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**Early Effects of the Medicare Modernization Act:
Benefits, Cost Sharing, and Premiums of
Medicare Advantage Plans, 2005**

by
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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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FOREWORD

The Medicare Prescription Drug, Improvement and Modernization Act (MMA), enacted by Congress in December 2003, made several significant changes to the Medicare program, most notably, the expansion of the Medicare benefit package to include coverage for outpatient prescription drugs. Other changes applicable specifically to the Medicare+Choice program (which the legislation renamed “Medicare Advantage” [MA]) affected plan payments: (1) As of March 2005, an additional payment option assures plans a payment of no less than 100 percent of a county’s per capita fee-for-service spending; and 2) The minimum increase was set at the greater of 2 percent or the national per capita growth rate of Medicare spending for MA plans and the traditional program. (The minimum update for 2004 was 6.3 percent that reflected increases in payments to fee-for-service providers under the MMA.¹ For 2006, the update will be 4.8 percent.²)

These changes can be expected to have a long-lasting impact on Medicare spending. In 2005, on average, MA plans receive about 8 percent more than Medicare would have spent for the same beneficiary in the traditional fee-for-service program.³ The payment disparity was exacerbated by CMS’ decision to implement risk adjustment in a budget neutral manner; budget neutrality added 2.3 percent in 2004 and 4.0 percent in 2005 to plan payments. Risk adjustment will again be budget neutral in 2006. Some experts question whether the favorable treatment of MA plans will undermine the fee-for-service Medicare program.⁴ Moreover, they fear the changes “will (ensure) the persistence of inflated benchmarks against which (MA) plans will bid” starting in 2006.⁵

Enrollment in private health plans is currently relatively small; only 12 percent of Medicare beneficiaries were enrolled in MA plans as of February 2005. However, as demonstrated by the incentives included in the MMA to induce private plans to enter and remain in the Medicare program, Congress signaled its interest in expanding private plan enrollment. Findings from this study examining the 2005 MA benefits and premiums indicate that MA plans responded to the new payment option by enhancing certain benefits (e.g., prescription drug coverage) and reducing beneficiary cost sharing. Enrollment is up

¹ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2004, page 210.

² Centers for Medicare and Medicaid, “Announcement of Calendar Year 2006 Medicare Advantage Payment Rates, accessed on April 18, 2005 at <http://www.cms.hhs.gov/healthplans/rates/2006/cover.asp>

³ Brian Biles, Hersch, L.N., Cooper, B. S., “The Cost of Privatization: Extra Payments to Medicare Advantage Plans, Update Tables for 2005 to May 2004 report, The Commonwealth Fund.

⁴ Robert Berenson, “Medicare Disadvantaged And The Search For The Elusive “Level Playing Field,” *Health Affairs*, W4-572-585, 15 December 2004.

⁵ Robert Berenson, “Medicare Disadvantaged And The Search For The Elusive “Level Playing Field,” *Health Affairs*, W4-574, 15 December 2004.

slightly, and more health plans are participating in Medicare. The new payment provisions also have apparently stimulated health plan interest in Medicare. The Centers for Medicare and Medicaid Services reports that it has received applications for more than 140 new local MA plans in 2005; if these are approved, beneficiaries in 39 states will have access to an MA plan.⁶

AARP commissioned this research to continue work that Mathematica Policy Research, Inc., has conducted since the inception of the Medicare+Choice program in 1997. As demands on the Medicare program continue to increase (e.g., resulting from the cost of new technology, increased enrollment as baby boomers become entitled to Medicare, etc.), it is important for policymakers, researchers, and other analysts to be able to identify benefit and premium trends in the MA program to determine how private plans use Medicare funds. Findings from this study can be used to assess whether current policies make the best use of Medicare resources; what effect expenditures for MA payments have on Part B premiums and the Hospital Insurance Trust Fund; and how different incentives affect enrollees' Medicare coverage choices. Going forward, it will be necessary to monitor Medicare's expenditures for MA plans by analyzing the consequences of the MMA payment policies that created the "un-level playing field" between MA plans and the traditional Medicare program.

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⁶ CMS press releases and fact sheets (HHS_CMS_Press@List.NIH.gov), February 18, 2005.

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Executive Summary

Background

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 changed the playing field for private plans participating in the Medicare program by substantially raising monthly payment rates in 2004 and 2005 in an effort to stabilize the market and reverse the decline in benefit generosity. In 2004, Medicare Advantage (MA) plans generally used the new funds to reduce premiums and restore brand-name drug coverage (Achman and Gold 2004a).

Purpose

This Issue Paper examines how MA plans have continued to respond to the increased MMA funding in terms of benefit design and beneficiary cost-sharing requirements through 2005. Additionally, it reviews the different types of MA plans available to Medicare beneficiaries and how they vary in terms of benefit generosity.

Methods

This analysis of plan benefits and premiums relies on a database that Mathematica Policy Research developed using MA health plan data from the Medicare Personal Plan Finder, a consumer-oriented database of plan benefit packages maintained by the Centers for Medicare and Medicaid Services (CMS). MA enrollee out-of-pocket spending by plan benefit package is estimated using methodology developed by HealthMetrix, Inc.

Findings

Key findings include the following:

1. Although health maintenance organizations (HMOs) still dominate the MA market, new types of health plans—particularly private fee-for-service (PFFS) and preferred provider organization (PPO) plans—have emerged in the last few years. These plans offer beneficiaries broader access to providers than do traditional HMOs, although generally at a higher cost.
2. Average monthly premiums in MA plans declined from \$25 to \$22 between 2004 and 2005; however, premium levels in 2005 are still substantially higher than they were in 1999. As in previous years, premiums for HMO benefit packages are typically lower than for benefit packages offered by PPO or PFFS plans.
3. In 2005, the share of MA enrollees with any drug coverage rose to 74 percent (from 71 percent in 2004), and the share with brand-name drug coverage rose to 36 percent (from 33 percent in 2004) as MA plans continued to use a portion of their extra payments to enhance plan benefits. HMOs are still more likely to offer prescription drug coverage than is any other type of MA plan.

4. In general, from a beneficiary's perspective, MA coverage of Medicare's cost-sharing requirements for physician and hospital services improved between 2004 and 2005. In 2005, more enrollees have no cost-sharing requirements for hospital admissions and outpatient visits, and fewer enrollees pay co-payments that exceed \$15 for visits to primary care physicians or specialists. Additionally, coverage increased for supplemental benefits, such as preventive dental services and vision benefits.

5. In 2005, MA enrollee out-of-pocket spending reverted to 2003 levels. Although enrollees in good health still pay significantly less out of pocket on average than do those in poor health, the gap between the two groups narrowed from previous years.

6. Taken together, the immediate payment increases for 2004 and 2005 instituted by the MMA seem to have accomplished the goal of providing much-needed stability to the MA market. However, this stability comes with a price tag; in 2005, the average MA plan is estimated to receive 7.8 percent more than average fee-for-service costs in a county. Thus, Medicare is paying more for MA enrollees than it would have paid if these same enrollees had stayed in fee-for-service Medicare (Biles, Nicholas, and Cooper 2004). For 2005, estimates put MA payments above fee-for-service costs at \$2.7 billion nationwide.

7. The options available for individual beneficiaries vary significantly by where they live. For example, urban areas still offer Medicare beneficiaries more private plan options. Additionally, within an area there may be significant differences in the benefit packages available to beneficiaries. To show the extreme differences in benefit packages offered in different parts of the country, we selected two local markets to examine in more depth to see how the choices of different plan types play out at the beneficiary level. In Pinellas County in western Florida, the market is mature and offers beneficiaries many coordinated care options. In stark contrast is Milwaukee County in Wisconsin, where there are only two MA plans offered, one HMO and one PFFS plan.

Conclusions

These findings are signs that the Medicare Advantage program is beginning to reverse its course from the premium increases and benefit reductions that marked the period 2000–2003. This, combined with a significant number of new MA plan entries into the program over the past two years, indicates that the 2004 and 2005 MA plan payment increases have accomplished the goal of providing much-needed stability to MA markets, at least in the short term. However, all health plans now receive payments that are higher than the average fee-for-service costs in the counties they serve. Future research will be needed to determine whether these trends continue into 2006, when CMS rolls out additional MMA provisions, including a new MA payment approach and a voluntary prescription drug benefit.

INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 changed the playing field for private plans in Medicare (see Appendix A for a brief review of the history of private plans in Medicare). Among many other changes, the MMA substantially raised the monthly payment rates to Medicare Advantage (MA) (formerly Medicare+Choice) plans in 2004 and 2005, hoping to stabilize the market and reverse the decline in benefit generosity. This was particularly important because the MMA envisions an expanded role for private plans in 2006, when the prescription drug benefit is introduced. Private plans will be the primary providers of the prescription drug benefit through stand-alone Prescription Drug Plans (PDPs) and through an expanded set of MA offerings (called MA-PD plans) that may include, for the first time, regional PPO offerings designed to span the nation and provide individuals in all parts of the country with a choice of managed care and other private health plans. This Issue Paper looks at how health plans have continued to respond to the increased funding the MMA provides in terms of monthly premiums and benefit generosity. In addition, this study examines the different types of health plans available to Medicare beneficiaries and how they vary in terms of benefit generosity.

BACKGROUND

Historically, Medicare beneficiaries have been drawn to private managed care plans when they perceive that these plans offer a competitive benefit package at a good price (Gold et al. 2001).⁸ For the most part, plans offered in the Medicare program have required beneficiaries to limit their choice of providers to those affiliated with the plan (for example, in traditional HMO products).

When the Medicare managed care program was growing rapidly in the mid-1990s, supplemental premiums for private plans were relatively low and benefits were comprehensive relative to the fee-for-service Medicare program, covering much of Medicare's cost-sharing liabilities and providing some additional benefits that Medicare did not cover (prescription drugs and dental, vision, and hearing services). These benefits have eroded and premiums have increased since the 1997 passage of the Balanced Budget Act (BBA). The BBA introduced changes that reduced growth in the capitation rates paid to private plans in most markets, both indirectly, through the effects on lowered Medicare fee-for-service (FFS) spending and directly, through changes in the methods used to determine private plan capitation rates. From a plan perspective, this slowdown in payments was particularly unfortunate as it occurred at the same time as rising medical costs and increased pressure from participating providers for higher payments, so maintaining stable provider networks and attractive products became more difficult.

