put in place to limit employers' future liability for retiree health insurance. Employers began setting caps in the early 1990s in response to the Financial Accounting Standards Board's approval of Financial Account Statement No. 106 in 1990. It required employers to report annually on their current and future retiree health benefit liabilities and include them on their balance sheets, beginning with fiscal years after December 15, 1992. The Governmental Accounting Standards Board Statement No. 34 makes a similar requirement for state and local governments, which is now being phased in.

15 Health benefits for retirees receiving care through the Indian Health Service (IHS) are an exception. For Native American and Alaska Native beneficiaries, the IHS is the primary payer. The IHS does not technically "supplement" Medicare; rather, it provides a wide range of health services, some of which are paid for by Medicare. About 60,000 Medicare beneficiaries were served by 47 IHS or tribal-operated hospitals in 2001. Since the passage of BIPA in 2000, Medicare reimburses IHS for services in hospitals and skilled nursing facilities, and also pays for services of physicians and nonphysician practitioners furnished in hospitals and ambulatory clinics. Noncovered services are provided by the IHS. Services may be provided through provider-based or freestanding tribal federally qualified health centers, hospitals, ambulatory care centers, or individual practitioners employed by the IHS. Native Americans and Alaska Natives using IHS health care may also be eligible for Medicaid benefits (Health Care Financing Administration April 10, 2001).

16 The Balanced Budget Act of 1997 (Public Law 105–33) allowed states to pay providers the lower of Medicare's cost-sharing requirements or the states' Medicaid rates, although providers are not permitted to charge beneficiaries the difference. In 1999, only 16 states reimbursed providers for the full amount of Medicare's cost-sharing requirements (Nemore 1999).

Medicaid benefits available to Medicare beneficiaries not eligible for full Medicaid benefits

Several mandatory Medicaid programs pay beneficiaries' Medicare premiums or cost-sharing requirements:

- **Qualified Medicare Beneficiary (QMB) program**. Under the QMB program, states pay Medicare's premiums, deductibles, and coinsurance for all beneficiaries whose income is at or below 100 percent of the federal poverty level and whose assets are at or below twice the Supplemental Security Income limit. In providing coverage for Medicare premiums or cost-sharing, QMB coverage resembles a Medigap plan C or plan F (covering most of Medicare's cost-sharing requirements without providing additional benefits).
- **Specified Low-Income Medicare Beneficiary (SLMB) program**. Under the SLMB program, states pay the Medicare Part B premium for beneficiaries with incomes between 100 percent and 120 percent of poverty.
- **The Qualifying Individuals-1 (QI-1) program.** Under the QI-1 program, states pay the Part B premium for beneficiaries with incomes between 120 and 135 percent of poverty. Because the QI-1 program's federal funding is limited, assistance is available on a first-come, first-served basis (General Accounting Office 1999).

Although Medicaid's premium and cost-sharing assistance programs are defined by federal law, states have discretion in how they implement these programs (Nemore 1999). ■

The benefit package for Medicare beneficiaries who are fully eligible to receive Medicaid (dual-eligible beneficiaries) is one of the most comprehensive of all Medicare supplemental options. The vast majority of dual-eligible beneficiaries do not pay premiums for Medicare or Medicaid, and any cost-sharing requirements are generally nominal (see text box above). In addition, dual-eligible beneficiaries generally receive a comprehensive prescription drug benefit through Medicaid.[17]

Despite the generosity of benefits available to dual-eligible beneficiaries, participation in Medicaid by eligible Medicare beneficiaries is low in most states. An estimated 24 percent of all noninstitutionalized beneficiaries are eligible for or enrolled in one of the Medicaid programs. However, fewer than half of those eligible to receive Medicaid assistance actually do (Laschober and Topoleski 1999).

Common explanations for the low participation rate include lack of knowledge of the programs, the stigma associated with Medicaid, and barriers to enrollment (such as a complex application process). Beneficiaries commonly believe that Medicaid is for only "poor people" and that applying could put their estates at risk (General Accounting Office 1999). Medicare beneficiaries who are eligible but not enrolled in Medicaid are more likely to be 80 years or older, married, and otherwise insured (through Medicare managed care or private supplemental insurance) than are enrolled beneficiaries (Laschober and Topoleski 1999). The way a state implements its Medicaid programs also affects participation rates. In 1999, more than half of states did not use a simplified enrollment application; more than three-quarters of states did not provide outreach materials in languages other than English; and about two-thirds of states did not make eligibility screening tools available to outside agencies, clinics, or senior centers (Nemore 1999). Other research has shown that enrollment in Medicaid is higher in states that have more generous Medicaid programs (Pezzin and Kasper 2002).[18]

In 1999, the proportion of Medicare beneficiaries classified as dual eligible varied by state, ranging from a high of almost 28 percent in Mississippi and Tennessee to less than 8 percent in Arizona, Idaho, and Utah (Ellwood and Quinn 2002). Compared with the rest of the eligible Medicare population, dual-eligible beneficiaries tend to be disproportionately female (63 percent versus 55 percent), over age 85 (18 percent versus 10 percent), and members of racial or ethnic minority groups (38 percent versus 14 percent) (CMS 2002).

