#2003-07
June 2003

The Medicare Preferred Provider Organization Demonstration: Overview of Design, Characteristics, and Outstanding Issues of Interest

by
Marsha Gold, Sc.D., Mathematica Policy Research, Inc.
Lori Achman, M.P.P., Mathematica Policy Research, Inc.
Jim Verdier, J.D., Mathematica Policy Research, Inc.

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP or MPR.

© 2003, AARP.
Reprinting with permission only.
AARP, 601 E Street, NW., Washington, DC 20049
http://www.aarp.org/ppi

ACKNOWLEDGMENTS

This work has benefited from both the data files from and insight we developed into the Medicare+Choice program and its participating firms and plans through monitoring the program for The Robert Wood Johnson Foundation, The Centers for Medicare and Medicaid Services, The Commonweath Fund, and the Henry J. Kaiser Family Foundation, among others. We are indebted to Joyce Dubow in AARP's Public Policy Institute for providing the opportunity to analyze the Medicare PPO demonstration and prepare this paper. We also appreciate the cooperation and assistance we received from Sharon Arnold and her staff at the Centers for Medicare and Medicaid Services (CMS) in providing access to information on the demonstration, particularly information on out-of-network benefits and risk sharing. We are also grateful for the valuable background and perspective on financial and risk-sharing issues we obtained from several actuaries, including Harry Sutton of Reden and Anders, and members of Mercer Government Human Services Consulting.

At Mathematica Policy Research, Debra Draper provided valuable suggestions on an earlier draft, Daryl Hall and Carol Soble edited the manuscript, and Felita Buckner provided secretarial support. Among the authors, Lori Achman was responsible for the quantitative work that forms the underpinnings of the paper; she also wrote chapters IV and VI and contributed to other chapters. Jim Verdier was responsible for much of the work on payment and risk sharing. As lead author, I take responsibility for any inaccuracies in the paper. Any opinions expressed in the paper are solely those of the authors and not those of MPR or AARP.

Marsha Gold
Senior Fellow
Mathematica Policy Research, Inc.
May 2003

Foreword

Until1997, Medicare beneficiaries had a choice of only two types of plans: the traditional, fee-for-service program and Health Maintenance Organizations (HMOs). The Balanced Budget Act of 1997 authorized the Medicare+Choice program (M+C), in part to introduce additional coverage options to the Medicare program (e.g., Preferred Provider Organizations –PPOs and Medical Savings Accounts—MSAs) so that people with Medicare could select options that were available in the private sector. However, in spite of the legislation permitting them to participate, very few of the newly authorized options have entered the program. At the same time, many of the HMOs that had been participating either withdrew from Medicare entirely or reduced their services areas. Those plans that did remain raised premiums and other charges and also reduced benefits, most notably, outpatient prescription drug coverage. Overall, the M+C program has been marked by considerable instability at the plan level and declining enrollment among beneficiaries.

In addition to shoring up the M+C plan through relaxation of certain requirements, the Administration and others have been actively promoting a greater role for private health plans in Medicare. The plan type that is considered to have the greatest potential appeal to Medicare beneficiaries is the PPO, primarily because it is a less restrictive form of managed care than the HMO and resembles the traditional Medicare program in that individuals can retain their current physicians if they so choose. Notwithstanding its potential appeal to beneficiaries, very few PPO plans signed up under the M+C program to participate in Medicare. Therefore, in January 2003, the Centers for Medicare and Medicaid Services launched a PPO Demonstration Project in an effort to stimulate greater interest among PPO plans in the Medicare program. One key objective of the demonstration was to test alternatives to the current payment rules "which may be more efficient and cost effective without compromising the quality of services."[1]

AARP commissioned this study because PPOs are very likely to become a major coverage option in the Medicare program of the future. Accordingly, we believe it is important to understand how they will work, both for the program and for enrollees. Will Medicare save money under the risk-sharing arrangements in the demonstration? How will beneficiaries fare, particularly those with chronic conditions? How will their out-of-pocket costs compare with other Medicare options? How do their experiences compare with those of enrollees in the traditional program and HMOs? How will insurers respond? Will the contracting terms offered to PPOs induce HMOs to convert to PPO's? This study represents a first look at the CMS demonstration and presents a comprehensive description of the plans participating in the demonstration, including the companies that came forward to participate, the markets they selected to serve, the benefits they are offering, and the premiums and cost-sharing they are charging. Further research is needed as soon as there are lessons from operational experience. Marsha Gold, Principal Investigator, Mathematica Policy Research, Inc., identifies several additional research questions that when answered will provide a better understanding of the effects of PPOs in Medicare. It will be critical to have a clear picture of the advantages and disadvantages of PPOs so that we can understand the implications of relying on this model in a "reformed" Medicare.

