

# **Private Insurance Plans & Medicare:**

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## **The Disappointing History**



**Congress Watch  
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## **Acknowledgments**

The principal author of *Private Insurance Plans & Medicare: The Disappointing History* was Public Citizen's Congress Watch legislative representative, Benjamin Peck, Ph.D. Research was conducted by legislative assistant April Greener. Congress Watch director Frank Clemente made significant editorial contributions to the report.

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# Private Insurance Plans & Medicare: The Disappointing History

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This week the House of Representatives is voting on legislation that would dramatically restructure the Medicare program so that it relies on private insurance plans. Under the proposal, the traditional Medicare program, which now covers almost 9 of 10 beneficiaries and guarantees them choice of almost any provider and standardized benefits, would be forced to compete with private insurance plan HMOs and PPOs. In this competition we can expect private plans to do almost anything to win: refusing to offer coverage in some parts of the country, especially rural areas; offering coverage in other areas one year only to withdraw later; forcing beneficiaries to scramble to find new sources of coverage; and limiting the number of doctors in their networks.

The intention of the bill is to push more Medicare beneficiaries to enroll in private insurance plans. The House Republican leadership's bill is more radical than legislation being considered in the Senate. Besides pushing beneficiaries into private insurance plans to get prescription drug coverage, the House legislation would also force many into private plans for their doctor and hospital coverage. In contrast, the Senate legislation would partially privatize Medicare by making private insurance companies the exclusive vehicle for obtaining subsidized prescription drug coverage. The Senate legislation would do less to push beneficiaries to enroll in private plans to obtain the doctor and hospital coverage they already have through Medicare.

This report exposes the disappointing history of private insurance plans in Medicare. Given their history, the House bill is likely to mean only more disappointment for seniors and people with disabilities. Here are the facts:

## I. Private HMO Plans Now In Medicare Have Proven Unreliable

- **HMOs do not serve rural parts of the United States well.** According to the Medicare Payment Advisory Commission, only 19 percent of rural Medicare beneficiaries in 2003 have the option of enrolling in a Medicare managed care plan (Medicare+Choice). That contrasts with 74 percent of beneficiaries living in urban areas.<sup>1</sup>
- **When HMOs serve an area they often prove unreliable and harm millions.** Between 1999 and 2003 there have been a total of 2.4 million occasions where Medicare beneficiaries have been forced to look for new providers after their HMO ceased providing service to them as part of a contract with the Medicare program, according to Centers for Medicare and Medicaid Services data. (See Figure 1) This includes withdrawals and scaling back of service areas by plans for 2003.
- **Ten states with the greatest number of beneficiaries dropped by HMOs.** The ten states with the greatest number of occasions where Medicare+Choice enrollees were dropped from their plans since 1999 are: Texas – 313,767; Florida – 264,170; California – 184,578;

New York – 179,941; Pennsylvania – 154,519; Ohio – 144,400; Maryland – 116,273; Connecticut – 110,783; Washington – 85,265; and New Jersey – 79,733. (See Figure 1)

