Seniors Face Difficulty Navigating Choices in Medicare Managed Care

Monitoring of Medicare+Choice

SUMMARY

In 1997, Congress approved the Medicare+Choice program, which sought to contain costs and expand seniors’ health plan choices by increasing access to managed care plans.

From February 1999 to August 2004, researchers from Mathematica Policy Research, Washington, assessed the implementation of Medicare+Choice (renamed Medicare Advantage in 2003), chiefly focusing on:

- How beneficiaries navigated among the expanded offerings and made informed decisions.
- Trends in plan availability and Medicare payments to the plans.

Key Findings

- Contrary to its goals, Medicare+Choice did not result in a substantially more varied mix of health plan types.
- Traditional Medicare managed care plans (i.e., HMOs) continue to remain an option primarily for urban Medicare beneficiaries.
- Over Medicare+Choice's history, premiums for participating plans increased while enrollees saw a drop in benefits, including less coverage for outpatient prescription drugs.
- The diversity of Medicare beneficiaries makes it difficult to promote informed choice.
- The vast majority of beneficiaries do not consider their choices on an annual basis, if at all.
**Conclusions**

The research team reported the following conclusion in its report *Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage*:

- Medicare+Choice is widely viewed as a failure, with plans leaving the program and fewer, less attractive choices available for beneficiaries.

**Funding**

The Robert Wood Johnson Foundation (RWJF) supported the project with two unsolicited grants totaling $2,380,887 between February 1999 and August 2004.

**THE PROBLEM**

Medicare began as a traditional fee-for-service health insurance program for the elderly and some disabled individuals. Over time, however, it has evolved to allow beneficiaries greater choice in their health benefits, including access to a variety of private managed care plans.

In 1997, Congress approved Medicare+Choice, which sought to control the government's health care spending and give seniors a greater choice of managed care plans. Medicare+Choice broadened the eligibility requirements for participating plans beyond health maintenance organizations (HMOs) to include a variety of other managed care plans, including preferred provider organizations (PPOs) and provider-sponsored organizations (PSOs). The act also authorized private fee-for-service plans.

Medicare serves a particularly vulnerable subgroup of Americans—many have physical and cognitive disorders, and others do not read English well. Although the law provided for a campaign to educate seniors on their new choices, there was concern about how well Medicare beneficiaries would be able to navigate among the expanded offerings and make informed decisions.

Mathematica Policy Research is a for-profit, employee-owned research firm experienced in analyzing public programs, including Medicare. In November 1998, a Mathematica team led by Marsha Gold, ScD, a senior fellow in the firm's Washington office, also began a study of Medicare+Choice premiums and benefits for the Commonwealth Fund of New York.
CONTEXT

RWJF shared the concern about how beneficiaries would fare in a more complex, market-based system. Although Medicare itself is not a designated grantmaking priority for RWJF, the Mathematica study directly affects two of its main goals: (1) ensuring that all Americans have access to quality health care at reasonable cost and (2) improving care and support for people with chronic conditions.

In 1998, RWJF funded the establishment of the Center for Medicare Education as a resource for public agencies and private organizations that provide consumer education about Medicare and its health plan options (ID#s 033093, 037817; see Program Results Report ID# 036397). RWJF staff viewed a study of the new Medicare+Choice system as complementary to the center's work. (For additional information on RWJF funding of projects related to Medicare+Choice, see Program Results Report on ID#s 035149, 031002, 046416, 035292, 031900, 032659 and 037564.)

THE PROJECT

Under the first grant (ID# 035068), Mathematica Policy Research monitored the implementation and impact of Medicare+Choice and disseminated the results to policymakers and other interested audiences. The project team planned to focus on how Medicare beneficiaries—especially vulnerable ones—responded to the new options.