Medicare beneficiaries and health plans in the marketplace

In this section, we describe constraints on Medicare beneficiaries' choices in the health insurance marketplace, and examine Medicare beneficiaries' actual choices and satisfaction. We then look at the health insurance marketplace from the perspective of the health plans that serve Medicare beneficiaries.

17 Some low-income beneficiaries who do not qualify for Medicaid receive assistance for the purchase of outpatient prescription drugs through Medicaid 1115 waivers. The programs can involve considerable cost-sharing.

18 The measures of state Medicaid program generosity were based on the percentage of state Medicaid long-term care expenditures allocated to home and community-based care (HCBC), and on Medicaid per capita expenditures per elderly enrollee on HCBC waiver programs designed to help beneficiaries remain in the community and avoid being institutionalized.

Medicare beneficiaries

When viewed at the national level, the health insurance market for Medicare beneficiaries appears to offer many choices, including whether to enroll in an M+C plan, or whether, or how, to supplement Medicare FFS. As we have discussed, however, the availability of options varies tremendously depending on each beneficiary's geographic location, work history, income, health care needs, and other factors. Beneficiaries may not be able to afford some of the health insurance coverage options available to them, especially the options with the broadest scope of benefits. Beneficiaries' coverage options are constrained not only by availability of the M+C plans described above but also by factors such as underwriting restrictions on Medigap policies for some beneficiaries, financial resources, and by what is available to them in employer-sponsored supplemental insurance programs. Beneficiaries' preferences and health care needs may also affect the extent to which they are willing to change providers or health plans, or are interested in considering options at all.

As noted above, statutory provisions allow for a 6-month period of open enrollment for all of the standardized Medigap options for beneficiaries entering the Medicare program at age 65, and (for a subset of plans) for beneficiaries affected by the withdrawal of M+C plans from their market area. Beneficiaries entitled to Medicare by reason of disability do not have this federal guaranteed access to Medigap until they reach age 65 and may therefore be denied coverage.[19] Beneficiaries who want to enter the Medigap market after the open enrollment period ends may be subject to underwriting based on age or health condition, depending on state law. Further, many states allow insurers to rate policies based on beneficiaries' ages. Some beneficiaries, particularly those who have existing health care problems or are older, may have only a small number of policies open to them and those policies may not be affordable.

For beneficiaries with employer- or union-sponsored retiree health insurance, choices among insurance alternatives may also be constrained. Employers may not offer Medicare managed care options. In 2002, about half of all large employers offered a Medicare managed care option (Henry J. Kaiser Family Foundation, Hewitt Associates 2002). Employers who do offer Medicare managed care may be able to take advantage of the supplemental benefits offered by the plans, lowering their own costs. This may lead some employers to require higher premiums for retiree benefits that supplement Medicare FFS, and lower premiums for managed care options. In fact, while many employers do not offer M+C options, those who do offer them play an important role in the M+C market. Unpublished CMS data from 2002 show that 18 percent of M+C enrollees were in employer or union-sponsored groups (Zarabozo 2003).

The ability to pay for insurance to supplement Medicare is clearly a limiting factor for some beneficiaries. Research has generally shown that the main reason people choose to join M+C plans is to obtain better benefits for less cost than they can get from Medicare plus private supplemental insurance (Gold 2000; Young and Mittler 2002). A survey of beneficiaries conducted in 2000 by Mathematica Policy Research, Inc. (MPR) showed that the majority of beneficiaries who had no supplemental insurance (Medicaid or private) reported that supplemental insurance was too expensive or that they could not afford it (Gold and Mittler 2001). Analyses reported in MedPAC's June 2002 report show that beneficiaries with incomes below 200 percent of poverty are more than twice as likely as higher-income beneficiaries to go without any form of supplemental insurance (MedPAC June 2002).

Beneficiaries' decisions about health plans and supplemental insurance also reflect their health care needs and preferences. Choice of a doctor, access to specialists, or a desire to stay with the same doctor may be particularly important to people with health care problems and long-standing relationships with particular providers. For many, coverage for services not covered by traditional Medicare—notably prescription drugs—is critically important. For some, particular details of plan offerings (e.g., provisions related to dental services, hearing aids or eyeglasses, or particular aspects of plan drug formularies) may be important.[20]

Finally, some research suggests that many Medicare beneficiaries are not highly motivated to make choices about their insurance coverage. MPR's 2000 survey of beneficiaries found that most beneficiaries (in both FFS and M+C plans) did not give serious thought to options for insurance coverage. Only 14 percent thought seriously about options or actually changed plans, and, of those, more than one-third were either new beneficiaries (who had to make a choice) or beneficiaries who switched from one M+C plan to another. Of those who did not consider options seriously, by far the most common reason offered (65 percent of respondents) was "I like what I have" (Gold et al. 2002). Other research suggests that retirees may be less likely than younger workers to make decisions about health insurance options based primarily on cost, in part because of concerns that retirees—especially those with health care problems—may have about changing doctors (Buchmueller 2000; Strombom et al. 2002).