- **Medicare HMO withdrawals affect a significant proportion of enrollees.** In 2001, when the highest number of beneficiaries were affected by withdrawals 13 percent of all beneficiaries enrolled in Medicare+Choice programs were dumped by their plan, according to CMS data. (Figure 2 provides year-by-year withdrawal data.)
- **In some states, more than 50 percent of those enrolled in private Medicare plans have been dropped by their plans in a given year.** The ten states (including the District of Columbia) with the highest percentage of their Medicare+Choice enrollees dropped in any one year from 1999 to 2003 were: South Dakota – 99 percent; Delaware – 95 percent; Arkansas – 90 percent; New Hampshire – 85 percent; Maine – 82 percent; Maryland – 79 percent; Utah – 76 percent; District of Columbia – 71 percent; Kansas – 54 percent; Connecticut – 52 percent. (See Figure 1)
- **Instability of private plans means that beneficiaries often are forced to give up relationships with a trusted doctor.** Figures for the number of beneficiaries affected by plan withdrawals alone do not adequately describe the instability created by relying on private plans to offer health care coverage.
  - A study prepared for the Kaiser Family Foundation found that 22 percent of beneficiaries affected by a plan withdrawal are forced to give up their relationship with their doctor.<sup>2</sup>
  - Another study found that beneficiaries in private plans often lose access to the doctor of their choice when the doctor does not renew his or her contract with the HMO. In 23 states at least 1 in 10 HMO doctors left the plan they were contracting with each year, and in 6 states the figure was 1 in 5 or more. Prominent reasons cited for doctors ending their contracts with HMOs were frustration with plans failure to pay doctors adequately and in a timely manner and the instability of market-based provider networks.<sup>3</sup>
- **Disrupting patients' relationship with a trusted doctor means lower quality health care.** Research suggests that long-term relationships between patients and their doctors lead to “increased patient satisfaction, lower health care costs, and lessen the need for hospitalization.”<sup>4</sup> The instability in doctor-patient relationships created by private plans makes it less likely that patients will be able to form beneficial long-term relationships with their doctors. Such relationships may be especially important to older Americans who use health care on a much more regular basis.
- **Private plans limit beneficiaries' choice of doctor.** It is generally accepted that HMOs limit enrollees' choice of doctor. The next section describes how this is also a problem with Preferred Provider Organizations (PPOs), the other type of managed care plan that the House Republican proposal would rely on to deliver doctor, hospital and drug benefits to seniors in Medicare.

**Figure 1**  
**Number of People Dropped by HMOs by State, 1999-2003**

State	Total Number of People Dropped*	Highest Percent Dropped in Any One Year
Alabama	5,263	5%
Alaska	0	0%
Arizona	69,430	11%
Arkansas	19,514	90%
California	184,578	5%
Colorado	42,804	9%
Connecticut	110,783	52%
Delaware	15,857	95%
District of Columbia	6,745	71%
Florida	264,170	12%
Georgia	27,549	36%
Hawaii	2,666	5%
Idaho	1,356	11%
Illinois	79,205	26%
Indiana	18,017	27%
Iowa	1,534	8%
Kansas	20,126	54%
Kentucky	21,194	43%
Louisiana	79,186	29%
Maine	1,632	82%
Maryland	116,273	79%
Massachusetts	46,310	9%
Michigan	35,275	39%
Minnesota	21,610	16%
Mississippi	1,042	14%
Missouri	32,020	12%
Montana	0	0%
Nebraska	5,413	38%
Nevada	9,592	12%
New Hampshire	17,821	85%
New Jersey	79,733	31%
New Mexico	15,954	37%
New York	179,941	13%
North Carolina	15,219	22%
North Dakota	15	2%
Ohio	144,400	22%
Oklahoma	10,924	13%
Oregon	16,809	4%
Pennsylvania	154,519	15%
Rhode Island	4,511	3%
South Carolina	1,060	46%
South Dakota	1,596	99%

<b>Tennessee</b>	20,611	43%
<b>Texas</b>	313,767	46%
<b>Utah</b>	18,562	76%
<b>Vermont</b>	0	0%
<b>Virginia</b>	48,254	44%
<b>Washington</b>	85,265	18%
<b>West Virginia</b>	148	1%
<b>Wisconsin</b>	18,572	24%
<b>Wyoming</b>	0	0%
<b>Total</b>	<b>2,386,825</b>	<b>13%**</b>

\*Figures in the total column overstate the number of discrete individuals affected by plan withdrawals because some individuals have been dropped more than once by a plan.

\*\*Figure does not represent a totaling of the numbers in the column above. Instead, it represents the percentage of all HMO enrollees nationally dropped in the year with the most enrollees dropped (2001).

