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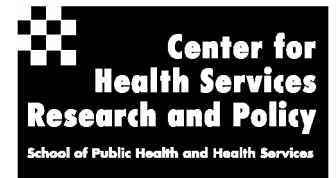
**MONITORING THE  
IMPLEMENTATION OF  
MEDICARE+CHOICE:  
  
PIMA COUNTY, AZ. SITE  
VISIT REPORT**

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## RESEARCH CONTEXT

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

In an effort to reduce health care spending and to allow 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 of the tendency to enroll a healthier population as compared to traditional Medicare. While managed care options existed for the Medicare population prior to 1997, it was hoped that the BBA would result in a more than a 100% 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 and burdensome compliance regulations.<sup>2</sup> By 2001, these withdrawals had affected over 1.6 million Medicare beneficiaries nationwide. These withdrawals, coupled with plan reductions in prescription drug benefits and provider network instability, have resulted in serious disruptions in care for the Medicare population.

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

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

<sup>2</sup> 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](http://www.aahp.org). AAHP President and CEO Karen Ignagni stated "the reality is that this program has been over-regulated and underpaid."



Tampa-St. Petersburg, New York City and Los Angeles. This report describes the implementation of the M+C program in Pima County (Tucson), Arizona and provides a microcosm from which to view the nationwide disruption in the M+C program. It is based on information obtained during a three-day site visit to Tucson in October 2000 and follow-up phone calls, as well as 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 M+C plan representatives, HCFA representatives, physician and provider organizations, area hospital representatives, and leaders of community-based organizations (such as the state SHIP and local Area Agencies on Aging) to get their impressions of the M+C market and implementation of Medicare+Choice. In addition, three focus groups were held with Medicare beneficiaries.

The report examines the following issues: (1) changes in M+C plan availability and benefits and factors contributing to these changes; (2) the adequacy and stability of provider networks in M+C plans; (3) beneficiary responses to M+C plan withdrawals, reductions in benefits, and changes in provider networks; (4) beneficiary understanding of the M+C program; (5) access and quality of care in M+C plans; and (5) the particular implications of these issues for vulnerable beneficiaries.

## THE TUCSON MEDICARE+CHOICE MARKET

### BACKGROUND

Tucson is located in Pima County, the fifth largest county in the country. Pima County is largely rural, covering some 9184 square miles.<sup>3</sup> Residents of rural communities, such as Ajo, located 140 miles west of Tucson, are often forced to travel an hour or more for medical care.

Fourteen percent of Pima County's population is elderly.<sup>4</sup> The county's elderly population has little disposable income. In 1999, 9,230 (8%) of Pima County's population over age 65 lived in poverty<sup>5</sup>, with an annual income below \$7990.<sup>6</sup> In 1999, the mean social security income in the county was \$11,538, and the mean retirement income, \$16,665<sup>7</sup>. Pima County's over-65 population is 12.6% Hispanic.<sup>8</sup>

<sup>3</sup> Pima County Area Information. Available at <http://www.co.pima.az.us/area.html>.

<sup>4</sup> U.S. Census Bureau, American Community Survey, Data for Pima County, AZ, 1999.

<sup>5</sup> American Community Survey

<sup>6</sup> U.S. Census Bureau, "Poverty Thresholds in 1999, by Size of Family and Number of Related Children Under 18 Years."

<sup>7</sup> American Community Survey



Tucson is rich in hospital resources. Tucson's major hospitals include the 609-bed Tucson Medical Center, the 365-bed University Medical Center of the University of Arizona, and the non-profit Catholic hospitals of the Carondelet Health Network (St. Joseph's has 285 beds and St. Mary's has 393 beds). Tucson also has a 48-bed for-profit hospital specializing in cardiac procedures, Tucson Heart Hospital. For-profit hospitals, Northwest Medical Center (144 beds) and El Dorado (166 beds), serve the northwest and east regions of Tucson, respectively, and are owned by the Dallas-based company Triad hospitals Inc. Kino Community Hospital, which is owned by Pima County, but no longer subsidized by tax revenues, has 209 beds. As discussed below, recent hospital nursing shortages have forced the closure of large numbers of hospital beds in the city, reducing bed capacity below the needs of the community.

Tucson's physician community has a long history of joining together to form medical groups. However, the bankruptcy of several long-established groups in the past few years has left the city with only two large physician groups: the 75-member Arizona Community Physicians, and University Physicians, consisting of 350 doctors, all faculty at the University of Arizona College of Medicine.

## GROWTH OF MEDICARE MANAGED CARE

There is a long history of managed care in Arizona. Medicaid programs, employers, and privately insured individuals in the state rely heavily on HMOs. About 3 million of the state's 5 million residents are enrolled in an HMO.<sup>9</sup> Over 79% of the members of the Arizona Health Care Cost Containment System (the state Medicaid program, which also assists other medically needy individuals) are enrolled in managed care plans. About 10% of the state's population are enrolled in AHCCCS.<sup>10</sup> Because of this history, Medicare managed care took hold early; Arizona's Medicare managed care enrollment—38 percent of the Medicare population—was the third largest nationwide in July 2000, behind California and Rhode Island.<sup>11</sup>

Medicare managed care in Tucson experienced early and sustained growth. Between 1993 and the passage of BBA in 1997, the number of Medicare HMOs in Tucson grew from three to seven.<sup>12</sup> Along with the growth in the number of plans, Medicare managed care enrollment has grown in Pima County from 33.7 percent of Medicare beneficiaries at the end of 1993 to 47.3 percent enrolled in June 2000. Medicare HMO enrollment is highly concentrated in three plans. As of June 2000, PacifiCare had 43 percent of all Medicare HMO enrollees, Intergroup, 31 percent, and United, 19 percent.

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8 U.S. Census Bureau population estimates, 1998, from <http://govinfo.library.orst.edu>.

9 See Erikson, Jane, "More Arizonans Bypass HMOs." *Arizona Daily Star*, Aug. 5, 2000.

10 Arizona Health Care Cost Containment System, "AHCCCS Overview," available at <http://www.ahcccs.state.az.us/Publications/overview/contents.htm>.