⁸ The "traditional" Medicare program pays for health care services rendered on a fee-for-service basis. In contrast, with the exception of private fee-for-service plans (that are MA plans), privately operated health plans that participate in the Medicare Advantage program, such as health maintenance organizations (HMOs) and other coordinated care plans, deliver health care services through limited networks of providers. These health plans receive a monthly capitated rate for all Medicare Part A and Part B services.

In response, from 1999 to 2003, large numbers of plans departed the Medicare program or reduced their service areas to lower their financial risk (Draper, Gold, and McCoy 2002). Many of the private health plans that stayed modified their benefit packages. Average monthly premiums increased from \$13 to \$40 (Achman and Gold 2003). Outpatient prescription drug coverage simultaneously declined from 84 percent of MA enrollees in 1999 to 66 percent in 2003 (Achman and Gold 2003). Furthermore, while nearly all enrollees with drug benefits in 1999 had brand-name drug coverage, by 2003, just 41 percent of enrollees had such coverage (Achman and Gold 2003).

When MA plans initially announced their benefit packages for 2004, it appeared that benefit generosity was going to decline again (Achman and Gold 2004a). However, the MMA mandated increased payments to MA plans. Among other changes to the payment rate structure, by March 2004, no MA plan would receive less than the average expenditures in fee-for-service Medicare in the county in which it operated. This was a significant change in policy, since Medicare managed care plans were originally intended as a means to save money over fee-for-service costs.⁹ Additionally, health plans were eligible for increases in the guaranteed minimum payment rates. As a result of the changes in the payment rate formula, Medicare health plans received an additional 7 percent over what they were already slated to receive in 2004 (Achman and Gold 2004b).¹⁰ The extra payments—totaling more than \$2.7 billion—are, on average, 8 percent higher than costs for traditional, fee-for-service Medicare (Biles, Nicholas, and Cooper 2004).

About half of the extra payments went to reduce monthly premiums and increase benefit generosity (CMS 2004a). By March 2004, when MA plans had to adjust their benefit packages to reflect the new payment rates, average monthly premiums dropped by about \$9, from \$34 in January–February 2004 to \$25 in March–December (Achman and Gold 2004a). And while overall levels of drug coverage remained stable, enrollees did see increased coverage of brand-name drugs. Most of the other benefits and cost-sharing structures remained the same. This may have been because of the short period (from enactment of the MMA until the effective date of the payment changes) that MA plans had to change their benefit packages. An additional \$256 million in extra payments were placed in plan stabilization funds to use in future years for additional benefits or premium reductions (“Provisional Rule—Establishment of the Medicare Advantage Program” 2004). These funds have to be used in 2005, because the MMA eliminated the stabilization fund option after 2005.

In this study, we examine how MA plans have responded to the continued increase in payments in 2005. Mathematica Policy Research (MPR) has been tracking trends in Medicare managed care benefits and premiums since 1999.¹¹ As the era when HMOs dominated Medicare private health plan offerings in managed care winds down, this paper

⁹ Before the BBA, Medicare managed care plans were paid at 95 percent of Medicare’s fee-for-service costs.

¹⁰ More information on payment rate methodology in the Medicare Advantage program is available in Achman and Gold 2004b; Biles, Nicholas, and Cooper 2004”; or Berenson 2002.

¹¹ Previous research was funded under contracts from The Commonwealth Fund.

explores how benefits and premiums in MA plans have changed since 1999, focusing especially on benefits in 2005. MA plans are paid based on the county of residence of their enrollees. For 2005, county payment rates were the higher of a 6.6 percent increase over the 2004 rate, or 100 percent of estimated fee-for-service costs in the county in 2005 (CMS 2004b). In comparison, most health plans would have received just a minimum 2 percent increase in payments had Congress not enacted the change in payment rate methodology in the MMA.

In addition to presenting a national picture of premium and benefit trends, this study compares benefit packages among different types of health plans. Specifically, we look at the health maintenance organizations (HMOs) that have traditionally comprised the Medicare managed care program; preferred provider organizations (PPOs) that began entering the program in substantial numbers under CMS's PPO demonstration and then more recently as nondemonstration products; and private fee-for-service (PFFS) plans that often offer beneficiaries a Medicare Advantage alternative in areas not traditionally served by managed care. The BBA was originally intended to encourage the participation of managed care plans other than traditional HMOs. However, these alternative types of private health plans emerged fairly recently. PPO offerings by now may serve as a clue to how regional PPOs might potentially structure their benefit packages in 2006. Additionally, PFFS plans will likely continue to be an option at the local level, and it is interesting to see how their benefit packages differ from those of traditional HMO plans.

METHODOLOGY

This analysis of plan benefits and premiums relies on a database developed by MPR using Medicare Advantage data from the Medicare Personal Plan Finder, a database of plan benefit packages maintained by the Centers for Medicare and Medicaid Services (CMS). The 2005 analysis presented in this paper is based on the December 15, 2004, data release of the Medicare Personal Plan Finder.¹² We merged this information with enrollment data from CMS's January 2005 Geographic Service Area File, which contains county-level MA enrollment by MA plan.

MA plans may offer more than one benefit package to enrollees in a given county or geographic service area, for instance, a lower-premium package with one level of benefits and a higher-premium package with an expanded level of benefits. CMS currently publishes only aggregate enrollment information by MA plan. For this reason, we assigned all enrollment to the basic plan offered by a managed care organization in a given county. (The basic plan is defined as the benefit package with the lowest premium. If the organization offers several benefit packages in a county that have equal premiums, the basic plan is defined as the package with the most generous prescription drug benefit. Part B premium reduction plans were treated as zero-premium plans for the purpose of identifying the basic plan.) The effect of assigning all enrollees to the basic plan is to understate coverage and premium levels, but doing so provides a consistent trend line of

¹² Benefit information for some of the plans entering the MA program in January 2005 was missing from the December 15, 2004, release of the Medicare Personal Plan Finder. Information was missing for seven HMOs, 12 PPOs, and one PFFS plan. In January 2005, all 20 of these plans accounted for just 60 total enrollees.

the most affordable option for enrollees. We include MA coordinated care plans—HMOs, point-of-service plans, and provider-sponsored organizations—in the analysis of trends in premiums and benefit packages. For 2005, we compare premiums and benefit packages for HMOs, PPOs, and PFFS plans.

This report only provides information on MA plans available in the individual market. Plan benefit information on MA plans that are offered to groups of retirees (and dependents) through their employer is not available in the Medicare Personal Plan Finder. Unfortunately, enrollment reports do not distinguish between group and individual market enrollment. Therefore, while we have not included in this analysis group enrollment in areas where the health plan does not operate in the individual market, individuals enrolled in an MA plan through their employer are included if they live in a county where the health plan is also open to individual enrollment. These individuals are assigned to the basic plan in the individual market. Approximately, 18 percent of MA enrollment is through retiree health plans (“Provisional Rule—Establishment of the Medicare Advantage Program” 2004), though group enrollment may account for more of total enrollment in particular health plans. Generally, MA plans in the group market offer more generous benefits than do those available in the individual market (Hileman et al. 2002).

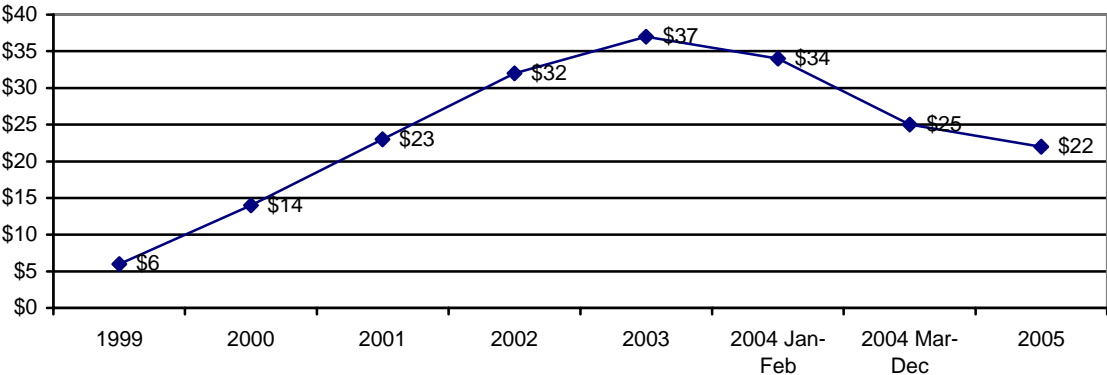
TRENDS IN MEDICARE ADVANTAGE PREMIUMS AND BENEFITS, 1999–2005

In 2005, enrollees will continue to benefit from the increased funding for MA plans under the MMA, at least on average, as premiums continue to decline, pharmacy benefits improve, and coverage of Medicare’s cost sharing for physician and hospital services increases.

Monthly Premiums

Average monthly premiums for supplemental benefits offered by MA plans declined from \$25 in late 2004 to \$22 in 2005, a 12 percent decrease (Figure 1). In addition, the number of MA enrollees with no monthly premium or a Part B premium reduction increased substantially over the past year, from 56 percent in 2004 to 62 percent in 2005 (Table 1). However, about one-fifth of enrollees still pay a premium of \$50 or more per month in addition to the \$78.20 monthly Medicare Part B premium. As a result of these changes, the average premium in 2005 is similar to 2001 levels of \$23.

Figure 1. Average Medicare Advantage Premiums, 1999–2005



Source: MPR analysis of Medicare Compare data. Analysis of 1999–2004 data funded by The Commonwealth Fund; analysis of 2005 data is funded by AARP Public Policy Institute.

Note: All data are weighted by enrollment.

