

MONITORING THE
IMPLEMENTATION OF
MEDICARE+CHOICE:

HENNEPIN AND
RAMSEY COUNTIES,
MN. SITE VISIT

REPORT

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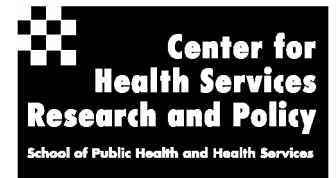


TABLE OF CONTENTS

I. Research Context

II. The Twin Cities Medicare+Choice Market

The Twin Cities' Vulnerable Seniors
Medicare Managed Care Market Penetration
Plan Withdrawals
M+C Plan Benefit Reductions

III. Findings

Market Choices

- The Twin Cities Medicare Market Offers an Array of Choices
- So Many Choices Confuse Medicare Beneficiaries
- Most Seniors Cannot Afford Options with Prescription Drug Coverage
- Educating Seniors About Managed Care Is a Challenge

Reasons for and Beneficiary Response to Plan Withdrawals and Benefit Reductions

- Local and National Factors Contributed to M+C Plan Withdrawals and Benefit Reductions
- Beneficiaries Are Confused and Angry About M+C Market Turmoil and Lack of Prescription Drugs

Access and Quality in M+C Plans

- M+C Plan Provider Networks Are Relatively Stable
- M+C Quality of Care Appears High, but Enrollee Satisfaction Varies by Plan

The Future of Medicare HMOs in the Twin Cities: Medicare HMOs May Not Be a Viable Option

Conclusion



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 Medigap 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, HMOs have been overpaid 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 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

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."



program in seven sites—Tucson, Minneapolis-St. Paul, Houston, Cleveland, Tampa-St. Petersburg, New York City and Los Angeles. This report describes the implementation of the M+C program in Hennepin and Ramsey counties (Minneapolis-St. Paul), Minnesota. It is based on information obtained during a three-day site visit to the Twin Cities in August 2000, as well as 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 three focus groups with Medicare beneficiaries.

This report examines the following issues: (1) changes in M+C plan availability and benefits and factors contributing to these changes; (2) the confusing Medicare market in Minneapolis-St. Paul; (3) beneficiary responses to M+C plan withdrawals and reductions in benefits; and (4) access and quality of care in M+C plans.

THE TWIN CITIES MEDICARE+CHOICE MARKET

For most of the past decade, Medicare HMOs were a popular option for Medicare beneficiaries in Minneapolis-St. Paul (the Twin Cities), especially for low-income elderly. Recently, however, rising premiums, the withdrawal of Medica (one of three Medicare+Choice HMOs in the market), and a decrease in the number of available products that offer substantial prescription drug coverage have made M+C a less attractive alternative for Minneapolis-St. Paul seniors, especially younger and healthier seniors.

THE TWIN CITIES' VULNERABLE SENIORS

The senior population in Minneapolis-St. Paul is relatively homogenous, so issues of racial and cultural diversity might be less important in navigating the Medicare managed care system than in other parts of the country. The demographic composition of Hennepin and Ramsey counties' residents aged 65 and older is quite similar. The senior populations in both counties are about 62 percent female and 38 percent male.³ Females are disproportionately represented in this group as compared to Medicare beneficiaries throughout the state of Minnesota and the nation.⁴ Over-65 residents in the two counties are 94.1 percent white non-Hispanic, 1.1 percent Hispanic, 2.7 percent African-American, 2.7 percent Asian, and 0.3 percent Native American.⁵ The region is much less diverse

³ Minnesota Demographer's office, state population projections, updated April 1998. Available at <http://www.mnplan.state.mn.us/demography/prj/hennepin.htm> and <http://www.mnplan.state.mn.us/demography/prj/ramsey.htm>.

⁴ Kitchman, Michelle, Green, Lisa, Cox, Don and Langwell, Kathryn. "Medicare State Profiles: State and Regional Data on Medicare and the Population it Serves". The Henry J. Kaiser Family Foundation. September 1999.

⁵ U.S. Census Bureau population estimates from <http://govinfo.library.orst.edu>.



than the U.S. senior population, but more diverse than the Medicare beneficiaries across the state of Minnesota, who are 98.1 percent white.⁶ However, immigrant populations, including Russian and Hmong groups, are growing in the Twin Cities.

The Wilder Research Center has estimated that the median income for all senior households in 1995 was \$24,463 in Hennepin County and \$20,859 in Ramsey County.⁷ In 1989, 8.0 percent of the over-65 residents of Hennepin and Ramsey counties were living below the federal poverty level (\$5947 annual income for a single person in 1989). Currently, fifteen percent of seniors statewide⁸ are living below the poverty line (\$7,990 a year).⁹ As discussed below, neither Medicare HMOs nor other insurance products have been able to meet these seniors' need for prescription drug coverage.

MEDICARE MANAGED CARE MARKET PENETRATION

The Twin Cities have a long history of managed care.¹⁰ The first Medicare HMO in the area began in 1980 as a demonstration project. By 1993, 19 percent and 22 percent of Hennepin and Ramsey county beneficiaries, respectively, had joined a Medicare risk HMO.¹¹

Since 1993, enrollment grew until 1996, then slowed each year. In June 2000, three M+C plans—HealthPartners, UCare, and Medica—provided care to 16 percent of Hennepin County Medicare beneficiaries and 20 percent of Ramsey County beneficiaries. All three plans are not-for-profit and are based in the Minneapolis-St. Paul metropolitan area. HealthPartners is based in Bloomington, Medica in Minnetonka, and UCare in Minneapolis.¹²

In December 1993, Medica dominated the Medicare market with 75 percent of Medicare+Choice enrollees. However, the relative market share for both

6 KFF State Profiles

7 Higgins, Veronica B. "Building toward the senior boom: Twin Cities seniors and their housing needs, from now to 2030." Prepared for East Metro Seniors Agenda for Independent Living by the Wilder Research Center, St. Paul, MN, August 1999.

8 KFF State Profiles

9 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>.

10 U.S. Congress, Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience, OTA-BP-H-130 (Washington, D.C.: U.S. Government Printing Office, July 1994.)

11 In total, 40 percent of Twin City beneficiaries were enrolled in either a cost or risk plan. Medicare pays cost plans the actual cost of serving a Medicare beneficiary. Beneficiaries who join a cost plan also may obtain services from original Medicare. By contrast, Medicare pays risk HMOs a set amount (capitated payment) per member per month. Enrollees of risk HMOs are said to be "locked-in"—if they seek care from non-plan providers, neither Medicare nor the plan will pay for the care.

12 www.allanbaumgarten.com



HealthPartners and UCare has grown rapidly¹³. By June 2000, the three major plans had very similar market shares—28.1 percent for UCare, 35.4 percent for Medica, and 36.4 percent for HealthPartners.¹⁴ Outside of the seven-county Twin Cities metropolitan area Medicare HMOs are not widely available.

