

MONITORING THE
IMPLEMENTATION OF
MEDICARE+CHOICE:
HARRIS COUNTY, TX.
SITE VISIT REPORT

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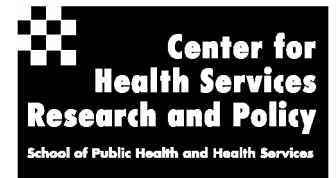


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RESEARCH CONTEXT

Since its inception in 1965, Medicare has operated primarily as a fee-for-service health insurance program for this nation's senior citizens and disabled. While one of the most successful programs in the history of US social policy, Medicare beneficiaries face a serious challenge stemming from the program's limited benefit package, including the lack of coverage for prescription drugs, and high copayments and deductibles. A parallel industry for Medicare supplemental insurance has evolved (Medigap), but the premiums are high, leaving large numbers of Medicare beneficiaries without adequate supplemental coverage. For those who are able to purchase a policy, most lack coverage for prescription drugs. Employers are also cutting back on retiree benefits that previously assisted many Medicare beneficiaries by filling gaps in Medicare's costs and coverage.¹

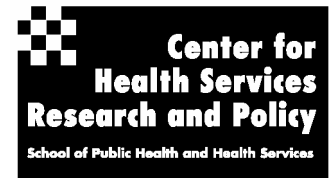
In an effort to reduce health care spending and to give the Medicare population more choice of private plans, the Balanced Budget Act of 1997 (BBA) substantially reduced provider payments under fee-for-service Medicare, created the Medicare + Choice (M+C) program, and imposed additional quality oversight and consumer protection standards. The BBA also altered payments to M+C plans to account for the fact that, historically, Medicare overpaid HMOs because they enrolled a healthier population compared to beneficiaries remaining in original Medicare. While managed care options existed for the Medicare population prior to 1997, it was hoped that the BBA would result in a more than a 100 percent increase in Medicare managed care enrollment by the year 2000.

Medicare HMOs have grown steadily since the early 1990s because these plans provide additional benefits not available in original Medicare (especially prescription drugs) as well as generally reduced out-of-pocket costs for health care. However, since passage of the BBA, large numbers of M+C plans have chosen to exit the market for reasons plans identify as low payment rates and burdensome compliance regulations.² By 2001, withdrawals had affected over 1.6 million Medicare beneficiaries nationwide. These withdrawals, coupled with plan reductions in prescription drug benefits and provider network instability, have resulted in serious disruptions in care for the Medicare population.

To assess the effect of the BBA changes to the Medicare program, staff of the Center for Health Services Research and Policy at The George Washington University School of Public Health and Health Services examined the M+C program in seven sites—Tucson, Minneapolis-St. Paul, Houston, Cleveland,

¹ The Henry J. Kaiser Family Foundation, "Medicare and Low-Income Beneficiaries: A Fact Sheet." (Washington, D.C.: 1999)

² See American Association of Health Plans press release, "Lack of Action from Washington Fails More Than 700,000 Medicare Beneficiaries," June 29, 2000, available at www.aahp.org. AAHP President and CEO Karen Ignagni stated "the reality is that this program has been over-regulated and underpaid."



Tampa-St. Petersburg, New York City and Los Angeles. This report describes the implementation of the M+C program in Harris County (Houston), Texas. It is based on information obtained during a three-day site visit to Harris County in July 2000 and follow-up phone calls, a survey of newspaper and other printed materials and an analysis of HCFA and M+C plan materials. During the site visit and follow-up phone calls, project staff interviewed representatives of M+C plans, HCFA, physician and provider organizations, area hospitals, and the senior community to get their impressions of the M+C market and implementation of Medicare+Choice. Staff also conducted two focus groups with Medicare beneficiaries.

THE HOUSTON MEDICARE+CHOICE MARKET

During the site visit, discussions with Medicare beneficiaries, and representatives of health plans, providers, and community organizations, as well as government officials, were colored by the recent announcement that seven of the eight managed care plans serving seniors in Harris County were intending to withdraw from the market effective January 2001. This announcement was all the more surprising because Medicare managed care had become an important source of care for Houston Medicare beneficiaries, especially many low-income beneficiaries who depend on Medicare managed care for prescription drugs.

HARRIS COUNTY'S VULNERABLE SENIOR POPULATION

Harris County's Medicare beneficiary population is vulnerable in several ways. First, 34.4 percent of the County's population is non-white, with Hispanics (12.7 percent) and African-Americans (17 percent) comprising the largest minority groups. A largely immigrant Asian population accounts for 4.4 percent of the County's elderly³. Many minority seniors face language and/or cultural barriers to accessing care. Over 67,800 seniors in Harris County live alone and are therefore at higher risk for being poor. In 1999, the mean income from retirement benefits in Harris County was \$14,861 a year (a monthly income of \$1,238), and mean social security income was \$11,052 (a monthly income of \$921).⁴ More than 10 percent of seniors living in Harris County lived below the federal poverty level, \$7,990 a year.⁵ The elderly poor with incomes too high to qualify for Texas' Medicaid program are dependent on Medicare HMOs to obtain prescription drugs and other supplemental benefits.