Joyce Dubow
Senior Policy Advisor
May 2003

[1] Federal Register/Vol. 67, No.72, April 15, 2002, p.18211.

CONTENTS

EXECUTIVE SUMMARY

I. BACKGROUND AND CONTEXT

As the health care market has evolved, Medicare has attempted to accommodate private health plans that have departed from the traditional fee-for-service model in place at the time of the program's inception. The Health Care Financing Administration (HCFA, now CMS) first turned to cost-based methods to pay for these departures but ultimately used risk-based payment to sponsor private managed care plans (most commonly health maintenance organizations, or HMOs). In areas where managed care plans are available, beneficiaries voluntarily enroll in (and disenroll from) the plans. While such plans are attractive to some beneficiaries, no more than a small minority of beneficiaries (under 18 percent) has ever enrolled in the plans at any one time.

The M+C program—enacted in 1997—authorized the most extensive range of choices ever available to beneficiaries, including PPOs. However, many of the options promised under M+C never materialized. Moreover, enhanced payment rates did little to draw managed care to rural and less urban areas, and plan exit was common. The resulting instability proved troubling to beneficiaries as well as to employers offering M+C plans to their retirees. Accordingly, the current PPO demonstration represents a formal effort by CMS to use the flexibility inherent in its demonstration authority to expand the number of Medicare PPOs available in the M+C program by modifying terms (primarily payment terms) that may, in the eyes of CMS and the industry, be more attractive to private plans.

II. PURPOSE

This paper analyzes the history and major features of the new Medicare Preferred Provider Organization (PPO) demonstration that started in January 2003. Sponsored by the Centers for Medicare and Medicaid Services (CMS), the demonstration aims to expand the range of private health plan choices available to Medicare beneficiaries to include looser forms of managed care—namely, PPOs—that are common in employer-paid offerings. It also modifies certain features of the existing and historically turbulent Medicare+Choice (M+C) program to make it more attractive to private firms.

As policymakers consider how to respond to concerns about M+C and, more broadly, to issues associated with Medicare reform, they will be seeking information on the structure of the PPO demonstration and the lessons it might hold. Several Medicare reform proposals, for example, rely heavily on private plans.

This paper reviews events leading up to the demonstration and the major features of its structure, including the geographic scope of choice, participating firms, benefits offered to Medicare beneficiaries and their associated costs, and payment and risk-sharing methods. To maximize the lessons to be learned from the demonstration, we conclude by discussing what we already know from the demonstration's early stages, the issues that should be monitored as the demonstration progresses, and the implications of the findings to date for proposals Medicare reform proposals. The paper is based largely on public documents and analysis of files we have created from publicly available CMS data.

III. PRINCIPAL FINDINGS

Description of the Medicare PPO Demonstration

CMS solicited applicants for the PPO demonstration in spring 2002, seeking to make awards by August 2002 so that plans would be available to Medicare beneficiaries on January 1, 2003. The demonstration was limited to state-licensed risk-bearing entities. As a result, some large commercial PPOs—those that typically do not bear risk and are not licensed for that purpose—could not apply directly to participate in the demonstration, although they could apply through a state-licensed entity. CMS structured the demonstration with at least three sets of features that it expected might make the demonstration attractive to private plans:

- **Payment levels modified from M+C.** Under the demonstration, plans receive the greater of 99 percent of the fee-for-service payment in each county (the AAPCC or average adjusted per capita cost) or the M+C payment amount. In contrast to the M+C program, plans are not required to submit an adjusted community rate (ACR) proposal for audit. In addition, the actuarial value of the monthly premium and beneficiary cost sharing under the demonstration can exceed the actuarial value of deductibles and coinsurance in the traditional Medicare program. These provisions are intended to address perceived inequities in M+C payment, reduce administrative costs, and provide plans with additional flexibility to accommodate the administratively set premium.

- **Ability to share risk.** Under the demonstration, CMS is willing to enter into risk-sharing agreements with firms; in contrast, M+C plans are fully at risk for the cost of medical services. CMS specified certain features of acceptable risk-sharing arrangements but negotiated details with each firm. Plans were required to assume full risk for administrative costs. As described later, risk sharing between the plan and CMS on medical costs must be symmetric (sharing gains as well as losses).

- **Reduced administrative requirements.** Under the demonstration, CMS offered to reduce some administrative requirements. Ultimately, CMS decided to apply a consistent set of requirements for all demonstration plans. Unlike nondemonstration PPOs, demonstration PPOs are not required to conduct Quality Assurance Performance Improvement (QAPI) projects. These require access to medical records, something PPOs are less likely than HMOs to have. PPO demonstration plans will also be limited to reporting only selected HEDIS/CAHPS[1] performance measures (breast cancer screening and select diabetes care) and information needed by CMS to examine satisfaction with the experience of care. Nondemonstration PPO plans also have a limited number of HEDIS/CAHPS measures to report.