PLAN WITHDRAWALS

In June 2000, Medica officials indicated the plan would withdraw from the M+C program at the end of the year, affecting 8,553 Medicare enrollees in Hennepin County and 4,794 in Ramsey County. This was not the first withdrawal to affect the Twin Cities area. In 1998, Medica pulled its Medicare HMO out of Carver, Dakota, Scott and Goodhue counties, affecting 2,550 beneficiaries and, in 1999, the plan withdrew from Anoka County, affecting 2,823 enrollees. Blue Cross Blue Shield's Medicare HMO also withdrew from the Twin Cities metropolitan area in 1998.

Informants indicated that plan withdrawals in the Twin Cities have been partially fueled by Medicare's low reimbursement rate to M+C plans in the area. Hennepin County M+C plans received \$458 per member per month in 2000, well below the national median. The rate in Ramsey County was only slightly higher, at \$471. Medicare payment rates are historically based on the costs of caring for Medicare beneficiaries in original Medicare, which studies have shown are below the national average in the Twin Cities.¹⁵ M+C plan representatives argue that this rate is far below what is needed to serve their Medicare enrollees and to provide them with extra benefits, such as prescription drugs, commonly offered by health plans in other parts of the country.

As discussed below, low federal reimbursements and high premiums for coverage have concerned Minnesota politicians and other local activists, who in 1999 filed a lawsuit challenging Medicare's reimbursement system. The suit was dismissed in U.S. District Court in July 2000.

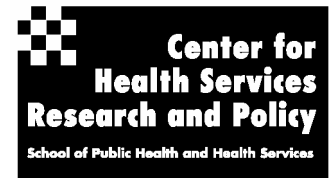
M+C PLAN BENEFIT REDUCTIONS

All three M+C plans operating in the Twin Cities in 2000 offered a variety of products. HealthPartners for Seniors offered a "standard" and a "high option"

13 Blue Cross Blue Shield of Minnesota's Blue Plus plan had a small enrollment from its inception in 1994 until its withdrawal in 1999.

14 Estimates derived from HCFA quarterly state/county/plan managed care enrollment reports.

15 See Christianson et al, 1995, and OTA, 1994. In 1993, fee-for-service Medicare costs in the Twin Cities were 7% below national fee-for-service costs and 15.3% lower than costs in other urban areas. By 1995, this gap had increased: Twin Cities Medicare costs were 11.7% below the national average and 17.8% below costs in other urban areas. In 1994, Hennepin County was second only to Volusia County, Fla. in having the lowest Medicare Part A and Part B expenses, even in comparison with other counties having a high level of participation in Medicare risk contracts. Overall health care costs in the Twin Cities have been shown to be low with respect to the national average in terms of the health care Consumer Price Index, hospital admissions, ER visits, and lengths of hospital stays.



product; Medica SeniorCare offered “Basic,” “Plus,” and “Complete” options; and UCare Minnesota offered “Value,” “Classic,” “Advantage,” and “Ultimate” products. These products differed largely in their prescription drug benefits and premiums, but also in copayments, dental coverage, and coverage while traveling (point-of-service coverage).

The enrollment period (the period in which beneficiaries can sign up for a plan) was generally shorter for the more expensive plan products. For example, beneficiaries could sign up with UCare’s Ultimate option only for the first six months after they become eligible for Medicare Part B and then annually, during the plan’s one-month open enrollment period. However, beneficiaries could sign up for UCare’s Basic, Classic, or Advantage plans, all of which offered fewer benefits than the Ultimate option (and no prescription drug coverage), at any time.¹⁶

The three M+C plans each offered a prescription drug benefit in 2000, which covered 80 percent of the costs of prescription drugs, with no limit.¹⁷ However, the premiums for these plans were, according to *The Minneapolis Star-Tribune*, the highest in the nation.¹⁸ In the Twin Cities area, premiums for a M+C plan with 80 percent coverage for prescription drugs were between \$270 and \$289 per month in 2000, while a “basic” plan, without drug coverage, cost from \$50 to \$94.75 monthly. Because of the high premiums, few beneficiaries chose to enroll in an M+C plan with prescription drug coverage.

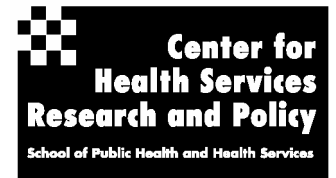
The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) increased Medicare reimbursement rates in Hennepin and Ramsey counties to \$525 a month. This increased payment did not cause plans to offer more generous HMO prescription drug benefit packages, but plans did make small positive changes. HealthPartners decreased the 2001 premium for its plan including 80% drug coverage from the planned amount of \$324 to \$300.50 (the 2000 premium was \$270.) UCare added a modest prescription drug benefit (limited to \$100 every three months) to its Classic plan after the passage of BIPA. In addition, plan officials changed the UCare Classic premium from the planned amount of \$87 to \$81 as a result of BIPA (the 2000 premium was \$71.)

Also as a result of BIPA, HealthPartners reduced the premium for its Standard Option (no drug coverage) from \$95 in 2000 to \$76 in 2001. UCare also reduced the premium for its Value plan (no drug coverage) from \$50 per month in 2000 to \$36 per month in 2001. Plan informants report that UCare

¹⁶ Senior Federation, “2000 Health Care Choices for Minnesota Seniors.”

¹⁷ State requirements specify that plans may offer only an 80% drug benefit or no drug benefit at all. A plan is not permitted to be on the market in Minnesota unless one of its products offers 80% drug coverage (this may be offered in the Cost, Select, or M+C plan.) Source: plan informant

¹⁸ Glenn Howatt, “Metro Area Gets Stung by Medicare: Seniors Here Pay Highest HMO Premiums in U.S.,” *Minneapolis Star-Tribune*, Nov. 7, 1999, p. 1A.



also lowered its \$150 co-payment for each hospital admission to \$50 and added a hearing aid benefit as a result of BIPA.

Medicare HMOs still do not provide affordable prescription drug coverage in Minneapolis-St. Paul. UCare discontinued its Ultimate product (which provided coverage for 80 percent of prescription drug costs) in 2001. The new benefit offered by UCare Classic is limited to only \$100 every three months. HealthPartners charges a \$300.50 monthly premium for its plan including 80% drug coverage.

FINDINGS

Findings from this site visit are organized in the following way. First, we discuss the complexity of Medicare choices that seniors living in the Twin Cities confront. This was a major theme of our site visit. Although choice of Medicare HMOs is diminishing, the complexity of the Medicare market in the Twin Cities contributes to the confusion of seniors affected by Medica's withdrawal. This complexity also influences how all seniors make enrollment decisions. We highlight major areas of beneficiary misinformation about managed care and challenges to educating seniors about their options. Next, we describe both national and local factors contributing to Medica's withdrawal and plan benefit reductions and affecting the future of M+C HMOs. We conclude our findings with a discussion on M+C plan quality, including stability of provider networks, performance and patient satisfaction measures and disenrollment data.

