

MEDICARE+CHOICE

AFTER FIVE YEARS:

HARRIS COUNTY,

TEXAS SITE VISIT

REPORT

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March 2002



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EXECUTIVE SUMMARY

During the past two years, Houston's Medicare+Choice (M+C) marketplace has been in a state of turmoil characterized by major health plan withdrawals, benefit reductions, and disruptions in provider networks. Enrollment in the M+C program fell steeply from a high of 27 percent of beneficiaries in 1999 after seven of the eight Medicare HMOs in Harris County (Houston), Texas terminated their coverage effective January 2001. Even after two new plans entered the M+C market in April-May 2001, only 10 percent of Harris County's Medicare population (30,303 beneficiaries) was enrolled in a managed care plan at the beginning of 2002. In Houston's outlying suburban counties, few, if any, M+C options remain.

Beneficiaries who still are enrolled in Houston's Medicare HMOs face significant reductions in benefits for 2002. None of the three M+C plans currently available in Harris County cover brand name medications, and all have added considerable cost-sharing requirements for Medicare-covered services. For example, beneficiaries in Houston's largest M+C plan have a new \$550 deductible for inpatient hospital care, a generic-only \$500 prescription drug benefit, and a 20 percent co-payment on oral chemotherapy drugs. M+C beneficiaries also face ongoing disruptions in their HMO's provider networks, which are reflected in primary care provider turnover rates in Houston's largest M+C plans of up to 29 percent, more than double the national average.

To examine the effect of this instability on the city's Medicare beneficiaries, project staff of the Center for Health Services Research and Policy, George Washington University conducted a site visit to Houston in October 2001. Staff interviewed representatives of health plans, physician and provider organizations, elderly advocacy groups and beneficiaries, regional Medicare officials, and other health care observers in Houston.

FINDINGS

- **“Provider pushback”, particularly by hospitals, is the most significant source of instability in Houston's Medicare+Choice marketplace.** M+C plans in Harris County benefited from one of the most generous payments rates in the country in 2001 (\$650 per member per month versus a national average of \$589), but now face rapidly rising costs because physician groups and hospitals refuse to accept capitated rates, have been unable to control utilization, and are demanding large payment increases. This is a response by providers to the failure of several large independent practice associations (IPAs) in Houston, which can be attributed to unsuccessful risk contracts with HMOs. Texas HMOs are struggling to contain utilization and costs and have recorded record losses in the last five years.
- **Plans, providers, and beneficiaries believe that Houston's Medicare+Choice enrolled population is increasingly low-income and of poor health.** Major stakeholders reported that many of the beneficiaries who remain in M+C are those most in need of prescription drug coverage and can least afford a supplemental



Medigap policy. This has created an incentive for plans to reduce benefits in an effort to control adverse selection and has further discouraged providers from accepting capitated payments from plans.

- **Medicare HMO withdrawals have meant significant loss of prescription drug coverage for Houston beneficiaries.** After plan withdrawals, a broad swath of seniors with incomes too high to qualify for Medicaid but too low to purchase supplemental insurance is now struggling with out-of-pocket prescription drug expenses of several hundred dollars per month. Limited generic-only M+C drug benefits will further increase costs for beneficiaries in 2002. The intractable prescription drug problem in Houston is exacerbated by the lack of a state pharmaceutical assistance program in Texas.

After the large-scale plan withdrawals of 2000, the Medicare+Choice program in Houston may now be achieving some modest level of stability, albeit characterized by lower enrollment, less generous benefits, and smaller provider networks in M+C plans. While health plans may be able to subsist in the short term off of Harris County's relatively generous payment rate, future prospects for a large-scale increase in M+C participation by plans and providers are bleak. Many beneficiaries are now looking to broader Medicare reform rather than managed care plans to deal with Medicare's significant gaps in coverage.



INTRODUCTION

Five years after the Balanced Budget Act of 1997 created Medicare+Choice in an effort to both restrain Federal spending on health care and offer an expanded choice of private health plans to Medicare beneficiaries, Medicare's managed care program now faces an uncertain future. Health plans have withdrawn from the program in large numbers since 1998, leading 2.2 million beneficiaries to either switch to another M+C plan or return to fee-for-service Medicare with its significant gaps in coverage. The elderly and disabled enrollees who do remain in managed care plans are facing increased premiums and reduced benefits, particularly for prescription drugs and inpatient hospital care. Strained relations between health plans, physicians, and hospitals have further weakened trust in the M+C program, as highly publicized plan-provider contract terminations continue to disrupt continuity of care for patients.

Houston, the fourth largest city in the country, has been hit especially hard by this recent turmoil. After seven years of rapid growth in Medicare managed care enrollment, Houston's M+C market seemed to change overnight – just prior to July 3, 2000 – when seven of the eight Medicare HMOs available in Harris County (Houston), Texas suddenly announced that they were withdrawing from the program effective January 2001. These non-renewals affected approximately 65,000 Medicare beneficiaries, representing over 85 percent of the county's M+C enrolled population. While 27 percent of Harris County's Medicare population was enrolled in a M+C plan before June 2000, only 10 percent is currently.¹ Although two managed care organizations did enter the market with new M+C products in the spring of 2001, neither they nor the one plan that did elect to stay in 2000, PacifiCare, now offer an expansive benefit package to their Harris County members. As in almost all other metropolitan areas, the days of zero-premium M+C plans with little or no cost-sharing and unlimited drug benefits are over for Houston's Medicare population.²

Houston's disappointing experience with Medicare+Choice deserves the attention of researchers and policymakers for two main reasons. First, current Medicare officials have set a goal of doubling M+C enrollment to 30 percent of beneficiaries by 2005.³ In order to reach this ambitious target, the substantial majority of new national M+C enrollment would have come from large urban areas like Houston that have sufficiently dense concentrations of providers to support managed care networks. By examining whether the factors that caused health plans' exodus from M+C in Houston are still present, policymakers can get a sense of whether a large-scale re-entry of health plans and providers into Medicare+Choice is feasible.