3 U.S. Census Bureau population estimates from <http://govinfo.library.orst.edu>

4 U.S. Census Bureau, American Community Survey, Estimates for Harris County, TX, 1999. Available at http://www.census.gov/acs/www/html/dataproduct/1999/tx_sub4.htm

5 10.5% of Harris County residents (11.7% of city of Houston residents) over the age of 65 are living in poverty. Source: U.S. Census Bureau, American Community Survey. Poverty line in dollars obtained from U.S. Census Bureau, Poverty Thresholds in 1999, by Size of Family and Number of Related Children Under 18 Years. Available at <http://www.census.gov/hhes/poverty/threshld/thresh99.html>.



THE GROWTH OF MEDICARE MANAGED CARE

Medicare managed care grew rapidly in the Houston area during the 90s. The percent of Medicare beneficiaries enrolled in a Medicare HMO grew from 4.1 percent in December 1993 to 27 percent in June 2000,⁶ higher than the overall Medicare managed care enrollment rate of 15.9 percent for Texas as a whole.⁷ The first Medicare HMO (Humana) began marketing in 1988; by 2000, eight plans vigorously competed for Medicare enrollment.

This growth did not occur without market disruptions. Plan mergers and acquisitions, especially in the last half of the 1990s, were common. In 1998, Aetna/U.S. Healthcare purchased NYLCare, but the company later sold NYLCare to Blue Cross Blue Shield in order to gain approval to acquire Prudential Healthcare.^{8,9,10} In addition, the local Memorial Sisters of Charity CHOICE 65 plan, first offered in March 1997,¹¹ was purchased by Lexington, KY-based Humana in Feb 2000.¹² Problems with marketing and consumer protections also roiled the M+C waters during the second half of the 90's.¹³

In June 2000, the largest Medicare HMO was NYLCare, with 43 percent of the market. The rest of the market was largely shared by four other HMOs—Humana (19.6 percent), PacifiCare (14.4 percent), Memorial Sisters of Charity (8.5 percent), and Prudential (7.1 percent). Methodist health plan carried 5% of Houston's Medicare+Choice enrollees, and CIGNA had only 1.3% market share. Texas Health Choice, which was losing members and was not marketed in 2000,¹⁴ had less than 1% market share¹⁵.

PLAN WITHDRAWALS AND NEW ENTRIES

The competitive M+C environment seemed to change overnight when, just prior to HCFA's July 3, 2000 deadline, seven of the eight Houston plans announced they were leaving the M+C market as of January 1, 2001. Harris County withdrawals affected more

6 HCFA quarterly state/county/plan managed care market penetration data file, June 2000.

7 "The Interstudy Competitive Edge: HMO Industry Report (9.2)". Table 15: Medicare HMO Enrollment by State (p. 34) Interstudy Publications, October 1999.

8 Ornstein, C., "Most HMOs in Texas to Continue with Medicare Program," The Dallas Morning News, October 3, 1998.

9 "Company News; Acquisition of Prudential Healthcare is Completed," The New York Times, August 7, 1999.

10 "Aetna agrees to sell NYLCare Texas as part of deal to buy Prudential," The Associated Press, September 14, 1999.

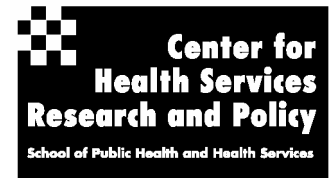
11 Mintz, B., "HMO launches new Medicare plan; Memorial-Sisters of Charity program part of federal experiment," The Houston Chronicle, March 12, 1997, Wednesday, Business; Pg. 2.

12 "Business Briefs," Corpus Christi Caller-Times, February 1, 2000, Business; Pg. D11.

13 Patterson, R., Dallek, G., et.al., Implementation of Medicare Consumer Protections in Missouri, New Jersey, Texas, and Vermont, 1999, available from the Kaiser Family Foundation.

14 Fort Worth Star-Telegram, March 16, 2000, "HMO Owner Cuts Jobs in North Texas, May Terminate Medicare Plan," Sarah Lunday

15 HCFA quarterly state/county/plan managed care market penetration data file, June 2000.



M+C enrollees—66,135¹⁶—than withdrawals anywhere else in the nation. Five nationally-owned HMOs (NYLCare, Prudential, Texas Health Choice, CIGNA, and Humana) and two locally-based HMOs (Memorial Sisters of Charity and MethodistCare) opted to withdraw from the Houston area leaving only PacifiCare remaining in Harris County.

This large number of withdrawals was surprising for two reasons. First, the 2000 Medicare reimbursement rate in Harris County was relatively generous at \$632 per enrollee per month compared to the rates in three other study sites with significant withdrawals, Minneapolis (\$458/\$471), Tucson (\$499), and Tampa-St. Petersburg (\$521/\$533). This was almost as high as the \$661 Medicare rate in Los Angeles, where ten of 11 plans remained in the market.

Second, plans had another option besides quitting the Houston market—to impose premiums or reduce some of the generous benefits offered to beneficiaries. This strategy was pursued by several plans in the other study sites, most notably in Tucson, Cleveland, Tampa-St. Petersburg, and Minneapolis-St. Paul. While some plans in these study sites pulled out of the M+C market, other plans opted to remain with higher premiums and/or reduced benefits.

