Medicare Privatization:
Bad for Seniors and People with Disabilities

Congress Watch
February 2003

Acknowledgments

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Technical Reviewer

Public Citizen would like to acknowledge Marilyn Moon of the Urban Institute who reviewed an earlier version of this report. Whatever errors of commission or omission remain should be attributed to Public Citizen.

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Table of Contents

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Executive Summary

President Bush and some members of Congress have said they want to "modernize" Medicare and add modest prescription drug coverage, but their real goal is to privatize the Medicare program. In January, the press reported that the administration was poised to introduce a proposal that would have forced seniors and people with disabilities to leave the traditional Medicare program and join a private plan, either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), in order to obtain any coverage for prescription drugs. That proposal has received a cold reception from important members of the President's own party, including Sen. Charles Grassley (R-Iowa), chairman of the Senate's powerful Finance Committee, which has jurisdiction over Medicare.

The criticism it has received may lead the administration to back off the most extreme elements of its proposal. Even if it does, the ultimate goal of the administration and its congressional allies is clear: they want to turn Medicare over to private insurers. What is ironic about the drive to privatize Medicare, unlike the case for Social Security privatization, is that we already have considerable experience with private plans in Medicare. As this report makes clear, the experience is a failure.

This report is an update of one issued by Public Citizen in September of 2002. It includes new information on the Bush administration's PPO demonstration program, which is an attempt to introduce a new type of managed care plan into Medicare that increases choice of doctor. The report also includes new information on HMO premiums and drug benefits for 2003. Based on Medicare's experience with private plans, the report concludes that relying more heavily on private plans is not the approach to reforming Medicare that is in the best interests of beneficiaries. Nor is it what beneficiaries desire. Instead, the existing Medicare program should be expanded to include prescription drug coverage.

The following are the report's major findings:

Private Plans Are Unreliable

- **Medicare HMOs offer unreliable coverage**. Real-world experience shows that beneficiaries cannot rely on HMOs to provide reliable coverage. From 1999 through the beginning of 2003 there were a total of 2.4 million occasions when Medicare beneficiaries were forced to look for new providers after their HMO reduced or ceased to provide service to them as part of a contract with the Medicare program, according to the Centers for Medicare and Medicaid Services (CMS). In 2001, the year with the highest number of beneficiaries affected by withdrawals, 13 percent of those enrolled in managed care plans were dumped by their plan. (See Figures 1 and 2).[1]

- **The ten states with the greatest number of occasions where Medicare+Choice enrollees were dropped from their plans since 1999 were:** 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 drug coverage is unreliable.** The number of states that had *no* Medicare HMO offering prescription drug coverage jumped from 9 to 17 from 1999 to 2003 – an 89 percent increase. (See Figure 3)

- **Unstable health care means lower quality health care.** Twenty-two percent of patients affected by a plan withdrawal were forced to switch doctors and many more were forced to switch when their physician stopped contracting with their HMO, according to one study. 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." 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.

Medicare Is More Efficient and Better at Controlling Costs than Private Plans

- **HMOs are much less efficient than the Medicare program**. The Medicare program spends a mere 2 percent on administrative costs, according to the Medicare Board of Trustees. By contrast, according to the Inspector General of the Department of Health and Human Services (HHS), HMOs on average spend 15 percent of their revenue on administrative costs rather than on health care. Some HMOs spend as much as 32 percent of their revenue on administration. This is a tremendous waste of resources that could be allocated instead to providing health care.

- **HMOs are paid more than it costs to cover beneficiaries directly through Medicare, yet, they still demand higher payments.** According to the General Accounting Office (GAO), from 1998 to 2000 federal payments to Medicare HMOs exceeded by 13.2 percent the costs the program would have incurred had providers been paid directly for care. In one year, 1998, Medicare HMOs were paid $5.2 billion more than it would have cost to cover them through the traditional Medicare program. (See Figure 4) Even the private plans that withdrew from the program between 1998 and 2000 received an average excess payment of 22 percent, which they used to provide extra benefits, such as prescription drug coverage.

- **Private indemnity insurers are much less efficient than the Medicare program.** Like HMOs, private Medicare supplemental insurance (Medigap) plans are extremely inefficient. They spend an average of more than 20 cents out of each premium dollar on agents' fees, marketing, advertising, administration and profits – not on health care, according to the General Accounting Office. In contrast, Medicare spends just 2 cents out of each dollar on administrative costs. These private insurance companies that now offer Medigap policies, are most likely to be the ones that would offer drug-only insurance if the

Bush administration's proposal to offer drug coverage through private plans becomes law. They would cover enrollees who wanted drug coverage but did not want to join an HMO to get it. This would be an extremely inefficient way to provide drug coverage.

- **Private insurers are *not* able to negotiate drug price discounts that are as deep as what the federal government gets.** Today, the federal government's Veterans and Defense departments negotiate price cuts of 52 percent off the price paid at the pharmacy. HMOs and other private sector purchasers negotiate discounts of only 12 to 40 percent. There is no reason that Medicare with its large market power should settle for the shallow discounts private insurers are able to achieve. It should demand price discounts at least as good as what the Department of Veterans Affairs receives.

Private Plans Not Viable in Much of the Country

- **Private plans are not viable in much of the country, especially rural communities.** In 2003 only 61 percent of beneficiaries will have access to enrollment in an HMO, according to the Medicare Payment Advisory Commission. This represents a significant decline from 1998 when 74 percent of beneficiaries had access to an HMO. Although one of the stated goals of the 1997 Medicare+Choice program reforms was to make HMOs available to more beneficiaries, certain areas of the country have proved inhospitable to HMOs. This is particularly the case in rural areas where there may be few health care providers, and providers have little incentive to contract with an HMO to offer services for a cut-rate fee.

Bush Administration PPO Demonstration Offers Little for Beneficiaries

- **Bush's PPO demonstration program will not increase the availability of private plans to the Medicare population.** Part of the administration's goal in creating the PPO demonstration program was to increase enrollment in private plans. However, in general insurance companies are offering PPO products in areas that already have an HMO available. They are not going into rural areas, for example, which are not served by HMOs. In total the PPO demonstration plans will lead to an increase of less than 2 percent in the number of beneficiaries who have *access* to a private plan.

- **Bush's PPO demonstration program meets the needs of the insurance industry not the needs of Medicare beneficiaries.** Under the demonstration program, PPOs will be allowed to charge beneficiaries more than HMOs are allowed to charge in premiums and copayments for Medicare covered services, but they will not give beneficiaries access to comprehensive and reliable benefits. On average it will cost beneficiaries $1,000 a year in additional premiums to enroll in a PPO. Like HMOs, PPOs can and will drop out of the program and their coverage for prescription drugs will be meager. Of the most generous plans offered (one for each of 18 areas in the country where PPOs offering some coverage for prescription drugs are being made available), according to information available from the Centers for Medicare and Medicaid Services only 4 will provide any coverage for brand-name drugs. One of them, Humana Gold PPO in Florida, will give beneficiaries a $5-off coupon for brand-name prescriptions. In 6 of the 18, beneficiaries will pay more in annual premiums to enroll in the plan than they will get in coverage for prescription drugs.

Increasing The Number of Plans Seniors Have to Choose from Will not Help Them

- **Seniors Prefer Traditional Medicare to Private Plans.** The majority of Medicare beneficiaries who have access to a private-plan HMO choose not to enroll. Moreover, the proportion of enrollees in the program has fallen steadily – from 17 percent in 1998 to 11 percent in 2003.

- **Beneficiaries are more concerned about whether they have access to reliable and reasonably priced benefits than in having a great number of plans to choose from.** A survey of beneficiaries in 2000 conducted by Mathematica found that 44 percent had never seriously considered their choices of health care coverage, and 14 percent last thought about it when they first became eligible for Medicare.

- **Health problems among seniors make proposals relying on private plan choice unworkable**. Nearly a quarter (23 percent) of Medicare beneficiaries have health (e.g., poor hearing or eyesight) or cognitive problems. One national survey found that 44 percent of adults over the age of 60 are functionally illiterate. Such problems make it difficult for beneficiaries to evaluate the important differences between prescription drug coverage offered by multiple HMOs or insurance companies. It would be much better to guarantee them a simple, easily understood, comprehensive benefit package through the traditional Medicare program.

Private Plans Game the System to the Detriment of Consumers and Taxpayers

- **HMOs cherry-pick the healthiest beneficiaries.** In order to make money, HMOs target their membership promotions to the healthiest seniors and try to avoid people with disabilities. This is likely to be one of the factors that has led to a situation where 13.8 percent of Medicare beneficiaries enrolled in the traditional Medicare program had both cognitive and physical difficulties, but only 6.6 percent of Medicare HMO enrollees reported such problems. The cost differences in caring for beneficiaries with cognitive and physical problems compared to those without such problems was dramatic in 1997 – $20,332 vs. $5,037. The HMOs and insurance companies that privatizers would rely on to provide health care coverage, including for prescription drugs, would be likely to continue such behavior in order to reduce their exposure to costly beneficiaries. (See Figures 5 and 6)

- **HMOs dump sick beneficiaries onto the government program in order to avoid the cost of treating them.** In general, Medicare pays HMOs a set amount for each beneficiary that a plan enrolls, and then the plan must cover the cost of treating patients from the "capitation" payments it receives. From 1991 to 1996 the U.S. Department of Health and Human Services found that Medicare paid hospitals $224 million for inpatient services provided to beneficiaries within three months of their disenrollment, whereas Medicare would have paid the private plans just $20 million in capitation payments if the beneficiaries had remained in the private plans – a difference of $204 million, or more than 1,000 percent!

I. Background

The most conservative elements in the Republican party have long opposed the popular Medicare program. Historian Robert Dallek has noted that former President Ronald Reagan saw Medicare as "the advance wave of socialism that would 'invade every area of freedom in this country.'"[2] Newt Gingrich, the former leader of the House Republicans, commented in 1995 about the traditional fee-for-service Medicare program that insures the vast majority of the nation's seniors, "Now, we don't get rid of it in round one because we don't think that's politically smart and we don't think that's the right way to go through a transition. But we believe it is going to wither on the vine because we think people are voluntarily going to leave it--voluntarily."[3]

Under the traditional fee-for-service Medicare program beneficiaries are able to go to any doctor that accepts Medicare (the vast majority do), and they are covered for their health care costs. Some beneficiaries elect to leave the traditional Medicare program and receive coverage from an HMO, which restricts their choice of doctor, because HMOs generally offer some additional benefits that are not part of traditional Medicare's benefits package. The privatizers want to see as much as possible of the program turned over to private plans, including HMOs.

The Bush administration shares the historical antipathy of the most conservative elements of the Republican party to the traditional Medicare program. The administration's proposal to lure beneficiaries away from the program to private HMO and new PPO plans reflects this antipathy. It has supported proposals by Senators Breaux and Frist that would dramatically transform the Medicare program. Under Breaux-Frist I, (S. 357), offered in the 107th Congress, the current Medicare program with its guaranteed benefits would have been discarded and replaced by a system in which beneficiaries would receive a set amount of money to purchase health insurance in the private market or from the traditional Medicare program.

Supporters of privatization occupy important leadership positions in the Republican party. Senator Frist is now the Senate Majority Leader and Rep. Bill Thomas (R-Calif.), the author of privatization legislation in the House, is Chairman of the pivotal House Ways and Means Committee.

Conservatives have not believed the time was politically ripe for legislation completely privatizing the Medicare program, including doctor and hospital services that are already covered by Medicare. Instead, privatizers are pushing a three-part, incremental agenda.

1) First, they would like an increase in payments to plans in the M+C program in order to demonstrate the feasibility of the larger transformation of Medicare. They are aware that critics point to the failures of the M+C program as proof of the folly of privatization.