MARKET CHOICES

Seniors in Minneapolis-St. Paul face a number of choices about their health care coverage that beneficiaries elsewhere do not encounter. Seniors in most urban M+C markets must choose whether to enroll in a Medicare HMO or to opt for original Medicare with or without a Medigap supplemental policy. Given the variability among Medigap plans, and the significant differences that sometimes exist among M+C plans in terms of provider networks, plan benefits and premiums, and plan quality, these may be difficult choices. Even if seniors do not always understand them, the tradeoffs associated with joining an HMO are relatively clear: physician and hospital choice is limited, but additional coverage not offered by FFS Medicare is available. The landscape for seniors in Minneapolis-St. Paul, however, has additional layers of complexity.

The Twin Cities Medicare Market Offers an Array of Choices

Medicare beneficiaries in the Twin Cities can choose from among six types of plans or supplements in addition to original Medicare: (1) a basic Medigap supplemental policy (with or without riders); (2) an extended basic Medigap supplement, (3) a Medicare Select plan; (4) a Medicare Cost plan; (5) a M+C private fee-for-service plan; and (6) M+C HMOs.



Medigap Policies: Under a waiver from the federal government, Minnesota state law does not permit insurance companies to offer the 10 standardized Medigap plans. Instead, Medigap insurers can offer only two types of policies—a “basic” and an “extended basic” product. The basic plan covers coinsurance for hospital and outpatient care as well as coinsurance for days 21-100 of a skilled nursing facility stay and 80% of all emergency care outside the U.S. Beneficiaries can choose to add up to six riders to this basic plan, one of which covers 50 percent of the cost of prescription drugs. The extended basic policy goes beyond the basic policy, covering the deductible for hospital visits and outpatient visits, 80 percent of the cost of prescription drugs, and 80 percent of medically necessary dental costs. Monthly rates in 2000 ranged from \$44 to \$100 for the basic plan without any riders. The cost of the extended basic plan ranged from \$211.75 to \$541, depending on the company from which it is purchased and, sometimes, on whether or not the policyholder is a smoker. Blue Cross Blue Shield (under its smokers’ plan) offered the most expensive coverage, while Physicians Mutual offered the least expensive coverage.

Select Plans: In 2000, HealthPartners and Medica both offered additional “managed care-like” products—Cost and Select plans. Select plans offer the benefits of a basic Medigap supplemental policy as well as 100 percent coverage of the Medicare Part A deductible and coinsurance and 100 percent of Part B charges for care provided through a network. Select plans are a cross between Medigap insurance and an HMO. In 2001, premiums for Select plans that did not cover prescription drugs ranged from \$91-\$125 a month for non-smokers and from \$120-\$153 for smokers, an increase of 2-12 percent from 2000. Monthly premiums for Select plans that covered 80 percent of prescription drug costs ranged from \$330-\$538 for non-smokers and from \$429-\$676 for smokers, an increase of 11-25 percent over 2000 premium costs. Blue Cross, HealthPartners, Medica, and UCare all offered Select plans in 2001. Like Medigap plans, Select plans may screen for pre-existing conditions and age after the required six-month open enrollment period for beneficiaries who first purchase Medicare Part B.¹⁹

Medicare “Cost” Plans: Under the Medicare Cost option, members may, but are not required to, visit plan providers for services, for which Medicare is billed directly on a fee-for-service basis. Beneficiaries may obtain services from any provider, but outside of the network, they are responsible for coinsurance and the 20% deductible. The plan pays the member’s coinsurance and deductible if the member stays within the cost plan’s provider network and in urgent and emergent situations. Copayments are required from Cost plan members for some services. Medicare Cost HMOs are offered by HealthPartners (HealthPartners 65+) and Medica

¹⁹ Source of information about options: Minnesota Senior Federation, Metropolitan Region, “2000 Health Care Choices for Minnesota Seniors.”



(PHP+Medicare). Each insurer offers two cost plans—one with and one without prescription drugs. In 2001, the non-prescription drug products cost from \$99.50-\$119.95. In 2001, Medica PHP+Medicare with prescription drugs cost \$176 a month and covered drugs up to \$500 a year. Since early 1993, Medica had closed this product to new enrollees, but reopened enrollment on January 1, 2001, following the withdrawal of its M+C risk HMO. HealthPartners 65+ with prescription drugs cost \$325 a month (a 20 percent increase over 2000) and covers 80 percent of the cost of prescription drugs.

Private Fee-For-Service Plan: In addition to the two Medicare HMOs, Sterling Life Insurance Company is offering a private fee-for-service M+C plan in Minnesota for a \$65 premium in 2001 (up from \$55 in 2000). Like Medicare HMOs, Medicare reimburses Sterling on a capitated basis, but unlike HMOs, Sterling pays providers on a fee-for-service basis. Sterling has no network, though providers must be “deemed” to participate.²⁰ Sterling enrollees get coverage for doctors’ visits (with a \$10 copayment) and pay less coinsurance for hospital stays (\$300) than they would under original Medicare, but receive no prescription drug coverage. The plan also requires beneficiaries to pay a \$25-a-day nursing home co-pay for days 1-100 and 50 percent of the costs of home health visits and durable medical equipment. As of January 31, 2001, the plan had no enrollees from either Hennepin or Ramsey county.

All told, in 2000, seniors living in Minneapolis-St. Paul had 16 different managed care products from which to choose. For seniors in fee-for-service Medicare supplementing their coverage with Medigap, choices are not any easier. Twin City seniors choose among 21 different providers of basic Medigap policies, each offering up to six different riders for coverage beyond Medicare. Each of these policies is underwritten, allowing the insurer to deny coverage based on health status or age.

So Many Choices Confuse Medicare Beneficiaries

Health insurance benefit counselors and representatives of the Senior Federation interviewed for this study noted that most seniors in the Minneapolis-St. Paul do not understand their Medicare choices. Focus group discussions confirmed this. In each of the three focus groups held during the site visit, seniors said they were very unclear about differences between Cost plans, Select plans, and M+C HMOs. One senior stated, “it is hard for us to grasp all the terms like choice, cost and select. Nobody lays it out for us and there is never anything specific said about it.” Seniors also couldn’t speak to the differences in premiums and benefits among these options and didn’t seem to know if they could be getting a better deal elsewhere. This was true even among seniors who were volunteer benefit counselors for the Area Agency on Aging. While seniors were insecure and anxious about this lack of information,

20 www.sterlingplans.com



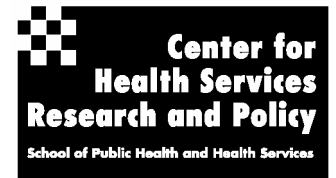
most were comfortable and satisfied with their current coverage. They thus had few incentives to look carefully at the different options being offered.