Source: Centers for Medicare and Medicaid Services

**Figure 2**  
**Percent of Medicare HMO Beneficiaries Affected by HMO**  
**Withdrawals by Year and State**

State	1999	2000	2001	2002	2003
Alabama	0%	0%	4%	5%	0%
Alaska	0%	0%	0%	0%	0%
Arizona	1%	11%	10%	5%	0%
Arkansas	0%	12%	1%	90%	0%
California	1%	1%	3%	5%	2%
Colorado	9%	9%	3%	6%	0%
Connecticut	12%	8%	49%	52%	0%
Delaware	95%	0%	74%	33%	49%
District of Columbia	27%	0%	14%	0%	71%
Florida	8%	4%	12%	9%	4%
Georgia	14%	3%	36%	1%	0%
Hawaii	0%	0%	0%	5%	0%
Idaho	11%	0%	0%	0%	0%
Illinois	10%	1%	10%	26%	0%
Indiana	0%	0%	27%	14%	22%
Iowa	0%	8%	0%	0%	1%
Kansas	0%	5%	0%	23%	54%
Kentucky	0%	0%	27%	43%	0%
Louisiana	13%	29%	24%	0%	8%
Maine	0%	0%	82%	0%	0%
Maryland	36%	17%	79%	0%	62%
Massachusetts	8%	2%	9%	0%	0%
Michigan	0%	0%	0%	39%	12%
Minnesota	4%	3%	16%	0%	0%
Mississippi	0%	0%	0%	14%	0%
Missouri	0%	1%	8%	4%	12%
Montana	0%	0%	0%	0%	0%
Nebraska	0%	38%	0%	0%	0%
Nevada	0%	12%	0%	0%	0%
New Hampshire	23%	85%	22%	0%	0%
New Jersey	4%	3%	7%	31%	0%
New Mexico	0%	0%	37%	0%	0%
New York	11%	8%	13%	3%	1%
North Carolina	0%	0%	8%	0%	22%
North Dakota	2%	0%	0%	0%	0%
Ohio	9%	4%	22%	5%	11%
Oklahoma	0%	2%	13%	5%	0%
Oregon	4%	2%	3%	0%	0%
Pennsylvania	1%	0%	15%	10%	1%
Rhode Island	2%	3%	3%	0%	0%
South Carolina	0%	46%	0%	0%	0%
South Dakota	0%	0%	0%	0%	99%
Tennessee	0%	2%	43%	0%	0%

<b>Texas</b>	8%	8%	46%	18%	15%
<b>Utah</b>	76%	0%	0%	0%	0%
<b>Vermont</b>	0%	0%	0%	0%	0%
<b>Virginia</b>	21%	35%	44%	0%	43%
<b>Washington</b>	16%	6%	18%	7%	0%
<b>West Virginia</b>	0%	0%	0%	0%	1%
<b>Wisconsin</b>	0%	16%	3%	24%	0%
<b>Wyoming</b>	0%	0%	0%	0%	0%
<b>Total</b>	6%	5%	13%	9%	4%

Source: Centers for Medicare and Medicaid Services

## II. New Managed Care PPO Plans in Medicare Are Likely to Mean Limited Choice of Doctor in Rural Areas: Iowa Case Example

The Bush administration and Republican leaders' alternative to HMOs are Preferred Provider Organizations (PPOs). These private plans also present a huge problem for rural Americans – they greatly limit choice of doctor.

PPOs negotiate on behalf of insurance companies with a limited number of doctors in a geographic area who are willing to offer their services at a reduced price in exchange for the plan steering patients to them as a “preferred provider.” PPOs do offer some coverage for seeing doctors not in their plan networks, but enrollees can face significant additional costs for doing so.

PPOs are operating right now in rural areas under the Federal Employees Health Benefits Program (FEHBP). FEHBP offers health insurance to federal employees, retirees and their families and it is the model for a “reformed” Medicare program touted by House bill proponents. Public Citizen’s study of 20 counties in Iowa, entitled *Bush Plan to Privatize Medicare: Limiting Patient Choice of Doctors in Iowa*, found the following about how these plans will hurt seniors choice of doctors:

### Generalists

- In the 20 non-urban Iowa counties studied, there were more than twice as many generalist physicians participating in the Medicare program (579) compared with the number participating in Blue Cross and Blue Shield standard option (265), the private PPO plan with the broadest network of providers in FEHBP. (See Figure 3) This means that there were more than twice as many generalists available to Iowa patients under Medicare as compared to Blue Cross and Blue Shield.
- After Blue Cross and Blue Shield, the other 6 PPO plans in non-urban counties all have fewer than 15 percent of the generalists that participate in Medicare. For beneficiaries concerned about being able to continue seeing their doctors this indicates that the other smaller plans may not be a serious option for them.