19 Some states require guaranteed issue and/or community rating on some or all plans (requiring insurers to charge the same premium to all insured persons, regardless of age or health status) for disabled Medicare beneficiaries.

20 As plans have revised or scaled back additional benefits, the array of benefits, cost-sharing arrangements, and exclusions can become very complicated. According to one study that compared options for actual plans in two cities, "differing plan packages make it nearly impossible to compare plans on costs" (Dallek and Edwards 2001).

Insurance choices made by Medicare beneficiaries

Although Medicare beneficiaries' insurance choices have been shaped by a variety of constraints, the resulting system of multiple insurance coverage has, for the most part, provided supplemental coverage for most beneficiaries. MedPAC analysis shows that only 9.3 percent of Medicare beneficiaries living in the community had traditional FFS Medicare coverage only for most of the year in 2000.

Note, however, that figures on the types of supplemental insurance held by Medicare beneficiaries are based on survey data available only through the year 2000. Because some M+C plans have withdrawn and some employers have reduced retiree benefits, these estimates of coverage may not accurately reflect beneficiaries' current insurance coverage.[21] MedPAC's analysis of the 2000 Medicare Current Beneficiary Survey (MCBS) Cost and Use file shows that about one-third of all beneficiaries living in the community have employer-sponsored supplemental insurance, and nearly 30 percent of beneficiaries have purchased Medigap (Table 5-3).

Analysis of choices about health care options also suggests that Medicare beneficiaries are particularly interested in obtaining prescription drug coverage when it is available. CMS data show that when plans offer a choice in benefit design, most beneficiaries in those plans choose to pay the higher premium for the packages that include drug coverage (Zarabozo 2002).

TABLE 5-3

Sources of additional coverage by selected beneficiary characteristics, 2000

		Percent distribution					
	Percent of beneficiaries living in the community	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other	Medicare only
All beneficiaries	100.0%	32.0%	27.0%	11.6%	18.3%	1.8%	9.3%
Age							
Under 65	13.6	27.2	5.0	34.4	9.7	3.2	20.5
65–69	23.9	35.6	23.0	7.4	21.0	1.9	10.9
70–74	22.2	34.1	30.2	7.3	19.7	1.7	7.1
75–79	19.0	32.3	33.0	8.4	19.4	1.3	5.6
80–84	12.1	30.9	35.4	8.0	19.4	1.1	5.2
85+	9.2	25.4	38.1	10.2	17.2	1.8	7.3
Income status							
Below poverty	15.9	9.8	13.9	46.2	12.0	2.2	15.9
100 to 125% of poverty	10.3	15.3	23.6	22.6	19.8	3.1	15.0
125 to 200% of poverty	22.1	27.7	30.9	6.2	21.6	2.3	11.4
200 to 400% of poverty	33.0	42.5	28.4	1.1	20.5	1.5	5.9
Over 400% of poverty	18.4	46.6	32.9	0.6	15.0	0.8	4.1
Residence							
Urban	76.1	33.7	23.0	10.5	22.9	1.6	8.1
Rural	24.9	26.7	39.8	12.8	3.9	2.6	13.1

Note: Income status is defined in relationship to the poverty level in 2000 ($8,259 if living alone and $10,419 if living with a spouse). Urban includes beneficiaries in metropolitan statistical areas (MSAs). Rural includes beneficiaries living outside MSAs. Beneficiaries according to the type of coverage they held for at least six months of the year.

Source: MedPAC analysis of 2000 Medicare Current Beneficiary Survey, Cost and Use file.

21 A large share of the beneficiaries who no longer have Medicare managed care coverage probably now have Medigap plans. Data from 2000 suggest that Medigap enrollment is increasing as managed care enrollment declines. A 1999 survey found that 75 percent of beneficiaries who were involuntarily disenrolled from M+C plans, and did not join a different managed care plan, found a different source of supplemental coverage (Barents 1999). The benefits offered may not have been as rich as in their M+C plans, however, or the premiums may have been higher. If we assume that people disenrolled from the M+C market between 1999 and 2002 obtained supplemental coverage in the same proportions as the survey respondents reported, then the fraction of beneficiaries with no additional coverage has grown from 9 percent in 1999 to an estimated 11 percent in 2002. These are MedPAC estimates based on the distribution in 1998, the change in Medicare managed care enrollment between 1998 and 2002, and the survey results regarding the sources of supplemental coverage obtained by those who lost their M+C plan. Note that this estimate of uncovered beneficiaries may be conservative. One survey of beneficiaries conducted in 2000 found that 17 percent had no supplemental coverage at the time of the survey (Gold and Mittler 2001).