Even if seniors understand their choices, the cost/benefit calculations needed to choose the plan that will best meet a beneficiary's needs are difficult. Some seniors with high prescription drug costs do try to assess their options. One plan respondent told us that sicker seniors who tend to have high drug costs go through complicated cost calculations, trying to figure out if their annual drug costs are higher than what they would have to pay in premiums. To help with this calculation, one health insurance benefits counselor tells beneficiaries to call their pharmacy to obtain a record of the amount of money spent on drugs last year.

Informants also revealed that prescription drug coverage is quite desirable. One senior told us she previously had a Medigap supplement through her deceased husband's former employer. This policy paid 80 percent of her drug costs. She recently lost this coverage and bought BCBS basic senior gold for \$93 per month. This policy pays for co-pays and deductibles but not for any prescription drugs. She told us that drug coverage would really help her because her prescriptions cost about \$1500 per year.

One informant noted that Medicare HMOs in the Twin Cities used to cost \$9 per month and were much less expensive than the other supplemental plans and Medigap policies. Now, she stated, the price differential between M+C plans and the other types of supplemental insurance has narrowed significantly, making it harder for seniors to figure out how best to supplement their Medicare. For seniors who cannot afford any plan offering prescription drugs, the choice of enrolling in an M+C plan versus remaining in fee-for-service Medicare with a basic Medigap policy and some additional riders is not clear-cut. The M+C plans are still less expensive, but only by 10-20 percent. Because benefits are similar, beneficiaries must balance these cost savings with having less choice of providers and hospitals. For example, in 2000, HealthPartners' standard M+C option cost enrollees \$94.75 a month. The BCBS basic supplemental policy with 3 riders, offering comparable benefits, cost \$104.00 per month.

When thinking about enrollment in a M+C plan, seniors must also consider out-of-state travel. "Snowbirds" (seniors who travel during the winter months to sunnier climes) who belong to M+C plans are have less coverage when receiving care that is out of the plan's network compared to seniors who opted for a Medigap supplemental policy or managed care plan with a POS option. Most Minnesota M+C plans do have a POS option: HealthPartners includes 80% coverage outside Minnesota up to a \$100,000 annual maximum in both their Standard and High Option products. UCare Value offers a travel benefit of 80% coverage outside Minnesota up to a \$5,000 annual maximum, and UCare Classic includes a Point-of-Service benefit of 80% coverage within the



U.S. up to a maximum of \$50,000. Often seniors don't understand that in some health plans, their out-of-pocket health care costs can be significantly higher when travelling.

Community informants were concerned that seniors do not comprehend the significance of open enrollment periods. In particular, seniors are unaware that Medigap supplemental policies are typically underwritten by health status. Thus, they do not grasp the importance of purchasing a Medigap policy during the open enrollment period when screening is prohibited by federal law. Two of our community informants expressed frustration that seniors do not choose a policy that offers them drug coverage at age 65 when they can secure this coverage at a lower price. When they are older and already taking three to five medications, they are often denied coverage. This is particularly a problem outside of the Twin Cities metropolitan area where M+C and Cost plans, which do not require health screening, are unavailable.

Because the market is so confusing, many seniors simply stay with what they know. Familiarity with, and loyalty to, a particular provider or clinic is an important factor in a beneficiary's decision to join an HMO and which one to join. According to community representatives and beneficiaries interviewed for this project, the first question many seniors ask when choosing a Medicare managed care plan is "can I continue to see my own doctor?" Several seniors in the focus groups explained that they made decisions about their health insurance coverage based upon what they had prior to retirement.

Most Seniors Cannot Afford Options with Prescription Drug Coverage

In addition to continuity of care, seniors also consider what they can afford and whether a plan offers prescription drug coverage. Noted one senior, "having drug coverage is on everybody's radar screen." He continued, "Those who have drug coverage through their employer count their blessings. Drugs are a big decision point in choosing a supplemental policy."

One health insurance benefits counselor stated she has a "frank financial discussion" with a client trying to make a decision about supplemental coverage. "Plans range from \$50-\$450, so it really depends upon what people can afford," she said.

Many seniors in Minneapolis-St. Paul cannot afford a plan that has any drug coverage. For example, only 500 of UCare's 18,000 enrollees elected the M+C product that provides drug coverage. Yet, many seniors who don't have drug coverage both want and need it. For seniors who can afford to purchase insurance with drug coverage, purchasing a M+C plan is more affordable than buying an extended basic Medigap policy. For example, in 2000, the price for a M+C plan with 80 percent drug coverage cost seniors on average a premium of



\$280 per month whereas an extended basic Medigap plan offering the same drug coverage cost between \$150-\$200 more. In 2000, BCBS extended basic supplemental insurance cost non-smoking Medicare beneficiaries \$431 a month and smokers \$541 per month—unaffordable for all but the wealthiest seniors.

Low-income seniors who cannot afford a health insurance policy with drug coverage may enroll in Medicaid or the Minnesota Senior Drug Program. These programs are for seniors with limited income and resources. Some seniors also travel to Canada for their prescriptions, often on organized bus trips, but many are afraid because of the “horror stories” they have heard about seniors getting the wrong prescriptions. The FDA issued a warning to members of the Senior Federation for allegedly breaking the law by refilling prescriptions bought in Canada by mail.²¹

Educating Seniors About Managed Care is a Challenge

One health insurance benefits counselor stated, “the biggest problem for people approaching 65 is that they don’t know that they have a problem.” She explained that seniors have no idea how challenging it will be for them to understand all of the categories of coverage available in the Minneapolis-St. Paul market. Seniors are also unaware of the implications of their decisions. A health insurance benefit counselor stated that seniors frequently do not understand when that they enroll in a M+C plan they are “100 percent locked-in,” and must receive all of their services within the M+C plans’ network. Another community informant stated that she did not think M+C plans explained networks well enough to seniors. However, a plan informant stated that seniors ask many questions about provider networks before signing up, and that plan representatives do explain the concept of “lock-in” to seniors—repeatedly, if necessary.

Some seniors are conscientious consumers, able to make the complicated decisions required of them. The majority, however, are unable to conduct a complicated cost/benefit analysis and frequently end up with supplemental coverage that is not suited to their needs.

According to many of our informants, HCFA publications sometimes work at cross-purposes in the Twin Cities market. While the general information that HCFA provides is applicable, the Medicare and You handbook does not provide information on many of the particulars of the Minneapolis-St. Paul Medicare market. This is especially true for Medicare Cost plans and Minnesota’s Medigap supplemental market, which has riders and basic/extended options instead of the 10 standardized plans described by

²¹ Gustafson, Kristin and Hamburger, Tom. “Minnesotans back controversial bills; Plans for prescription drug benefit, drug imports move through House.” Minneapolis Star-Tribune, June 30, 2000. See also Minnesota Senior Federation, “Congress allows prescription drug importation,” Minnesota Senior News, August 2000. Available on-line at <http://www.mnseniors.org/snaug00drugimport.html>.