NA: Not applicable.

Table 1. Monthly Premiums in Medicare Advantage Plans, 1999–2005

	Weighted by Enrollment						2005
	1999	2000	2001	2002	2003	2004	
Reduced Part B Premium	N/A	NA	N/A	N/A	0.2	7.9	6.5
\$0	79.6	59.0	46.0	40.7	38.1	47.8	55.3
\$1–\$19	3.1	8.7	8.2	4.8	1.3	3.0	2.0
\$20–\$49.99	13.5	19.3	27.1	22.8	25.3	17.5	15.0
\$50 or more	3.2	11.1	18.6	31.8	34.9	23.9	21.2
Unknown	0.6	1.8	0.1	0.0	0.0	0.0	0.0
Mean	\$6.37	\$14.43	\$2.94	\$3.08	\$3.72	\$2.53	\$22.00
Mean if premium not equal to \$0	\$3.21	\$36.19	\$4.25	\$5.40	\$6.04	\$5.26	\$53.79
Number of enrollees	6,254,616	6,094,767	5,577,787	4,964,007	4,563,635	4,503,282	4,619,576

Source: MPR Analysis of CMS data, including the Medicare Plan Finder Files and Market Penetration Files.

Note: Reduced Part B Premium plans became available in January 2003; premiums are for basic plans.

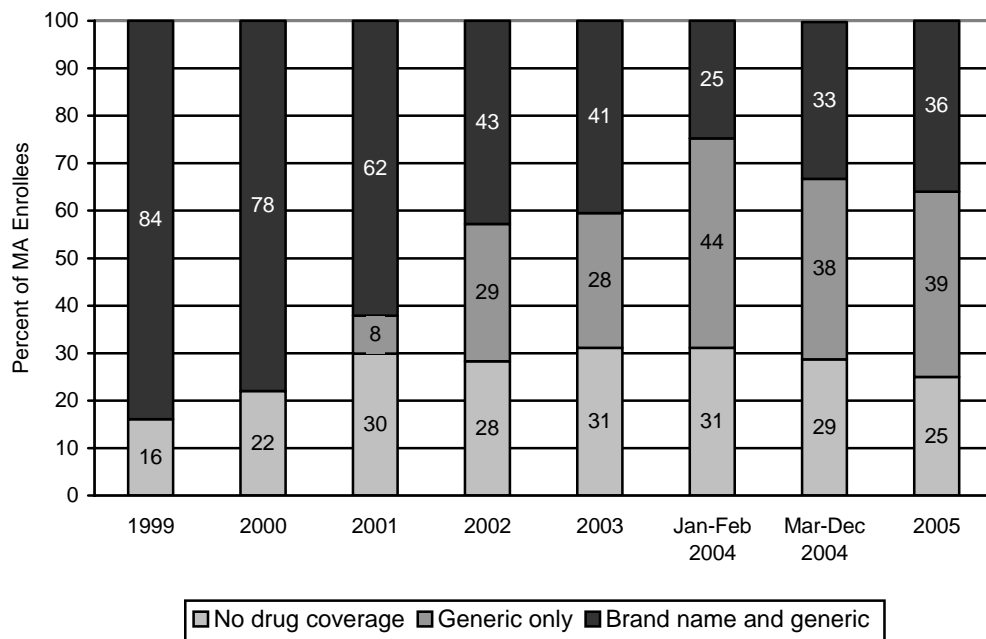
Prescription Drugs

While enrollment in basic Medicare Advantage plans with any outpatient prescription drug coverage has remained steady at about 70 percent since 2001, there was a dramatic shift between 2001 and 2003 (pre-MMA) toward coverage of only generic drugs (Figure 2). In 2001, 62 percent of MA enrollees had brand-name drug coverage; by January–February 2004, that number had dropped to 25 percent. While the MMA did not lead to significant increases in the overall level of drug coverage, some health plans did use the extra payments to return to brand-name coverage in 2004. As a result, brand-name drug coverage rates among MA enrollees rose to 33 percent for March–December 2004.

In 2005, the share of MA enrollees with any drug coverage rose to 74 percent, and the share of MA enrollees with brand-name and generic drug coverage rose to 36 percent as

health plans continued to use extra payments to enhance prescription drug coverage in basic MA plans (Figure 2).¹³ In addition, far more enrollees (24 percent) in MA plans were offered unlimited coverage for both brand-name and generic drugs than ever before (Table 2). The cause of this dramatic shift is not entirely clear. Plans may have increased prescription drug coverage to bolster enrollment in advance of 2006, when MA plans can become MA Prescription Drug (MA-PD) plans. Plans may also be responding to an increasingly competitive market by offering Medicare beneficiaries a desirable benefit. In addition, with experience, they may have become better at managing the drug benefit for their Medicare beneficiaries.

Figure 2. Changes in the Type of Outpatient Prescription Drug Coverage in Basic Medicare Advantage Plans, 1999–2005



Source: MPR Analysis of CMS Medicare Personal Plan Finder data.
 Note: Weighted by enrollment.

Still, individuals with unlimited generic and brand-name coverage remain a distinct minority, comprising just 8 percent of the MA enrollee population (i.e., 24 percent of the 36 percent with brand-name coverage.)

Enrollee cost-sharing requirements are not directly comparable from year to year since the set of plans within each category changes as plans decide to add brand-name coverage, drop brand-name coverage, or drop drug coverage altogether. However, the relative levels

¹³ Approximately 10 percent of MA enrollees with brand-name drug coverage, or 3 percent of all MA enrollees, have a drug benefit that requires high coinsurance (50 percent or more) on brand-name drugs. This high coinsurance may signal a discount on drugs rather than a full benefit.

of cost-sharing requirements among enrollees with each type of coverage are a good indication of trends. Between 2004 and 2005, enrollee cost sharing in plans covering both generic and brand-name drugs declined. For example, 21 percent of enrollees in plans that cover both types of drugs pay \$10 or less for brand-name drugs in 2005 (6 percent pay nothing, and 15 percent pay \$10 or less), versus 13 percent in 2004 (4 percent paid nothing, and 9 percent paid \$10 or less). Cost-sharing requirements seem to have increased for enrollees with generic-only drug coverage. In 2005, a higher percentage of these enrollees pay more than \$10 per prescription than in any other year except 2003 (Table 2).

Table 2. Outpatient Prescription Drug Coverage Offered by Basic Medicare Advantage Plans, by Type of Drug Coverage Offered, 2001–2005 (percent of MA enrollees)

	Weighted by Enrollment					
	2001	2002	2003	Jan– Feb 200 4	Mar– Dec 2004	2005
Rx coverage by type						
No drug coverage	29.9	28.3	31.2	31.1	28.7	25.6
Percent covering generics only	8.0	28.9	28.2	44.4	38.4	38.7
Percent covering generics and brand-name	62.1	42.8	40.6	24.8	32.9	35.7
Generic-Only Coverage						
\$500 or less	4.6	15.0	19.1	6.5	3.0	1.5
\$501–\$750	1.8	3.8	1.5	2.2	0.7	0.6
\$751–\$1000	8.2	3.4	0.0	1.4	0.3	0.3
\$1,001–\$1,500	0.0	0.0	1.5	0.1	0.0	0.7
\$1,501–\$2,000	0.0	0.2	0.0	2.5	0.9	0.0
\$2,001 or more	0.0	0.8	4.3	0.0	0.0	0.0
No Cap	85.4	76.8	73.7	87.2	95.1	91.1
Generic Co-pays for Plans Covering Generics Only						
None	0.0	2.0	0.0	2.8	1.1	2.6
\$10 or less	81.6	65.5	56.5	71.9	72.3	58.7
\$10.01 or more	18.4	32.5	43.5	25.4	26.6	38.7
Brand-name and Generic Coverage^a						
\$500 or less	19.7	16.1	20.5	33.8	34.6	30.3
\$501–\$750	12.1	12.2	12.9	13.9	13.0	11.7
\$751–\$1000	11.9	32.1	29.9	19.7	8.9	12.2
\$1,001–\$1,500	14.3	4.9	10.0	5.9	10.7	7.8
\$1,501–\$2,000	24.6	26.2	18.6	12.1	7.3	7.6
\$2,001 or more	5.8	4.9	5.8	8.3	20.4	6.7
No cap	11.6	3.6	2.4	5.4	4.6	23.6
Generic Co-pays for Plans Covering Generics and Brand-name Drugs						
None	8.8	10.1	9.7	11.9	17	22.5
\$10 or less	83.6	80.2	82.4	64.7	65	65.7
\$10.01 or more	7.6	9.7	8.0	23.4	18	7.8
Brand Co-pays for Plans Covering Generics and Brand-name Drugs						
None	2.4	0.0	0.8	1.8	3.7	5.6
\$10 or less	21.7	4.6	5.9	8.8	8.9	15.4
\$10.01–\$20	43.6	14.8	18.6	22.9	23.8	16.6
\$20.01 or more	32.3	80.6	74.7	66.5	63.8	57.9

Source: MPR Analysis of Medicare Personal Plan Finder. The analysis for 2001–2004 was funded by The Commonwealth Fund; the analysis for 2005 is funded by AARP Public Policy Institute.

Note: Information is weighted by enrollment; all information is for the basic plan.

^aIn some cases health plans may have different annual limits for generic and brand-name drugs. In these cases, the limits provided are the limits on brand-name prescription drug coverage.

Co-payments for Medical and Hospital Services

While the MMA's 2004 payment increases lowered premiums and restored some brand-name drug coverage, there was little change in 2004 in the levels of medical and hospital service co-payments set by MA plans. Co-payments for doctor visits remained relatively stable after the new benefit packages were announced in 2004, and there was no significant decline in the number of enrollees with a cost-sharing requirement for inpatient stays or outpatient hospital visits. Some of the MA plan reluctance to change these benefits may have resulted from the short period MA plans had to reformulate their benefit packages following announcement of the new payment rates.