Medicare beneficiaries' satisfaction with their plan choices

Most Medicare beneficiaries report that they are satisfied with their health coverage. A survey of beneficiaries conducted in 2000 found that 61 percent of all beneficiaries in fee-for-service (with or without supplemental coverage) and 69 percent of beneficiaries enrolled in M+C plans rated the value of their current coverage as excellent or very good, and 86 percent of FFS and 90 percent of M+C beneficiaries would recommend their plans to a friend (Gold et al. 2001). Data from a 2002 insurance industry-sponsored survey indicated that 89 percent of respondents were satisfied or very satisfied with their Medigap coverage, and 76 percent said that, considering the premiums they were paying, their policies were a good or excellent value. According to this same survey, over 80 percent said they would recommend Medigap coverage to a friend or relative turning 65 and enrolling in Medicare (Young 2002).

CMS has devoted significant resources to the development of programs to monitor beneficiaries' experiences and satisfaction with Medicare options. The ongoing Consumer Assessment of Health Plans Survey (CAHPS) was first fielded in 1998 to obtain information from beneficiaries in M+C plans. CMS is now also fielding a version of CAHPS designed to obtain comparable information from beneficiaries in the traditional FFS Medicare program.[22]

Data from the M+C CAHPS have consistently shown that beneficiaries generally report high levels of satisfaction with their health plans and with the health care they receive. In 1999, across 69 MSAs for which data were analyzed, 79.7 percent of M+C enrollees gave their plans an overall rating of 8 or more out of a possible 10 (Lake and Rosenbach 2001). These scores, however, differed significantly across the geographic regions in the first three years of the survey[23] (Goldstein et al. 2001; Zaslavsky et al. 2000).

Comparing data from the FFS and M+C CAHPS raises conceptual and methodological issues. The FFS sample includes beneficiaries with various types of supplemental coverage, and those without any supplemental insurance. The M+C sample reflects the nature of the current M+C market—the beneficiaries who are included in the sample are those who have access to, and have chosen to enroll in, M+C plans. This means that there are some significant differences in the populations included in either the FFS or M+C samples across geographic areas. There are few (or no) M+C options in some areas, the FFS CAHPS sample includes people who might have, if given the opportunity, chosen to be in an M+C plan.

Despite these caveats, however, the CAHPS surveys do provide an important insight: A large proportion of all beneficiaries are quite satisfied with Medicare and with their own health insurance coverage. Unpublished data from both the M+C and Medicare FFS CAHPS and the disenrollment survey indicate in general there is a relatively high level of satisfaction with Medicare regardless of the plan model in which beneficiaries are enrolled. A large proportion of all beneficiaries rate their health care and Medicare a "10," on a scale of "10" on composite measures constructed by CMS. Beneficiaries in poorer health, however, give Medicare lower ratings overall (Bernard et al. 2003). The data also suggest that M+C beneficiaries with health problems may be less satisfied than beneficiaries enrolled in the traditional FFS Medicare program: The disparities between the satisfaction ratings of people in fair or poor health and the ratings of people in excellent or very good health were greater for those enrolled in M+C than for those enrolled in the traditional FFS Medicare program (Table 5-4). There are also differences across individual measures included in the composite ratings.[24]

Changes that Medicare beneficiaries would like to see in insurance offerings

Beneficiary and advocacy organizations' concerns about available insurance options can be divided into four categories: the adequacy and cost of benefits and coverage, the stability of plans and plan offerings, the complexity of the options available, and the equity in choices across markets.

- **Benefits and costs.** The single greatest concern among beneficiary advocates is coverage of prescription drugs. Major beneficiary organizations have called for the addition of prescription drug coverage to the basic Medicare package (AARP 2002). Some advocates also believe that the addition of a drug benefit under Medicare would help to stabilize the M+C market, because Medicare payments to plans for covered benefits would relieve the plans from at least some portion of the rapidly increasing costs of prescription drugs. More generally, advocates are concerned about increases in out-of-pocket costs incurred by beneficiaries, both for uncovered services and for premiums—

22 These surveys are very large, and can be used to compare enrollees' reports about their health plans and health care experiences at the plan level, as well as within and across states and metropolitan statistical areas. A survey of beneficiaries who disenroll from M+C plans is also conducted each year. In addition, information on beneficiaries' views about their health plans and insurance coverage is collected in the Medicare Current Beneficiary Survey.