2) Second, they have established a demonstration program designed to show the feasibility of a new type of plan in the M+C program. The administration launched its Preferred Provider Organization (PPO) demonstration program last year. PPOs differ from HMOs in that they generally do not restrict patients' ability to get the care they want as much as HMOs. (Doctors generally do not have to seek prior authorization from the PPO before ordering tests or doing a procedure that they believe their patient needs.) They also do not directly prohibit

enrollees from seeing the doctor of their choice. However, that freedom of choice comes at a price. PPOs under the demonstration program are charging premiums that in general are higher than the premiums charged by HMOs, and if a beneficiary's doctor of choice does not contract with the PPO they are enrolled in, then the beneficiary typically will have to pay even more to see their doctor. PPOs control costs by contracting with a group of providers who agree to accept discounted payments for treating plan members. Members have an incentive to seek care from in-network providers, because their copayments and coinsurance are less when they do. The PPO does cover some of the cost of seeing out-of-network providers as well.

Tom Scully, Administrator of the Centers for Medicare and Medicaid Services, though he did not indicate that he was speaking for the administration, recently described the administration's privatization agenda. He explained that if it were up to him, most Medicare recipients would get their care through PPOs and HMOs.[4] Given that any such radical change in Medicare will likely be very controversial in Congress, the PPO demonstration and the proposed increase in spending for the Medicare+Choice plans proposed by the administration is "the best that we can do at this time," according to Scully. Representative Thomas in 2001 also voiced his support for an incremental privatization agenda. He urged the administration to move the privatization agenda forward through administrative actions. His worry was that "Congress would move ahead on prescription drugs for Medicare beneficiaries – a costly new benefit – without passing a more comprehensive set of changes . . ."(e.g. privatization of the program).[5]

3) Third, the privatizers oppose the creation of a drug benefit offered directly by the Medicare program. They will only support coverage for drugs if private plans are solely responsible for offering it, as was done in the House-passed prescription drug legislation in the 107th Congress, H.R. 4954. This proposal was somewhat more moderate than the proposal that was reported to be under consideration by the Bush administration in January 2003. H.R. 4954 would have allowed beneficiaries who stayed in the traditional Medicare program to get coverage for their prescription drugs through private indemnity insurance plans. It would not have forced them into managed care plans where they would have to give up their choice of doctor in order to get drug coverage. Either way, the agenda of the privatizers is to use the drug benefit to demonstrate the effectiveness of private plans in the Medicare program.

The reception to the President's plan may chasten the privatizers in the short term, but their long-term objectives should not be in doubt. This report argues that the nation's seniors and people with disabilities would be much better served if the administration and Congress strengthened the traditional Medicare program, instead of the private plans.

II. Private Plans Are Unreliable and Inefficient

A. Private Plans Cover a Small Proportion of Medicare Beneficiaries

The 1997 Balanced Budget Act (BBA) created the M+C program. One of the goals of the program was to increase the number of beneficiaries enrolled in private plans by increasing payments to HMOs so that they would provide services in areas where they had not before. Another goal of the BBA was to increase the kinds of plans that contract with Medicare to provide health care. It has failed to accomplish these goals. The new types of private plans that the BBA made room for were Provider Sponsored Organizations, Medical Savings Accounts, Preferred Provider Organizations, and Private Fee for Service organizations. (See Appendix A for a discussion of the plans authorized by the 1997 BBA and their current status.) However, today these new plans enroll a miniscule portion of the Medicare population and HMOs share of the Medicare population while significant is relatively small.

In 2003, only 61 percent of beneficiaries will have access to an HMO. This represents a significant decline from 1998, when 74 percent of beneficiaries had access to an HMO.[6] Certain areas of the country have proven inhospitable to HMOs. This is particularly the case in rural areas where there may be few health care providers, and therefore providers have little incentive to contract with an HMO to offer services for a cut-rate fee.

The Sterling company has made a private fee-for-service (PFFS) option available in many parts of the country, particularly rural areas where HMOs are not available. Theoretically, this increases the availability of M+C plans to 78 percent of all beneficiaries in 2003. However, Sterling is the only PFFS plan available nationally[7], and it enrolls a tiny fraction of beneficiaries, a little more than 20,000, or less than one-tenth of one-percent of the Medicare population.[8] This has obviously not been an attractive alternative for beneficiaries. So it is more realistic to think of 61 percent as the actual proportion of beneficiaries for whom the M+C program represents an alternative source of coverage from the traditional Medicare program.

Furthermore, even when coverage from a private plan is available, the majority of beneficiaries opt to stay in traditional Medicare where they retain the ability to see the doctor of their choice. When the 1997 BBA passed, Congress estimated that by 2002 25 percent of beneficiaries would be enrolled in private plans.[9] Instead, the proportion of beneficiaries enrolled in managed care has been falling steadily since 1998 when 17 percent of beneficiaries were enrolled.[10] In 2003 just 11 percent of beneficiaries are expected to be enrolled in private plans.[11]

B. HMOs Have Proven to Be Unreliable

Unlike the traditional Medicare program, which guarantees coverage to all beneficiaries no matter where they live, coverage through private plans is unreliable because plans back out of the program. Today, Medicare's 40 million beneficiaries can choose to have doctor and hospital services covered by the traditional fee-for-service Medicare program,

in which they retain freedom to see the doctor and use the hospital of their choice. Or, for the 61 percent with an HMO available to them, they can elect to be covered under the M+C program.[12]

HMO health care coverage for Medicare beneficiaries is a concept that has not fared well in practice. Many parts of the country are unattractive for HMOs, and millions of Medicare beneficiaries have been affected by private plans' on-again, off-again relationship with the program:

- Since 1999 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 CMS data. (See Figure 1) This includes recently announced withdrawals and scaling back of service areas by plans for 2003.

- The ten states with the greatest number of occasions where Medicare+Choice enrollees were dropped from their plans since 1999 were: 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)

- Withdrawals affect a significant proportion of M+C enrollees. In 2001, when the highest number of beneficiaries were affected by withdrawals 13 percent of all beneficiaries enrolled in M+C programs were dumped by their plan, according to CMS data. (See Figure 2)

- HMOs offering drug benefits are becoming increasingly hard to come by. In 1999, nine states and the District of Columbia had no Medicare+Choice plan offering prescription drug coverage. The number of states that do not have a Medicare+Choice plan offering drug coverage jumped to 17 in 2003 – an 89 percent increase.[13] (See Figure 3)

- 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.[14] Another study found that beneficiaries in private plans often lose access to the doctor of their choice when he or she does not renew their contract with the HMO that is serving them. 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.[15]

- 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."[16] 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. Long-term relationships with their doctors may be especially important to older Americans who use health care on a much more regular basis.

Figure 1

Number of Medicare Beneficiaries Affected by HMO Withdrawals by Year and State

State	1999	2000	2001	2002	2003*	Total**
Alabama	0	0	2,530	2,733	0	5,263
Alaska	0	0	0	0	0	0
Arizona	3,307	30,887	24,327	10,909	0	69,430
Arkansas	0	2,389	284	16,841	0	19,514
California	8,744	12,984	52,464	83,634	26,752	184,578
Colorado	14,526	14,574	4,454	9,250	0	42,804
Connecticut	12,175	8,638	51,185	38,785	0	110,783
Delaware	11,031	0	3,560	815	451	15,857
District of Columbia	2,362	0	932	0	3,451	6,745
Florida	62,206	29,292	87,727	59,348	25,597	264,170
Georgia	6,080	1,432	19,689	348	0	27,549
Hawaii	0	0	0	2,666	0	2,666
Idaho	1,356	0	0	0	0	1,356
Illinois	18,321	2,001	18,144	40,539	200	79,205
Indiana	0	0	9,081	4,017	4,919	18,017
Iowa	0	1,433	0	0	101	1,534
Kansas	0	1,416	0	6,765	11,945	20,126
Kentucky	0	0	9,153	12,041	0	21,194
Louisiana	14,336	33,959	25,131	0	5,760	79,186
Maine	0	0	1,632	0	0	1,632
Maryland	34,595	15,521	53,038	0	13,119	116,273
Massachusetts	18,296	5,621	21,781	12	600	46,310
Michigan	0	0	146	31,446	3,683	35,275
Minnesota	4,052	2,955	14,278	0	325	21,610
Mississippi	0	0	0	1,042	0	1,042
Missouri	124	1,897	10,112	4,965	14,922	32,020
Montana	0	0	0	0	0	0

Nebraska	0	5,413	0	0	0	5,413
Nevada	0	9,592	0	0	0	9,592
New Hampshire	3,911	13,412	498	0	0	17,821
New Jersey	8,172	5,707	12,411	53,144	299	79,733
New Mexico	128	16	15,810	0	0	15,954
New York	54,642	38,703	64,329	15,590	6,677	179,941
North Carolina	0	0	3,872	0	11,347	15,219
North Dakota	15	0	0	0	0	15
Ohio	24,775	13,031	65,617	13,993	26,984	144,400
Oklahoma	0	1,190	7,216	2,518	0	10,924
Oregon	7,011	3,089	5,767	442	500	16,809
Pennsylvania	6,198	844	89,641	54,561	3,275	154,519
Rhode Island	781	2,036	1,694	0	0	4,511
South Carolina	0	1,060	0	0	0	1,060
South Dakota	0	0	0	0	1,596	1,596
Tennessee	0	652	19,865	0	94	20,611
Texas	28,554	31,707	180,749	45,977	26,780	313,767
Utah	18,562	0	0	0	0	18,562
Vermont	0	0	0	0	0	0
Virginia	9,259	16,655	14,618	0	7,722	48,254
Washington	30,515	11,673	32,177	10,900	0	85,265
West Virginia	0	0	0	18	130	148
Wisconsin	0	6,796	1,410	10,366	0	18,572
Wyoming	0	0	0	0	0	0
TOTAL	**404,034**	**326,575**	**925,322**	**533,665**	**197,229**	**2,386,825**

*Based on plan withdrawals for 2003 announced in September of 2002.

**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.

Source: Public Citizen analysis of Centers for Medicare & Medicaid Services data.

Figure 2

Number of Beneficiaries Affected by Withdrawals as a Proportion of the Medicare+Choice Enrollees

State	Affected Enrollees 2001	Total M+C Enrollees 2000	Percent Affected
Alabama	2,530	60,173	4%
Alaska	N/A	127	0%
Arizona	24,327	250,578	10%
Arkansas	284	19,118	1%
California	52,464	1,581,670	3%
Colorado	4,454	162,991	3%
Connecticut	51,185	103,433	49%
Delaware	3,560	4,781	74%
District of Columbia	932	6,465	14%
Florida	87,727	751,905	12%
Georgia	19,689	53,965	36%
Hawaii	N/A	53,985	N/A
Idaho	N/A	16,583	N/A
Illinois	18,144	185,841	10%
Indiana	9,081	34,139	27%
Iowa	N/A	16,903	N/A
Kansas	N/A	30,143	N/A
Kentucky	9,153	34,201	27%
Louisiana	25,131	105,452	24%
Maine	1,632	2,000	82%
Maryland	53,038	66,798	79%
Massachusetts	21,781	238,942	9%
Michigan	146	80,939	N/A
Minnesota	14,278	86,646	16%
Mississippi	N/A	5,664	N/A
Missouri	10,112	133,911	8%
Montana	N/A	325	N/A
Nebraska	N/A	10,723	N/A
Nevada	N/A	80,348	N/A
New Hampshire	498	2,264	22%

New Jersey	12,411	168,933	7%
New Mexico	15,810	43,172	37%
New York	64,329	498,232	13%
North Carolina	3,872	48,282	8%
North Dakota	N/A	805	N/A
Ohio	65,617	295,510	22%
Oklahoma	7,216	54,346	13%
Oregon	5,767	184,613	3%
Pennsylvania	89,641	597,422	15%
Rhode Island	1,694	57,773	3%
South Carolina	N/A	1,083	N/A
South Dakota	N/A	551	N/A
Tennessee	19,865	46,343	43%
Texas	180,749	389,391	46%
Utah	N/A	6,769	N/A
Vermont	N/A	137	N/A
Virginia	14,618	33,059	44%
Washington	32,177	181,982	18%
West Virginia	N/A	25,558	N/A
Wisconsin	1,410	45,924	3%
Wyoming	N/A	1,441	N/A
Grand Total	**933,687**	**6,862,339**	**13%**
(Grand total includes about 8,400 beneficiaries who lived outside of the plan's service area and weren't included in the data above.)			