Second, Houston's experience also offers important insights into how the 2.2 million beneficiaries across the country whose coverage was disrupted by

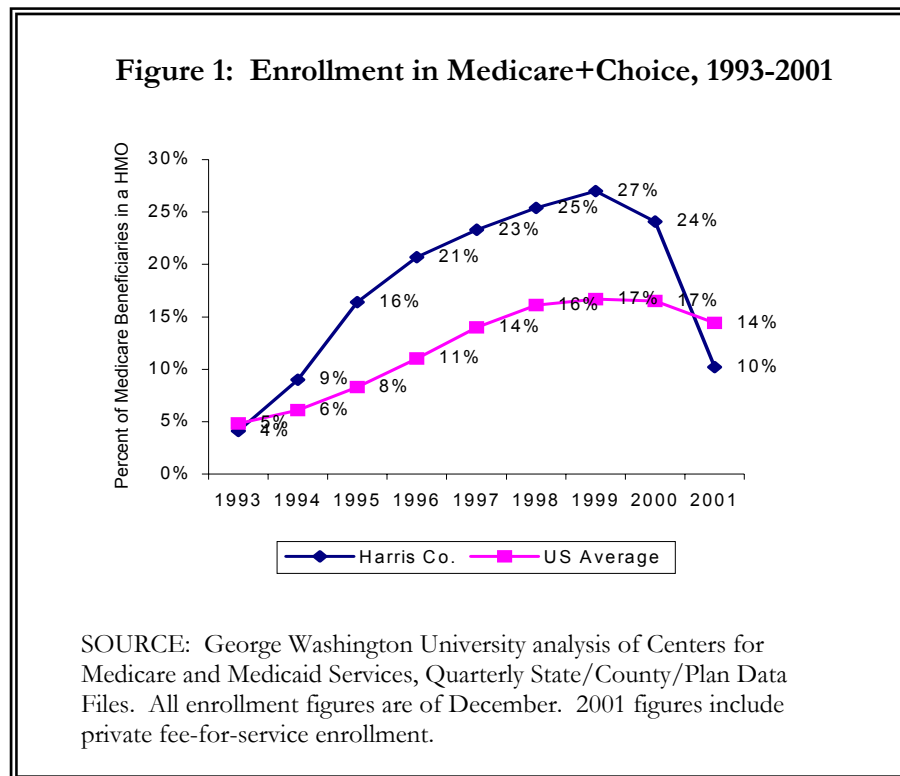
¹ Centers for Medicare and Medicaid Services (CMS), Quarterly State/County/Plan Data Files.

² In 2002, only 0.03% of beneficiaries nationwide are expected to be enrolled in a plan that offers unlimited brand and generic drug coverage. CMS, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002*, December 2001. Available at <http://cms.hhs.gov/healthplans/>.

³ R Pear, "H.M.O.'s Flee Despite Rise in Payments." *New York Times*, December, 4, 2001; A17.



plan withdrawals are dealing with changes in their health care arrangements. The near implosion of M+C in Houston is cause for concern because many of the city's Medicare beneficiaries, especially those with low incomes and chronic illnesses, had come to depend on an M+C plan to reduce out-of-pocket expenses, pay for needed medications, and avoid purchasing expensive supplemental Medigap policies. Now that their health plans have left the market, some of the most vulnerable elderly have few places to turn to for these lost benefits, particularly for drugs. In Texas, M+C plan withdrawals and benefit reductions are now putting additional stress on already overburdened senior services agencies and safety net providers.



In order to explore these two issues, project staff of the Center for Health Services Research and Policy, The George Washington University Medical Center conducted a site visit in Houston in October 2001. During the site visit and follow-up phone calls, staff interviewed representatives of M+C plans, the Center for Medicare and Medicaid Services (CMS), the Texas Department of Insurance, Harris County Area Agency on Aging, physician and provider organizations, areas hospitals, and a senior services agency. Staff also conducted three focus groups with Medicare beneficiaries and surveyed local newspaper articles and other relevant publications.

This work builds upon an earlier July 2000 site visit to Houston⁴ and is part of a continuing effort, supported by The Commonwealth Fund, to monitor the implementation of the Medicare+Choice program in nine different

⁴ J Stuber, K Maloy, C Edwards, B Biles. *Monitoring the Implementation of Medicare+Choice: Harris Co., TX Site Visit Report*. Washington, D.C.: The George Washington University Medical Center, Center for Health Services Research & Policy, July 2001. Available at: <http://www.gwhealthpolicy.org>.



metropolitan areas—Cleveland, Houston, Los Angeles, Long Island, Minneapolis, New York City, Seattle, Tampa-St. Petersburg, and Tucson.⁵

MEDICARE+CHOICE IN HOUSTON: PLANS AND BENEFITS FOR 2002

After seven firms – NYLCare, Humana, Memorial Sisters of Charity, Prudential, Methodist Health Care, CIGNA, and Texas Health Choice – all announced their withdrawals in the summer of 2000, PacifiCare’s Secure Horizons plan was the only option left for seniors looking to remain in Medicare+Choice in 2001. Two small locally-based plans, AmCare and SelectCare, later entered the market in April-May 2001. Sterling, an insurer that did offer a private fee-for-service M+C plan to beneficiaries in several outlying Texas counties in 2001, has chosen not to enter Harris County.



Table 1: Harris County Medicare+Choice Enrollment, 2000-2001

Prior to Withdrawals: June 2000		After withdrawals: December 2001	
Plan	Enrollment	Plan	Enrollment
NYLCare	33,412	PacifiCare	25,415
Humana	15,127	AmCare	4,073
PacifiCare	11,132	SelectCare	815
Memorial Sisters of Charity	6,608		
Prudential	5,497		
MethodistCare	3,915		
Cigna	1,039		
Texas Health Choice	537		
TOTAL	77,267 (26.7%)	TOTAL	30,303 (10.2%)

SOURCE: George Washington University analysis of CMS Quarterly State/County/Plan Data Files. <http://www.hcfa.gov/medicare/mpscpt1.htm>.

PacifiCare: substantial new cost-sharing for 2002

PacifiCare, the experienced plan in the market, eliminated its \$25 monthly premium for 2002, but substantially increased cost-sharing for most major services: physician visits, outpatient hospital care, diagnostic tests, nursing home care, durable medical equipment, and most importantly, imposed a new \$550 deductible for inpatient hospital care. PacifiCare is also introducing a new \$250 co-payment for outpatient injectible medications administered in a physician’s office and a 20 percent co-payment on self-administered injectibles and oral chemotherapy drugs. Prescription drug coverage was also cut considerably; last year’s \$1,200 combined brand/generic benefit has been replaced with a \$500 generic-only benefit. PacifiCare is not alone in this move; indeed, none of the Harris County M+C plans will cover brand name medication for 2002. In Houston as in most US

⁵ J Stuber, G Dallek, C Edwards, K Maloy, B Biles. *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries—Findings From Seven Case Studies*. The Commonwealth Fund, October 2001.



cities, the trend in benefits is towards generic-only prescription drug coverage and increased out-of-pocket expenses, especially for hospital care.⁶ (See Table 2).

Two new plans: limited benefit packages, modest enrollment

Two new health plans, AmCare and SelectCare, entered the Medicare+Choice market in Harris County in March-April 2001. This came as a relief to Medicare beneficiaries looking to join a managed care plan, because PacifiCare had closed its enrollment in September 2001 after its membership swelled from 11,000 to 26,000 after the July withdrawal announcements. Following this enrollment rush, the plan was forced to stop accepting new enrollees in order to maintain its network capacity. This effectively meant that there were no M+C plans accepting new members from October 2000 until the spring of 2001, when AmCare and SelectCare came in to fill this void.