HCFA publications. One community informant described HCFA publications as “awful” because they do not provide the information seniors need to make an intelligent choice among their health care options. A HCFA regional representative said she believes HCFA education materials would be improved if they were limited to universally applicable subjects like beneficiaries’ rights.²²

Seniors in Minneapolis-St. Paul use the Health Care Choices for Minnesota Seniors handbook—a Senior Federation publication that describes the intricacies of the Twin Cities’ complex Medicare market. One senior referred to it as “her Bible.” This booklet explains each type of supplemental coverage and contains comparison tables contrasting the costs and benefits of each option. However, many senior group representatives tell seniors to call health insurance plans if they really want to understand coverage differences. Informants also believe seniors are much more comfortable picking up the telephone and asking a question than reading through materials on their own. A plan representative echoed this perspective, saying she believes education for seniors about managed care is best done on a one-by-one basis.

One community informant said she thinks multiple approaches, including group meetings, personal contact, contact by phone, readable mailings and extra attention for those who need it, are needed to help seniors to make choices and to deal with the health insurance market. Another community informant said she believes that a Medicare “Boot Camp” should be required for seniors when they sign up for Social Security.

We also heard from several informants that many seniors are not aware that they may be eligible for Medicaid and the Minnesota Senior Drug Program. These programs are also problematic to some seniors who are sensitive about having to disclose their incomes and apply for government assistance.

The non-profit organizations that counsel seniors about their health insurance are inadequately funded to provide the full complement of needed educational services. For example, the Area Agency on Aging runs the Senior Linkage Line, which counsels seniors about legal, health, transportation, and nutrition programs for seniors. The organization receives funding through the Older Americans Act, from the state and from HCFA. However, these funds were described as “piecemeal” and inadequate to meet the demands of seniors for better information. The Senior Federation—the most prominent senior organization in the state—expressed similar concerns about funding. These programs also suffer from high turnover rates of volunteers because health insurance counseling in the Minneapolis-St. Paul market is so demanding and difficult.

²² Congress has mandated that HCFA provide a range of information to Medicare beneficiaries, including information



THE REASONS FOR, AND BENEFICIARY RESPONSE TO, PLAN WITHDRAWALS AND BENEFIT REDUCTIONS

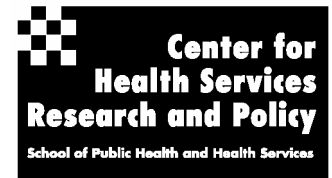
Both national and local factors have contributed to Medica's pullout from the M+C market and benefit reductions by the remaining two M+C plans. Predictably, turmoil in the M+C market has confused and angered Medicare beneficiaries.

Local and National Factors Contributed to M+C Plan Withdrawals and Benefit Reductions

Medica's gradual withdrawal from the M+C market culminated with the plan's pullout from Hennepin, Ramsey, and Washington counties at the end of 2000. Medica withdrew its Medicare HMO from its last Minnesota market because, explained a plan representative, "reimbursement rates are simply not keeping up with costs. It was not an easy decision for the plan to withdraw from this market. Medica has been involved in the managed care business for seniors in Minneapolis-St. Paul for more than 20 years." Medica was able to stay in the market as long as it did, this representative noted, because of cost-shifting between its M+C and commercial HMO product, but two years ago things went "south" for the commercial plan and it too began losing much money. Plan representatives felt that several factors made it impossible for Medica to remain in the M+C program and for all M+C plans to provide a generous package of benefits.

Medicare reimbursement limits: First, the years of low Medicare reimbursement rates and attempts to wring savings from other products finally caught up with the plan. Several plan representatives and community informants complained about low Medicare reimbursement rates, arguing that Minneapolis-St. Paul has been "punished" for holding down health care costs. One community representative explained that HMOs and Medicare providers generally had learned how to manage patient care and to hold down costs by monitoring utilization patterns closely. However, she noted that efficiencies aren't going to negate increasing health care costs, including high tech drugs, a rising medical inflation rate, and the availability of more complex and costly medical care. One informant described the Twin Cities as fertile ground for M+C plans because of well-organized physician groups with experience in controlling costs, but said she felt that because of low reimbursement rates, "M+C plans didn't have a chance in Minneapolis."

The small annual cap on payment increases: Second, many informants also felt that the two percent per year increase in government payments to plans is extremely low given medical inflation rates of between seven and 10 percent per year. Some informants believed that M+C plans in Minneapolis-St. Paul could have survived the low reimbursement rates, but that the small rates of increase made it too difficult for plans to survive, let alone thrive, in this market.



The disproportionate number of older beneficiaries in plans: Third, plan representatives argued that caring for seniors who joined their plan 20 years ago is now more expensive, making it impossible for M+C plans in the Twin Cities to hold down costs as effectively as in the past. A Medica representative said he felt that the plan’s enrollees were older, sicker and more costly compared to seniors in the other M+C plans. We heard from several sources that because of the high costs of M+C and Medicare supplemental products, healthier seniors are beginning to question whether purchasing any insurance to supplement their Medicare is worth the cost. Noted one community informant, “seniors in this market are trying to see value for their money and the healthier seniors just aren’t seeing it.” Because of the “drain on their pocketbooks,” healthier seniors are gradually beginning to exit the supplemental insurance market in Minneapolis-St. Paul. Without healthier and younger Medicare enrollees, the costs and premiums for plans with prescription drug benefits increase, making them even more unaffordable.

Table 1 provides support for the proposition that Twin Cities Medicare HMOs do in fact attract older (and likely sicker) beneficiaries than HMOs in the rest of the country.

Table 1				
Percentage of Medicare Beneficiaries by age in M+C HMOs Nationally and in Minneapolis-St. Paul				
	National Average		Minneapolis-St. Paul	
	Medicare risk HMOs	Fee-for-service Medicare	Medicare risk HMOs	Fee-for-service Medicare
<65 years	10.4%	19%	2.4%	20.9%
65-74 years	53%	42%	35.9%	44.5%
75-84 years	29.6%	28.6%	46.2%	24.4%
85+ years	7%	11.0%	15.5%	10.2%

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

One community informant discussed the need for appropriate risk-adjusted payments to M+C plans. Without risk adjustment, she argued, plans are rewarded for having healthy and younger enrollees and penalized for having older and sicker members. Therefore, plans with a high population of older and sicker seniors will find it more difficult to remain in the market.

Physician payment levels: Finally, several respondents posited that physician behavior contributed to Medica’s withdrawal. They explained that physicians have become less concerned about efficiencies and tired of accepting low reimbursement rates. Physicians are less willing to accept risk and are demanding higher reimbursement rates. M+C HMOs in Minneapolis-St. Paul are now paying physicians 105 percent of the Medicare FFS rate, substantially more than plans in many other parts of the country, which are paying doctors a discounted FFS or capitated rate.



The BBA regulations do not seem to have contributed to Medica’s decision to withdraw from the market. Although one plan representative acknowledged that the standards of accountability were higher in M+C plans as compared to the commercial insurance market, she thought this was appropriate given that Medicare is a public program. She was concerned, however, not with any particular regulation, but that so many regulations were implemented at times during the year not in tune with a plan’s “normal business cycle.”