Source: Public Citizen analysis of Centers for Medicare and Medicaid Services data.

UPDATED JUNE 24, 2003

Figure 3

States without Medicare+Choice HMOs Offering Rx Drug Coverage

1999	2003
Alaska	Alaska
Delaware	Arkansas
District of Columbia	Delaware
Iowa	District of Columbia
New Hampshire	Hawaii
South Carolina	Idaho
South Dakota	Indiana
Utah	Maine
Vermont	Maryland
Wyoming	Montana
	North Dakota
	South Carolina
	South Dakota
	Utah
	Vermont
	West Virginia
	Wisconsin
	Wyoming

Source: Public Citizen analysis of Centers for Medicare and Medicaid Services data.

C. Increased Payments to Private Plans Will not Necessarily Bring More Plans Into the Program and Is Unlikely to Make Them More Reliable

The managed care industry has argued that HMO withdrawals from the Medicare program are the result of low government payments to private plans. Privatizers argue that increased payments to private plans will assure their participation in the drug coverage program if one is created, and that they will continue participating in the current M+C program under which they cover hospital and doctor costs.

The Medicare program's experience with private plans suggests this is incorrect. There is a considerable body of evidence that indicates Medicare+Choice plans are overpaid, not underpaid. (See section below, "Medicare HMOs Are Overpaid"). Moreover, a recently released study by the Henry J. Kaiser Family Foundation[17] and an earlier report by the General Accounting Office (GAO)[18] have found that many other factors contribute to withdrawal decisions besides payment levels.

The Kaiser study came to the startling conclusion that private plan characteristics, not payment levels, had the single greatest effect on HMO decisions to withdraw between 1999 and 2001. It found that the two most important factors in determining withdrawal decisions were whether a plan operates on a for-profit or non-profit basis and whether the plan was owned by a large national corporation or by local managers. For-profit plans owned by large national corporations are *two-and-a-half times* more likely to withdraw from Medicare+Choice than are locally owned non-profit plans. This appears to indicate that private plans for whom participating in the Medicare program is strictly a business decision, as opposed to a decision rooted in a desire to serve the Medicare population, are much more likely to withdraw from the program.

The Kaiser report also confirmed earlier work by the GAO finding that withdrawals often result when HMOs that have recently entered a market are unable to recruit an adequate number of providers to offer benefits. This is a particular problem in rural areas.

Further evidence that the cause of HMO withdrawals is linked to the dynamics of the market, not solely to payment levels, can be seen in the Federal Employees Health Benefits Program's (FEHBP) experience with HMOs. FEHBP also experienced a sharp drop in the number of HMOs contracting with it from 1996 to 2000. During that period, the number of participating plans declined from 476 to 277. Many of the private plans withdrawing, a GAO report concluded, in part were new participants in the program and were simply unable to attract sufficient enrollment. The report found, in part, that "the number of HMOs participating in FEHBP is declining because of a natural weeding out of those that cannot compete in the marketplace."[19]

The FEHBP program is often held up as the model for reforming the Medicare program by those who would like to see Medicare turned into a system where beneficiaries would get a set amount of money to purchase coverage on the private market. Proponents of this sort of reform have argued that because premiums in the FEHBP are set through a market-like competitive bidding process, instead of by government regulation, a

Medicare program modeled after it would be better at retaining HMOs than the existing Medicare program. This is why it is particularly ironic that, according to the GAO, one of the leading causes of HMOs dropping out of the FEHBP program is the very market dynamics the supporters of privatization celebrate.

Private businesses fail and often decide to change the products they offer for a variety of reasons. The GAO's explanation for HMOs leaving the FEHBP, attributing it to a process of selection inherent in a market system where some firms will inevitably fail[20] could just as easily be said about the reasons HMOs withdraw from Medicare+Choice.

D. Private Plans Cost Medicare More than Insuring Beneficiaries Directly Under the Traditional Program

1. HMOs Are Much Less Efficient than Medicare

The Inspector General of the Department of Health and Human Services (HHS) has found that HMOs that contract with Medicare, on average, spend 15 percent of their revenue on administrative costs, rather than on health care.[21] Some HMOs spend as much as 32 percent of their revenue on administration. By contrast, the Medicare program spends only 2 percent of its budget on administrative overhead.[22] This HMO administrative inefficiency is a tremendous waste of resources that could be used to provide health care. The HHS Inspector General has found that if all HMOs participating in the Medicare program had been held to a 15 percent ceiling on administrative costs in 2000 this would have freed up $500 million that could have been used to provide additional health care to beneficiaries. If the health care provided by the plans were provided through Medicare directly, with its nominal administrative overhead costs, many more millions if not billions of dollars could have been saved.

2. Medicare HMOs Are Paid More than Traditional Medicare

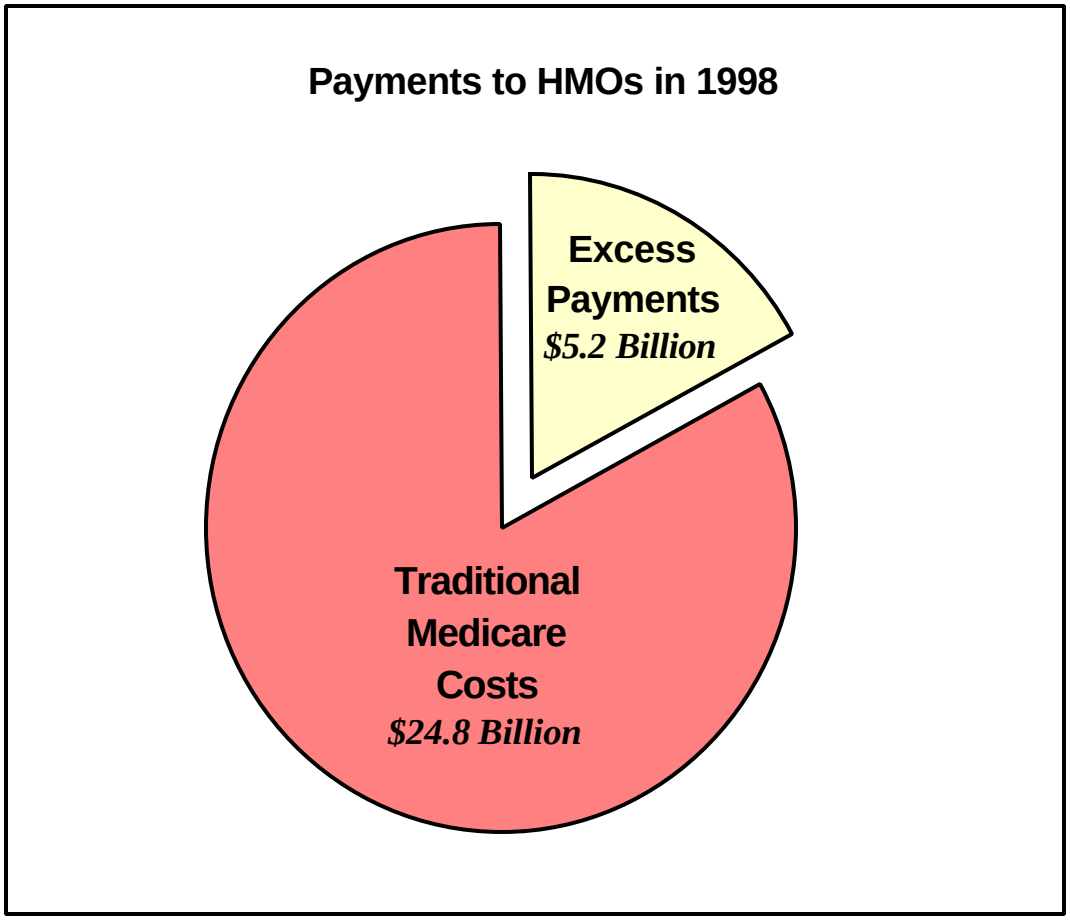
Under the Medicare+Choice program, HMOs contract with Medicare to offer Medicare covered services for a set per-enrollee payment. Originally the notion was that the M+C program would be a way of controlling costs. However, that is not what has happened. Instead, it has cost the Medicare program more to pay HMOs to provide services required by Medicare than it would have cost for traditional Medicare to have paid providers directly for beneficiary care. This is because the private plans attract healthier than average Medicare beneficiaries, but are paid based on the average of what it costs for Medicare to deliver services to the sicker enrollees who remain in the traditional fee-for-service program.

From 1998 to 2000 federal payments to Medicare HMOs exceeded the costs the program would have incurred for treating patients directly by an annual average of 13.2 percent according to the GAO.[23] In one year, 1998, HMOs were paid $5.2 billion more than it would have cost Medicare to cover beneficiaries' health care costs through the traditional program. (See Figure 4) Not only were payments

greater, but HMOs received cumulative rate increases that were larger than the growth in per capita spending in the fee-for-service system from 1999 to 2000.

It is worth noting that even the private plans that withdrew from the program reported having, on average, 22 percent excess payments over and above allowed profits available to provide extra benefits, such as prescription drug coverage.

Figure 4



Source: U.S. General Accounting Office, "Medicare+Choice Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000.

3. HMOs Demand to Be Paid more than Medicare to Stay in the M+C Program

If private plans are to attract enrollees, they must overcome beneficiaries' resistance to joining HMOs. The way they do that is by offering additional benefits, typically coverage for prescription drugs. In order to finance those additional benefits plans must receive resources over and above what it costs to offer the services Medicare

covers.[24] This is part of what leads HMOs to demand to be "overpaid" in order to stay in the Medicare program.

However, there is another reason that Medicare overpays private plans to keep them in the program. They are not as effective at controlling costs as the Medicare program. One study looking at this found that for services covered both by Medicare and private insurers, average annual per enrollee spending by Medicare increased less quickly than for private insurers.[25] Specifically from 1970 to 2000 private insurers posted a 10 percent increase per year as opposed to 9.4 percent increase for the Medicare program. For the purpose of this comparison, increases in costs for services not covered by Medicare but covered by private insurers, including prescription drugs, have been removed. If the comparison included the cost of covering prescription drugs, one of the principal drivers of increasing private insurance premiums, Medicare's comparative cost control performance would appear even better.

4. HMOs Enroll the Healthy and Avoid the Sick to Reduce Costs

- **HMOs cater to the healthy in order to avoid the expense of treating the sick**. A study by the Kaiser Family Foundation of the marketing practices of HMOs that participate in the Medicare program found that private plans deliberately target the healthy as opposed to the sick.[26] More than half of the television ads examined in the study portrayed seniors engaged in "physical or social activities such as running, biking, swimming, snorkeling, riding amusement park rides, and playing with grandchildren." None of the visuals in either newspaper or television ads showed people in hospitals or using wheelchairs or walkers. More troubling still was the fact that nearly one-third of the 21 HMO marketing seminars attended by researchers were not wheelchair accessible – an indication that enrolling the infirm was not a high priority for these HMOs. Although Medicare has 5 million beneficiaries who are under 65 and disabled, none were pictured in any of the television or newspaper advertisements examined for the study. Many newspaper ads fail to mention that disabled beneficiaries are eligible to apply and 8 out of 70 incorrectly stated that beneficiaries had to be 65 or older to enroll.