23 The overall plan ratings have generally been higher in the Northeast and lower in the Pacific and Northwest regions (Goldstein et al. 2001).

24 Analyses supplied to MedPAC by CMS indicate that among the 42 states with managed care and DC, M+C enrollees gave higher percentages of positive responses than FFS beneficiaries for 2 of the 6 indicators: "Good Communication" and "Flu Shot." For two other indicators, "Care Quickly" and "Rate Health Care," neither group had a notably higher percentage of positive responses. Generally, FFS received higher percentages of positive responses than M+C for the "Needed Care" composite and "Rate Medicare" indicator (Bennett 2003).

TABLE 5-4

Consumer Assessment of Health Plans ratings of Medicare FFS and Medicare+Choice plans

	Percent of beneficiaries surveyed giving answer, by perceived health status	
	Excellent or very good	**Fair or poor**
Rate their health care a "10"		
Medicare FFS	54.4*	43.7
M+C	58.9*	44.2
Rate Medicare a "10"		
Medicare FFS	49.8	44.6*
M+C	49.9	36.5*

Note: FFS (fee-for service), M+C (Medicare+Choice)
* Statistically significant differences ($p < .05$) between Medicare FFS and M+C.

Source: Consumer Assessment of Health Plans Surveys from CMS, Bernard et al. 2002.

particularly for the higher premiums charged by M+C plans offering supplemental benefits.

- **Stability.** Beneficiaries have growing concerns about the stability of M+C options. Plan withdrawals over the past four years have caused frustration and anger among affected beneficiaries, and some beneficiaries are reportedly seeking alternative prescription drug coverage or reverting to Medigap coverage rather than enrolling in an M+C plan (Stuber et al. 2002; Young and Mittler 2002). Some advocates have proposed regulatory changes to promote greater stability, including requiring that plan/provider contracts last throughout the calendar year and be finalized prior to the open enrollment period, and requiring plans that wish to participate in M+C to commit to the program for a fixed period (e.g., three years) (Stuber et al. 2002).[25] Some advocates also believe that the instability of the M+C program militates against provisions that would restrict beneficiaries from switching among plans over the course of a year.[26]

- **Complexity.** Changes in M+C availability, benefits, and premium costs, and the introduction of new plan options such as private FFS plans, have made the choice of insurance options more complicated. Researchers as well as advocacy groups report that beneficiaries can find it extremely difficult to sort out their options (Young and Mittler 2002; Barents 1999; Stuber et al. 2002). Specific conditions and limits of prescription drug coverage offered by M+C plans can be especially complicated and difficult to summarize in ways that are useful to beneficiaries.[27] Some advocates have called for expanded education and outreach programs to help beneficiaries understand their choices (AARP 2002). Greater standardization of M+C products to make it easier for beneficiaries to compare plan benefits and costs has also been proposed. One major beneficiary organization supports the use of standard definitions for all services covered by plans (AARP 2002).

- **Equity.** The geographic variations in health care and insurance costs that underlie the Medicare FFS system affect the insurance choices available to Medicare beneficiaries (see MedPAC's March 2002 Report to Congress). There are significant geographic differences in the Medicare+Choice options available to beneficiaries, as well as large variations in the richness of supplemental offerings and the premiums charged for these options. These variations are intertwined with cost differences for Medigap policies. Advocates view the variations as inherently unfair and as a threat to the underlying principles of equity embodied in Medicare. Some advocates believe that some of the variations, or at least some of their negative effects in terms of equity, could be reduced through standardizing benefits and through risk-adjusting payments to reduce adverse selection (Dallek et al. 2002).

Health plans

For health plans and insurers, the Medicare market presents both opportunities and frustrations. Insurers seek a dynamic environment in which a broad range of private options can meet the needs of a diverse population and where there are opportunities for profit. Plans as well as Medigap insurers believe

25 The effect of requiring plans to make multiple-year commitments is a topic of debate. Some analysts believe that, rather than providing stability for beneficiaries, these provisions might deter plans from entering into contracts with Medicare.

26 The lock-in provisions that were partially implemented in 2002 were delayed until 2005 in legislative provisions included in the Public Health Security and Bioterrorism Response Act of 2002 (Public Law 107-188).

27 A 2002 report issued by the HHS Office of Inspector General found that "The information that HMOs provide to beneficiaries about certain elements of the drug benefit is inconsistent, incomplete, and misleading" (Department of Health and Human Services 2002).

that they can better serve beneficiaries if there is a "level playing field" where Medigap products can compete with other products, including M+C plans, that are currently subject to different regulations governing underwriting, guaranteed issue and renewal, community rating, and flexibility in benefit design.

Plans' perspective

From the industry's perspective, three basic problems impede the development of more successful Medicare markets: Medicare payment levels, administrative and regulatory requirements, and limits imposed by Medicare on health plans' ability to design and market new, "flexible" products.