11 Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report, July 2000.

12 Analysis of HCFA geographic service area reports.



## PLAN WITHDRAWALS AND BENEFIT REDUCTIONS

Despite this steady growth in Medicare HMO enrollment, the M+C program in Tucson has been in turmoil since the passage of the BBA. At the beginning of the Medicare+Choice program in 1997, Pima County had seven Medicare HMOs—Premier, Cigna, United Healthcare, Humana, Blue Cross/Blue Shield, PacifiCare of Arizona, and Intergroup. By January 2001, only two plans remained in the Tucson market: Blue Cross Blue Shield and Humana withdrew from Pima County at the end of 1999, as did Premier, which experienced a financial collapse forcing it to terminate the plan statewide. In 2000, two of the remaining four plans—Cigna and United Healthcare—announced they would withdraw from the Tucson market on January 1, 2001, affecting 25.9 percent of the M+C-enrolled population and 12.2 percent of Tucson’s Medicare population.<sup>13</sup>

Historically, M+C plans have offered Pima County enrollees a generous benefit package. In 2000, all of the four M+C plans offered \$0 premium plans with unlimited coverage of generic prescription drugs and coverage of \$500 to \$2,500 in brand drugs. In 2001, the two remaining plans—PacifiCare and Intergroup—will dramatically reduce their prescription drug coverage. PacifiCare will offer a \$0 premium product with no drug coverage. It will also offer a \$25 a month premium product (called PacifiCare Plus) with a brand drug benefit limited to \$1000 and an unlimited generic drug benefit. Intergroup will offer a \$0 premium plan with unlimited coverage of generic prescription drugs only. In addition to the changes in prescription drug benefits, Intergroup Senior Care has added a \$500 hospital deductible for 2001 and has increased co-payments for doctors’ visits. PacifiCare also increased copays for doctors’ visits and generic drugs.

## A PRIVATE FEE-FOR-SERVICE PLAN ENTERS THE TUCSON MARKET

The Sterling Option 1 private fee-for-service plan became available throughout Arizona in mid-2000. The plan, which charges a \$65 a month premium, has enrolled only a handful of seniors thus far. As of January 31, 2001, only 17 beneficiaries were enrolled in Sterling. Sterling enrollees get coverage of doctor’s visits (with a \$10 copayment) and pay less coinsurance for hospital stays than they would under traditional Medicare. They receive no coverage for prescription drugs, however. The plan has no network—members may go to any doctor who accepts assignment and agrees to Sterling’s terms. The Sterling plan is reimbursed by Medicare on a capitated basis but pays providers fee-for-service.

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<sup>13</sup> Pima County is not the only area in Arizona that has experienced protracted withdrawals of M+C plans. The rural nature of the state is at least partially responsible for the instability of the M+C program. It is difficult for plans to negotiate a discounted rate from providers in rural communities, increasing the costs of plan operations.



## FINDINGS

The findings from this site visit are organized in the following way. We begin by describing the local and national factors that our informants believe contributed to the instability of Pima County's M+C market. We then explore the implications of M+C plan withdrawals and benefit cuts for Medicare beneficiaries. Section three of the findings describes instability in M+C provider networks and beneficiaries' understanding of provider networks. We then report on findings about quality and access in M+C plans from the perspective of providers, community informants and beneficiaries. We conclude with a brief discussion about how beneficiaries make decisions about enrolling in and leaving managed care and choosing between M+C plans.

### FACTORS INFLUENCING PLAN WITHDRAWALS AND BENEFIT REDUCTIONS

During the course of the Tucson site visit we came to understand many of the local and national factors contributing to M+C plan withdrawals and changes in plan benefits. Informants felt that low Medicare reimbursement coupled with the high costs of prescription drugs, the cost of implementing M+C regulations, the rural nature of Pima County, the inability of HMOs and providers to manage care, and a changing provider reimbursement system all played a role in plan withdrawals and benefit reductions.

#### **Medicare Reimbursement**

First and foremost, we heard M+C plans are leaving Pima County because their Medicare products contributed to plan financial instability. Premier HMO, which entered the M+C market in 1996, went bankrupt after three years in the business. In 2000, Intergroup reported a net loss of nearly \$24 million in 1999 and United, a \$13.7 million loss.

Prior to passage of the BBA, plans' Medicare payments were said to offset losses in the commercial side of their business. Medicare was, noted one observer, a "gravy train." A provider interviewed during the site visit agreed: plans were fighting a "commercial premium war" which was subsidized by Medicare. Plans were "making a killing" on Medicare, he concluded. The BBA, however, stopped the "gravy train."

Withdrawing plans claimed that Medicare reimbursement of \$499 a month per enrollee was insufficient to allow them to remain in Pima County. One plan executive stated that his plan needed approximately \$50 per member per month more to remain in the county. When asked why his plan decided to exit the market rather than increase premiums, he noted that "no plan wanted to be the first to charge a premium in Tucson's M+C market," and that his plan



would not have remained competitive had it charged seniors \$50 in additional premiums.

In addition to the low base reimbursement rate, the annual two percent increases in Medicare payments were felt to be inadequate. Tucson plans that had been receiving yearly 10-12 percent increases in Medicare payments were now forced to make do with two percent increases a year. According to plan executives, annual health care inflation in Pima County is 12-15 percent and prescription drug cost increases of 18-20 percent a year made it impossible for them to remain in the market.

### **BBA Regulations**

Plan representatives stated that regulations enacted under the BBA of 1997 are “extremely burdensome” and contributed to M+C plan withdrawals statewide. One executive stated that “the [Medicare required] paperwork is 50 times as much as required in the commercial health insurance business,” while another complained about Medicare “red tape.” For example, this plan executive complained about the requirement that M+C plans give all hospitalized patients a discharge notice at the time of discharge. It is often difficult to ensure that contracting hospitals meet this requirement, he said. Multiple plan informants were also upset by the timeline they were given to notify HCFA of their intentions to remain in the M+C market for the upcoming year. HCFA required a decision by July 3, 2000, leaving plans with little information with which to predict their costs for the following year.