To carry out the project, Gold and her team:

- Monitored information on Medicare+Choice and its implementation.
- Surveyed approximately 6,500 active Medicare beneficiaries by telephone in March 2000. The team drew the study sample from a beneficiary list provided by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program. It included about 2,000 beneficiaries from a national sample and about 750 beneficiaries from each of six urban communities selected for detailed study: Albuquerque, N.M.; Baltimore; Detroit; New Orleans; Orange County, Calif.; and Orlando, Fla.
- Conducted site visits in 2000 to these six communities to determine how local organizations that advise Medicare beneficiaries viewed the impact of Medicare+Choice. During these site visits, project team members interviewed representatives of insurance counseling services, government agencies responsible for elder affairs, managed care plans, large employers, labor unions, advocacy groups for seniors, health care providers and consumer groups. Project team members also conducted follow-up telephone interviews with these individuals in 2001.

An expert panel organized by Mathematica provided advice on research issues and procedures. (For a list of members, see Appendix 1.)
Changes in the Initial Project Plan

The project departed in several ways from the plan RWJF initially approved. The most important change resulted from an unexpected development: although Medicare+Choice had been expected to increase enrollment in managed care, numerous plans withdrew from the Medicare market or reduced their benefits, in part due to limits on payments to the plans from the Medicare program. These withdrawals forced many enrollees to find a new managed care plan or return to traditional Medicare. In response, the project team refocused its study to examine the implications of plan withdrawals from the Medicare+Choice program.

Mathematica also dropped a planned analysis of the enrollment and disenrollment experience of health plans in the six study communities because of the anticipated challenges in getting access to CMS data needed to support this work.

The Follow-Up Grant

Under the second grant (ID# 043005), Mathematica added several new foci to its Medicare+Choice monitoring project to account for two trends in the Medicare market:

- With the withdrawal of plans from the program, beneficiaries were left with more limited choices.
- In addition, many beneficiaries reported confusion and uncertainty about how to proceed when their health plans ended participation in Medicare.

In response, the project team:

- Used public CMS data files to track health plan participation.
- Used data from the National Association of Insurance Commissioners to analyze trends in the Medigap insurance market. (Medigap is a private insurance product that provides additional reimbursement on services covered by Medicare and offers reimbursement for some services the program does not cover. It includes 10 standardized plans—Plan A through Plan J—with Plan A offering the least amount of benefits and J offering the most.)
- Conducted 25 interviews with insurance counselors from state health insurance plans, staffs at Area Agencies on Aging, state aging and insurance officials and health plan officials in the six communities visited earlier.

In 2003, Congress passed the Medicare Modernization Act, which included changes in payment rates to participating Medicare+Choice plans and renamed the program Medicare Advantage. In the last year of this project, the researchers turned their attention to monitoring the impact of new regulations on the Medicare Advantage market.
FINDINGS

The research team reported the following findings in articles in peer reviewed journals, as well as issue papers produced under the grant (see the Bibliography for more details):

- **Contrary to its goals, Medicare+Choice did not result in a substantially more varied mix of health plan types.** The number of health plans with Medicare+Choice contracts decreased from 407 in 1999 to 285 in 2003. During the same period, the number of enrollees in Medicare+Choice dropped from more than 7 million to fewer than 5.5 million. By mid-2003, HMOs still dominated the program, with only five preferred provider organizations (PPOs) and three provider-sponsored organizations (PSOs) participating. Aside from a preferred provider organization demonstration project sponsored by the program, managed care options remained largely the same as they had been before the creation of Medicare+Choice. A few private fee-for-service plans also had entered the program.

- **Traditional Medicare managed care plans (i.e., HMOs) continue to remain an option primarily for urban Medicare beneficiaries.** In urban areas, the share of beneficiaries with a choice of any form of private plan remained at around 86 percent over the period from 1999 to the beginning of 2004. In rural areas, 25 percent of beneficiaries had such a choice in 1999, but this dropped to 15 percent at the beginning of 2004. Private fee-for-service plans were available in many rural areas, however, since they do not require a provider network or a local presence. The fee-for-service option raised the share of rural beneficiaries with a choice of any private plan from a low of 21 percent in 2000 to a high of 62 percent in 2003.

- **Over Medicare+Choice’s history, premiums for participating plans increased while enrollees saw a drop in benefits, including less coverage for outpatient prescription drugs.** The average monthly premium increased from $6 in 1999 to $37 in 2003. During the same period, the percentage of enrollees with any drug coverage dropped from 84 percent to 69 percent, and the estimated annual average out-of-pocket spending increased from $976 to $1,694.