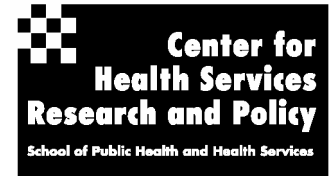
The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) substantially increased Medicare HMO Payment rates across the country and provided Medicare HMOs with a three percent increase in 2001. In Houston, the Medicare payment rate increased to \$650.54.

Even before the higher premiums were announced, two new plans—AmCare and SelectCare—had decided to enter the Houston M+C market. Both plans will began enrolling new members in March-April 2001.

M+C PLAN BENEFITS

In 2000, all M+C plans in Houston offered a generous benefit package at no premium cost. Physician co-pays ranged from \$4-\$10 for network primary care physician visits, and from \$4-\$15 for specialty visits. Two plans also offered a POS option allowing members to obtain care from non-network physicians for significantly higher cost-sharing. Only one HMO, Prudential, charged a hospital deductible (\$250 per admission). Finally, all plans offered a very generous prescription drug benefit. Co-pays for generic drugs ranged from \$5-\$7 and for brand drugs, from \$10-\$25. Five plans offered an unlimited generic drug benefit with caps on brand drugs from \$1200-\$2000. The other plans had a combined cap for generic and brand drugs from \$750-\$1800.

¹⁶ Estimate derived from HCFA quarterly state/county/plan managed care market penetration data file, June 2000. Data on withdrawals by county derived from HCFA (available at <http://www.hcfa.gov/medicare/nrwebdat.htm>.)



In 2001, PacifiCare’s Secure Horizons began charging a \$25 monthly premium, but did not change its generous 2000 benefit package. In 2001, enrollees will pay \$6 for primary care and specialty physician visits, no hospital deductible, and a \$5 generic co-pay and \$20 brand co-pay with a \$1,200 cap on prescription and brand drugs combined (see Table 1).

Neither of the two new M+C entries in the Houston market offers an expansive benefit package. AmCare does not cover prescription drugs, while SelectCare charges a \$97.50 a month premium (\$1,170 a year) for a \$500 generic prescription drug benefit with a \$10 copay. SelectCare is a point-of-service plan, which allows enrollees to go out-of-network if they are willing to pay 30 percent of the costs of care.

	National Average		Houston	
	Medicare Risk HMOs	Fee-for-service Medicare	Medicare Risk HMOs	Fee-for-service Medicare
<65 years	10.4%	19%	11.9%	20.1%
65-74 years	53%	42%	58.3%	43.7%
75-84 years	29.6%	28.6%	24.6%	26.5%
85+ years	7%	11.0%	5.2%	9.7%

Source: Center for Health Economics Research, analysis of 1999 Medicare Administrative Data.

A final local factor affecting Houston plans’ decisions to withdraw was plans’ inability to obtain favorable contracts with physicians and hospitals. According to one plan representative, M+C HMOs needed to pass on much of the financial risk of caring for Medicare enrollees to providers and hospitals, but current contracts did not reflect an appropriate balance of risk between providers and plans. An analysis by Deloitte and Touche backed up this observation; the study found that Houston hospitals were gaining leverage in contract negotiations. For example, Memorial Hermann hospital threatened to cancel a contract with United Healthcare if the health plan did not raise payments. Hospitals also were negotiating fee-for service contracts, significantly reducing their financial risk of caring for M+C patients.¹⁷ In several instances, this left physician groups with the added risk. These physician groups carried the risk of excess hospital care, but did not have the authority to make their own hospital contracts. As discussed below, in the late 1990s, several physician organizations and/or their management companies went bankrupt, further disrupting the market.

¹⁷ Sit-DuVall, Mary. “Medical power struggle; Hospitals outpunch HMOs ; Care facilities get upper hand on insurers in fight over cost,” The Houston Chronicle, August 23, 2000



Plan Withdrawals Upset and Angered Medicare Beneficiaries

The Houston site visit occurred shortly after seven of the eight Houston M+C plans announced their intention to withdraw. These withdrawals affected over 60,000 Medicare beneficiaries, 85.6 percent of beneficiaries enrolled in M+C plans. The beneficiaries we spoke with during the July site visit had just learned about the withdrawals from television and print media. A few had also received letters from their M+C plans explaining the withdrawals and that they would need to enroll in another M+C plan or return to traditional Medicare beginning January 2001. Seniors were surprised and dismayed by the number of M+C plans intending to withdraw. Even those not aware of the exact number of M+C plans withdrawing or the limited options available in the coming year seemed to grasp the magnitude of the situation. Beneficiaries affected by M+C pullouts, especially low-income beneficiaries, stated that they were fearful and anxious about their limited options and future access to care.

In response to M+C plans' withdrawals, seniors experienced a range of emotions including confusion, insecurity, anger and fear. Many seniors were confused about what the withdrawals meant for their current situation. Representatives of senior groups told us that some seniors, who had enrolled in HMOs a few years ago, were not aware of the gaps in Medicare's coverage and, therefore, were uninformed about the significance of decisions they would need to make in the coming months. Other seniors believed they were surrendering their Medicare coverage entirely when they joined an HMO and were scared that they would lose their health insurance along with their HMO. One senior, who is the primary caretaker for her aged and frail mother, told us her mother called "right away" when she heard about the plan withdrawals, fearing she would have no health insurance.