Beneficiaries are Confused and Angry by M+C Market Turmoil and Lack of Prescription Drugs

A representative of the Senior Federation reported that seniors are upset, anxious, confused and frightened by Medica’s withdrawal, particularly older and sicker seniors. One senior stated that she “might have a nervous breakdown waiting until October to hear about her health care coverage.” Another said she felt “helpless.”

“Seniors are looking for stability and can’t tolerate major changes,” noted one community representative. M+C withdrawals, she continued, are having a “chilling effect,” not only on seniors, but on the children of seniors helping their parents with decisions about Medicare.

One health insurance benefits counselor commented that Medica’s withdrawal has left beneficiaries wary of managed care in general and wondering if UCare and HealthPartners are going to survive. This benefits counselor thought that the current program instability might lead some beneficiaries to “lose faith in their traditional Medicare, which has always been good and solid.” Another community informant explained that Twin Cities seniors had made a lot of concessions by enrolling in M+C plans. Over time they have watched the provider networks and benefits shrink and premiums increase. She thought it was “too late” for seniors in this market to be reassured about the M+C program. However, a UCare plan respondent reported that the plan has received much positive feedback—in the form of letters from members and compliments from HCFA and the Minnesota congressional delegation—when the premiums were rolled back and benefits were increased after the passage of BIPA.

Provider choice is a big issue for seniors affected by Medica’s withdrawal. A large proportion of UCare’s current membership came from Medica as the plan gradually withdrew from outlying counties and terminated contracts with two major provider groups. Affected beneficiaries were very upset about Medica’s withdrawal, but were reassured when they learned that UCare and Medica’s provider networks were similar. At the time of the site visit, UCare was enrolling about 50 percent of Medica’s 14,000+ Medicare beneficiaries. The seniors that remained with Medica were shifted over to the plan’s other products.



At the time of our site visit, seniors enrolled in Medica were receiving letters about the withdrawal, yet did not seem to understand that only the M+C HMO risk plan was leaving the market and not the Cost and Select plans. Medica sent letters to the plan's entire senior membership to avoid confusion. The letter sent to seniors in Medica's Select and Cost products explained that these products were not leaving the market, but that premiums and benefits might change, and that subscribers would be notified of any changes in October. Medica sent its M+C enrollees a letter announcing the withdrawal and the need for enrollees to choose another form of supplemental coverage, but stating that they should wait until October to make their decision. Even though sending letters to all of Medica's senior membership was intended to reduce confusion, it seemed to have had the opposite effect.

In addition to being confused, beneficiaries losing their Medica HMO coverage were angry, as were many other respondents, about low Medicare payment rates in the Twin Cities. Several community representatives noted the unfairness of the Medicare payment rate in Minneapolis-St. Paul relative to the rest of the country. A Medicare beneficiary enrolled in a M+C plan in many other parts of the country has access to prescription drug benefits at little or no premium. For example, the 2000 cap rates for some of the counties in Florida, frequently pointed out by informants for purpose of comparison, were \$794 per member per month in Dade County and \$690 per member per month in Broward County. "The value of what seniors get in Minnesota is much less than what they could get in other states," complained one informant. Angered by the inequality of payment rates, the Senior Federation, along with providers and health plan representatives, formed the Medicare Justice Coalition to reduce inequality in Medicare reimbursement rates. The Coalition has pursued a three-pronged strategy: litigation against the federal government over the rate calculation, public education about the inequality, and support for federal legislative changes in the reimbursement rates. The Federation has formed coalitions with Wisconsin, Iowa, and Oregon, and is pursuing liaisons with other states concerned about Medicare reimbursement rates.

In 1999, the Senior Federation, joined by the state's attorney general and much of the Minnesota Congressional delegation, filed a lawsuit challenging Medicare's reimbursement system. The suit was dismissed in the U.S. District Court in July 2000. Judge Donald Alsop ruled that the system of Medicare reimbursement is "unfair," but does not violate the Constitution, and that Congress bears the responsibility to address the problem, not the federal courts.²³ The Minnesota Senior Federation, however, has appealed Alsop's ruling. Medicare Justice Coalition members are currently awaiting scheduling of a hearing at the Federal Court of Appeals in St. Louis, MO.

²³ American Health Line, Story from the National Law Journal, 7/10/00.



ACCESS AND QUALITY IN M+C PLANS

By almost all accounts, Medicare HMOs in the Twin Cities provide high quality care. A brief review of provider networks, disenrollment data and quality measures support observers' assessments of the quality of care provided by plans, although enrollees express some dissatisfaction with the two remaining M+C plans.

M+C Plan Provider Networks are Relatively Stable

Unlike other sites studied for this report, the Twin Cities boasts relatively stable provider networks in its Medicare HMOs. HCFA data on provider turnover, available only for HealthPartners, indicated that a modest four percent of the plan's primary care providers left the plan in 1999. M+C plan representatives from UCare and Medica stated that provider turnover is low in their M+C plans as well—generally, they believe, because the plans “do not play hardball with providers.” As noted above, plans pay providers 105 percent of the Medicare fee-for-service rate. Said one plan respondent, “the relationship between providers and HMOs in Minneapolis tends to be more collaborative than what is described in other parts of the country.”

Seniors in Minneapolis-St. Paul prefer to remain with those doctors and primary care clinics with which they have an established relationship. For example, according to one plan representative, only 25 percent of HealthPartners enrollees tied to a particular “care system” remained in HealthPartners following termination of that system's contract. Given beneficiaries' loyalty to their providers, Medica's withdrawal might have been very disruptive to plan enrollees. However, it appears that this was not the case, due to a significant overlap of provider networks between Medica and UCare. We were not able to confirm the actual degree of overlap from information provided by the plans. A Senior Federation publication includes information showing that UCare has more primary care and specialty physicians in its network, but fewer hospitals compared to Medica. In 1999, Medica's choice plan had 36 hospitals, 188 primary care physicians, and 2,282 specialists in its network. UCare had 17 hospitals, 850 primary care physicians and 2,000+ specialists. We were told that the composition of UCare's network is still changing to attract Medicare beneficiaries affected by Medica's withdrawal.

A HealthPartners representative reported that his plan is not actively recruiting new members, including beneficiaries affected by Medica's withdrawal²⁴. HealthPartners uses its own self-contained primary care clinics, which do not overlap significantly with the Medica and UCare provider networks. A HealthPartners representative reports that the plan reduced the size of its

24 A HealthPartners plan informant reported that the plan does market the M+C product, informs commercial members of its availability as their 65th birthdays approach, and conducts outreach activities through employers to inform Medicare beneficiaries about the product.)



provider network several years ago in order to better manage its costs. The network was further reduced by physicians electing to leave the plan. Plan representatives currently believe that limiting contracts will help the plan survive and that both reimbursement and the healthcare of M+C members can be most effectively managed in HealthPartners-owned primary care clinics. We did not hear complaints about inadequacies in HealthPartners' network. Seniors did tell us that they selected plans based upon the geographic location of provider networks. For example, seniors in one focus group affected by Medica's withdrawal were not interested in signing up for HealthPartners, because its network providers are too far from their apartment complex.