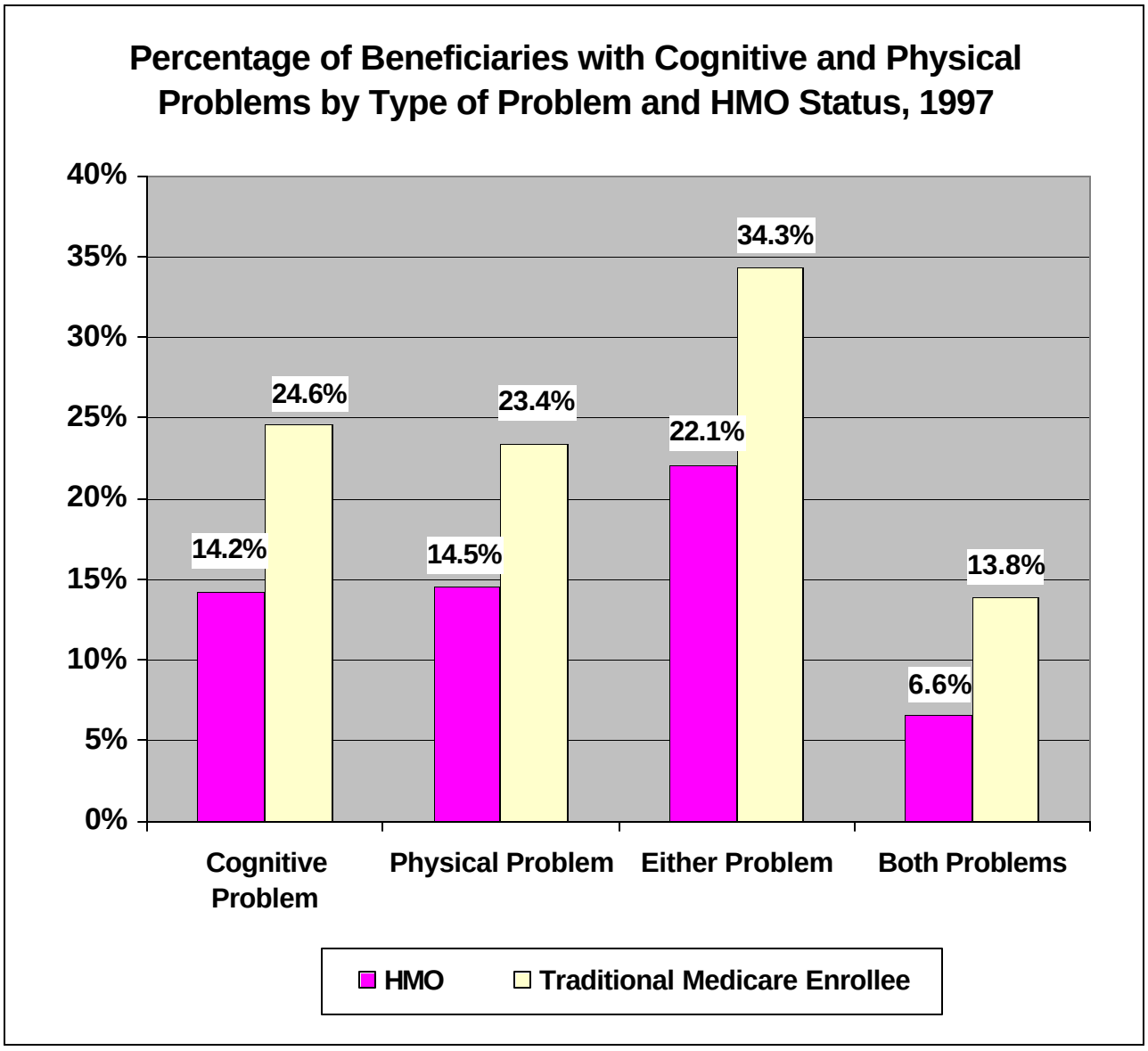
- **HMOs have attracted more healthy – and less costly – beneficiaries.** Perhaps as a consequence of their marketing campaigns that are targeted at the healthy, while 13.8 percent of Medicare beneficiaries enrolled in the traditional Medicare program in 1997 had both cognitive and physical difficulties; only 6.6 percent of Medicare HMO enrollees reported such problems.[27] (See Figure 5). Health care spending for enrollees with both physical and cognitive difficulties was more than four times what it was for those with neither of these problems ($20,332 vs. $5,037) in 1997. (See Figure 6) Moreover, those with both types of problems account for only 12 percent of the Medicare population but over 30 percent of total Medicare spending. Given these facts, it is a rational business decision on the part of managed care plans to avoid these sicker enrollees. Not only do private plans have an incentive to avoid the sick, but the sick are likely to be particularly

hesitant to join such a plan, which limits their choice of provider, because they will need to see doctors and specialists often.[28]

- **Incentives for private plans to avoid the sick are impossible to avoid.** While CMS makes slightly higher payments to plans that cover beneficiaries who are sicker, the Medicare Payment Advisory Committee reports that the payments are inadequate and that plans still have a financial incentive to avoid enrolling the sick.[29] Plans also have an incentive to deliver poor services to the chronically ill thereby encouraging them to disenroll. The answer would appear to be obvious – better systems are needed for paying plans based on the relative health of the beneficiaries they cover (so-called "risk adjustment"). While this a worthy goal, it is very difficult to accomplish. Some researchers estimate that risk adjustment techniques are likely to be only 50 percent effective.[30]

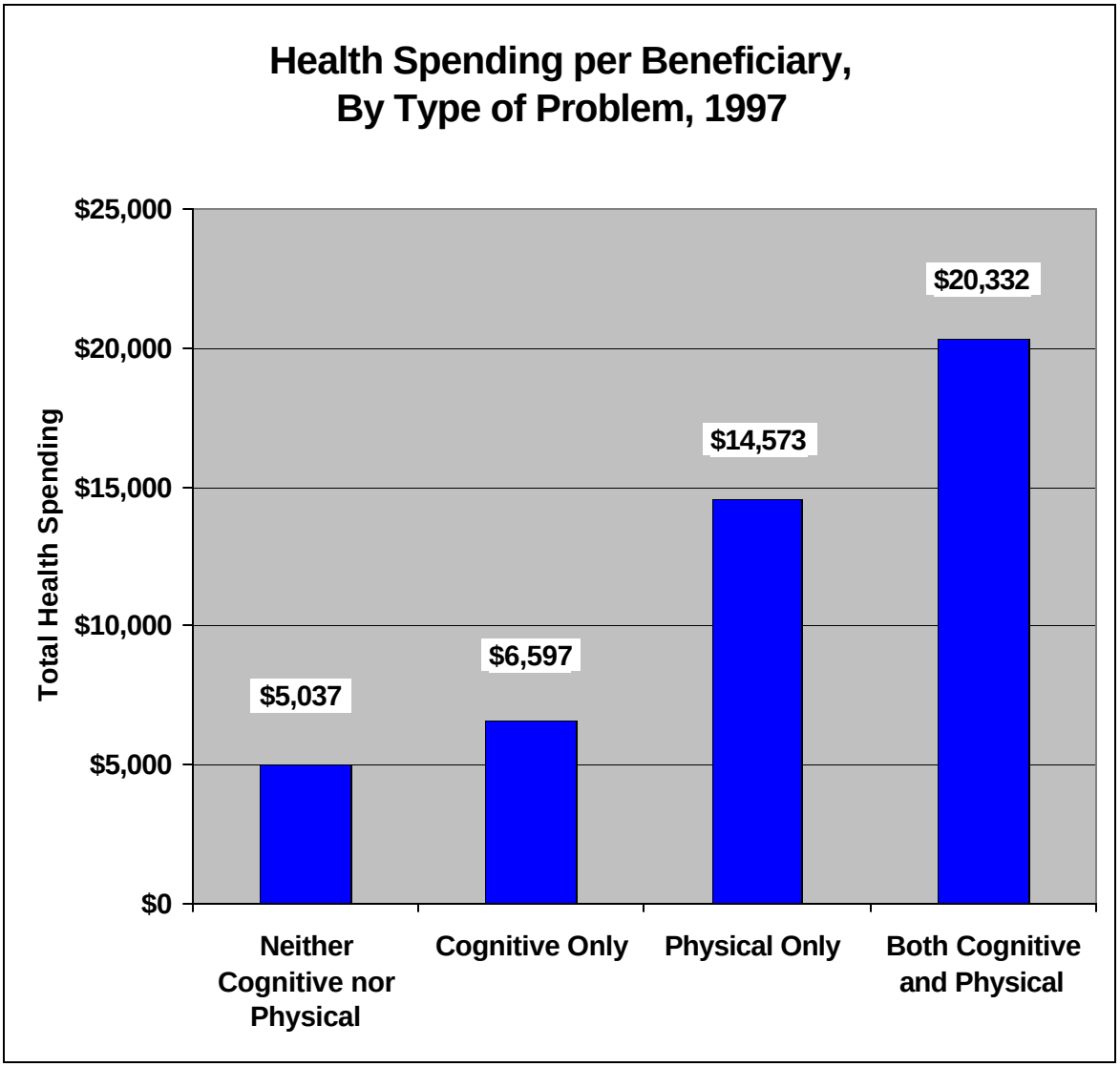
- **HMOs dump sick enrollees onto government programs**. The HHS Inspector General has found that managed care organizations' avoidance of paying high health care costs appears quite deliberate. The IG found that private plans have, in the past, avoided the expense of treating their sickest patients by having sicker beneficiaries disenroll, in order to have expensive hospital care delivered through the traditional Medicare program. Then, when they are healthy again plans reenroll them. In general, Medicare pays HMOs a set amount for each beneficiary that a plan enrolls, and then the plan must cover the cost of treating patients from the "capitation" payments it receives. From 1991 to 1996 the IG found that Medicare paid hospitals $224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment. Medicare would have paid the private plans just $20 million in capitation payments if the beneficiaries had remained in the private plans, a difference of $204 million, or more than 1,000 percent.[31]

Figure 5



Source: Marilyn Moon and Matthew Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," The Commonwealth Fund, September 2001.

Figure 6



Source: Marilyn Moon and Matthew Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," The Commonwealth Fund, September 2001.

III. New Private Plans for Medicare: the PPO Demonstration Program

Given the small share of Medicare beneficiaries covered by private plans in 2002, the Bush administration is beginning its Preferred Provider Organization (PPO) demonstration program in an attempt to boost the number of beneficiaries enrolled through private plans and vindicate Medicare's experiment with privatization. Existing law makes room for PPOs to participate in the M+C program, but they have been reluctant to do so, citing regulatory burdens. As discussed below, under the PPO demonstration program CMS is empowered to waive some of the regulatory protections built into the M+C program in order to recruit plans to participate. Under the demonstration program, plans will participate in 19 areas throughout the country. (See Appendix B; only eighteen areas are listed in the Appendix because in one of them there is no PPO offering drug coverage.) They are available to 11 million beneficiaries, or a little more than 1 in 4.[32]

The administration believes PPOs will provide an attractive option for enrollees in traditional Medicare, who enjoy the free choice of doctor but are struggling to pay the high cost of Medigap insurance. The administration estimates that PPOs will initially attract 200,000 beneficiaries who have stayed out of or fled HMOs because of restrictions on care.[33]

If one looks at what the PPO plans will be offering, it is questionable how attractive they will be. Indeed in many ways the demonstration program seems geared to meet the needs of private plans rather than the needs of beneficiaries or the taxpayers who fund the Medicare program.

The insurance companies that plan on making PPO plans available to Medicare beneficiaries under the demonstration program have made their proposals to CMS, and this is what they reveal:

A. Insurance Company Concerns Addressed By PPO Demonstration Program

1. Insurance Company Concerns About Inadequate Payments Addressed

As discussed earlier, one of the reasons HMOs have claimed they are withdrawing from the M+C program is because of inadequate payments. The PPO demonstration program addresses this complaint by allowing PPOs to charge copayments and premiums that are higher than traditional Medicare for Medicare-covered services – something they are likely to do when beneficiaries seek care from out-of-network providers. This is a waiver of current law, which forbids HMOs in the M+C program from charging premiums and copayments in excess of an amount that is actuarially equivalent to what traditional Medicare charges for Medicare-covered services, $102 a month.[34]

Allowing PPOs to charge beneficiaries more to see the provider of their choice means additional costs for beneficiaries. It may also mean additional profits for the insurance companies sponsoring PPOs since, if beneficiaries pay more, this will leave plans paying less. The plans could devote the money they save when beneficiaries seek care out-of network to additional benefits, such as coverage for outpatient prescription drugs, or to corporate profits. Unfortunately, as discussed below, the PPOs under the demonstration program do not appear to be providing much in the way of prescription

drug benefits. They do offer some lower copayments for doctor and hospital benefits if beneficiaries seek care from doctors and hospitals contracting with the plan. But it is unclear what the significance of these discounts are, since we do not know how broad the PPOs' networks will be and therefore how often beneficiaries will be forced to seek care out-of-network. CMS also has not made available information about the amount plans will charge when beneficiaries seek care out of network.