### **The Rural Nature of Pima County**

Two local factors influenced plans’ decisions to withdraw from the Tucson market.

First, several informants noted that the rural nature of Pima County made it difficult for plans to remain in the market. Plan representatives contend that providers and hospitals in rural areas are able to “name their price,” making it too expensive for M+C plans to maintain networks in rural communities. Consequently, plans have significantly scaled back their networks in rural parts of the county.

One newspaper article describes the circumstances of seniors living in Ajo, a small town of 3,000 located 140 miles west of Tucson in Pima County. Intergroup, PacifiCare and HealthPartners all had M+C products operating in Ajo in 1998 with a total of 631 members. One by one each of these plans terminated its contract with the Ajo Community Center, placing the future of the Center, the only source of health care in town, at risk. Although Intergroup and PacifiCare will remain in Ajo in 2001, Medicare beneficiaries who remain in these plans must travel two or three hours to see a doctor in Tucson or



Phoenix to obtain health care, or pay for out-of-plan care from a local physician.<sup>14</sup>

Because of the inability of M+C plans to negotiate a discounted rate with rural providers, M+C plans negotiated contracts with provider groups in Tucson to assume the risk of caring for rural members. These groups also lost money on caring for these rural beneficiaries. As described by one informant, “we learned that the lack of infrastructure for physical therapy or home health care and the fact that there are no hospitals nearby made it very expensive to care for seniors living in rural areas, particularly the very sick ones.” For example, provider groups might have to contract with a home health agency in Phoenix, which would have to travel hours to deliver oxygen to plan patients. These provider groups are no longer willing to accept the financial risk of caring for plan enrollees living in rural parts of Pima County.

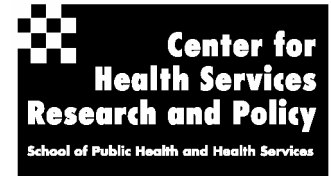
### **The Changing Nature of Plan-Provider Network Contracts**

A second local factor, the changing nature of plan-provider contracts, may also have influenced plans to leave Pima County. Historically, Medicare HMOs in Tucson paid providers a percent of the Medicare capitated rate. After taking a percent of Medicare reimbursement off the top for administration, HMOs passed the risk, along with the capitated payment, down to contracting provider groups. This enabled the HMOs (who were not at risk) to hold down costs. However, provider groups lost money under these arrangements. According to several respondents, capitation was a disaster for provider groups, several of which went bankrupt, including the Thomas Davis Group and Group Health Medical Associates (see discussion below). The groups that remained, most notably Arizona Community Physicians and the University Physicians, felt that they would not survive if they continued to be at risk for the medical and pharmacy costs of M+C enrollees.

By October 2000, pressured by both physician groups and hospitals, the two remaining HMOs in the Tucson market were reassuming the risk of providing care to their members. New hospital contracts were paying on a per diem basis and physician/group contracts on a fee-for-service basis (at least in the case of individual primary care physicians). This change in the way providers are reimbursed may have made plans less willing to remain in the market. One plan informant stated, “it is difficult to reorient an organization to behave like a health insurance business.” Another informant stated that as providers and hospitals got out of sharing risk, “it was no surprise that the M+C plans started to go under in Tucson.”

Some plan executives stated that they hope they can hold down utilization of specialists by paying physicians on a fee-for-service basis. With the bankruptcy of large medical groups (see accompanying box), solo practitioners and small

<sup>14</sup> Erikson, Jane. “Growing costs, shrinking care: Ajo’s elderly face dilemma, possible loss of health clinic.” October 18, 1998.



group practices dominate the Tucson medical market. One plan executive we spoke with believed that paying primary care physicians on a capitated basis created an incentive for them to refer patients to specialists, instead of providing the care themselves. Plans hope that switching to a fee-for-service payment system will give primary care physicians less of an incentive to refer patients to specialists, instead of caring for these patients in their own offices. However, this executive said he is not certain the strategy will reduce costs, calling the new payment system “a grand experiment.”

According to one respondent, primary care physicians in Tucson have mixed feelings about the change from capitation to FFS. He noted that some doctors do well under capitation, particularly those who have a patient mix of healthier seniors. Moreover, individual physicians may have a particularly difficult time with the transition from capitation to FFS because they lose a large source of up-front revenue. Finally, providers are concerned about delayed payment from HMOs despite recent Arizona legislation requiring plans to pay physicians within 45 days of submission of a clean claim.

**Timeline of Provider Group Financial Problems in Tucson**

- 1920: Thomas Davis Clinic started in downtown Tucson. Eventually it would become a large clinic chain.
- mid-70s: Pima Health Care, the first managed care plan organized by local doctors, was created.
- 1981: Thomas Davis and Tucson Clinic created Intergroup.
- 1994: Intergroup sells to Foundation Health.
- 1994: Tucson Medical Center, which owns the Partners Health Plan HMO, buys Group Health Medical Associates, formerly Pima Health Care. The resulting partnership becomes HealthPartners of Southern Arizona in July 1995.
- 1996: Foundation sold management of Thomas Davis Medical Centers to FPA
- 1998: Tucson Medical Center closes GHMA and sells its HMO (Health Partners) to United HealthCare.
- 1998: FPA filed for bankruptcy and pulled out of Arizona; Thomas-Davis Medical Centers, which has been a Tucson institution for 78 years, closes its doors.
- 1998: Group Health Medical Associates goes out of business.
- 1998: Talbert Medical Group, a spinoff of Pacificare, goes out of business.

**BENEFICIARY RESPONSE TO M+C PLAN WITHDRAWALS AND BENEFIT REDUCTIONS**

Because Tucson is heavily dependent upon HMOs to provide health care to its senior population, plan withdrawals have caused significant disruption among Medicare beneficiaries. In 2001, approximately one in ten Pima County Medicare beneficiaries will have to enroll in a new HMO or return to FFS Medicare. Two in five Pima County seniors will be affected by HMO changes in their prescription drug benefits.