Medicare payment levels Industry representatives maintain that inadequate funding is the biggest problem facing the M+C program. From their perspective, Medicare payments have to be sufficient to maintain their physician networks. In particular, plans believe that the statutory update amount, which has effectively limited plans to 2 percent increases, has failed to keep up with the increasing cost of providing Medicare and non-Medicare services. Payment updates to M+C plans in the past two years have been far lower than the increases in premiums for health plans in large employer-based markets (American Association of Health Plans [AAHP] 2002). One major industry group has called for Congress to change the payment system to one that pays Medicare plans the higher of 100 percent of local FFS costs or the current M+C rates[28] (Blue Cross and Blue Shield Association 2002).

Administrative and regulatory requirements imposed by Medicare Plan representatives believe that some of the data reporting and compliance requirements imposed by Medicare are excessively complicated and expensive, and divert funds from patient care. They also report that some of the instructions for complying with these requirements are unclear or contradictory. Plans, despite their appreciation of CMS's recent simplification efforts (see below), still have some concerns about the operation of the M+C risk-adjustment system (see Appendix A), which they believe is resource intensive and can, because of a need to correct errors, lead to delays in payments to plans (AAHP 2002).

Limits imposed by Medicare on plans' ability to offer "flexible" products Plans and insurers want to be able to market more varied insurance products, including products that look more like those available to the working insured population. The managed care industry has recommended expanding the range of choices for beneficiaries by making cost contracts a permanent part of Medicare and allowing M+C plans to vary benefits and premiums within segments of service areas (AAHP 2002). Other industry representatives have urged the Congress to develop options to increase participation of PPOs in M+C as a major policy objective (Health Insurance Association of America 2002). Some Medigap insurers would like to see the standard packages modernized, or have more flexibility in offering nonstandard packages. There is widespread agreement in the insurance industry that any major restructuring of the standardized benefit forms should, however, wait until the prescription drug issue and broad reform of Medicare benefits is settled.

CMS policy changes to encourage plan participation

CMS has already taken action to address perceived problems in M+C markets, in conjunction with a major project being directed by the Secretary of Health and Human Services' Advisory Committee on Regulatory Reform. Organizational changes at CMS, including the creation of a new Center for Beneficiary Choices, consolidate oversight responsibilities, which should improve communication with plans. CMS has also reduced the number of mandatory quality assessment activities that participating plans must conduct, and revised the processes for deeming plans to be in compliance with a variety of regulatory requirements.

The agency has also made significant changes designed to reduce the administrative burden associated with risk adjustment.[29] Data collection for risk adjustment across multiple sites of care began in October 2000, but M+C plans argued that CMS's requirements for collecting and submitting the data were too burdensome. In response, the Secretary suspended collection of data from ambulatory sites in May 2001 and directed CMS to investigate alternatives. CMS worked with M+C plans, trade organizations, and physicians to develop a multiple-site model to address plans' concerns. CMS announced a preliminary version of the model on March 29, 2002. Plans began to collect diagnosis data from physician office and hospital outpatient sources in July 2002 and began submitting the data in October 2002. CMS will announce the final version of the model by March 28, 2003, and will begin using the model on January 1, 2004.

As described earlier, CMS has also initiated a new demonstration program, focused on PPOs, to foster competition in the M+C program. Medicare's PPO demonstration could be attractive to insurers for several reasons:

- In some areas, the demonstration will pay more than the M+C payment rates. The demonstration will pay the maximum of the M+C rates or 99 percent of the per capita Medicare FFS spending in a county. Almost one-fourth of the beneficiaries who will have a PPO demo plan available live in counties where higher rates would be paid.

28 MedPAC has recommended that M+C rates be set equal to 100 percent of local FFS costs (MedPAC March 2002).

29 For 2004, CMS must begin using a risk adjustment system based on a model that uses data from hospital inpatient and ambulatory settings. Also, CMS is required to apply such a model to 30 percent of payments in 2004, and the agency must increase this percentage annually until it reaches 100 percent in 2007.

- Though M+C CCPs may not set premiums and cost-sharing for the basic benefit package above a cap actuarially set at the national average for all Medicare FFS beneficiaries, PPOs in the demonstration will not be limited by this cap. Benefit consultants have stated that lifting the cap will allow plans to compete with Medigap for those beneficiaries who are willing to buy a higher-priced product.
- The demonstration allows for negotiated risk-sharing between the plan and Medicare. Details of the risk-sharing arrangements have not been released, but apparently not all of the demonstration plans are availing themselves of the option.

When supply and demand meet in the marketplace

Medicare beneficiaries' demand for benefits beyond those found in the traditional FFS Medicare program has been filled by a broad spectrum of options, with varying degrees of success. Some options, such as M+C plans, primarily replace Medicare FFS while enhancing some benefits. Other options, such as Medigap, employer-sponsored supplemental, Medicaid, and VA programs, are designed only to supplement Medicare. Access to these various options depends on beneficiaries' circumstances and geographic locations.