AmCare began coverage on March 1, 2001 and enrolled just over 4,000 beneficiaries by the end of December 2001. AmCare's management has past experience in the Houston M+C market and is confident that its knowledge of local provider groups and market dynamics will ensure the plan's ability to compete.⁷ The firm's strategy is to strictly enforce global capitation, preferably with a primary care provider group accepting both risk and the responsibility for sharing risk with specialty providers and hospitals. For 2002, AmCare offers a zero premium plan with small co-payments and an unlimited formulary generic drug benefit, which may prove attractive to seniors in need of prescription drugs.

SelectCare, a local company with a marketing arrangement with United Healthcare, has been enrolling members in a high-option product called EncorEncore since April and opened enrollment in a low-option product, Texan Plus, this January. Unlike Houston's other M+C plans, SelectCare is a provider-sponsored organization (PSO) that is majority-owned by providers and is comprised of several IPAs, including Heritage Physicians Association and Golden Triangle Physicians Association. EncorEncore is a preferred provider organization (PPO) product and does not want to be perceived as an HMO; its members use network providers or face a 30 percent co-pay. It charges a \$95 monthly premium (up from \$85 a year ago), but offers a \$500

⁶ For an analysis of national trends in M+C benefits, see CMS, *M+C Changes in Access, Benefits, and Premiums, 2001 to 2002*, December 2001. Available at <http://cms.hhs.gov/healthplans/>.

⁷ Tom Lucksinger, AmCare's chief executive officer, previously managed NYLCare's Medicare HMO, which was the first managed care organization to enter the Medicare market in Houston.

generic prescription drug benefit. Texan Plus is a more traditional HMO with no premium, but only \$300 of generic drug coverage. As of December 31, 2001, only 815 Harris County beneficiaries were enrolled in these plans.



TABLE 2							
2001-2002 Premium and Selected Benefit Co-payments: Harris County Medicare+Choice Plans							
	PacifiCare		SelectCare			AmCare	
	2001	2002	2001 EncorEncore	2002 EncorEncore	2002 Texan Plus	2001	2002
Enrollment Limit	Yes	No	No	No	No	No	No
Premium	\$25	\$0	\$85	\$95	\$0	\$0	\$0
Doctor visits							
Primary Care	\$6	\$15	\$10	\$5	\$10	\$15	\$15
Specialist	\$6	\$30	\$10	\$15	\$15	\$15	\$15
Outpatient visits							
Ambulatory surgery	\$0	\$150/visit	\$0	\$0	\$50	\$50	\$50
Hospital visit	\$0	\$150/visit	\$0	\$0	\$50	\$50	\$50
Durable medical equipment	\$0	\$0-\$500 ⁸	\$0	\$0	\$10	\$0	\$0
Diagnostic Tests							
Clinical lab	\$6	\$0	\$0	\$0	\$0	\$0	\$0
X-rays/ Diagnostic lab	\$6	\$0-\$100/\$0	\$0	\$0	\$0	\$0	\$0
Radiation Therapy	\$6	\$100	\$0	\$0	\$0	\$15	\$15
Outpatient rehabilitation services	\$0	\$15-\$30/visit	\$10/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit
Inpatient hospital care	\$0	\$550 deductible	\$0	\$0	\$250 deductible	\$100 deductible	\$100 deductible
Skilled nursing facility							
Days 1-20	\$0/day	\$0/day	\$0/day	\$0/day	\$0/day	\$100 deductible	\$100 deductible
Days 21-100	\$0/day	\$99/day	\$0/day	\$50/day	\$75		
Diabetes Monitoring ⁹	\$0	\$0	\$0	\$15 20% co-pay for supplies	\$15 20% co-pay for supplies	\$0	\$0

⁸ DME is covered in full when authorized and provided by contracting providers, except scooters, which are covered after a \$500 co-payment per item.

⁹ Glucose monitors, test strips, lancets, and self-management training.

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	PacifiCare		SelectCare			AmCare	
	2001	2002	2001 EncorEncore	2002 EncorEncore	2002 Texan Plus	2001	2002
<u>Prescription Drugs Formulary</u>							
30-day supply							
Generic co-pay	\$5	\$15	\$10	\$10 (31-day)	\$15 (31-day)	\$10	\$10
Brand co-pay	\$20	not covered	not covered ¹⁰	not covered	not covered	not covered	not covered
90-day Mail order							
Generic co-pay	\$15	\$30	mail order not offered	mail order not offered	mail order not offered	\$30	\$30
Brand co-pay	\$50	not covered				not covered	not covered
Cap							
Generic	\$1,200	\$500	\$500	\$500	\$300	Unlimited	Unlimited
Brand	combined brand and generic limit	No brand coverage	No brand coverage	No brand coverage	No brand coverage	No brand coverage	No brand coverage

¹⁰ Except insulin, which SelectCare does cover.



MEDICARE+CHOICE IN HOUSTON: CONTINUING ELEMENTS OF INSTABILITY

The instability that has plagued Medicare managed care in Houston in recent years – plan withdrawals, reduced benefits, high rates of provider turnover within health plans – is part and parcel of a much greater instability that confronts Houston’s health care delivery system as a whole: double digit increases in health care costs, sub-market monopolies, provider pushback, increasing utilization, unaffordable drug prices, and overburdened safety net providers. Major stakeholders in Houston – plans, providers, and beneficiaries – agreed that this combination of national and local factors, which caused seven health plans to leave Medicare+Choice in 2000, is still present in the Houston market today. This continuing instability does not bode well for a large-scale re-entry of HMOs (especially, national, for-profit, IPA-model HMOs) into Medicare, with or without a major increase in reimbursement to plans.

PLANS’ PERSPECTIVE: MEDICARE+CHOICE CONTINUES TO LOOK UNATTRACTIVE

Across the country, plans have increasingly found that Medicare+Choice is unattractive and the most often cited reason for their withdrawals from the program is inadequate reimbursement from the Federal Government, which makes consistent profitability difficult if not impossible.

Plans, providers, and beneficiaries reported that M+C plans simply had difficulty making a profit in Houston and noted this problem as if it were all too obvious. One plan executive commented that “the money wasn’t there” and the plans were “losing their shirts.” Both providers and consumer advocates, as well as plans, pointed out that plans’ reimbursement from Medicare simply is not adequate to cover administrative costs (operations and marketing), payments to a comprehensive network of providers, plus the extra non-Medicare benefits, such as prescription drugs, needed to attract enrollees. Across the board, they observed that reimbursement was inadequate and that any additional money plans received from risk adjustment or the Benefits Improvement and Protection Act (BIPA) of 2000 was not enough to cover costs.

Medicare+Choice business has not been profitable for plans, despite the fact that Harris County’s average adjusted per capita cost (AAPCC) rate, upon which Medicare bases its payments to HMOs, is, relatively generous at \$650.54 per member per month for 2001. This rate put Harris County in the top 2 percent of counties nationwide for reimbursement, along with expensive markets such as Los Angeles and Boston. It is also well above the national average of \$589.35 and the rates of other Texas cities such as Dallas (\$561.93), Fort Worth (\$545.05), San Antonio (\$527.47), and Austin (\$525.00).