## **Seniors are “scared” and “confused” by plan withdrawals and benefit reductions**

On hearing about plan withdrawals and benefit reductions, seniors were described as “angry,” “scared,” “confused,” “stunned,” “panicked,” and “frustrated.” When told of cuts in her prescription drug benefit, one senior said she worried “I won’t be able to eat if I have to pay for my prescriptions.” Similar to this sentiment, a community worker noted that, “most seniors are pretty scared (about the M+C withdrawals) because of the expense.”

Despite numerous newspaper articles, plan mailings, and community educational presentations by the Pima Council on Aging, some seniors remained unaware of plan withdrawals and benefit cuts. For example, focus groups held during the site visit in November with seniors, particularly monolingual Spanish-speaking seniors, showed that many participants in Intergroup and PacifiCare were not aware of any changes in their drug coverage for the upcoming year. Community informants were also concerned that monolingual Spanish-speaking seniors enrolled in United or Cigna did not know that they would have to change plans or return to FFS Medicare in January. One representative of a senior organization also noted that, “seniors who are older than 75 also tend not to understand how limited the prescription drug benefit for next year will be.”

Agencies working with the Medicare population in Arizona and in Pima County have been swamped with calls from angry and confused beneficiaries. The State Health Insurance Program (SHIP) office received some 300 calls a day following M+C plan letters to members about withdrawals that included the SHIP number. Many seniors were confused by the letter sent by plans with its many pages of attachments. When a senior calls about the withdrawals, SHIP counselors spend roughly a half-hour on the phone with the caller and will sometimes make additional referrals to the Pima Council on Aging for a home visit if more help is needed.

The Pima Council on Aging (Pima County’s Area Agency on Aging) is also receiving hundreds of calls from Medicare beneficiaries about M+C plan withdrawals, sometimes forcing the switchboard to “shut down.” Calls have come in waves. The first wave occurred after the press announced in July that CIGNA and United would be leaving Pima County in 2001, catching the Pima Council without any information on the withdrawals or the ability to handle the large number of telephone inquiries. The agency responded to requests for assistance by urging callers to postpone making a decision until more information was available. The second wave of calls occurred following announcements by plans of withdrawals and benefit changes. The Pima Council expects a third wave of phone inquiries in January from seniors who remained completely unaware of the withdrawals and changes in plan benefits. Volunteers at the Pima Council said that some “seniors will only get it that



their drug benefits have been reduced when they go to purchase drugs next year.”

The agency also expects calls from seniors who were automatically enrolled in PacifiCare’s \$25 premium M+C plan. PacifiCare sent out a package of materials to members, asking them to select either the \$0 premium plan, which does not cover prescription drugs, or the \$25 premium plan, which does. Seniors who fail to select either alternative will automatically be enrolled in the \$25 premium plan (without their knowledge) because its coverage is closest to their 2000 benefit package. Come January 2001, some PacifiCare members will likely be confused when they receive their first request for payment of the \$25 premium.

Finally, Medicare beneficiaries call the Pima Council on Aging’s hotline when faced with changes in plan provider networks. As discussed below, recent plan-provider contract terminations have left beneficiaries confused and angry about having to find new providers.

### **Seniors blame Medicare and HMOs for the withdrawals and benefit cuts**

Seniors faced with plan withdrawals and significant benefit cuts also feel that Medicare has “reneged on its promises,” noted one community respondent. “Seniors were given the wrong message when the M+C program was initiated. They heard ‘Medicare is always there for you,’ and assumed that the benefits and low costs associated with M+C plans were their entitlement under Medicare. Now seniors in M+C plans perceive the entitlement they have worked for their whole life is being reduced or taken away.” One provider respondent agreed with this assessment, noting that many Tucson seniors enrolled in HMOs for a long time adjusted their budgets to reflect the lower costs associated with HMOs. Now that the benefits are changing, beneficiaries feel “deprived of their entitlement.”

Seniors also blame HMOs for pulling out of Tucson. HMOs are “only interested in making a profit,” charged one focus group member.

### **There are Few Alternatives to Medicare HMOs for Many Tucson Seniors**

About one in four seniors calling the Tucson Area Agency on Aging indicated that they would return to original Medicare when United and CIGNA withdrew from the Tucson market.<sup>15</sup> One community informant believes that the seniors in HMOs are increasingly lower-income because healthier and

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15 Informant interview



wealthier seniors are switching back to FFS Medicare. Many seniors who remain in M+C plans cannot afford the out-of-pocket costs associated with original Medicare.

One English-speaking senior enrolled in Intergroup described receiving a letter from the plan about 2001 benefits. She understood that the plan had increased dental coverage, but was not aware that the plan would no longer be covering brand name prescriptions. When told of the benefit changes during a focus group she became very upset. She told us she takes 13 regular prescriptions each month (of which two are brand-name). Currently, her total drug tab is \$120 per month. She stated “I will have to find a health plan that will help pay for brand name drugs so that I can continue to take the medication I need.” This senior told us she often receives samples from her doctor. She also keeps any leftover medication at the end of each month for a reserve supply in case there is any problem with her benefits or with affording the copayments for drugs.

Another senior complained that it was “unfair of Intergroup” to drop coverage for brand drugs. She had already made the decision to switch to PacifiCare despite the \$25 a month premium, explaining that she takes eyedrops for which there is no generic version. Except for the cut in drug benefits, this focus group participant was very satisfied with the health care she had received from Intergroup, and felt that despite the disruptions in care, it “was worth staying in an HMO- what would we do without them?”