In 2005, MA plans should have had ample opportunity to make these changes if they so desired. Table 3 shows that many MA plans have made changes to their benefit packages this year, reducing cost-sharing requirements for a number of medical and hospital services. Compared with cost-sharing requirements just prior to the passage of the MMA (that is, in 2003 and January–February 2004), fewer enrollees have co-payments over \$15, and more enrollees have no co-payments at all for primary care or specialist physicians.

Likewise, fewer enrollees have cost-sharing requirements for other services such as hospital admissions and outpatient visits than did in 2004. The share of enrollees with any cost sharing for hospital admissions declined from 82 percent to 76 percent, and the share with cost sharing for outpatient care declined from 57 percent to 45 percent between 2004 and 2005. In 2005, fewer than one-third of MA enrollees pay co-payments for X-rays.

SUPPLEMENTAL BENEFITS

In the past, many managed care plans have offered supplemental benefits for dental or chiropractic services, hearing exams, and other services not covered by traditional Medicare. However, coverage for all of these benefits was on the decline as MA plans reduced their benefit packages. In the wake of the 2004 MMA payment rate increases, MA plans have started to add these benefits again. As Table 4 depicts, the proportion of MA enrollees with dental benefits is up; about one-quarter of MA enrollees have coverage for preventive dental services in 2005, compared with 21 percent who had such coverage in 2004. Still, the extent of coverage for these services remains substantially lower than it was in 1999, when more than two-thirds of MA enrollees had preventive dental coverage.

In 2005, the vast majority of MA enrollees will have coverage for vision care and hearing exams. Coverage of such supplemental benefits may help MA plans compete with Prescription Drug Plans (PDPs) come 2006, since PDPs will only offer drug coverage and will not be able to provide benefits such as hearing and vision care.

Table 3. Copayments for Medical and Hospital Services in Basic Medicare Advantage Plans

	Percent of Enrollees				
	1999	2003	Jan– Feb 2004	Mar– Dec 2004	2005
Primary Care Physician					
None	18.0	7.1	9.9	15.1	18.5
\$1 to \$5	44.5	5.5	8.1	13.3	18.8
\$5.01–\$10	32.1	45.6	39.9	43.7	33.3
\$10.01–\$15	5.1	17.8	20.0	16.5	16.0
\$15.01 or more	0.3	24.0	22.2	11.4	13.3
Specialty Physician					
None	15.9	4.1	4.1	6.0	7.2
\$1 to \$5	39.6	1.7	1.0	1.0	4.3
\$5.01–\$10	26.8	11.8	10.3	22.6	17.7
\$10.01–\$15	9.9	18.9	13.9	15.4	11.8
\$15.01 or more	1.2	63.5	70.7	55.0	59.0
Varies	6.6	0.0	0.0	0.0	0.0
Emergency Room					
None	6.5	3.0	2.3	1.8	2.7
\$1 to \$20	24.5	0.4	0.0	0.0	0.0
\$20.01–\$40	30.5	5.9	3.2	3.3	2.7
\$40.01–\$50	38.2	91.0	94.5	94.8	94.6
\$50 or more	0.2	0.0	0.0	0.0	0.0
Any Cost Sharing					
Hospital admission	4.3	82.1	85.7	82.1	76.0
Hospital outpatient	30.7	58.3	58.3	56.8	45.3
X-ray	7.5	17.9	36.2	34.3	31.5
Lab	3.9	13.0	21.1	18.9	19.6

Source: MPR Analysis of Medicare Plan Finder Files and CMS Market Penetration Files.

Note: Enrollment is from March of each year for years 1999–2004; enrollment for 2005 is from January 2005. For 2002–05, many plans have provided dollar ranges for the co-payment amounts for these services. For instance, a plan may report that enrollees are responsible for a \$0–\$150 copayment for outpatient hospital services. The percentages reported here use the minimum co-payment.

Table 4. Supplemental Benefits in Basic Medicare Advantage Plans

	1999	2003	Jan– Feb 2004	Mar– Dec 2004	2005
Preventive dental	69.9	19.4	16.5	20.5	25.5
Vision benefits	97.8	88.2	87.5	92.4	92.2
Hearing benefits	91.3	57.1	54.2	62.2	98.6
Physical exam	100.0	99.6	98.6	99.7	100.0
Podiatry benefits	26.9	26.9	28.0	29.6	29.4
Chiropractic benefits	20.9	4.8	2.3	3.5	4.3

Source: MPR Analysis of Medicare Plan Finder Files and CMS Market Penetration Files.

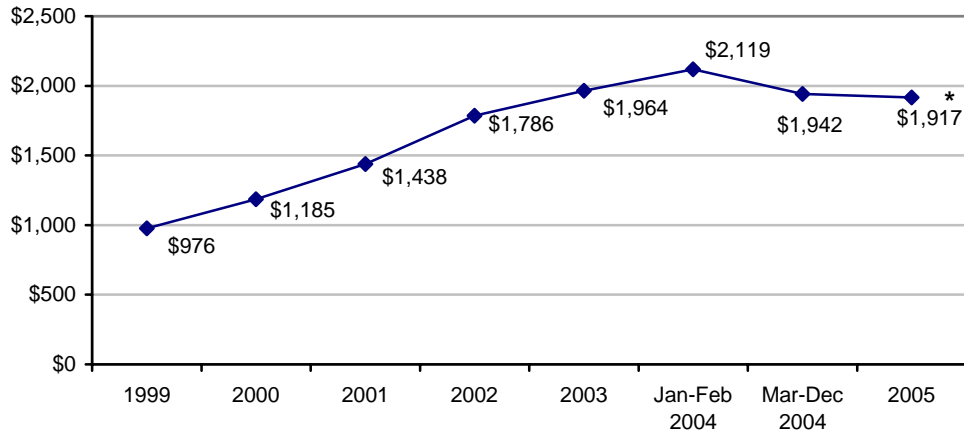
Note: Enrollment is from March of each year for years 1999–2004; enrollment for 2005 is from January 2005.

Medicare recently introduced some new MMA-mandated preventive benefits, including a one-time “Welcome to Medicare” physical exam for beneficiaries who enroll in the program on or after January 1, 2005. These Medicare beneficiaries will be entitled to receive this service starting in January 2006 (until then, they are not covered for physical exams through traditional Medicare). By contrast, almost all MA plans have covered this benefit since 1999. In 2005, every MA enrollee has coverage for routine physical exams.

OVERALL OUT-OF-POCKET SPENDING BY HEALTH STATUS

As a result of the 2004 payment increases mandated by the MMA, overall out-of-pocket spending levels returned to essentially where they were in 2003, staving off the increases that had been the trend in earlier years. In 2005, overall out-of-pocket spending levels continued to fall, albeit only slightly, to \$1,917 (Figure 3). Spending within certain categories of medical services declined markedly between 2004 and 2005. On average, out-of-pocket costs for prescription drugs decreased by 20 percent, while out-of-pocket costs for premiums decreased by 15 percent. Overall reductions were limited, however, because spending on hospital and medical services—which constitutes a large portion of medical costs for Medicare beneficiaries—remained about the same as it was in 2004. Additionally, the Medicare Part B premium increased by 17 percent in 2005.

Figure 3. Average Enrollee Out-of-Pocket Costs in Basic Medicare Advantage Plans, 1999–2005



Source: MPR analysis of Medicare Compare using HealthMetrix Research’s CostShare Report methodology.

* In 2005, HealthMetrix, Inc., changed the methodology for estimating out-of-pocket costs by increasing the number and length of hospital stays MA enrollees in fair and poor health are assumed to have over the course of a year. To provide consistent trend data, we based the numbers here on the same assumptions used for the 1999–2004 data. Using the updated methodology, we estimated the average enrollee out-of-pocket costs to be \$2,022.

Overall out-of-pocket costs for enrollees in fair and poor health continued to decline, from \$2,798 and \$5,573, respectively, in 2004, to \$2,647 and \$4,845 in 2005, respectively, primarily because of enhanced prescription drug benefits that limit out-of-pocket costs for prescription drugs (Table 5). However, the current level of out-of-pocket spending is still substantially higher than it was in previous years and may still represent a significant burden for low-income Medicare Advantage enrollees.

Table 5. Medicare Advantage Enrollee Out-of-Pocket Costs by Health Status

	1999	2003	Jan–Feb 2004	Mar–Dec 2004	2005	Percent Change Mar–Dec 2004 to 2005
Total Cost						
Sharing						
All	\$975.64	\$1,964.21	\$2,119.35	\$1,942.10	\$1,917.45	-2%
Good	\$836.19	\$1,564.48	\$1,651.90	\$1,495.71	\$1,556.51	4%
Fair	\$1,203.39	\$2,695.70	\$3,031.05	\$2,798.32	\$2,647.50	-5%
Poor	\$2,210.80	\$5,305.28	\$5,883.73	\$5,573.42	\$4,844.67	-14%
Premiums						
Annual Part B premium	\$546.00	\$704.40	\$799.20	\$799.20	\$938.40	17%
Annual Plan premium ^a	\$63.37	\$446.79	\$394.76	\$266.13	\$227.40	-15%
Medical-Hospital Cost						
Sharing						
All	\$132.08	\$301.04	\$354.96	\$317.27	\$304.49	-4%
Good	\$117.08	\$177.81	\$191.95	\$170.96	\$165.83	-3%
Fair	\$159.41	\$622.84	\$786.62	\$707.60	\$668.82	-5%
Poor	\$257.81	\$1086.98	\$1379.52	\$1,229.55	\$1,219.28	0%
Rx Cost						
Sharing						
All	\$234.19	\$511.99	\$570.43	\$559.50	\$447.16	-20%
Good	\$109.74	\$235.48	\$265.99	\$259.42	\$224.88	-14%
Fair	\$434.61	\$921.67	\$1,050.47	\$1,025.39	\$812.88	-21%
Poor	\$1343.62	\$3,067.11	\$3,310.25	\$3,278.54	\$2,459.59	-25%

Source: MPR Analysis of Medicare Plan Finder Files and CMS Market Penetration Files.