M+C Quality of Care Appears High, but Enrollee Satisfaction Varies by Plan

Our discussions with providers, M+C enrollees, and community informants led us to believe that the quality of care provided to seniors in M+C plans in the Twin Cities is high. Health insurance benefits counselors told us that seniors are generally pleased with the quality of care they receive and that they rarely hear questions from seniors about quality. From seniors we heard a couple of stories about problems accessing health care, long waiting periods, and denials of coverage but, for the most part, the level of satisfaction with health plans seemed high. Seniors did complain, however, about the high costs of HMO coverage.

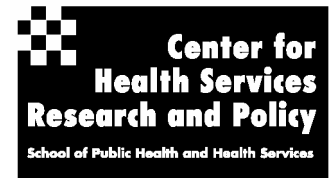
Managed care plans in Minneapolis-St. Paul are all held accountable to Minnesota's strong consumer protection laws. Minnesota heavily regulates HMOs, in some areas to a greater degree than the rest of the nation. For example, Minnesota requires all HMOs to be non-profit and closely monitors their financial status.²⁵

The Twin Cities' long history of managed care for seniors and the state requirement that HMOs be non-profit seemed to affect our informants' perceptions about M+C plans' commitment to caring for seniors. One plan informant stated, "This part of the country understands managed care. Doctors do a good job managing referral patterns and conducting utilization review." One community respondent agreed that M+C plans provide more appropriate utilization and higher quality health care. M+C plans in Minneapolis-St. Paul encourage their contracting clinics to develop care management programs.

Low voluntary disenrollment rates support the repeated comments by seniors, plan representatives, and community informants that the quality of care provided to seniors in M+C plans is high. The rate of beneficiary disenrollment from Hennepin County M+C plans was six percent in 1999.²⁶ Medica, UCare

25 Colombo, Barbara, and Webber, Robert P. "Regulating Risk in a Managed Care Environment: Theory vs. Practice, the Minnesota Experience." *Annals of Health Law*, Loyola University Chicago Institute for Health Law, 1999.

26 Medicare Compare



and HealthPartners representatives stated that disenrollment rates were less than five percent in 2000.

In addition, as shown in Table 2, reporting plans scored well on a number of Medicare performance measures, including providing flu shots, testing diabetic patients for glucose control, testing for high cholesterol and breast cancer, prescribing beta blockers after a heart attack, and seeing members at least once a year. Plans’ scores were more variable for patient satisfaction measures. All plans scored well on the percentage of enrollees who said they had no problems getting needed care. UCare and HealthPartners scored less well than Medica on patients who rated their plan as “the best possible managed care plan,” and who rated their “own care as the best possible care.”

	HealthPartners	Medica	UCare
Always get care when needed without long waits	59%	62%	63%
Getting care that is needed	87	91	89
Own managed care plan is the best possible plan (a rating of 10)	38	61	43
Own care is the best possible care (a rating of 10)	45	57	53
Plan doctors always communicate well	68	72	70
Not a problem to get a referral to a specialist	85	90	87
Received a flu shot	87	84	85
Diabetic enrollees who received an eye exam	84	Not available	57
Received a glucose control test	94	Not available	91
Received a cholesterol test	79	Not available	74
Women (aged 52-69)who received a mammogram within the past 2 years	86	Not available	Not available
Prescribed beta blockers after a heart attack	91	Not available	95
Percent of enrollees seen by a provider in the past year	95	Not available	96

Source: Medicare Compare

THE FUTURE OF MEDICARE HMOS IN THE TWIN CITIES: MEDICARE HMOS MAY NOT BE A VIABLE OPTION

There is some question about whether M+C is a viable option in the Minneapolis-St. Paul area. “Medica’s pull-out from these last two counties is indicative of a M+C market in trouble,” commented one plan representative. Another community informant concurred, noting that low payment rates have lead to a “death spiral of insurance pools.” She explained that healthy seniors will increasingly opt out of M+C and other expensive supplemental coverage, leaving the insurance market with high-cost enrollees who enroll in M+C plans to avoid health screenings and obtain some additional coverage. This will force M+C plans to squeeze providers and clinics, who will then drop out of the program, making the program even less attractive.

In response to Medica’s announced withdrawal, the Senior Federation asked the plan how much the Medicare rate would need to be increased for Medica



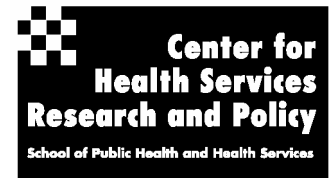
to reenter the M+C market. Medica estimated its break-even rate to be about \$541 for 2000 and \$590 for 2001. P.L. 106-554 (The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) substantially increased Medicare HMO payment rates across the country and provided Medicare HMOs with a three percent increase in 2001. However, the 2001 Medicare rate of \$525²⁷ in both Hennepin County and Ramsey County was not enough to lure Medica back into the Twin Cities Medicare market.

Even with these higher Medicare reimbursement rates, it is uncertain whether any M+C HMO will remain in Minneapolis-St. Paul. A HealthPartners plan representative told us that staying in the M+C market is something that the plan evaluates from year to year. The plan has recently had to cut a few poorly performing clinics with high utilization and high costs and has made a strategic choice to focus its network and to manage utilization more closely in order to remain viable. HealthPartners believes it can survive because it limits its contracts to providers who have a track record of efficiently managing patient care.

Observers questioned whether UCare, with its expansive provider network, could survive in the market. UCare has only been in the M+C market since 1998, which one observer thought was too soon to evaluate the plan's ability to manage its senior population. Said one non-UCare plan representative, "In Minneapolis once you have Medicare enrollees you have them for the long term. These members age and get sicker and cost a lot more in the long run. If a health plan is having problems managing costs in this market at the beginning they are only bound to have more problems in the future." Despite this assessment, she thinks that that UCare is committed to making it in the Twin Cities. UCare representatives were optimistic about the plan's chances of success, noting that the plan hopes to break even on its Medicare product in 2001. Further, plan representatives felt that because the plan pays providers more than Medicare fee-for-service, providers have an incentive to help UCare succeed. Plan representatives were, however, concerned about recent high hospital utilization, which they did not think could solely be explained by the aging of its enrollee population. One UCare representative, speaking in April 2001, noted that since the passage of BIPA, her plan's officials have felt even more confidence about the long-term stability of the plan.

Several observers felt that the M+C program would have "crashed" sooner had it not been for the fact that all of the M+C plans are non-profit. "Caring for seniors is never going to yield huge profit margins if the program is designed right," commented one community representative. "For-profit plans will never make the 20 percent profit margins they desire, which is why nationally we've seen many of the large national plans leave the program."