One plan executive stated that \$650.54 was high enough to “at least make a go of it” in Houston; it was a reason for plans’ entry into and continued participation in the program. Nonetheless, these representatives said that Medicare+Choice is still “a negative multiples business.” With health care

Table 2: Payment Rates in Top 20 Metro Areas, 2001

Metro Area-County	AAPCC Rate
1. Miami - Dade Co., FL	\$817.84
2. New York Co., NY	\$779.47
3. Philadelphia Co., PA	\$769.77
4. Detroit - Wayne Co., MI	\$698.10
5. Boston - Suffolk Co., MA	\$696.59
6. Los Angeles Co., CA	\$680.47
7. Houston - Harris Co., TX	\$650.54
8. Washington, DC	\$638.49
9. Chicago - Cook Co., IL	\$611.32
10. Cleveland - Cuyahoga Co., OH	\$592.86
NATIONAL AVERAGE	\$589.35
11. San Francisco Co., CA	\$588.75
12. Atlanta - Fulton Co., GA	\$586.16
13. San Diego Co., CA	\$580.67
14. Dallas Co., TX	\$561.93
15. Denver Co., CO	\$550.66
16. Phoenix - Maricopa Co., AZ	\$540.09
17. Tampa - Hillsborough Co., FL	\$536.98
18. Minneapolis - Hennepin Co., MN	\$525.00
19. Seattle - King Co., WA	\$525.00
20. St. Louis Co., MO	\$525.00

SOURCE: George Washington University analysis of CMS data. National weighted average computed using December 2001 enrollment figures.

costs consistently rising over 10 percent annually while Medicare payments have only increased at 2 percent per year in large urban areas,¹¹ “Every year, margins decrease to the point where you don’t operate.” One plan representative estimated that operating margins on Medicare business were between 10 and 20 percent prior to the Balanced Budget Act in 1997, but are now down to around 2 or 3 percent and will only decrease. Even if the AAPCC is sufficient to cover the cost of care today, due to its small rate of increase, this will not be the case in the near future and so today’s payment may not be enough to persuade many large, national, for-

profit plans to remain in M+C for the long haul. Low reimbursement continues to encourage withdrawals from other rural and suburban counties in the area; this September, PacifiCare announced its withdrawal from Brazoria, Chambers, Galveston, Hardin, Jefferson, Liberty, Orange and Waller counties. While PacifiCare is staying in Harris County for 2002, its benefit changes there are part of an apparent national strategy to increase cost-sharing in order to stay afloat in those counties where M+C is still viable in the short term.

Texas health plans’ claims about their sagging profitability clearly are credible. PacifiCare of Texas alone lost \$39 million in 2000, of which \$24 million was attributed to Medicare+Choice.¹² However, it is worth noting that the

¹¹ Average overall health care costs for Houston-area employers increased 12.8 percent from 2000 to 2001, up from 11.8 percent between 1999 and 2000 (*Houston Chronicle*, June 28, 2001). Since the Balanced Budget Act of 1997, Houston M+C plans have received 2 percent increases in reimbursement every year, except for a one-time 3 percent increase in reimbursement for 2001 as part of the Benefits Improvement and Protection Act (BIPA) of 2000.

¹² A Baumgarten. *Texas Managed Care Review 2001* (Minneapolis: Allan Baumgarten, November 2001), p. 19.



managed care organizations' financial problems are not unique to the M+C line of business. Even in the commercial market, where HMOs have been able to secure large increases in premiums from employers in recent years, this new revenue has not been able to keep up with increasing utilization and health care costs. Houston was the worst performing large HMO market in the country in 2000, according to InterStudy, which publishes an annual survey of data on managed care. It had the lowest average operating margin (-8.7 percent), the highest average medical expense ratio (96.9 percent), and the fifth highest average administrative expense ratio (15.6%) of all the US markets with populations over one million.¹³ Dallas, Fort Worth, San Antonio, and Austin ranked similarly poorly in these categories.

Houston HMOs have struggled with high medical loss ratios because of their failure to successfully use utilization review techniques to hold down costs. Historically, HMOs in Houston have been large IPA-model HMOs rather than group or staff model HMOs, which traditionally can exercise greater control over their physicians' practice patterns. The increasing cost of hospital care and prescription drugs were also cited as contributing factors to high medical loss ratios. Not surprisingly, these failures have had a direct impact on managed care organizations' bottom line. According to Allan Baumgarten's *Texas Managed Care Review 2001*, unlike other states, HMOs in Texas have been unable to rebound from their large losses in the late 1990s. Between 1996 and 2000, they lost \$1.5 billion in the state and continued to operate in the red in 2001.¹⁴ Some industry experts have begun to hypothesize that HMOs are a "dying breed in Texas" that will "die a slow and natural death over the next three to five years."¹⁵

In such a difficult environment for traditional managed care products, large for-profit national plans are looking for strategies to move away from public programs such as Medicare and Medicaid where payment is capped but provider costs are not. In response, PacifiCare, which has seen its stock downgraded by Wall Street analysts in recent years because of its heavy exposure to Medicare+Choice¹⁶, has withdrawn from many suburban and rural counties and begun marketing new Medigap policies in many of the same states, such as Texas and Oklahoma, where it withdrew.¹⁷ While plans foresee no new large source of revenue in the M+C business, premium increases are easier to secure in the market for Medicare supplemental

¹³ *The InterStudy Competitive Edge: Regional Market Analysis 11.2*. St. Paul, Minnesota: InterStudy Publications, 2001. Medical expense ratio represents expenditures for medical services, supplies, and equipment as a fraction of premium revenue. Administrative expense ratio represents expenditures for administration and marketing functions as a fraction of premium revenue. Because the sum of these two ratios exceeds 100 percent, it is clear that expenses have been exceeding premium revenues for HMOs in Houston.

¹⁴ A Baumgarten, p. 16. S Kreimer, "Texas HMO Industry Reports 21st Consecutive Losing Quarter," *Houston Chronicle*, August 30, 2001. "HMO Loses Continue, With \$207 Million Lost in Third Quarter, State Regulator Finds," *BNA Health Care Policy*, December 17, 2001.

¹⁵ P Rivera, "HMOs on Life Support in Texas, Experts Say," *Dallas Morning News*, January 27, 2002.

¹⁶ CMS, "Wall Street's View of Managed Care," *Health Care Industry Market Update*, November 28, 2001. Available at <http://www.cms.hhs.gov/hcimu/>.

¹⁷ "PacifiCare Subsidiaries to Market New PPO in 3 States." *BestWire*, August 22, 2001. T Banstetter, "Health Insurer PacifiCare Starts Medicare Supplement Plan in Texas," *Fort Worth Star-Telegram*, October 11, 2001.



policies. Between 1998 and 2000, insurers have increased Medigap premiums in Texas as much as 34 percent.¹⁸

Another trend in this market is the movement away from tight HMO products towards PPO and point-of-service plans with less reliance on gatekeepers and utilization review. SelectCare is following this trend, marketing its plan to a target group of seniors who have trouble keeping up with the cost of supplemental policies, which is “about half of the market”, but don’t want the restrictions of HMOs. Its high-option EncorEncore PPO competes with Medigap D, E, and F – policies that cover Medicare co-payments and deductibles, but not prescription drugs – rather than other M+C plans such as PacifiCare. If SelectCare’s niche strategy catches on within the industry, beneficiaries can expect more choice of providers in M+C, but nothing like the level of additional benefits that traditional Medicare HMOs once offered.