### Cardiovascular Disease Specialists

- For the 20 non-urban counties, the study found that Medicare had 81 cardiac specialists participating. The private PPO plan with the widest network after Medicare, Blue Cross and Blue Shield standard option, had only 48 participating cardiac specialists – 41 percent fewer than Medicare. (See Figure 3)
- For enrollees in any of the 6 smaller PPO plans in non-urban areas, their choices of participating cardiac specialists would be even more limited. The best of the second tier plans, Mail Handlers, has 24 specialists – 70 percent fewer than participate with Medicare.

## **Oncologists**

- For the 20 non-urban counties, the study found that there were 11 participating oncologists in Medicare. The private PPO plans with the widest network after Medicare, Mail Handlers and the National Association of Letter Carriers, each had 6 participating oncologists – 44 percent fewer than Medicare. (See Figure 3)

## **Narrow provider networks in private plans mean additional costs for beneficiaries**

- While PPOs do offer some coverage for seeing doctors not in their plan networks, enrollees can face significant additional costs for doing so. In the end, it is likely that they will be forced to pay more than they would have paid if they had remained in traditional Medicare to see the same doctor. First, they can face coinsurance rates greater than the 20 percent required under Medicare. Additionally, their coinsurance might be based on a higher allowed payment amount than Medicare’s approved fees. Finally, a FEHBP enrollee could be billed for the balance between their plan’s payment limit and a non-PPO physician’s charge, a practice often referred to as “balanced billing.” It is the practice of balanced billing that could add the most to patients’ costs.
- For example, if a Medicare beneficiary in the traditional program were to be seen by a doctor and Medicare specifies that the charge for that visit is \$100, the beneficiary would be responsible for \$20, 20 percent of the doctor’s fee. If a beneficiary were to be seen by a doctor who participates with their PPO they could be responsible for the same \$20 if their PPO had negotiated the same \$100 fee arrangement as Medicare with that doctor. However, if a beneficiary enrolled in a PPO were to see a non-participating doctor, then that doctor may charge \$150 for the same visit. And the PPO may “recognize” only \$100 of that bill. Also, the PPO is likely to pay a lower percentage of that recognized charge, perhaps only 70 percent, than they paid for an in-network doctor. Thus, the total out-of-pocket cost to an enrollee for the visit to a non-network doctor could be \$80, instead of \$20: \$30 for coinsurance (30 percent of the \$100 PPO charge), and an additional \$50 to make up the difference between the PPOs “recognized” charge of \$100 and the \$150 the doctor expects to be paid.

**Figure 3**

**Number of Doctors Participating in Medicare and FEHBP PPO Plans  
in 20 Randomly Selected Iowa Non-Urban Counties**

	MEDICARE	BCBS	GEHA	MAIL HANDLERS	ALLIANCE	APWU	NALC	PBP
<b>GENERALISTS</b>								
ADAIR	8	6	0	0	1	0	1	2
BENTON	14	11	8	0	5	5	0	8
BUENA VISTA	51	21	0	2	1	2	2	0
CEDAR	26	14	2	4	7	1	2	1
CLAY	35	15	0	0	0	0	0	1
DAVIS	10	4	3	3	0	2	3	0
DUBUQUE	77	63	0	25	2	26	25	0
FREMONT	6	3	2	0	3	0	0	1
HANCOCK	31	5	0	0	0	0	0	0
HUMBOLDT	17	6	0	0	0	0	0	0
JEFFERSON	40	13	1	0	1	0	0	0
LEE	49	22	2	10	14	9	10	0
MADISON	44	8	3	5	7	8	5	0
MITCHELL	26	3	0	0	0	0	0	0
O'BRIEN	26	11	7	9	0	9	9	0
POCAHONTAS	32	4	0	0	0	0	0	0
SAC	6	10	0	2	0	3	2	0
TAMA	13	13	2	7	1	7	7	5
WARREN	32	21	9	15	12	13	14	13
WINNESHIEK	36	12	11	1	0	1	1	0
<i>Total</i>	<b>579</b>	<b>265</b>	<b>50</b>	<b>83</b>	<b>54</b>	<b>86</b>	<b>81</b>	<b>31</b>
<b>CARDIOVASCULAR</b>								
ADAIR	4	0	0	0	0	0	0	0
BENTON	0	0	0	0	0	0	0	0
BUENA VISTA	13	7	0	0	0	0	0	0
CEDAR	0	0	0	1	12	1	1	0
CLAY	14	13	0	0	0	0	0	0
DAVIS	5	0	0	10	0	0	10	0
DUBUQUE	5	5	0	3	0	3	3	0
FREMONT	3	3	4	2	2	1	2	0
HANCOCK	8	2	0	0	0	0	0	0
HUMBOLDT	0	0	0	0	0	0	0	0
JEFFERSON	0	0	0	0	0	0	0	0
LEE	0	0	0	2	0	0	2	0
MADISON	4	0	0	5	0	0	5	0