A community leader we spoke with said that some of the seniors she counsels had a "freak-out" reaction when they learned of the pullouts, and were not quite sure what they were going to do. They were beginning to mull over what they saw as very limited options. One senior told us, "seniors fear they may have to sell their homes and everything they own [as a result of the M+C pull-outs]." She continued, "there are seniors out there who will be forced to choose between food and medicine, or running the fan or air conditioner and their medications."

And yet, in many cases, community leaders were less concerned about these seniors who were, at least, dealing with the crisis and the need to make decisions. Other seniors were reportedly shutting down in the face of impending decisions because they did not have the physical and/or cognitive or emotional capacity to cope with the situation. Many homebound seniors do not benefit from regular interactions with other seniors, important in helping them make necessary decisions and in accessing social support. These seniors, to the extent that they are enrolled in M+C plans, were particularly vulnerable to making an uninformed decision.



At the time of our site visit, Houston seniors able to express their anxiety and fears were doing so by calling their plans, local benefits counselors, HCFA, relatives and physicians. They were also expressing anger at the government. One especially angry focus group member remarked that he would be “voting my Congressman out of office this fall.” In contrast, other seniors, like Lillian, had faith that the government would make things right.

Lillian, a widow whose husband worked for many years for the city of Houston, didn't know anything about the withdrawals until her sister living in Arkansas called her. While Lillian didn't know anything about the remaining plan, she was quite sure the City of Houston would be in touch with her to help her find a solution to this dilemma. She remarked, “the City of Houston still feels an obligation to its senior retirees and they will be in touch to tell me about how to get my drugs paid for.” Lillian has three medical conditions (high blood pressure, diabetes and acid reflux) that require monthly visits to the physician and several prescriptions a month. Lillian acknowledged she is still “pretty shocked and shook-up” about all the plans leaving the Houston market and she just can't think right now about what she will need to do to get her expensive drugs paid for.

Other seniors cited practical reasons for their faith in the government: “they're [the government] going to come up with something, and it's going to be more expensive.” “The government is seeing the writing on the wall and with the election coming up--they need a carrot to lure us seniors to vote for them.” Anger about the M+C withdrawals was not solely directed at the federal government, however. One senior felt that, “it's both the plans' fault and the government's fault for plans pulling out.” “Amen,” replied another focus group participant. One senior wanted to know, “Why are the plans doing this? It is not fair and it is not right.”

Many Seniors Have Few Alternatives to Obtain Prescription Drugs

Beneficiaries were primarily upset and angry about plan withdrawals because they were afraid that they would have no alternatives to obtain prescription drugs.

Other M+C Plans: The one remaining M+C plan—PacifiCare—holding only 14.4% market share as of June 2000, could not absorb the large number of beneficiaries affected by the withdrawals.¹⁸ In fact, inundated with new applicants, PacifiCare sought and received HCFA permission to cap its Houston enrollment at 30,000. Thus only one-quarter of Medicare beneficiaries losing their HMO could enroll in the remaining plan. In the wake of the market withdrawals, PacifiCare's enrollment grew to 26,000 by the end of September,¹⁹ and by the beginning of October, the plan closed its enrollment. In the last three days of September, so many Medicare beneficiaries “flooded PacifiCare's

¹⁸ Personal communications with HCFA regional representative, 7/6/2000.

¹⁹ Sit-DuVall, Mary. “Houston's Last Medicare HMO to Stop Accepting New Members.” The Houston Chronicle, 9/22/00; and Medicare Compare.



offices” that the city fire marshal was called out.²⁰ One observer noted that Pacificare had to call in security at its beneficiary meetings, which he described as a “feeding frenzy.” Beneficiaries were frantic to enroll in what was, at the time, the only plan offering prescription drug coverage.

The lack of HMO access significantly eased in March–April 2001, when the two new M+C plans—AmCare and SelectCare—began operations in the Houston market. However, as noted above, AmCare provides no prescription drug coverage and SelectCare charges a \$97.50 a month premium for generic prescription drug coverage capped at \$500. The strong response to the announcement that SelectCare would be entering the Houston market with a prescription drug package indicates how much seniors feel they need this benefit: a plan informant told us that when the *Houston Chronicle* ran a story on SelectCare, the plan was overwhelmed with a “barrage” of phone calls from interested seniors.

Fee-For-Service Medicare and Medigap Insurance: We heard from seniors and community leaders that many Medicare beneficiaries living in Houston cannot afford the prescription drugs, deductibles and copays they will incur under fee-for-service Medicare. As one senior explained, “I live alone, on Social Security and a small pension. I take a few medications that are very expensive. If there is only one plan available in Houston next year, I will have to try and get in it.” The appeal of managed care is particularly strong for seniors with monthly incomes of or slightly above \$1200—too high to qualify for Medicaid, but too low to afford a supplemental Medicare policy. Said one senior who hoped to reenroll in a M+C plan because she could not afford the costs of supplemental insurance: “Medicare’s a joke without the supplement.”