After the withdrawals: plans and providers concerned about adverse selection

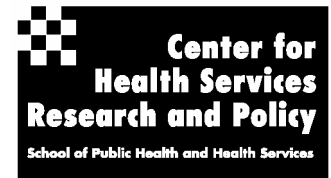
Virtually all the major stakeholders in Houston – plans, providers, and beneficiaries – agreed that the current enrollees in M+C are proportionally sicker and more vulnerable than were the M+C population before the withdrawals. Specifically, they believe that the beneficiaries most in need of prescription drugs (and least able to afford a supplement) now dominate Medicare’s managed care enrollment in the city. In response, benefits in Harris County plans appear to be an effort to pare down the risk of adverse selection.

There is evidence that adverse selection has been a continuing problem for providers and plans in Houston. For example, figures from the Kelsey-Seybold Clinic showed that its M+C members visited the doctor 15 times per year, compared to nine visits for the general Medicare population and three visits for patients in commercial HMOs.¹⁹ After the withdrawals of 2000, this problem may be getting worse. Some observers are concerned that PacifiCare’s current membership, the majority of which joined in the frantic weeks following major withdrawals, may be particularly problematic. Enrollment in its Secure Horizons plan swelled from 11,000 to 26,000 enrollees before it received a capacity waiver from CMS at the end of September. One plan executive referred to these enrollees, many of whom joined because they were seeking prescription drug coverage, as “the walking wounded.” While PacifiCare’s drug benefit reduction and co-payment increase apparently resulted from a national decision about financing, these changes may effectively serve to reduce their plans’ risk of adverse selection.

In an interesting development for 2002, PacifiCare of Texas has begun an effort to encourage its lower-income members to enroll in the Medicare savings programs QMB and SLMB. The plan sent a questionnaire to its members along with its 2002 Annual Notice of Coverage to determine

¹⁸ *Fort Worth Star-Telegram*, April 3, 2001.

¹⁹ M Turner, “Industry Braves Challenges of Medicare Managed Care,” *Houston Business Journal*, February 9, 2002.



whether they are eligible for these programs, which pay beneficiaries' Part B premiums (and in the case of QMB, deductibles and co-insurance as well), and PacifiCare is offering to complete all the necessary paperwork for its members with the state Medicaid office. The firm sees this as an opportunity to benefit from additional funding from the state for these QMB/SLMB members, who, they believe, do not pose significantly higher medical risk than the Medicare population at large.

SelectCare is also conscious of the threat of adverse selection. Their strategy with EncorEncore is to boldly target middle-income beneficiaries who cannot afford a high-end Medigap but need the co-insurance relief of a lower-end supplement. The firm has kept its drug benefits small. SelectCare's Texan Plus HMO will have a \$300 annual cap on generic prescription drugs—another effort to avert risk in a particularly costly benefit. AmCare appears to be avoiding risk by not expanding the size of its provider panels, making it less attractive for beneficiaries recently dropped from other plans.²⁰

Across the board, these three plans are also now charging inpatient hospital deductibles and fees for emergency and urgent care use. Some consumer advocates speculate that these increased charges are intended more as a deterrent against high users of medical care rather than income generators.

“PROVIDER PUSHBACK”: A MAJOR SOURCE OF INSTABILITY IN HOUSTON

Over the past five years, a well-noted sea change in the balance of power between health plans and providers has brought physicians and hospitals newfound leverage to demand increased rates and more professional autonomy from HMOs. This “provider pushback” has profoundly affected the Medicare+Choice program in Houston, where the city's leading providers have all either stopped accepting capitation entirely, or reduced it to a much smaller portion of their business.²¹ In this new environment, managed care plans find it difficult to negotiate rates that they find acceptable. Given caps in payments, Medicare HMOs increasingly find that they cannot accept these increased costs.

²⁰ T Banstetter, “Physicians Group Move to Curb HMO's Growth in Tarrant County, Texas, Area”, *Fort Worth Star-Telegram*, November 9, 2001.

²¹ For a national discussion of this topic, see transcripts from Center for Studying Health Systems Change conference “Emerging Health Care Market Trends; Insights from Communities” (Washington, D.C.; December 10, 2001), available at <http://www.hschange.org/>.



Prior to the managed care backlash, health plans had pushed hard in negotiations to have provider organizations accept global capitation, where a primary care medical group or IPA would accept risk that included primary and specialty physician services and hospital care. The medical group would then have to make risk-sharing agreements with specialists and hospitals. According to several informants, some provider organizations had problems managing the risk, and both plans and provider organizations lost money on these failed deals. Indeed, neither hospitals nor physician organizations were satisfied with global risk. After successes in fighting back against the rate cuts of the Balanced Budget Act, hospitals in particular have now been able to use their newfound leverage to secure better financial terms in their contracts with health plans.

**PLANS AND PROVIDERS CLASH OVER
LATE PAYMENT**

A major source of friction between health plans and providers in Houston have been complaints about late payment by HMOs. One hospital executive said that her organization still has unpaid claims with Medicare HMOs that withdrew from the market two years ago. In response to late payment, the Texas Department of Insurance placed a major Medicare+Choice plan under state oversight for five months and the state Senate established its own Special Committee on Prompt Payment of Health Care Providers.

Regional Medicare staff noted that they receive more complaints from providers about late payment than from beneficiaries about denials of care. In response, they advise providers to establish good contracts that specify how long it will take to pay claims.

Medicare staff cited this provider pushback, rather than the Medicare payment rate, as the number one reason that plans withdrew from Houston in 2000. One plan executive stated that the cost of maintaining a comprehensive network for his plan contributed to rising costs more so even than the increasing cost of prescription drugs.²² He estimated that his firms' hospital expenses increased 50 percent from 1998 to 2001. Another HMO representative complained bitterly about the hospitals' ability to secure new rate increases; he said of his firm in this market: "We're price takers; we're not price setters." Plan executives complained that hospital and provider groups had secured high rates from commercial insurers and were now trying to entirely eliminate managed care from Houston by playing hard-ball at the negotiating table.

Houston hospitals have benefited from a period of acquisition and consolidation in the 1990s, after which four large hospital systems –

²² Researchers have identified this as a national trend. See Center for Studying Health Systems Change, Data Bulletin No. 21 Revised, *Tracking Health Care Costs: Hospital Care Key Cost Driver in 2000*, September 2001.