Medigap is not an option for many low-income seniors. Medigap premiums in Tucson are higher than in many other parts of the country. A Medigap Plan A costs between \$61 and \$99 a month for a 65-year old. The most expensive plan A for someone 80 years and older is \$121 a month. Plan F—the guarantee-issue plan with the richest benefits—can cost up to \$217 a month. Plan J, which covers 50 percent of prescription drug costs up to a maximum of \$3,000 can cost up to \$361 a month for a 65-year old and \$389 a month for an 80-year old.<sup>16</sup> Medigap SELECT plans, which provide the same benefits as comparable Medigap plan for less cost, but require the use of network providers, are also offered in Arizona.<sup>17</sup>

Providers interviewed during the site visit described seniors’ options in terms of obtaining drugs in light of M+C plan withdrawals and reductions in prescription coverage. First, they tell seniors to shop around at the pharmacies in town. Sometimes the cost of drugs can differ by as much as 10-20 percent. Second, physicians tell seniors about the various Medigap policies, which, as previously noted, may be unaffordable to many Tucson seniors. Third, providers will often give patients free samples of their medications. Fourth,

<sup>16</sup> From informational packet distributed at the 13th Annual Medicare Update Seminar.

<sup>17</sup> Ibid.



providers will try to switch patients to the generic version of the brand drug if there is one.

Finally, providers and community representatives might describe the option of going to Nogales, Mexico to fill their prescriptions. The providers with whom we spoke did not seem concerned about this practice. One physician was “worried” years ago about “seniors going to Mexico for their drugs,” until he started going himself to treat his dog for valley fever. He was able to get the expensive pills needed to treat the disease in Mexico for one-fifth of the cost he would have paid in the US. This physician is not concerned about the quality, safety, or efficacy of the drugs over the border, and has never had a patient have a problem with going to Mexico for his or her prescriptions.

Other providers echoed this sentiment. Mexican pharmacies sell brand-name drugs manufactured by large international companies. Oftentimes the drugs sold in Mexico come in the same packaging as that used in the U.S. The savings for those who travel to Mexico for their drugs are significant. The cost of a drug in Mexico is typically one-third the cost of the same drug in the U.S.

One provider did, however, express concerns about the potential for miscommunication between Spanish-speaking pharmacists and English-speaking seniors traveling to Mexico. While this provider acknowledged that the communication between physicians, patients and pharmacists was potentially hampered by seniors going to Mexico for their drugs, the alternative, “seniors not getting a pill,” seemed far worse to him. A bigger concern, he commented, is that “life-threatening diseases may not get treated.”

Several seniors we spoke with in the focus groups understood the option of going to Mexico for medications. Few of these seniors were making the drive, but many commented that this practice is popular among seniors in their community because “the drugs are so much cheaper and they are usually given out in a 2-3 month supply.” Some of the seniors weren’t going to Mexico because they weren’t able to make the one-hour drive from Tucson. Many said, however, they may ultimately have to find a way to get their prescriptions filled in Mexico if HMO drug benefits are reduced further.

Most of the seniors in our focus groups were not sure whether they would return to original Medicare if a prescription drug benefit were available. Many said their decision would depend on the cost of the drug benefit.

## PROVIDER NETWORKS

The HMO withdrawals and benefit cuts are not the only factors affecting access to, and continuity of, care for Medicare beneficiaries. Shortages of



staffed hospital beds and some medical specialists in Pima County generally, as well as HMO plan-provider contract terminations, have disrupted care to Medicare beneficiaries.

### **Plan-Provider Contract Disputes and Terminations**

Because of the high penetration of managed care in the Tucson market, few physicians and hospitals are able to afford going without HMO contracts. However, the buyouts and eventual bankruptcy in 1998 of Tucson's two largest medical groups—Group Health Medical Associates and Thomas-Davis Medical Centers (which was founded in the 1920s)—plan withdrawals, and recent contract disputes between HMOs and their provider networks has resulted in disruptions in care. Plan enrollees are often forced to change physicians or plans because of contract disputes:

In 1999, the Carondelet hospitals pulled their contract with PacifiCare. Since then, the plan has renegotiated its contract with these hospitals, but the initial pullout left PacifiCare enrollees feeling the plan had deceived them into thinking that St. Mary's and St. Joseph's hospital were part of the plan's network.

Intergroup recently required enrollees to obtain prior plan approval to see specialists in the University Physician Group. The HMO will often deny the referrals because of the higher costs associated with the Group.

The University Medical Center's unilateral decision in 1999 to terminate its HMO contract left many Medicare beneficiaries scrambling. One informant described this development as "heart-wrenching" news. The only exception is for patients in need of transplants who can only get this procedure done at UMC. UMC officials made this decision because they felt that it took too long to get HMO approval for procedures, claims were frequently denied, and there were long delays in payment.

As of this writing, PacifiCare has contracted with only one hospital—Tucson Medical Center—as its preferred network hospital. Patients who wish to go to another hospital will have to pay a \$150 deductible.

Provider turnover in M+C plans has been disruptive and confusing to seniors. "First and foremost, seniors want to stay with their doctor, so changes in networks force seniors into [the] difficult choice between staying with their doctor and what they can afford," commented one respondent. Another respondent agreed, noting that, "seniors don't understand that they may have to change their doctor once they enroll in an HMO when a contract changes. The doctor leaving can be just as traumatic as the HMO leaving. Having the same doctor is very important to seniors."



Provider turnover and instability is considered an even greater problem for seniors living in the more rural parts of Pima County. As described above, M+C plans terminated their contracts with providers located in rural communities because of the inability of plans to negotiate competitive rates. Also, rural communities frequently lack health care infrastructure in terms of specialty, home and acute care services, forcing seniors to travel long distances to obtain care. For example, Arivaca, a small town halfway between Tucson and Nogales, Mexico, has a clinic with primary care physicians but no specialists. If a senior from Arivaca needs to see a specialist he or she must drive 63 miles to Tucson. The nearest hospital is St. Mary's, also 60 miles from Arivaca. Because PacifiCare does not contract with the Arivaca clinic, a PacifiCare member living in the town has to travel to Green Valley, a 30-45 minute drive, for a physician visit. PacifiCare operates a van, but it only goes to Green Valley once a week between 10:00 AM and 2:00 PM. If Arivaca patients need a lab or other tests ordered by their physician, they will be unable to take the van home or have to forego the test.