HCFA’s Medigap Compare website lists forty-four insurers selling Medigap Plan A policies to Texas seniors. Monthly premiums for Medigap policies vary by county, by plan, and by the age of the insured person, but the benefits provided under each type of supplement, A–J, are standardized by law. Option A, the supplemental policy with the fewest benefits, covers only the daily coinsurance payments for seniors in the hospital more than 60 days and the 20 percent coinsurance for physician visits. The cost of Plan A from AARP, a well-known provider of supplemental Medigap coverage, is \$67.25 per month (\$807 per year). Supplement J is one of three policies providing limited drug coverage. Option J policies pay 50 percent of annual prescription drug costs up to \$6,000 after a \$250 deductible and provides assistance to beneficiaries with other out-of-pocket expenditures. The cost of Plan J from AARP is \$200.50 per month (\$2,406 per year).²¹

20 Sixel, L.M. “Houston to get 2 Medicare HMOs; AmCare and SelectCare to offer services soon.” *The Houston Chronicle*, February 06, 2001.

21 Source: AARP Representative. Prices quoted are for someone newly turned 65.



For many seniors in Harris County, Medigap is not a realistic alternative to M+C plans. An elderly Harris County resident who lives alone at the median Social Security income level (\$921 per month) would spend more than 7 percent of her income for an AARP Medigap A policy and more than 20 percent of her income for a J policy. Without a M+C plan, many low-income seniors will return to seeking care at the County's public hospital or forego prescription drugs and doctors visits because of their costs. Marsha's story illustrates some of the perceived choices for low-income beneficiaries without HMO prescription drug coverage.

Marsha took early retirement from her job as a schoolteacher at age 62 because of arthritis. She was uninsured for three years until she qualified for Medicare. To see a doctor and to obtain prescriptions for her debilitating condition she would go to the [public] Harris County Hospital District. Marsha told us she could rarely see the same doctor at the District and often had to wait "all day" to see a doctor and to get her drugs. Marsha is currently enrolled in an M+C plan withdrawing from the Medicare market. Her response to the withdrawals was "What are we going to do? We can't afford supplemental coverage." She continued with tears in her eyes, "one thing I could do is to stockpile my medications by taking 2 arthritis pills a day instead of the prescribed 3." Ultimately, she told us she would return to the Harris County Hospital District if she had to, but she was concerned the burden of doing so would be higher as a lot of seniors are in her situation. Marsha liked her M+C plan and couldn't understand why "they [the plans] were doing this."

Seniors who can afford a supplemental policy upon returning to original Medicare may not have been able to purchase the plan they want. Beneficiaries affected by the pullouts had 63 days (from October 2, 2000 to December 4, 2000) to purchase an A, B, C or F Medigap supplement. During this time period, Medigap insurers could not impose exclusions based on pre-existing conditions or discriminate in pricing because of health status, claims experience, receipt of health care or medical condition. This same 63-day protection exists for Medicare beneficiaries who wait until their M+C coverage expires on December 31, 2000 and are automatically enrolled in original Medicare.²²

But different rules govern the availability of supplemental policies with a prescription drug benefit. AARP and all Medigap insurers underwrite their prescription drug policies and may deny coverage because of age, health status, and pre-existing conditions. According to community respondents, many seniors in Harris County who have been enrolled in Medicare HMOs for several years have acquired health conditions or have seen their health deteriorate over time. These seniors will likely be unable to purchase supplemental policies H, I, or J.

²² HCFA Fact Sheet. Protecting Medicare Beneficiaries After Medicare + Choice Organizations Withdraw.

www.hcfa.gov/medicare/mcfactf.htm



Medicare Beneficiaries Lack Information about Their Options

Educating Medicare beneficiaries affected by plan withdrawals is all the more difficult because many do not understand the basics of either original Medicare or the M+C program. Representatives of senior groups told us that seniors, as well as providers, frequently do not know what is covered in original Medicare. Noted one community informant, “sometimes beneficiaries are surprised when they learn that Medicare pays for neither prescription drugs nor long-term care.” Seniors and providers seem confused about the home health benefits available to discharged hospital patients. Also, many seniors and their doctors remain unaware that diabetic supplies can be paid for under traditional FFS Medicare, and many patients do not receive the durable medical equipment to which they are entitled. Groups working with the Medicare population also felt that beneficiaries frequently don’t understand the differences between the standardized Medigap supplemental policies.

During our site visit to Houston, we spoke with plan and community representatives who counsel seniors about their decisions to enroll in managed care. Generally, we heard that seniors are not well educated about managed care because they do not read the “fine print” about plans. Part of the problem is that this generation of seniors has no experience dealing with managed care. Educating seniors about managed care is particularly difficult with less educated seniors and with seniors for who English is not their primary language.

According to representatives of senior organizations, beneficiaries operate under four fundamental misperceptions about the M+C program. First, some seniors think they are surrendering their Medicare when they enroll in an M+C plan. Second, seniors do not always understand that they have to continue paying their Part B premium when they enroll in a M+C plan. Third, seniors are often not aware of their grievance and appeal rights in HMOs. Finally, seniors often do not understand the tradeoffs they make when joining a managed care plan, especially the loss of provider choice. During focus groups, several seniors told us they would not have enrolled in an HMO had they known about these tradeoffs, despite the strong financial incentives to enroll.

Beneficiaries seem to have the greatest problems in understanding that when they join a M+C plan they will be locked in to a specified network of physicians and hospitals. Often seniors will leave a plan when they find out about network restrictions or that their primary care physician does not participate in the plan. One provider, who did not contract with any M+C plans, said that her patients frequently quit their M+C plan when they learned they could no longer see her for their care. Sometimes her patients who have joined an M+C plan don’t realize they are no longer covered for her visits until they next show up for an appointment.