2. Insurance Company Concerns About Bearing the Risk of High Health Care Costs Are Addressed

Most HMOs contracting with Medicare to offer health care coverage are at risk for 100 percent of beneficiaries' health care costs. They are given a set amount of money for each beneficiary and have to cover the cost of whatever health care the beneficiary needs out of that set amount. In order to attract more plans to participate, under the PPO demonstration program CMS is able to relax the requirement that plans assume 100 percent of the risk. Instead, the federal government will assume some of the risk associated with high health care costs – but at this time it is unclear how much.

B. Taxpayer Concerns about Controlling Costs in the Medicare Program Are not Addressed

There is no reason to believe that the PPO demonstration program will save the Medicare program money. As discussed above, the experience of the M+C program has been that HMOs have cost the program more than if Medicare had provided benefits directly. The PPO demonstration program has a requirement for budget neutrality, not savings. It is not clear if there will be risk adjustment included in the calculation of budget neutrality so that PPOs are not overpaid if they enroll more healthy beneficiaries. Also, in comparison with HMOs, PPOs are generally less able to control costs, because they do not restrict beneficiaries' access to providers and care as much as HMOs do. The experience in the under-65, non-Medicare population, which has seen a shift from HMOs to PPOs, has been that this change has contributed to an increase in health care costs due to the relaxation of constraints on choice of provider.

C. Beneficiaries Concerns Are not Addressed by the PPO Demonstration Program

1. Access to Guaranteed, Comprehensive and Affordable Benefits, Including Prescription Drugs

- **PPOs charge significant additional premiums.** The Bush administration's PPO demonstration plans are charging $1,000 on average additional premiums on top of what beneficiaries have to pay currently for Medicare.[35] While this is less than what Medigap plans generally charge, beneficiaries get little in exchange for paying the extra premium. (see below). Premiums for Medigap plans that offer some coverage for prescription drugs range from $1,320 to $2,559 in the areas where the PPO demonstration plans will be operating. (See Appendix B)

- **PPOs are unreliable**. Just like HMOs now, PPOs are able to pull out of the Medicare program and reduce any benefits they offer that are over and above what traditional Medicare covers.

- **PPO plans appear not to be viable in much of the country**. Because PPOs are being made available under a demonstration program it was not expected that they would be available throughout the country. However, their almost complete failure to move into any of the areas that are not served by HMOs indicates that PPOs appear not to be able to address what some see as the problem of lack of access to private plans for many beneficiaries. The Medicare Payment Advisory Commission (MedPac) has found that the PPO demonstration program will lead to a mere 500,000 people, less than two percent of beneficiaries, having access to an M+C program who did not previously have access. This estimate includes 150,000 people in rural areas and 350,000 in non-rural areas.[36]

- **PPO drug coverage is meager.** In order to assess the drug coverage that is being offered by the PPOs we analyzed data from CMS. We found that the most generous plans in each of 19 areas where a PPO option is being offered will generally offer some prescription drug coverage. However, the coverage is so meager that in six of the 19 areas, beneficiaries will pay more in annual premiums to enroll in the PPO than they will get in coverage for prescription drugs. Of the 19 areas, Health Net of Oregon PPO, which services both Oregon and Washington states, does not provide any drug benefit to its enrollees. Among the 18 plans that do provide drug coverage, only four provide any coverage of brand-name drugs, with one plan, Humana Gold PPO in Florida, limiting its brand-name drug coverage to a $5-off coupon per brand-name prescription. The remaining 14 cover generic drugs only, with six plans setting annual limits on coverage at $600 or below. (See Appendix B) Given that only 19 of the 50 most used drugs by seniors were generics or were brand-name drugs with a generic equivalent on the market,[37] generic-only coverage does not give Medicare beneficiaries' access to the prescription drugs they use.

- **PPO coverage for doctor benefits no better than traditional Medicare.** PPOs charge copayments ranging from $5-$25 per doctor visit. Beneficiaries in traditional Medicare must pay a $9.62 copayment for the most common doctor visits.[38] When you consider the fact that beneficiaries pay an additional premium to enroll in the PPOs this leaves beneficiaries that enroll in the PPOs potentially paying more than if they had stayed in traditional Medicare.

- **PPO coverage of hospital benefits varies widely, with some plans double billing beneficiaries.** Under traditional Medicare, after beneficiaries pay an initial $840 deductible Medicare will cover their hospitalization costs for a stay of up to 60 days. The copays and deductibles charged by the PPO demonstration plans vary widely. For a 12-day stay in the hospital, most charge less than traditional Medicare – 13 out of 46 plans offered do not charge anything for a 12-day stay in the hospital and nearly half charge between $100 and $750. However, seven out

of the 46 PPO plans available (15 percent) will charge copayments and deductibles greater than traditional Medicare for a 12-day hospital stay and collect premiums from beneficiaries over and above what Medicare charges them—in essence double billing beneficiaries.

In general it is only the sickest portion of Medicare beneficiaries who require extended hospital stays. The plans that charge more than traditional Medicare for staying in the hospital may be doing this as a way of discouraging the sickest and most expensive beneficiaries from enrolling or encouraging those who become sick to disenroll.

2. A Non-Issue for Beneficiaries will be Addressed by the Demonstration Program – Expanded Choice of Types of Plan

There is no evidence that beneficiaries are looking for an expansion in the types of plans they can choose from or for the opportunity to join a PPO in particular. If they are able to afford Medigap there is little reason for them to enroll in a PPO in which they may have to pay more than they would under traditional Medicare to see the doctor of their choice. Supporters of increased competition suggest that Medicare is outdated, because it is a fee-for-service system in which beneficiaries are guaranteed free choice of any doctor willing to take Medicare payments. They note that the under-65 health insurance market moved away from the fee-for-service model in the 1980s and 1990s and is now dominated by competing private plans that restrict beneficiaries' choice of doctor as a way to control costs.

However, simply because the system of competing plans for the under-65 population is new does not mean it is better than traditional Medicare. It is important to remember that the multiple plans competing to cover the employed population were not created in response to the demand of consumers. They were a response to the demand of payers to find a way to control costs, and they were imposed on workers by their employers. Given that traditional Medicare has done a better job at controlling costs than private insurance and has managed to maintain something beneficiaries highly value, the ability to see the doctor of their choice, why should the private insurance market be used as the model to reform Medicare. Indeed, there seems to be ample reason to reform the private insurance market to look more like traditional Medicare.

IV. Problems with a Privatized Drug Benefit

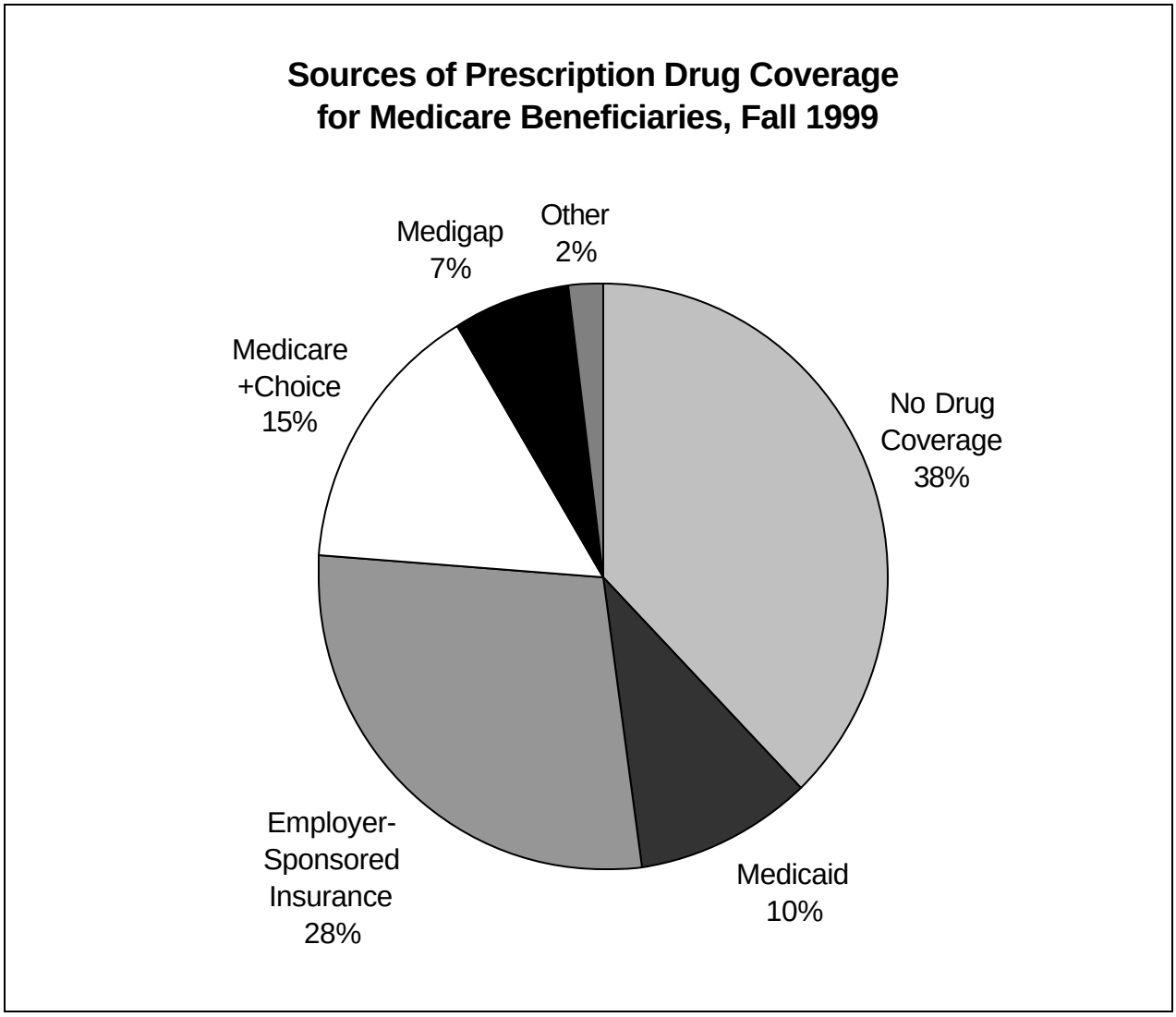
Until the Bush administration's proposal floated in January, privatizers have not been willing to force all beneficiaries to join private plans in order to get drug coverage. However, they oppose drug coverage being offered directly by traditional Medicare. In the last Congress they passed legislation in the House that would have subsidized HMOs and indemnity insurance companies to offer coverage to beneficiaries that remain in the traditional Medicare program. The difference between this model and Medicare supplemental policies (Medigap) already offered by insurers is that these new policies would be for drugs only and, because they would be subsidized with federal dollars, their premiums would be lower.

A. Private Insurance Is Inefficient

Medigap insurance is one of a range of options that seniors currently have to get coverage for some of the gaps in Medicare. Most seniors who do not join an HMO generally have some form of supplemental insurance to help with the costs of prescription drugs, which Medicare does not cover, and the high deductibles and coinsurance amounts for the doctor and hospital care that Medicare does cover. (Payment for care by doctors is subject to a $100 deductible and 20 percent coinsurance. There is an $840 deductible on coverage for hospital care.) For many low-income people this supplemental coverage is provided by Medicaid. The more fortunate obtain coverage through a present or former employer. Approximately 7 percent of Medicare beneficiaries seek coverage on the private market and purchase a Medigap policy, a few of which offer coverage for some prescription drug costs. (See Figure 7 and Appendix B).