The supply of health insurance options for Medicare beneficiaries is influenced by the overall health care marketplace. The stage of the underwriting cycle and insurance company circumstances influence the supply of plans and the premiums they charge. Also, the economic and regulatory environment influences employers' willingness to provide retiree benefits. Finally, the nature of local markets and the balance of power between plans and providers drive plan decisions to enter and remain in local markets. In this section, we look at the interplay of supply and demand in the marketplace.

Beneficiary demand

The demand for more comprehensive benefits is clear: In 2000 only 9 percent of beneficiaries in the community had just traditional FFS Medicare. But the market may be changing in the future. While employer-sponsored coverage was held by 32 percent of beneficiaries in 2000, many companies are cutting back on postretirement health coverage and eliminating it for new employees. Cost pressures will likely fuel the demand for less-expensive options for employers or options that retirees can afford on their own.

Despite the popularity of Medigap coverage—27 percent of beneficiaries had Medigap in 2000—it may be becoming less affordable for many beneficiaries, particularly when prescription drugs are part of the plan. Even those Medigap plans that include a drug benefit do not provide comprehensive drug coverage.

Medicaid provided additional coverage for 12 percent of beneficiaries living in the community in 2000. That coverage may change to some extent if state budgets come under increasing pressure. States have taken a variety of steps to limit Medicaid spending, including cutting back on prescription drug benefits, increasing cost sharing, and tightening eligibility criteria (Smith et al. 2003). A survey conducted by the National Conference of State Legislatures in late 2002 found that 16 states reported they would consider eligibility reductions for the elderly as a means of reducing their Medicaid costs in 2003 (Bureau of National Affairs 2002).

All of this potential increase in demand for more comprehensive benefits may represent an opportunity for M+C plans, other alternatives to FFS, and Medigap insurers. But those opportunities may be limited by marketplace realities.

Health plan willingness to supply coverage

Health plans will only enter the Medicare market under certain conditions. Medicare+Choice plans and other alternatives to Medicare FFS, for example, need payments that exceed their costs. If payments are set to equal those for FFS Medicare, then the other plans must lower their costs of care below those of Medicare by an amount sufficient to offset their administrative and marketing costs, plus their profits. They can do so by being more efficient (through utilization controls or disease management programs, for example), receiving discounts from providers, enrolling healthier beneficiaries, or using some combination of these actions. (If risk-adjusted payments are fully implemented and accurately capture the cost of caring for enrollees, then enrollee health status would not matter.) Alternatively, plans can enter areas where payments are set above FFS Medicare costs.

On the other hand, in the current environment M+C plans do not compete against only Medicare FFS. Instead, they compete against a combination of Medicare FFS and Medigap. To be successful, they have to deliver the same combined set of benefits for less. This challenge raises the possibility of not having to undercut Medicare FFS costs but being about equal to Medicare and less than Medigap for the additional benefits. In the past, M+C plans tried to keep premiums low or at zero because they did not think that beneficiaries were willing to pay a premium (or thought that those who were willing to do so were bad risks). Sometimes M+C plans left markets rather than adding premiums. Now that premiums for M+C have been increasing, it appears that some beneficiaries are willing to pay for their product and may be comparing M+C plans and the combination of FFS and Medigap more carefully than they may have in the past. For example, although plans in many markets have increased premiums, and decreased the value of

additional benefits offered in the last two years, enrollment in those plans has not decreased precipitously.

Plans that supplement the basic Medicare benefit package take their lead from FFS Medicare. Medigap and employer "wrap-around" plans usually depend on the Medicare programs' coverage decisions in order to determine coverage for cost sharing. The levels of cost sharing under FFS Medicare determine plan cost-sharing liability and thus the cost of the plans to beneficiaries. Also, the plans—including M+C plans that supplement the basic Medicare package—are greatly affected by regulations that determine how the supplements must interact with Medicare. This is especially true of regulations on plan marketing and rules on how the plans may integrate employer-sponsored contributions.

For network-based alternative plans, a major constraint on supply is the feasibility of putting together a network. In some areas of the country, particularly rural areas, it is very difficult to recruit providers because they are in a monopoly position and have no interest in dealing with managed care organizations. In the M+C program, this has resulted in very few MCOs entering rural areas. In California, for example, the overall penetration rate of HMOs is very high and the M+C penetration rate is 35 percent, but the participation rate in counties outside MSAs is only 1.1 percent (Gold and Lake 2002). The only M+C choices in many rural areas are non-network private FFS plans which so far have very limited membership. Network formation will also be crucial to success in expanding the Medicare Select program.