Note: This analysis uses methodology from HealthMetrix Research, Inc., to calculate out-of-pocket costs. HealthMetrix revised the utilization assumptions it uses for enrollees in fair and poor health in 2005 by increasing the assumed number of hospital stays and the length of hospital stays. However, to provide trend data that are consistent with the 1999–2004 estimates, MPR shows estimates based on the original methodology. A detailed description of the methods is available in Appendix B. Using the revised methodology, we estimated out-of-pocket costs at \$2,022 overall; \$1,557 for enrollees in good health; \$3,154 for enrollees in fair health; and \$5,323 for enrollees in poor health. Results are weighted by plan enrollment in March of each year, except 2005, which is weighted by enrollment in January 2005. The “all” category assumes 79 percent of enrollees are in good health, 15 percent are in fair health, and 6 percent are in poor health. This distribution corresponds to the distribution of self-reported health status among Medicare managed care enrollees in the 1999 Medicare Current Beneficiary Survey (Liu and Sharma 2003).

^aAverage MA premium takes reductions in Part B premiums into account.

Out-of-pocket costs grew modestly for MA enrollees in good health (4 percent), despite escalating costs for medical and hospital services and a 17 percent increase in the Medicare Part B premium. In 2005, average out-of-pocket costs are \$1,556 for enrollees in good health. Since 1999, out-of-pocket costs for these enrollees have almost doubled.

BENEFITS BY PLAN TYPE

The overwhelming majority of MA program enrollment—4.7 million of 4.9 million, or 95 percent—continues to be in traditional HMOs. In the first few years of the 21st century, in a lagged response to the BBA, however, different types of private health plans have begun to enter the market. While these plans comprise only a small proportion of total MA enrollment (Table 6), they generally offer their enrollees a broader choice of providers than traditional HMOs offer. The offerings by local PPOs now may serve as a clue to what the regional MA plans will offer. Additionally, the PFFS plans will remain an option at the local level. It is interesting, therefore, to examine how the benefit packages of these plans differ from those of traditional HMO plans.

Table 6. Enrollment in Medicare Advantage, by Plan Type

Plan Type	Number of Contracts	Percent of Total Contracts	Enrollment	Percent of Total Enrollment
HMO	149	68.0%	4,700,381	95.4%
PSO	5	2.3%	29,044	0.6%
PPO	24	11.0%	25,817	0.5%
PPO Demonstration	34	15.5%	113,943	2.3%
PFFS	7	3.2%	58,072	1.2%
Total	219	100.0%	4,927,257	100.0%

Source: CMS's January Geographic Service Area File; information as of January 2005.

PPOs have been allowed to enter the M+C market since 1998, when the BBA provided for PPO plans in the coordinated care program in an effort to expand beneficiary choice (Gold, Achman, and Verdier 2003). However, few PPO plans materialized between 2000 and 2002. The first major beginnings of a PPO market in MA came about as a result of CMS's PPO demonstration.

The PPO demonstration began in January 2003 with 31 contracts. Initially, approximately 70,000 beneficiaries enrolled in demonstration PPO plans, although 9 million had access to at least one of these plans (Gold, Achman, and Verdier 2003). Most beneficiaries who enrolled in PPO demo plans had previously been enrolled in other M+C plans (Greenwald

et al. 2004). Originally, the payment rates received by PPO demonstration plans differed from the M+C program. PPO demonstration plans were paid the greater of two rates: (1) the M+C rate in the county or (2) 99 percent of FFS costs. Since the MMA mandated that, as of 2004, all county payment rates equal a minimum of 100 percent of county fee-for-service costs, the PPO demonstration plans are now paid the same rate as other MA plans in a county, although the demonstration plans do have the opportunity to share some financial risk with CMS that nondemonstration plans do not have. In 2005, there are 34 PPO demonstration contracts operating in 21 states (or a total of 441 counties). About 12.7 million Medicare beneficiaries, or 30 percent, have access to a PPO demonstration. As in previous years, PPO demonstration plans operate predominantly in areas also served by HMO plans.

In 2003, the first year of the PPO demonstration, demonstration plans had considerably higher premiums than coordinated care offerings and did not offer much in the way of increased coverage or benefits. Prescription drug coverage, in particular, was lower than the coverage offered by HMOs overall and in counties where both plan types were operating (Gold, Achman, and Verdier 2003). This has continued into 2005. Table 7 shows that the average monthly premium for PPO demonstration plans is double the average premium charged by HMOs. PPO demonstration plans are less likely to offer any drug coverage than any other type of plan, and where drug benefits are available, they are typically limited to coverage for generic drugs. Thus, in selecting a PPO demonstration plan, beneficiaries typically forgo some coverage and pay higher premiums to gain access to a wider network of providers as well as the option of having some coverage for out-of-network services.

Table 7. 2005 Premiums and Drug Coverage, by Plan Type

	Plan Type			
	HMO ^a	PPO Demonstr ation Plan	PPO Nondemon -stration Plan	PFFS
No. Contract Segments	380	48	21	39
Monthly Premiums				
Average premium	\$24.80	\$51.62	\$28.95	\$33.41
Percent with \$0 premium	60.3	2.1	71.4	43.6
Percent with premium \$50+	24.0	47.9	19.0	25.6
Drug Coverage (percent)				
No drug coverage	24.5	35.4	81.0	30.7
Generic only	44.5	47.9	4.7	51.3
Brand-name and generic	31.0	16.7	14.3	17.9

Source: MPR Analysis of CMS Medicare Plan Finder Data.

^aHMO includes provider-sponsored organization (PSO) plans.

Perhaps in anticipation of regional PPOs in 2006 and the planned two-year moratorium on new local PPOs (or service area expansion)¹⁴, or possibly because of the experience gleaned from the PPO demonstrations, a number of MA plans began offering PPOs at the local level at the end of 2004 and in 2005. There are now 24 local PPO contracts. MA plans could be using these local offerings for three possible reasons: (1) to beat the moratorium deadline to avoid having to enter the regional program; (2) to gain experience with PPOs in 2005 in anticipation of the regional program (although some may ultimately decide to continue as local PPOs); or (3) to be able to compete with regional PPOs in these areas on a more equal footing by competing as the same type of plan rather than as an HMO.

Rather than entering new areas, most of the local PPO plans are in areas already served by PPO demonstration plans. In fact, of the 24 local PPO contracts, 18 compete against another local PPO or PPO demonstration plan in at least some of their service area. Like demonstration PPOs, these plans offer beneficiaries the option of choosing a non-network health care provider (although plans often charge higher cost sharing for out-of-network services). Local PPOs generally offer enrollees a less expensive, but less generous plan than the available PPO demonstration plans. As shown in Table 7, local PPOs charge a premium of about \$29, which is considerably less than the \$52 average premium for PPO demonstration plans. The benefit packages available in local PPO plans are less generous than those offered by demonstration plans. Only 19 percent of these plans offer any prescription drug coverage, versus 64 percent of demonstration plans. Likewise, local plans are far less likely to limit the out-of-pocket costs enrollees can incur annually for in- or out-of-network services.¹⁵ Instead of entering the market with premiums similar to those in the demonstration PPOs, these newer plans are competing more directly with HMOs—the average premium for a nondemonstration PPO plan is similar to that for an HMO plan—but they still are not offering the benefits HMOs offer. Such findings are consistent with managed care organizations' reported experiences with the PPO demonstration. The PPO demonstration plans that were the most successful were those most likely to offer a well-priced PPO option compared to that offered by the HMO plans available in the area. Health plans reported that beneficiaries did not appear willing to pay higher premiums for a PPO or point-of-service (POS) product just for the opportunity to use out-of-network providers (Greenwald et al. 2004).

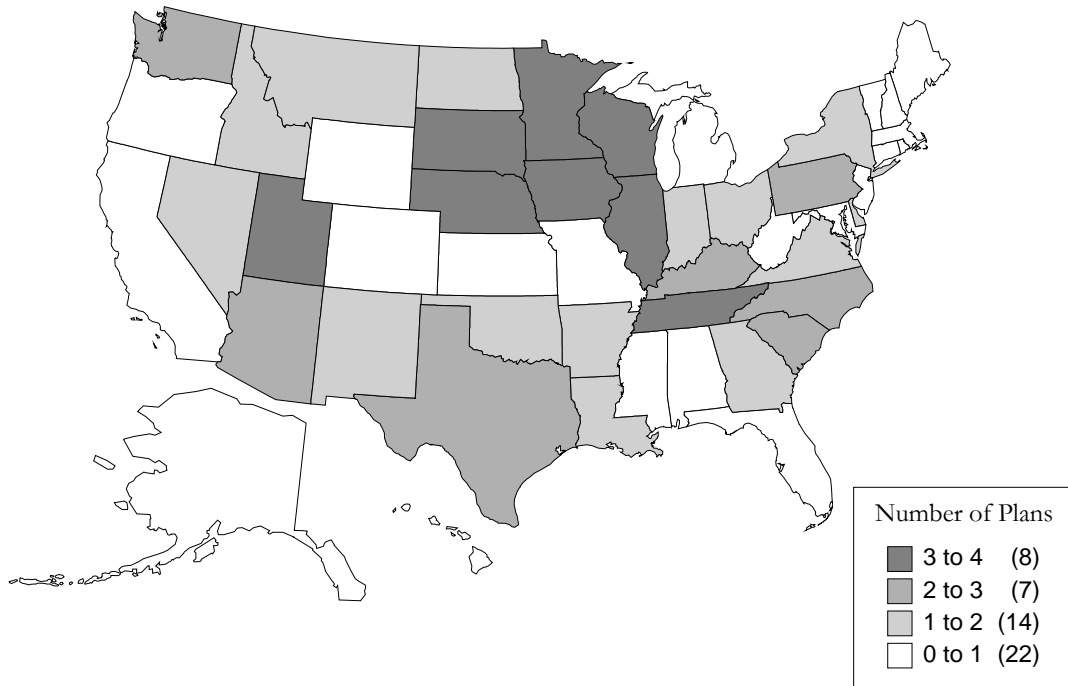
About 3 percent of the basic plans operating in the MA market in 2005 are private fee-for-service (PFFS) plans. Such plans generally have larger service areas than traditional coordinated care plans do and serve multiple states, mainly those states with extensive

¹⁴ Beginning in 2006, in addition to the local county-by-county MA program, there will be a regional PPO program. CMS has created 26 state-based regions. Regional PPOs will be required to provide the same benefit package, at the same premium, to everyone within a region. To encourage entry into the regional PPO program, the MMA does not allow new local PPO contracts or service area expansions in 2006 and 2007.