The companies that would offer drug-only insurance policies as part of a privatized drug coverage program would be many of the same companies that now offer Medigap policies. These policies would be subsidized by federal dollars – resulting in lower premiums and greater participation than is found in the current Medigap market for drug coverage. However, like current Medigap policies, they would be extremely inefficient. The General Accounting Office has found that Medigap policies on average spend over 20 cents out of each premium dollar not on health care but on agents' fees, marketing, advertising, administration, and profits.[39] This compares very unfavorably to Medicare, which spends less than 2 cents out of every dollar on administrative costs.[40] This means that seniors and the federal government would not get good value for the resources they put into a program that depends on private insurance.

Figure 7



Source: Laschober, Mary et al., *Health Affairs Web Exclusive*, February 27, 2002.

B. Recipe for a Boondoggle

The supporters of a private insurance model claim that a market-based approach will be more efficient and more nimble than a government-run Medicare program. That is the rationale they have offered for creating a program in which private plans would compete with each other to offer drug coverage at the lowest possible cost to beneficiaries and the Medicare program. Yet, a close analysis of the 2002 House-passed prescription drug proposal (H.R. 4954) shows they have not stuck by their free-market convictions. This is because when the Republican leadership in the House put forward a proposal in 2000 that would have relied on private companies to offer drug-only insurance under a truly

market-based system, the companies said they would not participate. The reason – it would be too financially risky!

So in 2002 the Republican leadership drafted a proposal that sweetened the pot enough for private insurers to say they would offer coverage under the program.[41] What did the leadership have to do to get the insurance industry to agree to participate? It had to increase the subsidies to the industry and virtually guarantee the industry's profits at taxpayers' expense.

Under the 2002 proposal, private plans can pick and choose where and when to offer drug coverage. And 67 percent of the costs they pay out will be repaid by the federal government, leaving them at risk for only 33 percent of those costs. If they are unwilling to offer drug coverage in a particular area, the federal government is authorized to do whatever it takes to lure them into offering coverage, including assuming virtually all of a plan's financial risks and guaranteeing a plan's profitability.

This is a clear recipe for a boondoggle, since Medicare could be forced to pay not only for the cost of the drugs covered by a private plan but for the plan's administrative costs and profits – which, based on experience with the Medigap market are likely to amount to at least an additional 20 percent on top of the cost of the prescription medications covered. Given that Medicare could offer drug coverage directly and only uses 2 percent of its resources for administrative costs, relying on private plans will lead to significant resources being wasted.

C. Privatized Drug Coverage Leads to Less Effective Cost Containment

The reason the drug industry objects to legislation providing drug coverage through Medicare is because it fears Medicare would act aggressively to negotiate deeper price reductions.

By subsidizing many HMOs and other private insurers to offer prescription drug coverage, instead of providing coverage under Medicare, the buying power of Medicare's 40 million beneficiaries would be fragmented among many different entities, reducing its bargaining clout.

The effect of fragmenting Medicare's buying power can be seen in the dramatic difference between the drug price discounts the federal government is able to negotiate in other programs, and the usual discounts that private insurers and HMOs are able to achieve.[42] The Federal Supply Schedule Price, which the Department of Veterans Affairs negotiates with the drug companies on behalf of the federal government, is generally 52 percent less than the price paid by cash customers at the pharmacy (not including a reasonable pharmacy dispensing fee).[43] This contrasts with the 12 to 40 percent discount from the manufacturer's list price that Pharmacy Benefit Managers (PBMs), insurers and HMOs are able to achieve.

If the drug industry is successful, and Medicare prescription drug coverage is made available through multiple private plans, this would be a win-win for the drug industry. It

would receive additional revenues as a result of taxpayer subsidies to the program, and it would not have to worry about Medicare using its market power to negotiate lower prices.

The likely effect of failing to take maximum advantage of Medicare's buying power to negotiate lower prices can be seen in the ever-rising additional premiums of HMOs offering drug coverage and the ever-escalating costs paid by Medicare supplemental insurers for prescription drugs. In 14 states that had Medicare HMOs offering drug coverage in both 1999 and 2003, the average additional premium for such plans increased more than 100 percent. In 5 states, the average premium for private plans with drug coverage increased more than 300 percent. (See Figure 8). (Increasing premiums is not solely due to rising prescription drug costs. However, since such costs are growing faster than any other portion of health care costs it is logical to assume that they are an important factor.) During that same time HMOs scaled back the generosity of the drug benefits they offered. By 2002, 69 percent of plans, enrolling 51percent of beneficiaries in the M+C program, had annual caps of $500 or less on the drug benefits they offered, up from 23 percent in 1999. Also in 2002, 70 percent of HMOs' basic plans either offered no coverage for prescription drugs or offered coverage for generic drugs only. This was up from 48 percent the year before.[44]

The experience is similar with private indemnity plans. From 1996 to 1998 insurers offering Medigap coverage for prescription drugs experienced a 15 percent annual increase in drug costs.[45]

In its evaluation of the effectiveness of proposals that rely on competing private insurers to control costs, the Congressional Budget Office has found that they would achieve savings by creating tight formularies that would deny beneficiaries coverage for prescription drugs that they would like to have covered.[46] In contrast, if the federal government were to use its buying power to negotiate lower prices with drug companies, large cost savings would be possible without limiting beneficiaries access to certain prescription drugs.

Figure 8

Average Monthly Premium Change for HMOs Offering Rx Drug Coverage 1999 & 2003

State	Avg. Monthly Premium 1999	Avg. Monthly Premium 2003	Difference	Percent Change
Alabama	$0	$0	$0	0%
Alaska	No plans	No plans	n/a	n/a
Arizona	$21	$23	$2	10%
Arkansas	$89	No plans	n/a	n/a
California	$26	$46	$20	77%
Colorado	$26	$76	$50	190%
Connecticut	$33	$99	$66	200%
Delaware	No plans	No plans	n/a	n/a
District of Columbia	No plans	No plans	n/a	n/a
Florida	$9	$16	$7	78%
Georgia	$5	$28	$23	460%
Hawaii	$68	No plans	n/a	n/a
Idaho	$78	No plans	n/a	n/a
Illinois	$25	$76	$51	204%
Indiana	$45	No plans	n/a	n/a
Iowa	No plans	$71	n/a	n/a
Kansas	$25	$33	$8	32%
Kentucky	$40	$80	$40	100%
Louisiana	$0	$0	$0	0%
Maine	$58	No plans	n/a	n/a
Maryland	$15	No plans	n/a	n/a
Massachusetts	$15	$123	$108	720%
Michigan	$21	$123	$102	486%
Minnesota	$230	$103	($127)	-55%
Mississippi	$0	$0	$0	0%
Missouri	$30	$37	$7	23%
Montana	$40	No plans	n/a	n/a
Nebraska	$0	$71	$71	n/a
Nevada	$26	$17	($9)	-35%

New Hampshire	No plans	$100	n/a	n/a
New Jersey	$26	$125	$99	381%
New Mexico	$17	$33	$16	94%
New York	$23	$59	$36	157%
North Carolina	$32	$0	($32)	-100%
North Dakota	$46	No plans	n/a	n/a
Ohio	$18	$68	$50	278%
Oklahoma	$20	$31	$11	55%
Oregon	$114	$106	($8)	-7%
Pennsylvania	$38	$108	$70	184%
Rhode Island	$13	$74	$61	469%
South Carolina	No plans	No plans	n/a	n/a
South Dakota	No plans	No plans	n/a	n/a
Tennessee	$33	$41	$8	24%
Texas	$11	$27	$16	145%
Utah	No plans	No plans	n/a	n/a
Vermont	No plans	No plans	n/a	n/a
Virginia	$20	$63	$43	215%
Washington	$0	$160	$160	n/a
West Virginia	$65	No plans	n/a	n/a
Wisconsin	$15	No plans	n/a	n/a
Wyoming	No plans	No plans	n/a	n/a

Source: Public Citizen analysis of Centers for Medicare and Medicaid Services data. Go to www.medicare.gov, look for “Medicare Compare.”

V. Bush's Proposal to Offer Greater Choice of Plans Does not Address the Needs of Beneficiaries

Beyond the problems specific to Medicare's experience with HMOs and Medigap is a fundamental problem with the Bush administration's proposal to give seniors more choices among private plans but take away the guarantee that Medicare has always offered of stable and reliable benefits.

A. Beneficiary Health Problems Make Proposals Relying on Choice Unworkable

In order for a private insurance model to succeed at delivering the highest level of benefits for the lowest premium, there must be vigorous competition between multiple private plans. Moreover, consumers must have access to information about the alternatives available to them and the ability to process that information.

At this time it is unclear if under a privatization proposal a sufficient number of private plans would come back into the Medicare program to create vigorous market competition for the coverage of doctor, hospital, and/or drug costs. However, what we do know is that even if such a market were to develop, a significant portion of Medicare beneficiaries will not be able to make effective use of the opportunity to choose between private plans.

Try as they might, their age and disabilities often means that Medicare beneficiaries are simply not able to assess the value of complicated competing insurance plans. Nearly a quarter (23 percent) of Medicare beneficiaries have physical health and/or other problems that make it difficult for them to evaluate important differences between plans or make good choices.[47] A survey conducted by Mathematica Policy Research Inc. in 2000 found that 12 percent of Medicare beneficiaries are blind (1 percent) or say their vision is poor even with corrective lenses (11 percent). Nine percent are either deaf or have poor hearing even with hearing aids.[48] And a 1992 National Advent Literacy Survey found that 44 percent of adults over the age of 60 are functionally illiterate.[49]

Beneficiaries also lack basic knowledge about Medicare, which makes decisions between competing coverage options particularly difficult. Mathematica found that despite ongoing controversy over legislation to add a drug benefit to Medicare, in 2000 32 percent of beneficiaries were unaware that Medicare does not pay for all health care costs. The people whom beneficiaries turned to for assistance in understanding Medicare and their coverage options were slightly better informed, but still 24 percent did not know that Medicare does not cover all health care costs. Other scholars writing for the *Health Care Financing Review* have looked at beneficiaries' knowledge and confirm Mathematica's conclusions. They found that beneficiary knowledge is low particularly in areas that would be essential for making informed choices between plans such as what benefits are offered by traditional Medicare as opposed to private plans and that current educational efforts seem to be accomplishing little. In their study less than a quarter of beneficiaries, even after they have received the educational materials provided by Medicare, the "Medicare and You" handbook, are able to identify which benefits are covered by original Medicare.[50]

B. Beneficiaries Prefer Reliable Benefits to Confusing Choices

Proponents of a market-based approach are ignoring the preferences of the people the program serves. They seek stable, reliable, and easy-to-understand benefits over the ability to choose among a confusing set of insurance policies.[51]

- **Choice of plan is relatively unimportant to beneficiaries.** A survey of beneficiaries in 2000 found that only 14 percent who had the option of enrolling in an HMO in that year changed or even seriously considered changing how they receive basic Medicare services or supplemental coverage for costs and services not covered by Medicare.[52] Forty-four percent said they had *never* seriously considered their choices and 14 percent last thought about it when they first became eligible for Medicare. Even those who must make a change because they are new to the program or because their plan withdrew from the program do not seriously consider their choices. Only 30 percent of new beneficiaries and 52 percent of those dropped by their HMO thought very or somewhat seriously about their choices.

- **Beneficiaries dominant concerns are whether they will have access to care that is reliable and affordable and their choice of physician.** Sixty-three percent of beneficiaries felt that the ability to get care if sick would be extremely important if they were choosing a plan in 2000; 49 percent said choice of doctor would be extremely important and 47 percent said keeping premiums down would be extremely important. A survey of educators, advocates, and plans in 2000 confirmed what the survey of beneficiaries found – what matters to beneficiaries is price, drug coverage and whether they can continue to see the doctor of their choice.[53]

VI. Conclusion

Clearly the superior alternative to turning Medicare over to private insurers and HMOs is to protect and expand the traditional program. This would best meet the needs of beneficiaries. The vast majority of beneficiaries receive their coverage from the traditional program, and it accomplishes something that private plans have not and likely never will accomplish – it provides guaranteed coverage throughout the nation, not just to 61 percent of beneficiaries who happen to live in area served by an HMO. Its superior efficiency and cost containment ability means that it meets the needs of taxpayers for cost containment. And the traditional Medicare program is reliable. It has never withdrawn from an area where it offers coverage.