- **The diversity of Medicare beneficiaries makes it difficult to promote informed choice.** Many seniors contend with financial and information barriers that limit their ability to consider coverage options and make choices that are beneficial to them. Most beneficiaries do not understand the basics of the Medicare program and Medicare+Choice, according to local contacts interviewed in the six study communities.

- **The vast majority of beneficiaries do not consider their choices on an annual basis, if at all.** In 2000, only 15 percent of the beneficiaries thought seriously about their choices in the previous six months—which included the fall 1999 open-enrollment period—and fewer than 5 percent changed their coverage.

- **When beneficiaries do switch plans, they typically do so because they wish to improve benefits and lower premiums, because their plan has withdrawn from**
their area or because they have moved to another area. Among beneficiaries who want to switch but cannot, the most common reason is that they cannot afford the change.

- In 2003, shrinking prescription drug coverage drove the coverage choices made by Medicare beneficiaries. In addition to looking at Medicare+Choice plans, beneficiaries also investigated Medigap plans, state pharmaceutical assistance programs, Medicaid and private assistance to meet their needs.

- Beneficiaries tend to rely on informal sources of information—family members, friends and personal physicians—to help them make choices. Although the National Medicare Education Program emphasizes counseling by local organizations, these groups reach few beneficiaries. Material provided directly by Medicare is an important source of information for new beneficiaries.

- Reaching all Medicare beneficiaries will require diverse information strategies, including greater availability of one-on-one counseling from informed sources that are independent and have no stake in any particular plan selection. There are differences in how different groups of beneficiaries seek information and go about the decision-making process. Differences also exist from community to community in the way beneficiaries obtain information. Increased contact between information intermediaries and organizations representing ethnic, disabled and other distinct groups would help.

- In 2004, payment rate increases to plans implemented under the Medicare Modernization Act translated into slightly more generous benefit packages and cautious optimism among health plans for the future of the program.

- Growth in the Medigap market is largely in the basic benefit plans. Between 1999 and 2001, enrollment in Plan A (the basic benefit plan) increased as much as enrollment in the other nine Medigap plan types put together.

CONCLUSIONS

The research team reported the following conclusion in its report Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage:

- Medicare+Choice is widely viewed as a failure, with plans leaving the program and fewer, less attractive choices available for beneficiaries. It is unclear whether Congress will succeed where it has failed before in pursuing the changes in private plan participation called for under the Medicare Modernization Act. History suggests, however, that failure is inevitable unless:

  — participating health plans view Medicare as a reliable business partner.
— beneficiaries receive better information about the program through health plans that are well financed and focused on their needs.

— legislators, administrators, health plans and beneficiaries form realistic expectations about how much change to expect as a result of the Medicare Modernization Act.

Communications

The project team disseminated its research findings and analyses in several forms, including:

- Seven reports, including the comprehensive *Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage*.

- A monthly e-mailed newsletter, the *Medicare Advantage Monthly Monitoring Report*, which summarized Medicare+Choice developments compiled from various government and private sources.

- Thirteen *Operational Insights*, short publications that examined different aspects of Medicare+Choice and related market developments, drawing on results of the telephone survey, community studies, and tracking activities.


- A profile of each of the six studied communities, summarized demographic characteristics of the local beneficiary population, local health-plan options and how seniors were dealing with Medicare+Choice.

- Journal articles in *Health Affairs* and *Harvard Health Policy Review*.

- Presentations at a number of professional meetings and conferences.

- A website that includes the *Operational Insights* and *Fast Facts* series, the community profiles and some reports.

The project team hired the Stein Group of Washington to edit, design and print the publications. Staff at Mathematica distributed the publications through a mailing list that included Medicare administrators, advocates, educators, policy-makers, researchers and the media. They also distributed the publications at conferences, reaching between 1,200 and 2,500 people. (See the Bibliography for details.)