While seniors may not understand the concept of a provider network generally, they sometimes also don't understand that every physician in a M+C plan directory may not be available to them. According to several respondents, when joining an HMO, seniors are often unaware that they cannot go to any provider in the HMO's network. They do not understand that network providers are often divided into subgroups and that they must pick a subgroup from which to obtain care. Also, beneficiaries do not always understand that access to specialists is limited by the choice of an enrollee's primary care physician.

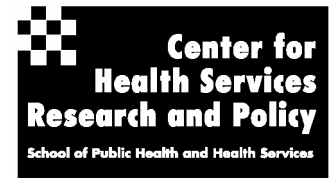
While some beneficiaries do not comprehend the tradeoffs of managed care, others carefully weight the pluses and minuses of managed care before making an enrollment decision.

Sam, age 75, described how he thought about the tradeoffs of enrolling in a M+C plan. Sam told us he decided not to join a M+C plan because he had heard stories about people in M+C plans not being able to get needed care. Sam was also concerned about the limitations on provider choice. "With regular Medicare you can choose any doctor you want and go to them as often as you want, access to specialists is not a problem. Doctors in M+C plans might be okay but you have to go to their doctors even if they are on the other side of town." Sam told us during a focus group discussion that he could afford a supplemental policy. He said he was still active, making several trips a year to Mexico to scuba dive. Later, in speaking with Sam in private about his Mexico trips, he revealed that he doesn't have a supplemental policy, but sets \$150 aside each month to the purchase prescription drugs he needs in Mexico. These drugs cost a fraction of what they would in the United States.

We heard different opinions about how seniors went about choosing a M+C plan in Houston.

Some plan and senior organization representatives felt that beneficiaries opted for plans based on small differences in benefit packages. Others believed that a plan's physician and provider networks were the deciding factor in joining a plan, especially among seniors with serious health conditions. Several respondents felt that physicians influenced beneficiaries' decisions about whether or not to join an HMO and which one to join.

Finally, several respondents felt that plan marketing, especially home visits, played a crucial role in a beneficiary's decision-making process. In-home marketing was of concern to some senior representatives because they thought that many homebound seniors were lonely and particularly vulnerable to an in-home marketing presentation. Provider representatives also questioned the use of in-home marketing. Plan representatives have a more positive perspective on in-home marketing. They think it provided a service to Medicare beneficiaries who frequently can't get all of their questions about managed care answered in a group session. From this perspective, in-home marketing allows the marketing representatives to tailor their presentation to the needs of the senior considering enrollment in managed care.



One provider who sees a large number of Hispanic seniors said he believes that his patients have a harder time comprehending managed care and are less informed about what M+C enrollment means than are his non-Hispanic patients. He said this is, in part, due to language barriers. From his perspective, the problem was not that plans do not have enough Spanish-speaking marketing representatives and counselors, but rather that to communicate ideas about managed care in Spanish, one must be extremely proficient in the language. Our community informants agreed that additional materials aren't going to help seniors' understanding of managed care. More important is adequate access to counselors whom beneficiaries could trust and who could present information in an understandable way.

Obtaining accurate information from trustworthy sources is difficult in Houston because of scarce community resources. The Houston/Harris County Area Agency on Aging, for example, has been overwhelmed with seniors seeking information about their options: as late as February 22, 2000 a caller to the Agency was put on hold for 45 minutes because of the overwhelming number of calls inundating staff. Because SelectCare had not yet published its benefit package, seniors were unable to make any kind of decision about whether the plan would meet their needs. Thus the uncertainty caused by plan pullouts has lasted for far longer in Houston than in other parts of the country.

ACCESS AND QUALITY IN M+C PLANS

In addition to the instability caused by plan withdrawals, M+C enrollees have had to deal with changing plan provider networks. Medicare data indicate some problems with access and quality in Houston M+C plans exist.

Recent Instability of Plan Provider Networks Affects Beneficiaries

Over the past three years, relations between Houston providers and HMOs have been contentious. The financial problems of several large physician groups have exacerbated the general turmoil in the market. In July 1998, FPA, a physician practice management group, declared bankruptcy, owing thousands of dollars to between 600 and 1,000 Houston doctors on their payroll.²³ In 1999, MedPartners sold off its physician practices and PhyCor, which manages multi-specialty practices, restructured to address several problems including the exit of unhappy physicians.²⁴

23 Sit-DuVall, Mary. "The Business Side of the Operation; Physicians Linking with Managers; But Problems Prompt Call for Restructuring." The Houston Chronicle, August 6, 1998.

24 Sit-DuVall, Mary. "Practice Makes Profits; A Medical Manager's Different Approach May Help it Succeed in a Tough Specialty," The Houston Chronicle, August 15, 1999.