In addition to providing reliable coverage for all beneficiaries, only traditional Medicare has the capacity to meet beneficiaries' desire for low premiums, high quality benefits, including drug coverage, and the ability to choose their doctor. Because of Medicare's efficiency it is able to keep costs down for doctor and hospital coverage and because of its market power if drug coverage were added it would be able to keep drug costs down better than competing private insurers that would have a smaller share of the market. And Medicare, unlike private plan HMOs, allows beneficiaries to see any doctor that is willing to accept its payments. In 2001, 96 percent of doctors who were accepting new patients were accepting Medicare beneficiaries.[54]

Privatizers talk about the value of competition, but they do not support it in actual practice. They have objected all along to proposals that would make it possible to have a truly head-to-head competition between the traditional Medicare program and private plans by making federal moneys available to both to offer coverage for prescription drugs. Instead they have insisted on maintaining and expanding on the current flawed system in which only private plans are given the resources to offer drug coverage.

Why is it that they will not support giving the traditional Medicare program the resources and legislative authority to also offer coverage for prescription drugs? Perhaps it is because they fear that in a truly fair competition the traditional Medicare program will prove once and for all its superiority to private plans. They fear that in a truly fair competition it will be shown that beneficiaries prefer the traditional program with its free choice of doctor and guaranteed benefits and that the traditional program is better able to control costs than private plans. Therefore, only by maintaining the current system where M+C plans and private indemnity insurers can offer attractive additional benefits, like coverage for prescription drugs, can the privatizers maintain the illusion that private plans are attractive to beneficiaries and ought to serve as the basis for reforming the Medicare program.

Endnotes

[1] Percentage of enrollees dropped in 2001 corrected on June 24, 2003.
[2] Quoted in Bob Herbert, "Behind the Smile," *New York Times*, November 11, 2002.
[3] Quoted in Edwin Chen, "Gingrich: Today's Medicare Will 'Wither,'" *Los Angeles Times*, October 26, 1995.
[4] Michael Waldholz, "Medicare Through HMOs," *Wall Street Journal Online*, September 30, 2002.
[5] Mary Agnes Carey, "Thomas to Bush: Save Medicare from Hill Politics" *CQ Weekly*, April 7, 2001, p. 761.
[6] M+C Changes in Access, Benefits, and Premiums 2001 to 2002, Centers for Medicare and Medicaid Services, available on CMS website.
[7] Information current as of December 2002.
[8] Commonwealth Fund, "Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002," November 2002.
[9] Paul Van de Water, CBO, Testimony Before Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 25, 1997.
[10] Kaiser Family Foundation, "Medicare+Choice," June 2002.
[11] U.S. Department of Health and Human Services, FY 2004 Budget in Brief.
[12] Up until now, HMOs have been virtually the only type of plan to offer coverage through the Medicare+Choice program. With the administration projecting that only 200,000 beneficiaries will initially enroll in the PPO plans, HMOs will still be the only type of private plan enrolling a significant number of Medicare beneficiaries in the short-term.
[13] Public Citizen analysis of data provided by Centers for Medicare and Medicaid Services.
[14] 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.
[15] Geraldine Dallek and Andrew Dennington, "Physician Withdrawals: A Major Source of Instability in the Medicare+Choice Program," Commonwealth Fund, January 2002.
[16] Dallek and Dennington, January 2002, p. 1.
[17] Timothy Lake and Randall Brown, "Medicare+Choice Withdrawals: Understanding Key Factors," Kaiser Family Foundation, June 2002.
[18] U.S. General Accounting Office, "Medicare+Choice Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000.
[19] U.S. General Accounting Office, "Federal Employees Health Program: Reasons Why HMOs Withdrew in 1999 and 2000," May 2000.
[20] U.S. General Accounting Office, "Federal Employees Health Program: Reasons Why HMOs Withdrew in 1999 and 2000," May 2000, p. 8.
[21] Inspector General, Department of Health and Human Services, "Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997," September 2000.
[22] 2002 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds.
[23] U.S. General Accounting Office, "Medicare+Choice Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000. The Medicare Payment Advisory Commission report, March 2002, estimated that spending for beneficiaries in the M+C program was 4 percent higher than spending for demographically similar beneficiaries in the traditional Medicare program in 2001. However, this estimate did **not** adjust for the relative health of beneficiaries in the M+C program. If it had it likely would have shown that M+C plans were even more overpaid.
[24] Kenneth E. Thorpe and Adam Atherly, "Medicare+Choice: Current Role and Near-Term Prospects," Health Affairs, July 17, 2002.
[25] Cristina Boccuti and Marilyn Moon, unpublished analysis of National Health Expenditure data.
[26] Ed Maibach and Tricia Neuman, "Marketing HMOs to Medicare Beneficiaries," Health Affairs, July/August 1998.
[27] Marilyn Moon and Matthew Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," The Commonwealth Fund, September 2001.
[28] Moon and Storeygard, September 2001.
[29] The Medicare Payment Advisory Committee, "Report to Congress," March 2002, p.32.
[30] Thomas Rice and Katherine A. Desmond, "An Analysis of Reforming Medicare Through a 'Premium Support' Program," Kaiser Family Foundation, February 2002.

[31] Inspector General, Department of Health and Human Services, "Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997," September 2000.
[32] Scott Harrison, "New developments in the Medicare+Choice program, MedPac, October 10, 2002.
[33] Amy Goldstein, "In a Test, HHS Seeks to Aid Medicare PPOs," *Washington Post*, August 28, 2002.
[34] www.cms.hhs.gov/healthplans/rates/2003/cover-01.asp, accessed on December 9, 2002.
[35] Public Citizen calculation based on data from Center for Medicare and Medicaid Services.
[36] Scott Harrison, "New Developments in the Medicare+Choice program," Transcript of October 10, 2002 MedPac meeting and phone conversation October 12, 2002.
[37] Families USA, "Bitter Pill: The Rising Prices of Prescription Drugs for Older Americans," June 2002, p. 11.
[38] Most common service found at Table 64, "Services Submitted and Allowed Charges, Calendar Year 1998," *Health Care Financing Review, Statistical Supplement*, 2000, p. 241. Updated allowed charge for most common service, Federal Register, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003," December 31, 2002, p. 80038.
[39] William Scanlon, U.S. General Accounting Office, Testimony Before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 14, 2002.
[40] 2002 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds.
[41] Don Young, President, Health Insurance Association of America letter to Honorable Bill Thomas, Chairman, Committee on Ways & Means, U.S. House of Representatives, June 18, 2002.
[42] Department of Health and Human Services, "Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices," April 2000.
[43] Department of Health & Human Services, "Report to the President: Illustrative Example of Pricing for Brand Name Prescription Drugs," Table 3-1, April 2000.
[44] Lori Achman and Marsha Gold, "Trends in Medicare+Choice Benefits and Premiums, 1999-2002," Mathematica, November 2002, p. 5-6.
[45] National Association of Insurance Commissioners, "Medicare Supplement Insurance Issue Paper," November 30, 2000, p. 13.
[46] Dan Crippen, Director, Congressional Budget Office, letter to Honorable Bill Thomas, Chairman, Committee on Ways & Means, U.S. House of Representatives, July 26, 2002.
[47] Patricia Neuman and Kathryn Langwell, "Medicare's Choice Explosion? Implications for Beneficiaries," Health Affairs, January/February 1999, p. 156.
[48] Marsha Gold et al., "Medicare Beneficiaries and Health Plan Choice, 2000," Mathematica Policy Research, Inc. January 2001.
[49] Cited in Gold et al., January 2001.
[50] Laura A. McCormack, "Measuring Beneficiary Knowledge in Two Randomized Experiments," *Health Care Financing Review*, Fall 2001, p. 8.
[51] Marilyn Moon, "Can Competition Improve Medicare?," The Urban Institute, September 1999.
[52] Gold et al., January 2001.
[53] Beth Stevens and Jessica Mittler, "Making Medicare+Choice Real: Understanding and Meeting the Information Needs of Beneficiaries at the Local Level," Mathematica, November 2000.
[54] Kevin Hayes and Joan Sokolovsky, "Assessing payment adequacy and updating payments for physician services," Medicare Payment Advisory Committee, December 12, 2002.

Appendix A

Guide to Plans Authorized to Cover Medicare Beneficiaries by the 1997 BBA and Their Current Status

Health Maintenance Organizations (HMOs) have contracted with the Medicare program to cover health care costs of beneficiaries for a set fee since 1985. Beneficiaries enrolled in an HMO generally must seek care from a set group of providers designated by their HMO. Care by specialists as well as procedures and tests often must be approved by the HMO before they can be performed. HMOs are the one type of plan that enrolls a significant number of beneficiaries, approximately 4.6 million, or 11 percent of the program's total population.[55]

Preferred Provider Organizations (PPOs) typically control costs by negotiating lower prices for health care services with providers and giving beneficiaries incentives to use those providers by charging lower co-payments if they receive care from them and higher copayments if they seek care from providers outside of the PPO's network. Today there are only 2 PPOs in operation in the Medicare+Choice program, not including those participating as part of the demonstration program. These two plans enroll just over 21,000 beneficiaries.[56] (Independence Blue Cross in Philadelphia offers a PPO to Medicare beneficiaries; EncorEncore operates as a PPO in Southern Florida.) Supporters of private plans have argued that the reason PPOs have not up until now entered the Medicare market in greater numbers are the "prohibitively costly" data collection and implementation of quality programs mandated by CMS, as well as the payment structure of the 1997 M+C program.[57] The demonstration program hopes to lure more plans into participating with more regulatory flexibility and the possibility of higher payments.

Provider Sponsored Organizations (PSOs) are made up of physicians, hospitals, and other health care providers who contract with CMS to provide health care to Medicare beneficiaries for a set amount of money every month. The difference between a PSO and an HMO is the health care is managed by physicians, not an insurance company.[58] To date there are only two PSOs participating in the Medicare program. Selectcare of Texas began contracting with CMS in early February 2001 and began enrolling beneficiaries in a handful of western Texas counties. Selectcare of Texas currently has just over 13,000 enrollees.[59] The other PSO, Preferred Care Partners (PCP), has been providing service to Miami-Dade county, Florida for about six months.[60] Out of 326,000 eligible beneficiaries, PCP has enrolled only 713 in its plan.[61] One reason why PSOs have not been widely offered as a plan option under Medicare+Choice is the physicians, hospital, and other health care providers often are unwilling to accept financial responsibility for the operation and success of a PSO.[62]

Medical Savings Accounts (MSAs) are a high-deductible health care option. MSAs were included in the 1997 BBA as a demonstration project with a capped enrollment of 390,000. An MSA combines the ability to save tax free for health care costs with catastrophic health insurance set at $6,000 by the 1997 BBA. Under agreement with Medicare, providers would have to cover at least the services of fee-for-service (FFS) Medicare after the deductible is met.[63] Currently there are no companies offering MSAs under the Medicare program.