### **Shortages of Medical Resources**

Newspaper articles and persons interviewed for this report described Tucson as in the throes of a health care crisis brought on by a shortage of staffed hospital beds and specialists. Several respondents described Tucson's health care system as "dangerously unstable," and on the "brink of a crisis." The system is suffering from a serious shortage of some types of specialists, including rheumatologists and dermatologists, and a growing shortage of gastroenterologists, endocrinologists, nephrologists and orthopedic surgeons. For example, there are 10-15 practicing rheumatologists in Pima County for a population of 900,000 and only 35 FTEs in dermatology. One Medicare beneficiary told us that she had to wait over four months for an appointment with her dermatologist. We also heard that orthopedic patients are having difficulty obtaining an appointment. "People sometimes have to wait 2-6 weeks to see a doctor if they are sick. New patients may have to wait 2-6 months to see a doctor."

One physician explained that although the population in Tucson has grown from 400,000 to 480,000 since 1990 and, in Pima County, from 500,000 to 900,000, the physician population in the county had grown by only some 350 physicians during these same years. Today, there are about 2100 physicians in the county, approximately 100 of them retired. Several provider representatives felt that the shortage of specialists was due to low payment rates, particularly from HMOs. One provider described a recent attempt to recruit a rheumatologist from Grand Island, Nebraska. "She wouldn't come to Tucson from Nebraska because it would have meant a pay cut." He explained that Medicare HMOs pay some doctors only 60-70 percent of FFS payments.

Contributing to the shortage of some types of specialists is a change in HMO referral rules. Commercial HMO members no longer need a primary care



physician's referral to visit a specialist. Patient self-referrals may be leading to an increased demand for specialty care.

Several respondents also felt that there was a shortage of primary care physicians, but others argued that the ratio of PCPs to the population met access requirements and was similar to that in other states. One provider respondent felt that low co-payments of \$5 for primary care office visits resulted in excess utilization of these providers.

There was unanimity, however, with respect to the dangerous shortage of staffed hospital beds in Tucson. Nursing shortages and financial problems have caused a number of Tucson hospitals to close beds, forcing hospitals to go on "divert" (turn away patients) and patients to "wait in emergency rooms for staffed beds to become available."<sup>18</sup> The high number of uninsured who use the hospital ER as their primary source of health care also contributes to overcrowded emergency rooms. This is a "huge crisis-huge" one Tucson internist commented after spending an afternoon trying to find a bed for a seriously ill AIDS patient.<sup>19</sup> One focus group participant described calling an ambulance for her neighbor last year when she got sick. She followed the ambulance in a car as two hospitals diverted the ambulance because they had no empty beds. Finally, a third hospital admitted the neighbor. "It was very scary," she commented. Providers and community informants were very concerned about the lack of staffed hospital beds this winter, especially because of a delay in receiving flu vaccine in the city.

In September 2000, many Tucson hospitals were operating at half to two-thirds of their licensed bed capacity.<sup>20</sup> Tucson Medical Center (TMC) lost \$7.5 million in 1999, and cut 300 jobs in February 2000.<sup>21</sup> Tucson General, a for-profit osteopathic hospital, unable to pay its creditors, was ordered by the Department of Health Services to cease admissions and transfer patients in October 2000. UMC and the Carondelet hospitals have also cut jobs in recent years to stem financial losses and are under-staffed.<sup>22</sup> Kino Community was said to be \$46 million in debt in January 2000, and officials have been hashing out survival plans for the hospital.<sup>23</sup> By contrast, Northwest Medical Center is fully staffed and growing due to economic and population growth in the northwest part of the city.<sup>24</sup>

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18 Informant interviews; Erikson, Jane. "Hospitals in 'huge crisis'." Arizona Daily Star, 9/23/00

19 Erikson, Jane. "Hospitals in 'huge crisis'." Arizona Daily Star, 9/23/00

20 Ibid.

21 Erikson, Jane. "U.S. hospitals wrestle with Medicare cuts, HMOs." Arizona Daily Star, 2/19/00

22 Erikson, Jane. "Hospital workers get extra pay," ADS, 9/1/00; Erikson, Jane. "Hospitals in 'huge crisis'." Arizona Daily Star, 9/23/00

23 Erikson, Jane. "Huckleberry plans drastic cuts at Kino," ADS, 3/28/00.

24 Ibid.





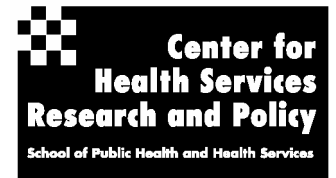
Hospital officials have blamed cuts in Medicare reimbursement mandated by the BBA for the layoffs. In addition, some providers have also blamed HMOs for enormous damage to the healthcare system.<sup>25</sup> The terms of HMO contracts, whereby the hospitals assumed risk for hospital care, were a financial disaster for many of the hospitals in Tucson, especially Tucson Medical Center.

### **Adequacy of HMO provider networks**

According to several Tucson observers, provider networks are perceived to be inadequate. We were told that PacifiCare's M+C plan network was only one-third the size of Intergroup's, and that the plan's network had almost no rheumatologists and dermatologists. The specialist scarcity is especially troubling as enrollment in PacifiCare, the largest M+C plan in Tucson, is expected to grow dramatically with the CIGNA and United pullouts. PacifiCare is trying to address network shortages by allowing beneficiaries to go to any contracting provider, eliminating previous rules requiring enrollees to seek care from one of several medical groups or subgroups, called "pods." PacifiCare is also trying to expand its network in 2001 by contracting with additional providers. For example, the plan is in contract negotiations with University Physicians, a large source of specialists in Tucson. PacifiCare members we spoke with in focus groups said they did not think that access to specialists was a problem.

Compared to PacifiCare, we were told that Intergroup has a broader network of providers, despite its smaller size. Intergroup's provider network is much more restrictive than it appears, however. For example, although the plan contracts with The University Physicians group, it requires plan approval before it will permit a referral to the group. This approval is seldom given. Intergroup members in our focus groups said they understood that they could not see a UP physician. Intergroup holds a contract with Arizona Community Physicians, the largest provider group in Tucson.