Recently, North American Medical Management (NAMM)—a company that managed 19 Houston IPAs and processed HMO payments to these groups—announced in September 2000 that it was facing bankruptcy. In late July, 10 of the 19 IPAs began canceling their contracts with NAMM because of a concern over payment mismanagement. NAMM began losing money when HCA’s hospital chain renegotiated contracts with its HMOs. The new contract changed the hospital payment system from capitation to fee-for-service. This moved the financial risk of inpatient care from the HCA-owned hospitals to NAMM’s IPAs. According to a NAMM executive, the difficulty of obtaining claims information from Humana and low Medicare reimbursement rates also led to financial problems.²⁵

Reacting to NAMM’s financial problems, M+C plans began canceling contracts with its IPAs, contracting with the IPA’s individual physicians on a fee-for-service basis. The bankruptcy of NAMM resulted in significant disruptions in care for PacifiCare enrollees, some of whom had to travel more than 30 miles for care. In response to a lawsuit, PacifiCare agreed to pay for travel expenses incurred by enrollees and to assign members to physicians with closer offices.²⁶

Since the withdrawal announcements of the other seven M+C HMOs, PacifiCare has experienced problems with both profitability and its provider network. PacifiCare’s profits dropped 98 percent in the third quarter of 2000, to four cents a share as of November 2000.²⁷ In addition, about half of the physicians in the Secure Horizons network terminated their contracts, leaving the plan with 253 primary care doctors and 1,160 specialists.²⁸ As a result of these problems, the Texas Department of Insurance placed PacifiCare on administrative oversight. The Department will closely watch the plan for compliance with specific goals, including timely payment to providers and the adequacy of provider networks. The plan also must submit weekly progress reports.²⁹

Several respondents told us that contract disputes resulted in significant provider turnover. The physicians with whom we spoke were frustrated and unhappy with their HMO contracts. They, like physicians in a number of our

²⁵ Sit-DuVall, Mary. “Houston Practice-Management Firm Struggles, May Leave Doctors Holding the Bag,” *The Houston Chronicle*, November 4, 2000.

²⁶ Sit-DuVall, Mary. “Swallowing a Bitter Pill; Group that Ran Physician’ Practices Got Overwhelmed, Leaving Doctors Holding Bag,” *The Houston Chronicle* (Star Edition), November 4, 2000.

²⁷ “PacifiCare’s Profit Falls 98 Percent in 3rd Quarter Because of Rising Costs.” Fort Worth Star-Telegram, 11/10/00.

²⁸ Sit-DuVall, Mary. “Houston’s Last Medicare HMO to Stop Accepting New Members.” *The Houston Chronicle*, 9/22/00, and Medicare Compare.

²⁹ Schnurman, Mitchell. “Texas Regulators Assume Oversight of Health Insurer PacifiCare.” Fort Worth Star-Telegram, 11/16/00.



other study sites, prefer Medicare fee-for-service reimbursement to HMO contracts. Houston physicians are particularly frustrated with some of the capitated arrangements under which they work. One provider told us about a contract her physician organization negotiated with a M+C plan under which she receives a \$9 monthly capitation rate for each of her M+C patients. Sometimes patients come to see her two to three times a month, making the capitated rate a losing proposition. Provider groups are also concerned about retaining risk for hospital care and pharmacy. One Houston provider group executive commented that a good contract from a physician's perspective would be to relinquish pharmacy and hospital risk and to limit the number of M+C lives that each provider accepts. This informant warned physicians to be "cautious" about the number of M+C patients in their practice, because "physicians cannot make money on these patients." Physicians, he went on to note, "need to balance their practices with patients for whom it is easier to manage care."

Market turmoil and contract disputes have resulted in significant provider turnover in some M+C plans. In 1999, between 7 and 27 percent of primary care providers quit their Medicare HMOs. PacifiCare had the highest turnover rate (27 percent). Prior to the pullouts, PacifiCare was experiencing serious defections of providers from its network because of payment arrangements, paperwork and referral delays.³⁰

Anecdotal Reports and Medicare Data Raise Access and Quality Concerns

We heard a range of complaints about access and quality in Medicare HMOs. Several beneficiaries and community informants complained about difficulties in obtaining access to network specialists. Physicians also expressed frustration with the care they were able to provide in a Medicare plan and the time it takes to get approval from M+C plans for certain procedures. We also heard that some IPAs had provider networks too small to provide the full range of needed specialty care. For example, one physician representative advised Medicare patients with a serious health condition not to join a particular HMO, because its physician network had too few specialists. She further observed that one HMO had only one hospital in its network, which was not appropriate for some really ill patients.

Focus group participants were equally concerned about denials of care. One senior described a friend who was denied surgery for a drooping eyelid that obstructed her vision because her M+C plan said the surgery was cosmetic. Another senior described switching to original Medicare to obtain knee surgery denied by her plan and switching back to the plan once the surgery was performed. She explained that she couldn't manage without the prescription

³⁰ Schnurman, Mitchell, and Sarah Lunday. "HMO says its tougher approach profitable; But many doctors, patients quitting PacifiCare network." The Fort Worth Star-Telegram, September 3, 2000; Lunday, Sarah. "Blue Cross members face loss of doctors," The Fort Worth Star-Telegram, August 25, 2000.



drug benefit offered by the plan. A third senior told us about a friend who couldn't get needed kidney surgery until she switched plans.

Community informants also stated that M+C plans are “notorious” for shorter hospital stays compared to FFS Medicare. One community informant described enormous tension between HMO doctors responsible for hospital utilization and hospital social workers. She noted that social workers were frustrated by the discharge of patients they felt were not ready to go home. Another senior organization representative said she believed that HMOs are “stingy” in authorizing home health care. A home health representative confirmed this impression. She felt that the HMO reimbursement rates for home health care agencies were too low to provide adequate care. This results in termination of home health benefits too early. We were told that some home health agencies in Harris County have opted to discontinue providing care to Medicare beneficiaries enrolled in M+C plans.