Memorial Hermann, HCA, Methodist, and Tenant – now control more than 70 of the set-up beds in the Houston area.²³ While Medicare+Choice plans have continued to secure access to most of these hospitals for their members, overall access is on the decline. Of three major hospital systems that we spoke to, none continue to take capitation agreements; they now negotiate direct agreements with health plans, not with primary provider groups. Their contracts are now based on fee-for-service, per diem rates and/or DRGs. Hospitals' Medicare revenues improved after their M+C contracts ended because traditional Medicare generally pays more than the non-renewing plans did. (One representative said of the financial effect of plan withdrawals on her hospital, "It was great.") Now, hospitals are successfully negotiating rates that are slightly higher than regular Medicare, in order to account for the "authorization hassles" that the hospital assumes when it deals with a managed care plan. The volume of M+C patients remains low at many hospitals. During the last ten months, one major Houston hospital had over 10,000 regular Medicare patients, while the discharges of M+C patients numbered just 200.

Hospital system and health plan representatives agreed that hospitals are doing well now, and have been for approximately the last three years. According to Allan Baumgarten's *Texas Managed Care Review 2001*, Houston area hospitals realized profits of \$427.3 million in 2000 on a margin of 5.5 percent, in contrast to HMO's recent losses.²⁴ One noted that, "it has been a hospital market," for both Medicare and commercial business. Hospitals acknowledge that in their current position, they would prefer to do no M+C business, but continue to do some in order to stay available to certain patients and primary care providers. They can negotiate from strength and clearly have greater clout in M+C negotiations.

Providers, like hospitals, had been damaged financially by global capitation agreements. One medical group representative noted that HMOs had been insulated from risk and that now "providers need to protect themselves." This large Houston medical group had accepted professional capitation with one of the plans that withdrew at the end of 2000, but is now not participating in M+C because the rates are "too low." They lost patients after the plan withdrawal, but are not anxious to rejoin M+C. Observers also noted that many provider groups, particularly small ones, were simply unsuited to effectively handle the complex tasks of controlling utilization and processing claims.

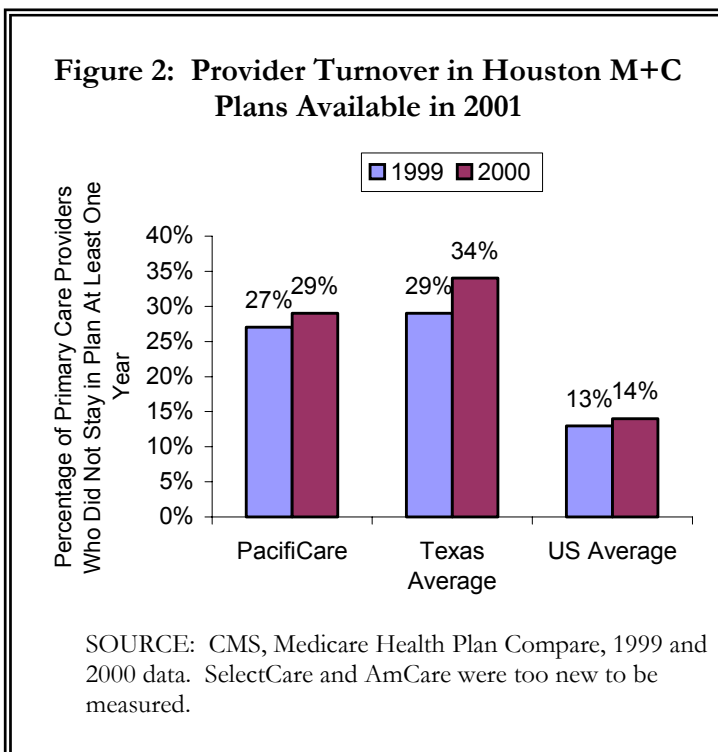
The outlook for Medicare HMOs seeking to make global capitation arrangements with its providers is now bleak in Houston. At the current time, AmCare appears to be the only plan pushing strongly for global capitation within its networks.

²³ A Baumgarten, p. 33.

²⁴ A Baumgarten, p. 30.

Instability in IPAs; HMOs assuming more risk

Financial turmoil in medical management firms and independent practice associations (IPAs), which Houston’s HMOs have traditionally relied upon to manage risk, is another key factor in the decline of M+C in the city. Most strikingly, the demise of North American Medical Management (NAMM), which fell into insolvency and then disintegrated in 2000, affected over 1,800 physicians and 50,000 M+C patients. This was an event that triggered a domino effect among IPAs; shortly afterwards, other IPAs began to show signs of financial strain and difficulty managing risk.²⁵



Then in September 2001, Heritage Physicians Network announced that it was dropping its contract with PacifiCare, affecting another 20,000 members in the Houston area.²⁶ These disruptions are reflected in primary care provider turnover rates in PacifiCare of over 25 percent in 1999 and 2000, compared the national average of 13 to 14 percent. (See Figure 2). Additionally, four Texas IPAs declared bankruptcy in 2001 and another is currently being monitored by the Texas Department of Insurance.²⁷ Physicians now are increasingly wary of joining medical management firms and IPAs.

A major concern about these changes is whether the IPAs who are now signing up thousands of new physicians will have the capacity to handle the increased membership load as well as the increased number of claims. The issue will continue to be a concern, as the plans have decided not to contract directly with physicians, but rather only work with IPAs. (This is occurring both in Medicare and in commercial products.) Despite their wariness about

²⁵ The physicians who had been in NAMM have now been encouraged to join another “reconfigured” IPA, called Renaissance Physicians Network.. See A Wollam, “Physician Groups Join Renaissance: NAMM Founder Signs on Old IPAs,” *Houston Business Journal*, January 19, 2001. J Harkey, “Phy-Cor-owned NAMM Bails out of Houston, its Flagship Market,” *The Harkey Report*, November 30, 2000.

²⁶ S Kreimer, “Health Care Switch Creates Confusion,” *Houston Chronicle*, September 20, 2001.

²⁷ J Jacob, “Don’t get caught unaware if your IPA fails,” *AMNews*, December 17, 2001. W Borges, “Medical Bankruptcies,” *Texas Medicine*, October 2001, p. 24-28.



IPAs many physicians now join several IPAs simply to participate in the plans of their patients.²⁸

The fallout from medical group failures is that IPAs are no longer accepting global risk from plans. CMS staff noted that Houston’s IPAs simply could not manage this risk. Risk for primary and specialty physician services, hospital care, and prescription drug use has frequently shifted back to the HMOs in this market. Now it is the health plans that are concerned about this shift of risk and its potential effect on their profitability.

THE IMPACT OF INSTABILITY ON BENEFICIARIES

After the plans withdrawals of 2000, many beneficiaries have been left with a sour taste in their mouth and are now “gun-shy” of Medicare HMOs. Focus group participants were angry and confused at being “dropped” by health plans by health plans that offered coverage with which they were broadly satisfied. One HMO

executive said that after beneficiaries have been dropped by an M+C plan, “you can’t even get them to fill out an application.” Trust in the program has declined as long-standing patient-physician relationships are disrupted by IPA failures and contract terminations. All of these developments are reflected in static M+C enrollment in Harris County.