²⁷ Reimbursement rates cited are without taking risk adjustment into account.



CONCLUSION

Medicare beneficiaries living in Minneapolis-St. Paul appear to have a lot of choice in the supplemental health insurance market. In 2001, there are two M+C plans (offering 4 different products), cost and select plans, and numerous carriers of Medigap supplemental insurance policies. A M+C private fee-for-service plan is also being marketed in Minnesota. This appearance of choice, however, is somewhat illusory. Medicare beneficiaries in Hennepin and Ramsey Counties who do not qualify for Medicaid or the state's prescription drug program have no access to affordable prescription drug coverage (except UCare's small [\$100 cap/quarter] benefit and HealthPartners' pricey [\$300.50/month] benefit). Low Medicare payment rates have disadvantaged seniors in Minneapolis-St. Paul compared to seniors living in many other urban areas of the country.

Insurance products with a prescription drug benefit are in a death spiral. Because of high premiums, healthier seniors are withdrawing from the more expensive supplemental coverage options offering prescription drugs, forcing insurers to raise premiums for the older and least healthy seniors remaining in the plans.

The future of Medicare HMOs in Minneapolis-St. Paul is in doubt. As a result of the low Medicare payment rate, one of three M+C plans withdrew from Hennepin/Ramsey Counties in 2001 and one significantly reduced prescription drug benefits. Plan and community informants agreed that M+C plans in the Twin Cities area were in a sense "being punished" because of the state's long history of managed care, which has resulted in significant cost savings and efficiencies relative to other parts of the country. Because of a decision to pay providers more than the Medicare fee-for-service rate, plans have little ability to balance low Medicare reimbursement rates with reductions in the provider fee schedule. Of the remaining M+C plans, UCare representatives were optimistic about their ability to remain in the M+C market, although many community informants were concerned that the plan was too new to assess its long-term viability. HealthPartners representatives were less optimistic, planning to assess whether to remain in the Twin Cities' M+C market from year to year.

Congressionally mandated higher reimbursement rates will translate to \$67 and \$54 more per enrollee per month in Hennepin and Ramsey Counties, respectively. In the short term, this increased payment rate did not result in a reversal of Medica's withdrawal decision. However, UCare and HealthPartners responded to the reimbursement changes by modifying their benefits and premium. In the longer term, whether the increased payment rate will make a substantial difference in HMOs' ability to remain in the Twin Cities Medicare market and in the benefits offered remains to be seen. What does seem clear,

however, is that Medicare+Choice is not the answer to Minneapolis-St. Paul's seniors' need for affordable prescription drugs.



Table 3

A Comparison of Benefits Offered by Insurers in Minneapolis-St. Paul for Risk HMOs, Cost HMOs, and Medicare Select Plans: 2000

Benefit Summary	MEDICA Select SeniorCare Secure	MEDICA Cost PHP+ Medicare	MEDICA Choice Senior Care Complete
Hospital Inpatient	Unlimited days as authorized by Medica, no copays or deductibles	Up to 90 inpatient days when authorized by PHP Physicians, no copays or deductibles	Unlimited days as authorized by SeniorCare physicians, all deductibles and copays covered in full
Outpatient Physician	Covered in full through Medica physicians and hospitals	Covered in full through PHP physicians and hospitals	Covered in full through Senior Care physicians after \$15 copay
Non-network services	Same as cost.	Non network services are covered only for Emergencies	TRAVEL: 50% coverage for non-emergency services, \$5,000 maximum per calendar year
Emergency Services	Emergency services covered in full.	Emergency services in network covered in full. Non-network \$40 copay.	\$50 copay for ER visit
Preventative Services	Same as choice and cost	Same as choice plan.	Annual health assessments, immunizations, cancer screening, routine eye and hearing exams
Home health care	Same as choice and cost except additional at-home recovery benefit of a maximum of \$40 per visit or \$1600 per year (Extended Basic only)	Same as choice plan.	Unlimited visits paid in full if Medicare approved
Skilled Nursing Care	Same as choice and cost	Same as choice plan.	Paid in full up to 100 days based upon Med approved criteria
Outpatient Prescriptions	Basic: None Extended Basic: covers 80% of drug costs	80%	80%
Open Enrollment	Open	Closed until Jan. 1 2001	Open
Number of in Network Providers	192 hospitals 20,603 physicians	148 hospitals 7,850 physicians	36 hospitals 188 physicians 2,282 specialists
Health Screening	Health screens applicable	No health screening	No health screening

Table 3

A Comparison of Benefits Offered by Insurers in Minneapolis-St. Paul for Risk HMOs, Cost HMOs, and Medicare Select Plans: 2000

Monthly Rate	Basic: Smoker: \$122.60 Non-smoker: \$99.95 Extended basic: Smoker- \$343 Non-smoker- \$268	\$269.50	\$279.95
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Benefit Summary	HealthPartners Select Senior Health Advantage	HealthPartners Cost HealthPartners 65+	HealthPartners Choice Standard Option
Hospital Inpatient	Unlimited days as authorized by participating physicians, no copays or deductibles	Same as Select	Same as Select
Outpatient physician	Covered in full through participating physicians and hospitals.	Same as Select	\$10 copayment required
Non-network services	Emergency services in network covered in full, for non-emergency services out of network the member is responsible for Medicare deductibles, coinsurance, and paperwork.	Emergency services mostly covered (see below.) Out of network non-emergency: same as Select.	Emergency services mostly covered (see below.) Out of state non-emergency: 80% coverage for a maximum of \$5000.
Emergency services	Coverage for 100% of Medicare deductibles and copayments; 80% coverage outside the U.S.	100% coverage after a \$35 copayment which is waived if the member is admitted.	100% coverage after a \$30 copayment which is waived if the member is admitted.
Preventative services	Routine physicals, immunizations, routine eye and hearing exams, routine mammograms and pap smears covered in full.	Physicals, immunizations, eye and hearing exams, and cancer screenings covered in full.	Same as Cost.
Home health care	Basic: no additional coverage beyond Medicare. Extended basic: Additional at-home recovery benefit: max \$40/visit and \$1600/calendar year.	Unlimited visits covered, although Medicare rules apply for eligibility	Same as Cost.
Skilled nursing care	Covered in full for 100 days per benefit period after a 3-day hospital stay. Extended basic permits 20 additional days per year.	Same as Basic Cost plan.	Same; prior hospital stay requirement may be waived by plan.
Outpatient prescriptions	Basic: None	None	Standard Option: None High Option:

	Extended basic: covers 80% of all drug costs at participating pharmacies		same as Select Extended Basic.
Enrollment	Open	Open	Open
Number of in-network providers	104 hospitals 6,953 physicians	104 hospitals 2647 PCPs 4748 specialists	10 hospitals 492 PCPs 1,697 specialists
Health Screening	Health screened after 6 month window of Medicare Part B enrollment for Extended Basic members only.	None.	None.