The project received media coverage—much of it in connection with the decreasing number of Medicare+Choice plans—in numerous articles in health care industry publications and general interest newspapers, including the *Washington Post, New York Times* and *Detroit News*. The PBS television program *Health Week* interviewed Gold in October 2001.
LESSONS LEARNED

1. **By using a variety of communications methods, a project team can disseminate its research findings to a broader audience of interested individuals.** This project had high visibility, including substantial attention from the news media. In large part, that was the result of a dissemination strategy that went beyond producing academic journal articles. (Project Director)

2. **Combining qualitative and quantitative data adds coherence to research findings.** The six site visits and follow-up telephone interviews gave the project team insights into local insurance markets and beneficiaries' experience that could not be learned from a telephone survey. (Project Director)

3. **Building flexibility into a project allows researchers to respond to changing dynamics of the program under study.** This project team altered a number of its plans and products in order to accommodate changes in the Medicare+Choice market. (Project Director, RWJF Program Officer)

4. **Outside researchers seeking confidential Medicare data from CMS should be prepared to make a strong case for the project and its importance.** CMS personnel have many demands, and obtaining information from them is not an easy process. Demonstrating why the results of the proposed research will be beneficial to the field, including CMS, will lessen the difficulty. Developing personal relationships is also helpful. (Project Director)

AFTERWARD

Mathematica requested funding for a follow-up project that would include a second survey of beneficiaries. RWJF rejected the proposed survey because it did not fit under any of its new priority areas, but awarded the firm a two-year, $386,203 contract to continue monitoring Medicare+Choice. With this funding, which ran through November 2003, Mathematica continued to produce the *Monthly Tracking Report* and issues of *Operational Insights* and *Fast Facts*. It also kept up with developments in the six study communities and studied trends in the market for supplemental Medigap policies.

Mathematica also continued its study of Medicare+Choice benefits and premiums for the Commonwealth Fund and did related work for the Henry J. Kaiser Family Foundation and AARP Public Policy Institute.

---

**Prepared by:** Michael H. Brown and Robert Crum  
**Reviewed by:** Robert Narus, Marian Bass and Richard Camer  
**Program Officer:** David C. Colby  
**Grant ID #:** 35068, 43005  
**Program area:** Enterprise Level
APPENDIX 1

Expert Panel

(Current as of the end date of the program; provided by the program’s management; not verified by RWJF.)

Randy Brown
Senior Fellow
Mathematica Policy Research, Inc.
Princeton, N.J.

Kathy Claunch
Program Director
Senior Health Insurance Program
Illinois Department of Insurance
Springfield, Ill.

Geri Dallek
Project Director
Institute for Health Care Research and Policy
Washington, D.C.

Joyce Dubow
Senior Analyst
Legislative and Public Policy Division
AARP
Washington, D.C.

Susan Edgman-Levitan
President
Picker Institute
Boston, Mass.

Liz Goldstein
Center for Beneficiary Services
Centers for Medicare & Medicaid Services
Baltimore, Md.

Judith Hibbard
Professor
Department of Planning, Public Policy and Management
University of Oregon
Eugene, Ore.

Harold Luft
Director
Institute of Health Policy Studies
University of California, San Francisco
San Francisco, Calif.

Jeanne McGee
McGee & Evers Consulting, Inc.
Vancouver, Wash.

Shoshanna Sofaer
Schering Plough Professor of Health Policy
Baruch College
New York, N.Y.

Roger Taylor
Senior Strategist
RAND
Santa Monica, Calif.
APPENDIX 2

Glossary

Health Maintenance Organizations (HMOs) require enrollees to obtain services from a designated network of doctors, hospitals and other health care providers who have agreed to serve plan enrollees. The plan serves a limited geographical area, and enrollees must live in the service area to enroll. Enrollees who receive unauthorized care outside the plan network must pay for it themselves.

Preferred Provider Organizations (PPOs) require enrollees to obtain services from a network of health care providers who have agreed to serve the plan enrollees. Unlike an HMO, enrollees are not locked in to receiving services only from the network providers. Enrollees can choose to go to Medicare providers outside the network for services, and the plan will make a payment. Costs will be greater outside the plan network.

Provider-Sponsored Organizations (PSOs) work much like HMOs. However, this type of organization is formed by a group of hospitals and doctors who directly take on the financial risk of providing care, rather than being backed by an insurance company.
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Articles


Reports


**Survey Instruments**


**Data Tapes**


**Grantee Websites**

Presentations and Testimony