Benefit reductions and high prescription drug costs stretch seniors’ budgets

Many health care observers in Houston reported that low-income Medicare beneficiaries are facing serious financial challenges in the wake of plan withdrawals and benefit reductions. The high cost of prescription drugs is a particularly pressing problem. None of the M+C plans in Harris County now cover brand name drugs, and only AmCare has an unlimited (generic) drug benefit. Seniors are “between a rock and a hard place” finding supplements unaffordable, and the co-insurance and necessary drugs unaffordable as well. In particular, some beneficiaries with chronic

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Dorothy was a member of Humana, but was dropped when Humana left. She was upset at the withdrawals; “It was like they just dumped me,” she said. She has a discount card from a pharmacy chain, but she still spends about \$500 per month on drugs. She feels like she “robs Peter to pay Paul.” She might consider joining another HMO, but she is very concerned about the dependability of HMOs. Dorothy apparently misunderstood that she could continue to see her cardiologist after her HMO left and she was back on regular Medicare, so she stopped seeing him. The doctor finally called her to see how she was doing, explained that she was not restricted from seeing him, and she began to see him again.

²⁸ Although IPAs play a critical role in today’s managed care industry, some do not have the trappings of typical businesses. Even as they enroll thousands of “covered lives,” some IPAs in the Harris County area do not even have listed phone numbers.



illnesses will be forced to pay out-of-pocket for drugs for which there is no generic equivalent, such as insulin.

Beneficiaries from three focus groups reported that they are responding to this crisis in different ways. Some seniors do without prescription drugs, at least from time to time, or are taking a lower than appropriate dosage. Many physicians provide free samples when possible. Some seniors obtain discounts on drugs at select grocery stores and pharmacies or through membership clubs, though some experts question the value of the discounts that these programs offer²⁹. Many veterans are taking advantage of low drug costs at the Department of Veterans Affairs, which offers co-pays on a 30-day prescription as low as \$2. Some low-income seniors are able to use manufacturers’ discounts if and when physicians are able to do necessary paperwork. Advocates sometimes direct “electronically savvy” seniors to other websites for advice on prescription assistance, such as the site of the National Committee to Protect Social Security and Medicare.

SOURCE: <http://www.aarphealthcare.com>

A	B	C	D	E	F	G	H	I	J
\$102.85	\$114.53	\$120.91	\$114.75	\$114.75	\$121.12	\$115.17	\$162.56	\$163.41	\$204.00

Altogether, low-income Medicare beneficiaries in Houston face a hodge-podge of separate public and private prescription assistance programs that is difficult to navigate. Unlike other large states such as California and New York, the State of Texas has not established a pharmaceutical assistance program to reduce seniors’ out-of-pocket expenses. One option left for beneficiaries who need help paying for medications is to apply for Medicaid, however, Texas maintains historically low Medicaid eligibility criteria – 74 percent of federal poverty level, or \$6,356.60 annual income for an individual or \$8,591.40 for a couple.³⁰ Clearly, the drug issue is an intractable problem, and the relief in M+C is diminishing—with lower caps, generic-only plans and greater reliance on formularies.

Supplemental insurance on the open market is still beyond the financial means of many beneficiaries. (See Table 3.) However, several focus group seniors reluctantly paid between \$150 and \$200 monthly for supplement policies, seeing no alternative means to “fill the gaps” in Medicare and still have choice—and a “voice”—in their medical care. Other seniors, particularly former public employees, are fortunate enough to have supplement insurance as a retirement benefit. Occasionally these policies cover prescription drugs, but benefits can be reduced over time.

²⁹ U.S. House of Representatives, Committee on Government Reform, Special Investigations Division, *Problems With Prescription Drug Cards*, July 12, 2001. Available at: http://www.house.gov/reform/min/pdfs/pdf_inves/pdf_prescrip_card_rep.pdf. This research shows that private discount cards offered an average savings of 2-3 percent on a given market basket of drugs commonly used by seniors.

³⁰ Kaiser Family Foundation, State Health Facts Online, <http://www.kff.org>.



A major new concern for 2002 will be how M+C enrollees adapt to new cost-sharing requirements for Medicare-covered benefits such as injectable medications and oral chemotherapy drugs. In January, Texas television stations reported cases of cancer patients who can no longer afford treatment under their M+C plan's new co-payments, which have increased out-of-pocket expenses anywhere from \$400 to \$1,500 per month.³¹ New \$100 co-payments for radiation therapy can also add up thousands of dollars of out-of-pocket expenses for cancer patients.

Lower-income beneficiaries turn to Houston's safety net providers after plan withdrawals

Some beneficiaries are changing to the Harris County Hospital District, a public safety-net provider, for their health care; the Hospital District charges fees on a sliding scale, so drugs are available to those with incomes under 250 percent of federal poverty guidelines. Staff at the Harris County Hospital District also noted that a significant number of Medicare patients had come to the District after being dropped from a Medicare HMO in 2000.³² Nevertheless, some seniors are reluctant to go to the District for care because of perceived long waits at the clinics and other disadvantages of seeing a "welfare-type" provider.

BENEFICIARIES' PERSPECTIVES

Verna joined Medicare as disabled many years ago, and has chronic health problems. She has been her Medicare HMO for one year, after she was dropped from another plan that left Houston. She is disappointed in her current plan, and preferred her previous HMO, where there was no monthly premium, and she paid \$5 or \$10 for prescriptions. Now she pays a premium and has to pay \$25 for medications. She preferred her doctors that she saw in the previous HMO; her earlier doctor used to participate in her current HMO but he decided to leave the plan. (One reason was the plan's failure to pay bills.) Now she has to go to a clinic far away, and she rarely sees her regular doctor there. She has numerous medications and pays over \$100 per month for drugs, even with the plan's drug benefit. It is hard to get good information from her HMO, and specialists are far away. She thinks there will be a problem covering the higher co-pays will be charged in 2002. She will find out about new plans with lower cost-sharing. She says that HMOs "are here in the USA just to make money."

Local advocates reported that when a client is desperately in need of medication and unable to afford it, they or the client will call the county's

³¹ C Huff, "Some Texas Cancer Patients Faced with High Insurance Deductibles," *Fort Worth Star-Telegram*, January 17, 2002. Transcript, 11 News at Six, January 22, 2002, KTVT-TV (CBS) Channel 11, Dallas.

³² J Stuber, K Maloy, C Edwards, B Biles. *Monitoring the Implementation of Medicare+Choice: Harris Co., TX Site Visit Report*. Washington, D.C.: The George Washington University Medical Center, Center for Health Services Research & Policy, July 2001. Available at: <http://www.gwhealthpolicy.org>.



Adult Protective Services unit, which will furnish a one-time only 30-day supply of needed medication. Clearly this is not a long-term solution, but seems symbolic of the sheer need of vulnerable beneficiaries for needed prescriptions.