M+C plans appear to have an adequate number of Spanish-speaking physicians, at least in the southern part of Tucson, which has a large Hispanic community. Some concern, however, was expressed that Hispanic seniors living on the east side of the town did not have this same level of access to Spanish-speaking providers.



## **Medicare Beneficiaries' Understanding of Provider Networks**

There were differences in opinion about the extent to which Medicare beneficiaries understand provider networks. Many informants said they thought that relative to other parts of the country, "seniors in Tucson are sophisticated about networks." Others thought some seniors didn't really grasp provider network rules. "No, [seniors] don't understand provider networks, at least not until the first time they have to pay because they went to the wrong doctor," stated one community representative. A provider voiced concern that sometimes plans give approval to senior enrollees to see the doctor of their choice even if he or she is not in the network, only to refuse to pay the doctor for the visit. Seniors who come to him without an HMO referral will call the HMO and obtain verbal approval for the care, but, this physician asserted, the claims are never paid.

## **QUALITY OF CARE**

### **Care and Access of Medicare Beneficiaries in M+C Plans**

Because of the shortage of specialists there are long waits for both HMO and non-HMO patients to see a doctor. Seniors enrolled in HMOs may be particularly disadvantaged in terms of access to specialists. First, these specialists may favor original Medicare patients because of higher FFS reimbursement levels. Second, Medicare HMOs hold contracts with only some of the specialists in the community. Seniors enrolled in M+C plans described waiting 3-6 months to see a dermatologist. One community informant stated, "the way to get in to see a doctor in Tucson is to show up at his office and to cough on his receptionist."

As noted above, informants were especially concerned that PacifiCare does not have enough contracting specialists to meet the needs of its membership. The lack of specialists in the HMOs' networks is particularly troubling because we were told that primary care physicians are less willing to make the effort to ensure that their patients gets a timely referral. One provider we spoke with refers his Medicare HMO patients to the HMO when they have trouble obtaining a specialty appointment.

Community informants also perceived the hospital bed shortage to be a more serious problem for M+C plan enrollees compared to FFS Medicare beneficiaries; M+C enrollees are restricted to contracting hospitals for admission. For example, PacifiCare's M+C enrollees are restricted to the plan's "preferred hospital," Tucson Medical Center. With that hospital frequently on divert, beneficiaries, sent to non-preferred hospitals, are forced to pay a deductible of \$150.<sup>26</sup> In addition, PacifiCare does not hold contracts with either

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25 Arizona Daily Star, February 19, 2000

26 Beneficiary interview; this information is available on Medicare Compare for 2001 only.



University Medical Center or Northwest Hospital, further restricting the network of available facilities for members in need of hospital care.



### Access Problems in an HMO

One senior interviewed during the site visit, a member of PacifiCare, described the difficulties associated with the hospital bed shortage and PacifiCare's contracting hospital network. He described how his wife woke up one Sunday morning not feeling well. Their neighbor, a nurse, advised them to go to the hospital because of his wife's high blood pressure. The couple waited five hours at TMC's emergency room only to be told they should go home. The next morning this senior's wife had to be rushed by ambulance to the hospital. TMC was on divert so they ended up at St. Joseph's hospital where this senior was informed his wife had kidney failure. Although he was happy and comfortable with the care his wife was receiving at St. Joseph's, a hospitalist informed him that his wife would be transferred to TMC because she was a PacifiCare member. Although the transfer upset the husband, he ultimately agreed under the condition that her physician would continue to be the final arbiter of her care. His wife was transferred to TMC on a Saturday where her physician informed her that she should not be released until Monday at the earliest to wait for further test results. The next day, Sunday, his wife, despite their doctor's objections, was released. Fortunately, she had an uneventful recovery at home.

### Views on HMO Quality

A number of respondents felt that HMOs have improved the quality of care for seniors. The Health Services Advisory Group, the Peer Review Organization for Arizona M+C plans, felt that plans in the state were doing a good job of improving access by monitoring access and placing a "greater emphasis on prevention" than FFS medicine. PRO spokespersons noted that "HMOs have the infrastructure to improve the quality of healthcare that is delivered beyond [the] FFS [system]."

The Arizona PRO and Medicaid and Medicare HMOs are working cooperatively to improve quality. The Arizona Managed Care Quality Enhancement Program (AMCQEP) is a joint venture based on the idea that that plans should not be competing on quality, but instead work together to improve quality. For example, plans are working on adopting agreed-upon protocols for a number of illnesses and conditions, including the treatment of depression.

Many of our community informants disagreed that Medicare HMOs have led to improved care, arguing that Tucson plans had fallen far short of their potential in terms of quality. One informant felt that M+C plans weren't interested in doing prevention because they weren't sure they would be around next year. We heard that the HMOs don't use screening assessment exams to the maximum extent possible, partially because the large number of solo practitioners make it more difficult to affect provider practices.



It was difficult to differentiate concerns about the quality of health care in M+C plans that were not also related to broader concerns about Pima County's health care system. Indeed, as described by one informant, "What is going on in Tucson in terms of its M+C plans is symptomatic of what is going on in the health care system overall. While managed care may exacerbate some of the problems, it is a symptom and not the cause."

### **M+C Plan Disenrollment Rates**

M+C plan disenrollment rates, considered to be a measure of plan quality, are fairly low in Tucson. In 1999, Intergroup had a 9 percent and PacifiCare, a 12 percent disenrollment rate, percentages under the statewide average of 14 percent. It should be noted, however, that in other communities noted for high-quality M+C plans, such as Minneapolis-St. Paul, disenrollment rates are less than 5 percent.

### **HEDIS/ CAHPS Scores**

Quality information, including "Beneficiary Satisfaction" ratings obtained from CAHPS and "Helping You Stay Healthy" and "About Your Providers" ratings obtained from HEDIS, are available for Intergroup and PacifiCare on HCFA's Medicare Compare web site. On most measures, the two plans received quality scores similar to each other's and to the average for the state. Scores were low in some areas—for example, only 42 percent of Medicare beneficiaries statewide rated their plan as the best possible managed care plan (including 40% of Intergroup enrollees and 42% of PacifiCare enrollees) The same percentage statewide and in Intergroup and PacifiCare rated their own care as the best possible care. Large differentials in quality scores between the two plans were rare, but some did occur: for example, 70 percent of diabetic Intergroup members received an eye exam, while only 54 percent of diabetic PacifiCare members did. But 81 percent of diabetic PacifiCare members received a glucose control test, compared to 69 percent of diabetic Intergroup members. Eighty-two (82) percent of PacifiCare members received a cholesterol test as opposed to 46 percent of Intergroup members.