National marketplace dynamics

The Medicare alternative and supplement markets are only a small part of the larger health insurance marketplace. As such, they are not immune to larger-scale trends in the overall market. In recent years the M+C program has reflected some of those trends, including the underwriting cycle, the move to larger and looser networks with less utilization control, and provider pushback and the decline in full-capitation and other models of risk sharing with providers.

The underwriting cycle is a term often used by health policy analysts to describe the tendency of commercial insurance premiums to rise at a rate lower than cost increases when the market is profitable as insurers compete to increase market share, and then to rise at a higher rate as insurers try to repair profit margins and rid themselves of money-losing lines of business. This tendency has been reflected in the M+C market as plans used M+C to grow market share in the mid-1990s, in the anticipation of higher M+C profits, and then pulled back beginning in 1999 (Grossman et al. 2002).

In reaction to the anti-HMO backlash of the mid-1990s and changes in state laws, plans started to move to less-restrictive networks and less emphasis on utilization controls in commercial plans. This broadening of networks and lessening of controls moved into M+C plans as well, which further restricted plans' ability to manage underlying care and costs. In a competitive market, if costs and premiums rise in reaction to fewer restrictions, more restrictive plans may begin to once again look attractive, which may carry over into the M+C market as well.

Another larger-scale trend has been provider pushback against contract terms proposed by network plans. Providers in many markets have consolidated, increasing their market power and making it difficult to form desirable networks without them. They have also moved away from accepting risk from plans and moved to a more FFS-like relationship. In California, some plans relied heavily on the capitated risk model, and pushback from providers has caused turbulence and withdrawal from some markets (Gold and Lake 2002).

Taken together, these larger trends reveal a dynamic M+C marketplace in which plans enter and exit just as they do in other managed care markets. This entry and exit by health plans can cause instability for Medicare beneficiaries and concern among policymakers, but it is part of the reality of competition. The Medigap market has not been particularly volatile over the last few years, however. Instead, Medigap enrollment and premiums have grown modestly.

Importance of local markets

Whatever the national trends, local markets are where beneficiaries make their choices, where health care is delivered, and where insurance plans have to compete.

Beneficiaries' real choices are limited to what they perceive as acceptable and affordable. Conceptions of acceptable insurance products will vary along with beneficiary expectations in different areas of the country. For example, local employers' provision of health insurance will have an effect on their retirees' choices when they become eligible for Medicare. If a beneficiary was in an HMO when employed, belonging to an HMO as a Medicare beneficiary may be an obvious, and perhaps a preferable, choice. For a beneficiary with no experience with managed care and an attachment to a particular physician, an HMO may not be an obvious choice.

Beneficiaries' ability to afford different choices may also depend on their employment history, as well as on their income in retirement. If, for example, beneficiaries have an option that subsidizes their expenses, such as employer-sponsored wrap-around supplemental insurance or Medicaid, their demand for HMO options or Medigap may be lower than without such support. Affordability is a key determinant. In low-income areas, the demand for pricier products may be low, unless the premiums are subsidized by former employers.

Health care providers operate in local markets as well. They frequently draw customers from specific geographic areas and sociodemographic groups. At the same time, they may have existing relationships with other providers that

influence expected practice patterns. These relationships can also influence which insurance arrangements are considered acceptable in local markets. In some areas capitated contracts with insurance plans are much more routine than in others. Therefore, products that depend on capitation may only succeed in certain areas.

Health insurers are also sensitive to local market conditions because of the regulatory environment. Most insurance is regulated at the state level. Plans judge some states to be more conducive to certain forms of insurance than others. State rating rules may also greatly affect the competition between plan types. Because Medicaid differs by state, plans that interact with Medicaid also differ by state. At a more local level, plans react to beneficiary preferences and provider characteristics that differ by local area. For example, if there is a monopoly local provider of a service, such as a large local hospital, plans will be constrained in their contracts with that provider in ways they would not be if competing providers were available or not be able to contract at all. Plans also react to the presence of other plans. Some researchers have found that larger numbers of M+C plans competing is correlated with greater value for beneficiaries at the same cost to the program (Pizer and Frakt 2002).

To understand the choices available to Medicare beneficiaries, the individual features of local markets and how they relate to competition and market dynamics must be examined. MedPAC plans to draw on existing research on local health care markets and conduct some case studies of actual markets to comprehend the Medigap and supplemental marketplace. We hope to use the case studies to clarify what happens in markets, and then draw some conclusions about where particular kinds of choices might be made available to Medicare beneficiaries. We might also learn that M+C payment rates, Medigap rating rules, or state assistance programs may have unintended consequences for insurance competition in some areas. Designing a national program flexible enough to support different kinds of choices in different kinds of local markets will be difficult and raise issues of equity as well. Nevertheless, it will be necessary to address these difficulties if the goal is to foster increased choice for Medicare beneficiaries. ■

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