In general, seniors seem resigned to change. Those who purchase Medigap policies to reduce the burden of Medicare’s cost-sharing requirements are buying those supplements grudgingly. Those sticking with an HMO because of its limited drug benefit (and as a result, often lose their first choice of provider) also do so grudgingly. Especially for seniors on fixed incomes, the increased cost-sharing in both Medicare+Choice and the fee-for-service program consumes an increasing percentage of beneficiaries’ income and forces them to make other sacrifices in their daily lives.

M+C plan instability makes it difficult for beneficiaries to make informed choices

As the number of Medicare+Choice plans available in Harris County dwindles and their marketing becomes less visible, beneficiaries’ ability to make an informed

choice among them becomes less and less of a pressing issue. Nonetheless, state and local agencies, including the Harris County Agency on Aging and the Texas Department of Insurance, continue in their mission to provide comparative information to seniors about managed care and their health care options.³³ As beneficiaries’ familiarity with managed care has increased over the last several years, the Medicare population has

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Ray has been in the same M+C plan since 1993. He picked the plan among the several plans; the plan “is not 100% good, but [he] gets along.” He doesn’t like the \$25 premium, and the HMO limits him to one doctor and one dentist. The doctor “is poor in quality,” but Ray works his way around that by “flattering” the doctor and getting him to refer to specialists. This was particularly the case when Ray’s wife was alive and had many health problems that required specialists. Ray only takes one medication, for high cholesterol. His HMO has a reasonably priced mail order plan where he can get a 90-day supply of the drug. He stays in his plan because he’s used to it and it’s a stable situation. Long after his wife died, he was receiving bills for her care that the HMO had not paid. He finally reached someone at the plan who was able to take care of the billing problem. Ray thinks that “less clever” people cannot do as well in the HMO system.

developed a fairly firm grip on the rules of being in a Medicare HMO. Many

³³ The notion that comparative information is substantively helpful to seniors when they make decisions about Medicare plans, has been questioned. See Hibbard JH, Slovic P, Peters E, Finucane ML, and Tusler M, “Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?,” *Health Affairs*, 20, 1 (May/June 2001): 199-203.



“savvy” seniors know networks and the gatekeeper process well, as well as the need to ask for referrals to specialists.

Nonetheless, senior services volunteers report that less “savvy” seniors, particularly those homebound or living alone, can often be confused by the health care choices that confront them. Persistent areas of misunderstanding include the difference between primary and secondary insurance and many of the fundamentals about traditional fee-for-service Medicare. Since many beneficiaries had been in Medicare+Choice since age 65 and had no experience in traditional fee-for-service Medicare, after the plan withdrawals of 2000, senior services agencies had to re-introduce these seniors to basic information about the program, including its 20 percent co payments and limited benefit package. Representatives from these agencies consistently reported that instability in Medicare+Choice had increased the volume and complexity of their caseloads.

CONCLUSIONS

Medicare+Choice is a national program that operates in separate local markets across the country, where participation is voluntary at three levels. First, health plans make annual decisions about which counties to service and what benefits to offer, based on both national factors, such as payment rates and firm strategy, and local market dynamics. Second, physicians and hospitals make periodic decisions about which managed care plans they will contract with and on what terms. Finally, Medicare beneficiaries themselves must see a financial advantage to joining a Medicare+Choice plan that offsets any loss of provider choice that comes with enrollment. As witnessed by plan withdrawals, provider turnover, and flat enrollment in Houston’s three remaining plans, these three parties are separately coming to the same conclusion that participation in this program is not in their interest.

Medicare payment policy, which has given plans in large urban counties only minimal 2 percent increases for five years, is a national factor that influences the decisions of all three parties – plans, providers, and beneficiaries. Houston’s experience with Medicare+Choice is instructive because even with a payment rate almost equal to that of Los Angeles—where there are still nine M+C plans and many offer expansive drug coverage of up to \$2,000—participation in the program has fallen sharply.

The managed care backlash of the late 1990s explains much of Medicare+Choice’s problems in Houston. Many of the same problems that have forced Texas HMOs deep into the red on their commercial business are seen to have caused the slumping profitability of Medicare managed care. Local factors such as hospital consolidation, the financial demise of large provider groups, and prescription drug demand that is fueled by direct-to-consumer advertising have all indirectly driven up costs for health plans in Houston. Plans, in turn, feel that they have lost leverage in contract negotiations and must retreat from public programs where payment is capped but expenses grow increasingly difficult to control. In this new world for managed care, it is an open question whether plans and providers would re-enter Medicare+Choice in Houston, even with a reasonable increase in payment from the Federal Government.



The instability in Medicare+Choice over the last five years has had a clear impact on beneficiaries in markets such as Houston, in particular for seniors on fixed-incomes. All stakeholders – plans, providers, consumer groups and government officials – agree that the rising cost of prescription drugs is a daunting problem for seniors, and calls for broad reform of fee-for-service Medicare that reduces the program’s cost-sharing requirements are growing more frequent in Houston.

Looking ahead to this year and beyond, several questions about Medicare+Choice in Houston deserve the attention of policymakers.

1. **How will beneficiaries be affected by the loss of coverage for brand name prescription drugs?** Several widely used drugs, including insulin, do not have generic equivalents. It is unclear where vulnerable and chronically ill seniors will turn to for coverage, given that Texas does not have a pharmaceutical assistance program.
2. **Will lower-income Medicare+Choice enrollees be able to afford new copayments for Medicare-covered services?** Of particular concern are new hospital deductibles of up to \$550 and 20 percent co-payments for benefits, such as chemotherapy treatment, that are not listed on Medicare’s on-line consumer database Medicare Compare. Providers have voiced concern that these requirements may simply be unaffordable to many seniors, who will then stop needed treatments.
3. **Will the provider networks of Houston’s new Medicare+Choice plans be large enough to handle an increased number of enrollees?** An increase in M+C enrollment in Houston depends crucially on seniors’ being satisfied with their access to care in the program, particularly in a sprawling metropolitan area where proximity to a physician is of utmost importance to many.
4. **What will be the effect of Medicare’s new “lock-in” policy in Houston?** Under existing law, Medicare will begin implementing a new system of enrollment restrictions in Medicare+Choice modeled after the open-enrollment practices of employer-based health insurance plans. Beneficiaries will be able to switch M+C plans or reenroll in traditional fee-for-service Medicare only once during the first six months of 2002, and then will be locked into their plan from July 1 until an open enrollment period in the month of November. Starting in 2003, beneficiaries will be locked in to their plan beginning on April 1.³⁴

Will beneficiaries understand this new provision? If they learn that a trusted doctor or hospital is no longer in their plan’s network after

³⁴ G Dallek, B Biles, A Dennington. “The 2002 Medicare+Choice Plan Lock-in: Should It Be Delayed?” New York: Commonwealth Fund, January 2002.

July 1, what will be their reaction? Will beneficiaries who are diagnosed with cancer but cannot afford new copayments for treatment be allowed waivers to disenroll from their plan? Lock-in could potentially increase distrust of the Medicare+Choice program in Houston, which has already been forced to deal with high rates of provider turnover.