It is not possible to assess the quality of care provided by Medicare HMOs based on these anecdotes. Some data, however, lend credence to reports that Medicare HMOs in Houston have some access and quality problems. High disenrollment rates may reflect enrollee dissatisfaction with plans, as well as marketing problems and unstable provider networks. In 1999, several Harris County plans had very high disenrollment rates. The average disenrollment rate from managed care plans was 16 percent across Texas. Compared to the state average, several Houston plans had much higher disenrollment rates: In 1999, Cigna had a 53 percent quit rate; Texas Health Choice, a 32 percent quit rate; Prudential, a 22 percent rate, and PacifiCare, a 15 percent quit rate. NYLCare had the best success at holding on to its Houston members with an 8 percent disenrollment rate.

Another way to assess quality is through Medicare enrollee satisfaction scores and performance measures. PacifiCare—the one remaining plan for which data are available—performed less well than the state average on a range of measures. In some instances, PacifiCare's scores were below an acceptable level, especially when compared to M+C plans in other states (Table 3). Only 69 percent of PacifiCare's enrollees said it was not a problem to get a specialty referral when needed. PacifiCare also scored poorly on a number of performance measures, especially providing diabetics with eye exams and women with mammograms.

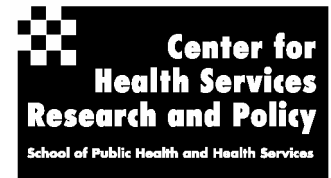


Table 3			
Medicare Performance Measures: Texas, PacifiCare, Minneapolis M+C Plans—1999			
	Texas Average	PacifiCare	Minneapolis M+C Plans
Enrollee Satisfaction Scores			
Always get care when needed without long waits	59%	55%	59-63%
Getting care that is needed	80	77	87-91
Own managed care plan is the best possible plan (a rating of 10)	51	43	38-61
Own care is the best possible care (a rating of 10)	53	44	45-57
Plan doctors always communicate well	71	65	68-72
Not a problem to get a referral to a specialist	78	69	85-90
Performance Measures			
Received a flu shot	75%	66%	84-87%
Diabetic enrollees who received an eye exam	51	35	57-84
Received a cholesterol test	74	76	74-79
Women (aged 52-69) who received a mammogram within the past 2 years	66	43	86 (one plan reporting)
Prescribed beta blockers after a heart attack	84	81	91-95

CONCLUSION: THE FUTURE OF M+C IN HOUSTON IS AT A CROSSROADS

Almost eighty-six percent of Harris County Medicare beneficiaries enrolled in M+C plans were affected by the mass exodus of M+C plans in in 2001. Many of these seniors will have difficulty affording the prescriptions, deductibles and copays not covered under traditional FFS Medicare. Some seniors were “frantic” to enroll in the one remaining M+C plan, PacifiCare, yet this plan capped its enrollment at 30,000 enrollees. Roughly three-fourths of seniors living in Harris County affected by M+C plan withdrawals are being forced to return to traditional FFS Medicare or join one of two new M+C plans. Many of the seniors returning to original Medicare will do so without adequate knowledge of the program or the Medigap market.

Houston’s M+C program is at a crossroads. Since the market exit of seven of Houston’s eight Medicare HMOs, PacifiCare has been experiencing serious financial problems and provider upheaval. The entrance of two new plans may calm the turbulent M+C waters. The owners of both plans have experience in the Houston market, and thus, may be able to avoid some of the pitfalls which led to the mass exodus of M+C plans at the end of 2000.³¹ However, whether these plans will be able to fill in the gaping hole left by plan withdrawals is not known at this time. Medicare beneficiaries may find AmCare unattractive

³¹ AmCare acquired the members of Sierra Health Services’ Texas Health Choice plan and the plan’s network of physicians in October, 2000. Fowler, Tom. “Regional Health Care Provider Acquires Network in Houston Area.” The Houston Chronicle, 10/27/00. Selectcare is a Provider-Sponsored Organization, a managed care plan owned by physicians and hospitals. Thus, both plans have some experience in the Houston market.

because it lacks coverage for prescription drugs. They may also find SelectCare's premiums unaffordable.

The future of M+C in Houston will depend on M+C plans' ability to work out agreements with providers and to address access and quality concerns. Contentious plan-provider relations and provider group financial difficulties have roiled the Houston M+C market and negatively impacted continuity of care for Medicare enrollees. Access within M+C plans—specifically limited provider networks and difficulties obtaining referrals—also appears to be a problem. High past disenrollment rates, as well as PacifiCare's low scores on enrollee satisfaction and a number of other measures, raise some questions about the quality of care provided by M+C plans in Houston.

Plan pullouts, financial instability among Houston's provider groups, and plan-provider contract disputes have undermined the confidence of seniors in M+C plans. Yet, seniors have no viable alternative to obtaining the prescription drugs offered by some M+C plans. The future of M+C in Houston is hard to predict. Whether M+C is a viable alternative to original Medicare in Houston is yet to be seen.