¹⁵ Twenty-nine percent of local PPO plans limit out-of-pocket costs for services received in network, while 19 percent of local PPO plans limit out-of-pocket costs for services received out of network. By contrast, over 90 percent of PPO demonstration plans limit out-of-pocket costs for services received in network, and 50 percent limit out-of-pocket costs for services received out of network. Regional PPOs entering the market in 2006 and beyond will be required to have an out-of-pocket limit.

rural areas that are not served by other types of MA plans. For example, PFFS plans are available in Montana, Utah, and South Carolina (Figure 4), and PFFS plans are located in many

Figure 4. Location of Basic Private Fee-for-Service Plans, 2005



Source: MPR Analysis of CMS Medicare Personal Plan Finder Data.

Note: Health plans are counted in each state in which they appear even if they serve more than one state.

of the predominantly rural Medicare Advantage regions—for example, region 19, which encompasses Minnesota, Iowa, North Dakota, South Dakota, Nebraska, Montana, and Wyoming.¹⁶

Sterling Life Insurance Company offered the first PFFS plan, but in the last couple of years other organizations have entered the PFFS market. There are now four additional PFFS contracts (which together offer 36 basic plans) sponsored by Humana, Unicare,

¹⁶ A map showing the location of MA regions is available on the CMS Web site, <http://www.cms.hhs.gov/medicarereform/mmaregions/mapdpreions.pdf>.

United Health Insurance, and American Progressive Life and Health Insurance.¹⁷ Despite reducing its service area, Sterling is still the largest PFFS plan sponsor, serving 23 states and 21,533 enrollees. In 2005, as in earlier years, Sterling premiums are well above the national MA plan average of \$22, ranging between \$28 and \$68 per month (Table 8). Sterling does not provide enrollees with drug benefits.

Table 8. Benefit Packages in the PFFS Plans

	Plan Sponsor				
	Sterling	Humana	Unicare	United	American Progressive
States available in	AZ, AR, DE, ID, IL, IA, KY, LA, MN, MT, NE, NV, NM, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA	AZ, GA, IL, IA, MN, NC, ND, SC, SD, TN, UT, WI	IL, IN, IA, KY, MI, MN, NE, NC, UT, VA, WI	NE, IA, SD, WI	Upstate NY and Central PA
Contract effective date	7/1/2000	1/1/2003	4/1/2003	9/1/2004	5/1/2004
Enrollment as of 1/1/05	21,533	18,159	14,743	518	1,440
Premium range	\$28-\$68	\$0-\$105	\$9 or \$64	\$0	\$49.50
Drug coverage	No coverage	No coverage to \$1000 brand coverage	No coverage	Unlimited Generic Coverage	No coverage
Physician visit co-payments	\$15	\$5 or \$15	\$10	\$5	\$15
Inpatient hospital cost-sharing requirements	\$150/day for days 1–5	\$165 to \$300/day for days 1–7	The two \$9 plans have a \$150/day co-pay for days 1–5; the \$64 plan has a \$50/stay charge	\$265/day for days 1–10 of a stay	\$150/day for days 1–5 with a \$2,000 out-of-pocket maximum per year
Overall out-of-pocket limit	None	None	None	\$2400	None

Source: MPR Analysis of CMS Medicare Personal Plan Finder Data for 2005.

¹⁷ Humana also offers a second PFFS plan in one county in Illinois. This plan, part of the alternative payment demonstration, is not discussed further in this paper. Blue Cross of California is also offering a PFFS plan in 2005 in the counties of Sacramento, Yolo, Fresno, and Santa Barbara; however, this plan is not listed in the Medicare Personal Plan Finder, so it is not included in the analysis for this paper.

The premiums and benefits offered by the newer PFFS sponsors vary. United offers a plan with no premium, unlimited generic drug coverage, and a relatively low out-of-pocket limit—but only 518 Medicare beneficiaries (living in four states) were enrolled as of January 1, 2005. In contrast, American Progressive, a sponsor that serves two states and 1,440 enrollees, charges a premium of \$49.50 for a plan without any drug coverage. Humana and Unicare offer beneficiaries a range of plans.

CMS has established rules and payment policies that allow PFFS plans to offer a product that is privately operated but similar in function to traditional Medicare. PFFS plans do not establish networks of providers. Instead, like traditional Medicare, these plans pay all providers who are willing to treat their enrollees on a fee-for-service basis (Gold 2001a). PFFS plans have some flexibility in the rates paid to providers for services—for example, PFFS plans can allow providers to charge beneficiaries for up to 15 percent of the difference between the *plan* payment rate and the provider charge—although plans can choose to pay providers the rates Medicare uses. The fact that PFFS plans do not have provider networks has allowed these plans to serve areas that other plans have shied away from, as mentioned above. PFFS plans have also benefited from the floor payments implemented in the Balanced Budget Act of 1997 and the Benefits Improvement and Protection Act, which provided minimum payment rates in areas where fee-for-service spending has traditionally been very low.

CHOICES AT THE BENEFICIARY LEVEL

While information at the national level is important, Medicare beneficiaries must make their decisions at the local level. The options available for individual beneficiaries vary significantly by where they live. For example, urban areas still offer Medicare beneficiaries more private plan options. Additionally, within an area there may be significant differences in the benefit packages available to beneficiaries. To show the extreme differences in benefit packages offered in different parts of the country, we have chosen two local markets to examine in more depth and see how the choices of different plan types play out at the beneficiary level. In Pinellas County in western Florida, the market is mature and offers beneficiaries many coordinated care options. In stark contrast is Milwaukee County in Wisconsin, where there are only two MA plans offered, one HMO and one PFFS plan.

PINELLAS COUNTY, FLORIDA

The first market we examined was Pinellas County in western Florida, which includes St. Petersburg and is adjacent to Tampa. Pinellas County benefited from the new payment rate structure introduced by the MMA that guaranteed every county payment rate would be at least equal to fee-for-service spending in the county. County payment rates in 2004 rose from \$592 to \$688 following the payment changes, a 16 percent increase. In 2005, as a result of CMS rebasing the fee-for-service spending calculations, the county payment rate in Pinellas increased another 7 percent to \$736.

Pinellas County has a relatively mature Medicare Advantage market with eight managed care organizations offering products. Approximately 22 percent of Pinellas Medicare beneficiaries are enrolled in an MA plan. Residents in Pinellas are offered traditional

HMO plans, two PPO demonstration plans, and a new local PPO plan (Table 9).¹⁸ The differences in benefit packages among the HMO plans and the PPO plans in Pinellas are the same as we observed nationally. All of the HMOs have no monthly premium. One of the HMOs is even offering a full Medicare Part B premium rebate¹⁹ of \$78.20 per month, which means that enrollees in that plan do not have to pay the Medicare Part B premium. In comparison, the PPO demonstration plans packages are the only two plans charging a premium; one charges \$59 a month and the other, \$32 a month. The new local PPO plan, which entered the market in January 2005, has no premium, like the three HMO plans. All of the HMO plans also offer an unlimited generic drug benefit and some brand-name prescription drug coverage. As is the case nationally, the PPO demonstration plans do offer a drug benefit, but the benefits cover only generic drugs and are less generous than the benefits offered by the HMO plans. The nondemonstration PPO offers no drug benefit, although it is competing more directly with the HMOs on price than the demonstration PPO products are. Potential enrollees in Pinellas also must consider the value of going outside the health plan network, a benefit that is only available in the PPO products. However, the out-of-network benefit also comes with steep cost-sharing requirements: 20 percent in all cases.

MILWAUKEE COUNTY, WISCONSIN

Milwaukee County does not offer the range of choices that is available in Pinellas. Milwaukee County's payment rate has been the floor rate for urban counties for a number of years. In 2004, following passage of the MMA, the county payment rate increased 3.6 percent, from \$592 to \$614. In 2005, that payment rate increased by the minimum, 6.6 percent, to \$654.

Just 6 percent of Medicare beneficiaries in Milwaukee are in an MA plan, so the private health plan market is much newer than Pinellas's. There are two MA plans in Milwaukee: Humana's private fee-for-service plan and an HMO product offered by UnitedHealthcare (Table 10). Both products have no monthly premium, but only UnitedHealthcare's offers a small drug benefit (\$500 annual generic benefit). Additionally, UnitedHealthcare's plan offers an out-of-pocket maximum of \$4,800, whereas the Humana plan has no out-of-pocket maximum.

In comparison to the benefit packages available to beneficiaries in Pinellas, the choices in Milwaukee are less generous. While Pinellas County beneficiaries can access unlimited generic coverage and some brand-name drug coverage in certain plans, the drug benefit in UnitedHealthcare's plan is limited to \$500 in generics. Additionally, cost-sharing requirements for inpatient hospital and physician visits are on the high side, compared to

¹⁸ Information on the benefit packages of two HMOs that entered the market in January 2005 was not available in the December 15 release of the Medicare Personal Plan Finder.

¹⁹ Beginning in 2003, MA plans were allowed to offer beneficiaries rebates on their Medicare Part B premiums. Under this option, MA plans use part of their monthly payment rate to pay all or part of the Medicare Part B premium for their enrollees. Seventy-five percent of the plan payment goes to reduce the enrollee's Part B premium, and the government retains the other 25 percent. Typically, enrollees are required to pay the Part B premium in addition to any supplemental premium their MA health plan may charge.

those in Pinellas's plans. The out-of-pocket maximum in UnitedHealthcare's plan is \$4,800, compared to \$2,400 and \$3,000 in the Pinellas plans offering an out-of-pocket limit. Furthermore, no PPO plans are offered in Milwaukee. It is clear that beneficiary options must be considered on a market-by-market basis.