	MEDICARE	BCBS	GEHA	MAIL HANDLERS	ALLIANCE	APWU	NALC	PBP
MITCHELL	0	0	0	0	0	0	0	0
O'BRIEN	10	7	0	0	0	0	0	0
POCAHONTAS	3	4	0	1	1	0	0	0
SAC	7	5	0	0	0	0	0	0
TAMA	0	0	0	0	0	0	0	0
WARREN	4	0	0	0	0	0	0	0
WINNESHIEK	1	2	2	0	0	0	0	0
<i>Total</i>	<b>81</b>	<b>48</b>	<b>6</b>	<b>24</b>	<b>15</b>	<b>5</b>	<b>23</b>	<b>0</b>
<b>ONCOLOGY</b>								
ADAIR	2	0	0	0	0	0	0	0
BENTON	0	0	0	0	0	0	0	0
BUENA VISTA	0	0	0	0	0	0	0	0
CEDAR	0	0	0	0	0	0	0	0
CLAY	1	0	0	0	0	0	0	0
DAVIS	0	0	0	0	0	0	0	0
DUBUQUE	7	3	1	3	0	3	3	0
FREMONT	0	0	0	0	0	0	0	0
HANCOCK	0	0	0	0	0	0	0	0
HUMBOLDT	0	0	0	0	0	0	0	0
JEFFERSON	0	0	0	1	0	0	1	0
LEE	0	0	0	2	0	0	2	0
MADISON	0	0	0	0	0	0	0	0
MITCHELL	0	0	0	0	0	0	0	0
O'BRIEN	0	0	0	0	0	0	0	0
POCAHONTAS	0	0	0	0	0	0	0	0
SAC	0	0	0	0	0	0	0	0
TAMA	0	0	0	0	0	0	0	0
WARREN	0	0	0	0	0	0	0	0
WINNESHIEK	1	1	1	0	0	0	0	0
<i>Total</i>	<b>11</b>	<b>4</b>	<b>2</b>	<b>6</b>	<b>0</b>	<b>3</b>	<b>6</b>	<b>0</b>

BCBS: Blue Cross and Blue Shield  
GEHA: Government Employees Hospital Association  
Alliance: Alliance Health Plan  
APWU: American Postal Workers' Union  
NALC: National Association of Letter Carriers  
PBP: Postmasters Benefits Plan

Source: Public Citizen analysis of Blue Cross and Blue Shield (<http://www.fepblue.org/>), Government Employees Hospital Association (<http://www.geha.com>), Alliance (<http://www.ahbp.com>), American Postal Workers' Union (<http://www.apwuhp.com>), National Association of Letter Carriers (<http://www.nalc.org/depart/hbp>), and Postmasters Benefits Plan (<http://www.postmasters.org/pbp.asp>) data.

## Endnotes

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<sup>1</sup> Scott Harrison, “New developments in the Medicare+Choice program,” Presentation delivered at Meeting of Medicare Payment Advisory Commission (MedPAC), October 10, 2002.

<sup>2</sup> Barents Group, WESTAT, Kaiser Family Foundation “How Medicare HMO Withdrawals Affect Beneficiary Benefits, Costs, and Continuity of Care,” Kaiser Family Foundation, November 1999, p. 26.

<sup>3</sup> Geraldine Dallek and Andrew Dennington, “Physician Withdrawals: A Major Source of Instability in the Medicare+Choice Program,” Commonwealth Fund, January 2002.

<sup>4</sup> Dallek and Dennington, January 2002, p. 1.