### **BENEFICIARY RESPONSE TO CHOICE**

Despite the long history of Medicare managed care in Tucson, Medicare beneficiaries are still confused about some aspects of the M+C program. We were told that Medicare beneficiaries frequently do not understand M+C prescription drug formularies. They also do not understand why M+C plan benefits and premiums, as well as availability, vary from county to county. We heard also that original Medicare is confusing to a number of beneficiaries, especially those who have always opted for a Medicare HMO and are now facing the possibility of enrolling in original Medicare for the first time.



Seniors are sometimes confused by the information they receive about Medicare. Health insurance counselors who volunteer for the Pima Council on Aging felt that the “materials provided to seniors about the Medicare program are too complex,” especially for some seniors with cognitive or physical disabilities. One senior counselor commented that “the materials we get from HCFA are too technical, like income tax forms.” Counselors estimated HCFA’s *Medicare and You* handbook was published at a 9<sup>th</sup> grade reading level and thought it should be simplified. Generally, however, counselors emphasized seniors are given too much information, which is frequently overwhelming to them, and that the HCFA materials are not focused enough. Many of the counselors thought education materials about plan options should be designed and provided at the local level.

We heard from Spanish-speaking seniors that materials were available from plans in both Spanish and English. One plan representative explained that the plan was trying to establish a database of its enrollees who are monolingual Spanish speakers so that materials printed in the Spanish language would be sent out to them automatically. It appeared that seniors wishing to talk with Spanish-speaking plan representatives were able to do so.

One health insurance counselor thought that while the political emphasis is on health care choices, “it is not really choice that seniors want, but security.” Another community informant emphasized his belief that seniors want choice until they get sick, but when they become ill, seniors want a health care system that will be there for them. Another community informant questioned whether choice is real, noting that “many seniors don’t really have the option of walking away from the M+C program [because of their need for prescription drugs], which is essential for any market competition to work.”

Nor was the added choice of the new M+C product—Sterling, the Private-Fee-for-Service plan—viewed as positive by many community representatives. Community informants indicated there was confusion about the Sterling Plan and expressed little optimism that this choice would become a viable alternative for seniors. At the time of our visit, Sterling hadn’t made any information about its product available in writing. Nor are private insurance agents marketing the plan. Information about Sterling and who to call are coming from HCFA and the Arizona SHIP. Several seniors in our focus groups had heard about Sterling from a presentation by the Area Agency on Aging, but registered a level of distrust about the new plan. Said one senior “we don’t trust them. They are not local. I think they are from Washington State and we have no idea how long they will be here.” There is also a lot of confusion about Sterling in the provider community. A representative of the Pima County Medical Association stated he had received no response to his inquiries about the plan. It seems likely that the first area physicians will learn about Sterling is when a beneficiary in the plan shows up at their office.



Sterling is charging a \$65 a month premium and offers no drug coverage. There was speculation that Sterling wouldn't be competitive with the two remaining M+C plans in Tucson that still offer a prescription drug benefit with small or no premiums. However, some observers believed that Sterling was more likely to pick up membership among seniors and the under-65 disabled living in rural areas that have no access to HMOs. Informants questioned whether Sterling could survive under these circumstances because enrollees were more likely to have high health risks. Unlike Medigap insurers, Sterling must enroll under-65 disabled Medicare beneficiaries.

## THE FUTURE OF M+C PLANS IN TUCSON

We heard from several providers, community and plan representatives who were concerned that the two remaining Tucson plans—PacifiCare and Intergroup—would be unable to remain in the market after next year. Almost everyone we interviewed was quite pessimistic that unless there are substantial increases in the Medicare payment rate, no plans would remain in Pima County in 2002. However, some interviewees were optimistic that if Intergroup left the M+C market in 2002, PacifiCare might be able to survive because of its large membership and its increased ability to spread risk. Others worried that PacifiCare would face financial problems because its coverage of brand-name drugs would attract a disproportionate number of high-cost patients. Whether added BIPA payments made to Tucson HMOs (per member per month payments increased to \$525 from the planned amount of \$509.02 in 2001 as a result of this legislation) will result in a reassessment of plans' decisions to leave the area or reduce benefits remains to be seen.

## CONCLUSIONS

Tucson's health care system is in turmoil. The shortage of some specialists and hospital beds has reached near-crisis proportions, affecting access for all area residents. The Medicare+Choice program may exacerbate these access problems by further limiting provider and hospital choice for M+C enrollees. There is some evidence that the managed care system in Tucson has contributed to medical shortages through contracts which proved to be financially problematic for both medical groups and hospitals. Managed care payment rates to specialists do not appear sufficient to attract these providers to the Tucson community. Hospital financial problems are also the result of Medicare reductions authorized by the Balanced Budget Act of 1997.

Changes in the composition of M+C plans' provider networks has resulted in disruption and insecurity for seniors enrolled in these plans, as has the steady withdrawal of M+C plans in Pima County and the gradual reduction in plan benefits. The most recent round of plan withdrawals affects approximately twenty percent of the seniors enrolled in M+C plans in Pima County. Perhaps even more significant are the reductions in prescription drug benefits offered by the two remaining M+C plans, PacifiCare and Intergroup. Many seniors

were uninformed about the 2001 reductions in benefits. Of those who knew about the benefit cuts, many were concerned about the financial consequences of the reduced drug benefit. Seniors, dependent on M+C plans for their prescription drugs, were also worried that the two remaining plans would leave the area. Community, provider and plan informants were also pessimistic about the future of the M+C program barring significant increases in the Medicare payment rate.