Table 9. Medicare Advantage Benefit Packages Available in Pinellas County, Florida

Plan	Plan Type	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Co-payment	Specialist Co-pay	Other Plan Cost-sharing Information
Humana Gold Classic	HMO	\$0	Unlimited Tier 1 benefit and \$1,000 combined annual limit for Tier 2 and Tier 3 drugs*	\$175/day for days 1–7	\$0	\$20	None
WellCare Dividend	HMO	Medicare Part B premium rebate of \$78.20	Unlimited generic benefit	\$150/day for days 1–5	\$5	\$25	\$3,000 maximum out-of-pocket limit every year
UnitedHealthcare Medicare Complete	HMO	\$0	Unlimited generic benefit and \$360 annual limit for brand-name prescription drugs	\$195/day for days 1–13	\$10	\$20	\$2,400 maximum out-of-pocket every year
Humana Choice PPO Blue	PPO demonstration	\$59	Unlimited generic benefit	\$100/day for days 1–10; 20% of cost for out-of-network hospitals	\$10; 20% for out-of-network physician visits	\$25; 20% for out-of-network specialist visits	None
United Medicare Complete Choice	PPO demonstration	\$32	\$750 annual limit for generic prescription drugs	\$180/day for days 1–14; 20% of cost for out-of-network hospitals	\$10; 20% for out-of-network physician visits	\$25; 20% for out-of-network specialist visits	\$2,400 out-of-pocket limit every year
United Healthcare's Evercare Choice	PPO	\$0	No prescription drug coverage	No co-payment for in-network hospital stays; 20% of cost for out-of-network hospital stays	\$0; 20% for out-of-network physician visits	\$0; 20% for out-of-network specialist visits	\$110 annual deductible for out-of-network services
Citrus Health Care	HMO	NA	NA	NA	NA	NA	NA
Aetna Health	HMO	NA	NA	NA	NA	NA	NA

Note: Only basic benefit packages are listed. Benefit package information on Citrus Health Care and Aetna Health's products were not listed in the December 15, 2004, release of the Medicare Personal Plan Finder data. The options in this table are only Medicare Advantage options. Medicare beneficiaries may also have the option of choosing Medigap, employer-sponsored retiree, or Medicaid coverage, depending on the individual's circumstance. NA = Not available.

*The Medicare Personal Plan Finder does not make clear what types of drugs are included when the MA plan has decided to list drug coverage by tiers, and plans vary in their use of what tiers correspond to what drugs. Therefore, we cannot describe this coverage precisely. However, based on a review of the benefits, we would assume that Tier 1 drugs are generic drugs, and Tier 2 and 3 drugs are brand-name drugs.

Table 10. Benefit Packages Available in Milwaukee County, Wisconsin

Plan	Plan Type	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Co-payment	Specialist Co-pay	Other Plan Cost-sharing Information
Humana Gold Choice Basic	PFFS	\$0	No prescription drug coverage	\$200/day for days 1-7	\$15	\$30	None
UnitedHealthcare Medicare Complete	HMO	\$0	\$500 annual generic drug benefit	\$265/day for days 1-19	\$20	\$20	\$4,800 annual out-of-pocket maximum

Note: Only basic benefit packages are listed. The options in this table are only Medicare Advantage options. Medicare beneficiaries may also choose Medigap, employer-sponsored retiree, or Medicaid coverage.

CONCLUSION

In 2005, MA plans continue to use the increased payments from the MMA to reduce premiums and increase the generosity of their benefit packages. Monthly premium levels are down to where they were in 2001, although most packages still cover substantially less than they did then. Coverage of prescription drugs increased in 2005, with more enrollees benefiting from brand-name prescription drug coverage. Coverage of supplemental benefits is also on the rise again. As this era of Medicare managed care comes to a close, MMA payment changes appear to have begun to reverse course from the premium increases and benefit reductions of 2000–2003. In addition, CMS is reporting a significant number of health plan entries into the market, and enrollment is beginning to increase again as well. Taken together, the immediate payment increases for 2004 and 2005 instituted by the MMA seem to have accomplished the goal of providing much-needed stability to the MA market. However, this stability comes with a price tag; in 2005, the average MA plan is estimated to receive 7.8 percent more than average fee-for-service costs in a county. Thus, Medicare is paying more for MA enrollees than it would have paid if these same enrollees had stayed in fee-for-service Medicare (Biles, Nicholas, and Cooper 2004). For 2005, estimates put MA payments above fee-for-service costs at \$2.7 billion nationwide.

HMOs continue to be the main force in the Medicare Advantage market; however, new types of health plans have begun emerging in the last few years that provide Medicare beneficiaries with a choice of provider models. PPOs and PFFS plans offer beneficiaries broader access to providers than traditional HMOs do, but not without trade-offs. For instance, PPO demonstration plans are typically priced significantly higher than HMO plans and offer less in the way of benefits. And while the new nondemonstration PPO plans offer more competitive premiums, the benefits are less generous than those provided by HMOs. Similarly, PPOs offer enrollees the opportunity to go out of the plan network, but often at a steep price. PFFS plans are also slightly more expensive, on average, than HMO plans are and offer less generous benefits, but these plans do offer MA coverage in regions of the country where traditional HMOs have been unwilling to enter. In 2006, a new type of plan, the regional PPO, will enter the market, extending still further the range of Medicare private health plan options.

Given these findings, the Medicare Advantage program seems to be in a relatively strong position going into 2006. Certainly, the program is stronger than it has been in the recent past with respect to the value and variety it offers to beneficiaries. Future research will be needed to determine whether this new strength carries over into 2006 and attracts substantially more beneficiaries to the program once the new prescription drug benefit becomes available.

APPENDIX A: MEDICARE'S HISTORY WITH PRIVATE PLANS

While an overwhelming majority of Medicare beneficiaries have always been enrolled in the traditional fee-for-service Medicare program, Medicare has tried to offer beneficiaries the option of enrolling in a private health plan for a number of years. This appendix briefly reviews Medicare's history with private plans, including the Medicare risk-contracting program, the Medicare+Choice program, and the current Medicare Advantage program.

Early Contracting with HMOs

When the Medicare program was created in 1965, it was structured to resemble fee-for-service insurance products that were typical in the health insurance market at the time. However, even in the early days, Medicare experimented with managed care plans. At the time a few private prepaid health plans served the private employer market. These plans were allowed to contract with Medicare. Initially, these plans were paid on the same basis as other providers were for Part A services and received cost-based reimbursement for Part B services.

In 1972, Congress introduced a voluntary Medicare HMO program under section 1876 to Title 18 of the Social Security Act. Section 1876 allowed Medicare HMOs to receive capitated payments for all Part A and B services. This program also established risk sharing with the government. Health plans and the federal government would split up to 20 percent any savings HMOs could provide to deliver Part A and B services over the Adjusted Average Per Capita Costs (AAPCC) that the government would have incurred had the enrollee remained in the fee-for-service system (Berenson and Dowd 2002). Any savings greater than 20 percent went wholly to the government. Any losses remained with the health plan, although they could be carried over to future years and applied to subsequent savings.

In addition to this risk-sharing program, section 1833 of the Social Security Act allowed Medicare HMOs to continue to contract with the government and be reimbursed for their estimated actual costs. Given the option of cost-based contracts or risk-based contracts, most health plans choose cost-based contracts (Berenson and Dowd 2002).

The TEFRA Risk Contracting Program

Congress authorized the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982. Under this new risk-sharing program for private plans in Medicare that became active in 1985, HMOs assumed responsibility for providing all Medicare-covered services to beneficiaries, Part A and B, in return for a capitated payment. The capitated payment an HMO would receive from the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services) for each enrollee in the health plan equaled 95 percent of the cost HCFA estimated it would have spent had the same beneficiary remained in traditional fee-for-service Medicare. Health plans were also required to return any additional savings they achieved in caring for enrollees (beyond the 5 percent) in the form of additional benefits or reduced premiums. Additional benefits could include

services not covered by the traditional Medicare program, such as prescription drugs, dental, vision, and hearing services.

The additional benefits and low premiums offered by health plans were the main reason that Medicare beneficiaries enrolled in private health plans in most markets; other factors were more important in markets such as Portland, Oregon (Brown and Gold 1999). In exchange for the lower costs and added benefits, beneficiaries had to give up the choice of provider by agreeing to see the HMO's restricted set of providers.

When the new program began in 1985, fewer than a half a million Medicare beneficiaries were enrolled in private health plans (Gold 2001b). Enrollment in the program grew steadily, however, and by 1993, 5 percent of all Medicare beneficiaries—about 1.8 million people—were participating in the risk program. An HCFA evaluation of the program found that enrollees in the HMOs received comparable care to those enrolled in fee-for-service Medicare and had substantially lower out-of-pocket costs. However, the evaluation also found that the government wasn't saving any money by having the Medicare beneficiaries in the HMOs because Medicare beneficiaries with better health status were more likely to enroll in the HMOs (and therefore lower costs) (Brown et al. 1993).

The Medicare+Choice Program

Congress created the Medicare+Choice (M+C) program as part of the Balanced Budget Act of 1997 (BBA) to further expand enrollment in private plans within Medicare. The M+C program was intended to provide more alternatives to traditional fee-for-service Medicare by encouraging newer types of private health plans beyond the traditional HMO to enter the program.

The M+C program incorporated the existing Medicare risk program but also authorized a range of new plan options. In addition to HMOs, the BBA provided for: (1) preferred provider organizations (PPOs), which allow beneficiaries to seek out-of-network care at higher cost-sharing levels; (2) provider-sponsored organizations (PSOs), where the providers sponsor their own managed care organization rather than contracting with an HMO or PPO; and (3) private fee-for-service (PFFS) plans that do not restrict an enrollee's access to providers.²⁰ As under the Medicare risk program, beneficiary enrollment in private plans remained voluntary.