Private Fee-For-Service (PFFS) plans differ from traditional Medicare fee-for service in several ways. Delivery of services is done by a private network of doctors associated with a private insurance company. Doctors are paid through the private insurance company rather than through Medicare, and there is generally an additional premium for PFFS plans. Currently there are just 2 PFFS plans, only one of which has a presence beyond one local area. Slightly over 20,000 are enrolled in Sterling Option I, a national PFFS plan that has grown significantly since its inception in 2000 to the point where it now offers coverage in 25 states.[64] Since its start in January 2002, the other PFFS plan, Humana Gold Choice, has had about 2,000 beneficiaries enrolled in the DuPage County, Illinois area.[65]

Endnotes: Appendix A

[55] U.S. Department of Health and Human Services, Budget FY 2004.
[56] Independence Blue Cross Medicare PPO in Philadelphia, Pennsylvania has a current enrollment of about 21,000 according to "CMS Intends to Test New Models for Medicare Disease Management," in *News and Strategies for Managed Medicare & Medicaid*, September 23, 2002. According to CMS enrollment data for September 2002, enrollment for EncorEncore, which operates in Broward and Palm Beach counties, is less than 100.
[57] Gail R. Wilensky, "The Balanced Budget Act of 1997: a current look at its impact on patients and providers," July 19, 2000, a statement before Subcommittee on Health and Environment, Committee on Commerce, U.S. House of Representatives.
[58] CMS website, Glossary section.
[59] CMS data on November 2002 enrollment in Medicare+Choice plans.
[60] CMS approved PCP's request to service Medicare beneficiaries in July 2002. PCP has been operating as a M+C PSO since August 1, 2002.
[61] CMS data on November 2002 enrollment in Medicare+Choice plans.
[62] Joseph White, *False Alarm*, 183.
[63] In 1997, the ceiling for a MSA deductible was set at $6,000. CBO, "Budgetary Implications of the Balance Budget Act of 1997," December 1997, 29.
[64] Commonwealth Fund, "Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002," November 2002.
[65] CMS data on November 2002 enrollment in Medicare+Choice plans.

Appendix B

Drug Benefits and Premiums for the Most Generous PPO Plan and Other Private Plans in the 18 PPO Demonstration Areas Where a PPO Offers Drug Coverage

AL	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	UnitedHealthCare Medicare Complete Choice	Seniors First		Five Star Life Insurance Co
Area Served	Blount, Chilton, Jefferson, St. Clair, Shelby	Jefferson, Shelby		Statewide
Drug Benefit	$12-36 copay for generic drugs; $500 annual limit on generic drugs.	$10-30 for formulary generic drugs; no limit on formulary generic drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$468	$0		$1,704
AZ	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	Health Net Of Arizona, Inc.: Options Plus	SeniorCare	Secure Horizons Classic Plan	Blue Cross & Blue Shield of Arizona
Area Served	Pima	Pima	Pima	Statewide
Drug Benefit	$10-24 copay for formulary generic drugs; no limit on formulary generic drugs.	$12.50-31.50 for formulary generic drugs; no limit on formulary generic drugs.	$15-30 for formulary generic drugs; no limit on formulary generic drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,128	$348	$0	$1,464

FL	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	Humana Gold PPO	Humana Gold Classic		United Healthcare Insurance
Area Served	Pinellas	Pinellas		Tampa, St. Petersburg, Clearwater
Drug Benefit	$10-24 copay for generic drugs; $5 off price of brand name drugs; no limit on generic drugs	$15-45 for generic drugs; no limit on generic drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$948	$0		$2,136
IL	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	Order of St. Francis Care Preferred			Five Star Life Insurance
Area Served	Boone, Knox, Livingston, Marshall, Mclean, Peoria, Stark, Tazewell, Winnebago, Woodford			Statewide
Drug Benefit	$10-20 copay for generic drugs; $100 monthly limit for generic drugs			Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$900			$1,788
IN	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	ADVANTAGE Preferred Plus			Five Star Life Insurance
Area Served	Allen, St. Joseph			Statewide
Drug Benefit	$5-10 copay for generic drugs; $125 quarterly limit for generic drugs			Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,140			$1,704

LA	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	HealthCare Select	Tenet Choices 65		United Healthcare Insurance
Area Served	Jefferson, Orleans, Plaquemines, St. Tammany	Jefferson, Orleans, Plaquemines, St. Tammany		New Orleans
Drug Benefit	$10-30 copay for generic drugs; no limit on generic drugs.	$25-75 for formulary preferred brand drugs; $10-30 for non-formulary generic drugs; 50% of the cost for non-formulary brand drugs; no limit on non-formulary generic drugs; $1200 annual limit for combined formulary-preferred brand and non-formulary-brand drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,020	$0		$2,559
MD	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	Aetna Health, Inc.: Golden Choice Plan			United Healthcare Insurance
Area Served	Anne Arundel, Baltimore, Baltimore City, Calvert, Charles, Harford			Statewide
Drug Benefit	$15 copay for generic drugs; no limit on generic drugs.			Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,320			$1,884
MO	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	UnitedHealthCare Medicare Complete Choice	GHP Advantra	GHP Gold Advantage	Healthy Alliance Life Insurance Co.
Area Served	Crawford, Franklin, Jefferson, St. Charles, St, Louis, Warren	Jefferson, St. Charles, St. Louis	Jefferson, St. Charles, St. Louis	Statewide
Drug Benefit	$12-36 copay for generic drugs; $500 annual limit on generic drugs.	$15-30 for formulary generic drugs; $40-80 for formulary brand drugs; $500 combined annual limit on formulary generic and brand drugs.	$15 for formulary generic drugs; $40 for formulary brand drugs; $750 combined annual limit for formulary generic and brand drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$780	$792	$0	$1,809

NV	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	Secure Horizons Medicare POS	Secure Horizons Classic Plan		Equitable Life & Casualty Insurance
Area Served	Clark	Clark		Statewide
Drug Benefit	$10 copay for formulary generic drugs; no limit on formulary generic drugs.	$10-20 for formulary generic drugs; $40-80 for formulary brand drugs; no limit on formulary generic drugs; $1000 annual limit for formulary brand drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$660	$0		$1,709
NJ	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	Horizon Health Care of New Jersey: Horizon Medicare Blue Plus	AmeriHealth 65 Standard		Bankers Life & Casualty
Area Served	Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Glouster, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem Somerset, Sussex, Union, Warren	Salem		Statewide
Drug Benefit	$10-20 for formulary generic drugs; $20-40 for formulary brand drugs; $35-70 for non-formulary generic drugs; $35-70 for non-formulary brand drugs; no individual limit on formulary & non-formulary generic drugs; $150 quarterly limit for combined formulary-brand & non-formulary-brand drugs.	$15-30 for formulary generic drugs; $15-30 for non-formulary generic drugs; $1500 annual limit for formulary-generic and non-formulary-generic prescription drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,388	$1,500		$1,743

NY- Rest of State	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	Healthnow New York, Inc.: Medicare PPO 202 Plus	Senior Blue 403	WellCare Choice Plan	Empire Healthchoice Inc.
Area Served	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington	Albany, Greene, Rensselaer	Albany
Drug Benefit	$7-25 copay on formulary drugs; $125 quarterly limit on formulary brand drugs; no limit on formulary generic drugs.	$7 for formulary generic drugs; $20 for formulary brand drugs; $40 for non-formulary generic drugs; $40 for non-formulary brand drugs. $125 quarterly limit for combined formulary-brand, non-formulary - generic and non-formulary - brand drugs.	$15 for formulary generic drugs; $15 for non-formulary generic drugs; $100 monthly limit for formulary-generic and non-formulary-generic drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,997	$1,560	$348	$2,038
NY- NYC	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	HealthFirst PPO Complete Benefits	Oxford Medicare Advantage Plus	WellCare Choice Plan	BlueCross BlueShield of Central New York
Area Served	Bronx, Kings, New York, Queens, Richmond	Bronx, Kings, New York, Queens, Richmond	Bronx, Kings, New York, Queens	New York City
Drug Benefit	$5-25 copay on formulary generic drugs; $25 on formulary brand drugs; $50 monthly limit on formulary and non-formulary brand drugs; no limit on formulary or non-formulary generic drugs.	50 % of the cost for Formulary Generic, formulary preferred brand drugs, non-formulary brand drugs, non-formulary generic drugs; no limit on formulary or non-formulary generic drugs; $750 annual limit for combined formulary-preferred brand and non-formulary brand drugs.	$15 for formulary and non-formulary generic drugs; $30 for formulary preferred brand drugs; $50 for non-formulary brand drugs; $150 monthly combined limit for formulary and non-formulary drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,236	$1,500	$0	$1,769

NC	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	UnitedHealthCare Medicare Complete Choice	UnitedHealthcare Medicare Complete		UnitedHealthcare Insurance
Area Served	Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham, Wake	Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham, Wake		Statewide
Drug Benefit	$10-30 copay for generic drugs; $500 annual limit for generic drugs.	$15-45 for generic drugs; $500 annual limit for generic drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$720	$0		$1,758
OH	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	UnitedHealthCare Medicare Complete Choice	Anthem Senior Advantage - Premier 1	UnitedHealthcare Medicare Complete	Community Insurance
Area Served	Mahoning	Mahoning	Mahoning	Statewide
Drug Benefit	$12-36 copay for generic drugs; $500 annual limit for generic drugs.	$15-30 [or 25 % of the cost] for formulary generic drugs; $500 annual limit for formulary generic drugs.	$15-45 for generic drugs up to a 31-day supply; $500 annual limit for generic drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$828	$780	$0	$1,784
PA-Rest of State	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	UPMC for Life PPO Deluxe	SecurityBlue Direct Southwestern PA	Advantra	Philadelphia American Life Insurance
Area Served	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Crawford, Fayette, Huntington, Indiana, Lawrence, Mercer, Somerset, Venango, Washington, Westmoreland	Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Indiana, Lawrence, Washington, Westmoreland	Fayette, Lawrence, Westmoreland	Pittsburgh
Drug Benefit	$10-80 copay for formulary brand and generic drugs; $150 quarterly limit for formulary generic and brand drugs.	$12-24 for formulary generic drugs; $20-40 for formulary preferred brand drugs; $30-60 for formulary brand drugs; $350 quarterly limit for formulary-generic, formulary-preferred brand and formulary-brand drugs.	$12-24 for formulary generic drugs; $25-50 for formulary brand drugs; $500 annual limit for combined formulary-generic and formulary-brand drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,716	$1,524	$300	$1,320

PA-Phila.	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	Aetna Golden Choice Plan	SeniorBlue-1		Philadelphia American Life Insurance
Area Served	Lehigh, Monroe, Northampton, Schuylkill	Lehigh, Northampton		Philadelphia
Drug Benefit	$15-30 copay for generic drugs; no limit on generic drugs.	50% of the cost for formulary generic drugs; 50% of the cost for formulary preferred brand drugs; 50% of the cost for formulary brand drugs; $250 quarterly limit for formulary-generic, formulary-preferred brand and formulary-brand prescription drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$1,260	$2,004		$1,651
RI	**PPO**	**HMO-High End**	**HMO-Low End**	**Medigap**
Plan Name	UnitedHealthCare Medicare Complete Choice	BlueCHiP for Medicare Preferred	UnitedHealthcare Medicare Complete	UnitedHealthcare Insurance
Area Served	Providence, Kent, Washington	Providence, Kent, Washington	Providence, Kent, Washington	Statewide
Drug Benefit	$10-30 copay for generic drugs; $500 annual limit on generic drugs.	$7-14 for formulary generic drugs; $25-50 for formulary brand drugs; $40-80 for non-formulary brand drugs; $5000 limit annually for formulary generic drugs; $1000 limit annually for combined formulary-brand and non-formulary-brand drugs.	$10 for generic drugs; $500 limit annually for generic drugs.	Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$780	$1,776	$0	$1,671

TN	PPO	HMO-High End	HMO-Low End	Medigap
Plan Name	HealthSpring Medicare+Choice PPO Plan	HealthSpring Medicare Plus Plan		BlueCross BlueShield of Tennessee
Area Served	Cannon, Cheatham, Davidson, Dekalb, Macon, Marshall, Robertson, Rutherford, Smith, Sumner, Trousdale, Willaimson, Wilson	Cannon, Cheatham, Davidson, Dekalb, Macon, Marshall, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson, Wilson		Statewide
Drug Benefit	$15 copay for formulary generic drugs; no limit on formulary generic drugs.	$15 copay for formulary generic drugs; no limit on formulary generic drugs.		Plan H pays 50% of drug charges up to $1,250 per year and has $250 annual deductible
Annual Premium	$840	$0		$1,472