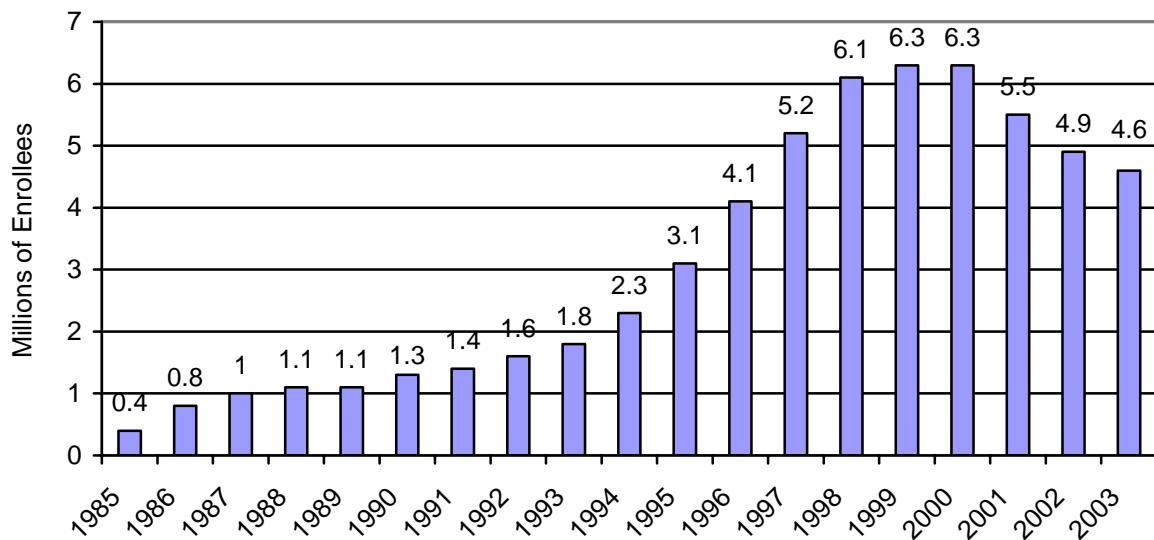
HCFA paid health plans an administered price based on the county of residence of each enrollee. County payment levels varied across the country to encourage health plans to enter areas that were previously underserved by managed care plans. County rates also reflected the geographic differences across country.

From 1999 on, significant numbers of health plans withdrew from the M+C program. In December 1998, there were 346 contracts in the Medicare risk program (CMS 1998), but

²⁰ Under the M+C program, Congress categorized HMOs, PPOs, and PSOs as coordinated care plans.

by 2003, just 155 coordinated care plans and private fee-for-service organizations were participating (CMS 2003). In total, approximately 2.4 million M+C enrollees were affected by plan withdrawals between 1999 and 2003 (Gold et al. 2004).

Figure A.1. Enrollment in Medicare Risk/Medicare+Choice Plans, 1985–2003



Source: Gold et al., 2004.

Note: Data for 1999–2003 are for enrollees in M+C coordinated care plans; data for prior years are for enrollees in Medicare risk contracts. All data are for December of the given year based on CMS’s annual “Medicare Managed Care Contract Plans Monthly Summary Report.”

Health plans cited a number of reasons for withdrawing from the program, including inadequate payments from the government, burdensome administrative requirements, and an inability to maintain an adequate provider network. For many national firms, Medicare was not a major line of business (Draper, Gold, and McCoy 2002).

Congress tried to make a number of changes in the program to encourage health plans to remain in the program or perhaps re-enter it. In 1999, the Balanced Budget Refinement Act (BBRA) relaxed barriers to re-entry for exiting plans and authorized new entry bonuses to health plans that entered areas previously not served by health plans. The BBRA also relaxed reporting requirements for PPOs to encourage greater participation in Medicare. Then in 2002, Congress passed the Benefits Improvement and Protection Act (BIPA), which raised payment rates to M+C plans, particularly in lower-paid areas. In addition to congressional fixes, CMS attempted to reduce the perceived administrative burden on health plans (Draper, Gold, and McCoy 2002). Despite congressional action, however, enrollment in the M+C program declined substantially (Figure A.1). By 2003, enrollment in the program had dropped to 4.6 million, down from its peak of 6.3 million in 1999.

Those Medicare beneficiaries remaining in the M+C program faced a changed environment as well. The traditional incentives for Medicare beneficiaries to join M+C plans had been lower premiums than Medigap’s and the availability of benefits not covered under the fee-for-service benefit package (Gold et al. 2001). Those M+C enrollees still in the program saw the benefit generosity of their health plans decline. Average monthly

premiums increased from \$6.37 in 1999 to \$37.35 in 2003 (Achman and Gold 2003), and pharmacy coverage, one of the most sought-after supplemental benefits, declined from 84 percent of enrollees in 1999 to 69 percent in 2003. Even those with drug coverage saw many of their health plans drop coverage of brand-name prescriptions (Achman and Gold 2003).

The Medicare Advantage Program

In late 2003, as part of the Medicare Modernization Act (MMA), Congress renamed the M+C program Medicare Advantage (MA). Congressional changes to the private plan component of Medicare were in the larger context of reforming the Medicare program and adding a prescription drug benefit. The MMA envisions a much larger role for private health plans within Medicare.

To provide immediate stability to the MA program, Congress increased payment rates to health plans in 2004 and 2005. Under the new payment rate methodology, no health plan will be paid less than 100 percent of the expected fee-for-service costs in a county. However, many health plans will be paid more than 100 percent of fee-for-service (Achman and Gold 2004b; Biles, Nicholas, and Cooper 2004; MedPAC 2004) because floor rates above fee-for-service costs had been established earlier in much of the country to try to attract health plans to previously underserved areas.

Beginning in 2006, all Medicare beneficiaries who want the Medicare prescription drug benefit will have to join a private plan. Those wishing to stay in traditional Medicare will be able to do so, but to access the drug benefit, they will need to join a private, freestanding prescription drug plan. Another way to get prescription drug coverage will be to enroll in a managed care organization that provides the drug benefit—either a local MA plan or a new regional PPO plan. Local MA plans will continue to choose which areas they serve, but new regional PPO plans will be required to serve one of 26 newly created regions. The regions span at least one and sometimes multiple states.

Under the restructured Medicare program, Medicare enrollees will have a stronger incentive to join either local or regional MA plans. The MA plans will be able to offer enrollees a coordinated set of benefits, including the prescription drug benefit. In comparison, an enrollee who wishes to stay in fee-for-service Medicare and who also wants the drug benefit will have to enroll in a prescription drug plan. That enrollee may also have a Medigap plan or other supplemental insurance plan to pay for some of the cost sharing charged in the fee-for-service Medicare program.

Since passage of the MMA, there has been increased health plan participation in the local MA program. The number of MA contracts in January 2005 is up to 181 coordinated care plans and private fee-for-service plans (CMS 2005). Enrollment is also beginning to increase as well; as of January 2005, it stands at 4.8 million (CMS 2005).

Moving Forward

As Medicare reform moves forward and the prescription drug benefit is implemented, it will be interesting to see how the role of private plans evolves within Medicare. As yet, private plan enrollment has never been more than 15 percent of total Medicare enrollment. However, the MMA provides greater incentive to beneficiaries to join health plans, through both increased payments that plans can use to restore benefit generosity and simplification of the Medicare benefit package that MA plans will be able to offer. Given these incentives, more beneficiaries may well choose to enroll in a local or regional MA plan.

APPENDIX B: OUT-OF-POCKET COST ESTIMATE METHODOLOGY

Out-of-pocket spending for Medicare Advantage enrollees was estimated using methodology from HealthMetrix, Inc. The methodology is based on utilization profiles for Medicare Advantage enrollees in good, fair, and poor health. The estimates reflect enrollee spending on premiums and preventive services such as physical exams (which are the same for all enrollees regardless of health status) and spending on prescription drugs, inpatient admissions, physician office visits, urgent care, and emergency room visits (which vary based on enrollee health status).

Since 2003, MA organizations have had the option of offering a plan with a reduced Medicare Part B premium. To ensure that our estimates reflect all out-of-pocket spending, MPR added the Medicare Part B premium into the calculations for out-of-pocket cost estimates.

To support estimates for out-of-pocket spending for prescription drugs and other medical services, we made assumptions about the costs of prescription drugs, how MA plans calculate their drug benefit limits, and the cost of other medical services. A detailed description on the costs assumptions and utilization profiles used in this paper is available on the HealthMetrix Research CostShare Report Web site at www.hmos4seniors.com, or by contacting the authors.

The model assumes no changes in utilization patterns or the price of medical services between 1999 and 2004. However, HealthMetrix Research changed the assumptions about the number and length of inpatient hospital stays expected over the course of the year among MA enrollees in fair and poor health in 2005. In 2005, HealthMetrix assumes that enrollees in fair health are expected to have two four-day inpatient stays, and enrollees in poor health are expected to have three four-day inpatient stays. In previous years, the model assumed that enrollees in fair health would have one three-day inpatient stay, and those in poor health would have two three-day inpatient stays over the course of the year. To provide consistent trend data, MPR used the original methodology in calculating the average out-of-pocket cost estimates for 2005, making them comparable to 1999–2004 estimates. Using the revised utilization assumptions, the average enrollee was estimated to incur \$2,022 in out-of-pocket costs in 2005. Enrollees in good, fair, and poor health were estimated to incur \$1,557, \$3,154, and \$5,323, respectively, in annual out-of-pocket costs.

The estimate for “all enrollees” was created by weighting out-of-pocket cost estimates for those in good, fair, and poor health according to the self-report health status of Medicare beneficiaries enrolled in Medicare managed care plans in the 1999 Medicare Current Beneficiary Survey (MCBS) (Liu and Sharma 2003). Data in the 1999 MCBS indicate that 79 percent of enrollees are in good health, 15 percent are in fair health, and 6 percent are in poor health.

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