CMS releases indicate that the agency initially selected 17 organizations in 23 states to participate in the demonstration, which ultimately would include 35 plans. Negotiations to finalize contracts have led to minor changes in these numbers. Overall, CMS expects about 150,000 beneficiaries to be enrolled in the demonstration, with premiums likely to fall in the range of those typical of M+C and Medigap plans.

Geographic Scope of the Demonstration

Plans participating in the PPO demonstration will eventually be available to 10.7 million Medicare beneficiaries in 206 counties across the country, though only a small number are expected to enroll. (Almost all of these plans are now available; those not available exclude less than 2 million beneficiaries in 20 counties included in the demonstration.)[2]

Under the demonstration, 31 PPO plans were available as of February 2003 (all but one were available as of January), with four additional plans scheduled to be operational by the end of the year. In some cases, PPOs will compete in the same geographic areas; therefore, the demonstration includes 28 contiguous county areas in which plans will be offered. (In areas with multiple plans, competing PPOs may not be available in all counties.)

In addition, offerings are highly concentrated in areas that already had an existing M+C plan. With the short application time frame, it would not have been realistic to expect networks to be established in new areas. Less than 3 percent of beneficiaries in counties where demonstration PPOs are now or will be offered do not have a choice of a Medicare

[1] HEDIS, the Health Plan Employer Data and Information Set and CAHPS formerly known as the Consumer Assessment of Health Plans Study, are now commonly known only by their acronyms.

[2] These counts exclude additional counties where PPO options are offered only to employer groups. Three contracts provide such employer-only options: (1)Aetna's Pennsylvania PPO contract (H3914); (2) Coventry's Illinois/Missouri contract (H1412); and (3)Coventry's Ohio/West Virginia contract (H3615). Employer group-only options are particularly extensive in Coventry's plans, especially in West Virginia. Medicare Compare does not include information on employer-only group products, and CMS materials typically do not refer to this component of the demonstration.

coordinated care plan (CCP). In fact, more than 60 percent of Medicare beneficiaries in counties where a PPO demonstration plan is already available have three or more CCPs. Firms, under the demonstration also have favored markets with a more stable M+C history. Therefore, firms participating in the demonstration appear to be less interested in operating in new markets than in developing a product that will be attractive to those in markets favorable to managed care who already have the option of enrolling in a M+C plan but elect not to do so.

Though demonstration sites in many ways mirror the areas offering M+C, demonstration PPOs are disproportionately concentrated along the East Coast and much more limited on the West Coast, where M+C is a strong presence. Despite payment rates on the East Coast that in some cases parallel those on the West Coast, PPO sponsors might perceive the more loosely structured PPO as more consistent with the style of delivery and beneficiary preferences along the East Coast, where M+C penetration has lagged. (Commercial HMOs also are more dominant on the West Coast.)

Profile of Plan Sponsors (Participating Firms)

For the most part, the 17 firms participating in the demonstration are diverse types of health insurance or managed care organizations. Four are provider organizations or provider-sponsored organizations.

Of the 17 firms, all but one operated an M+C contract in 2002. The exception is Group Health, Inc. (GHI) in New York, which offers a Medicare PPO product in New York City and two surrounding counties. With its base of Medigap products and group retiree accounts (including New York City employees), GHI may be aiming to offer a looser and potentially more attractive product for its group accounts while providing a lower-priced alternative to its Medigap products. (New York City has also attracted two other firms offering PPO products there.)

All but two of the seven national firms that account for more than half of M+C enrollment will participate in the demonstration in some form—PacifiCare, UnitedHealthCare, Humana, Health Net, and Aetna. Kaiser Permanente—with a prepaid group practice model that is less suited to PPOs—and Cigna—which has greatly reduced its role in M+C—are not participating. Other firms participating in the PPO demonstration tend to be more locally based. The firms' responses to the solicitation probably reflect their reluctance to ignore a potential new product line for the large and still-growing senior market.

However, firm strategies appear to differ with respect to product offerings. UnitedHealthCare, for example, offers the most extensive set of products (10 of the PPO demonstration's current 31 products), whereas Humana offers only one product. Firms also appear to be structuring their benefits in ways that may reflect an interest in targeting different groups (e.g., group accounts versus the individual market).

In addition, although the demonstration has attracted few firms new to M+C, it appears to have acted as a vehicle for existing M+C participants to diversify their product line and

further their strategic objectives. If policymakers are to benefit fully from the demonstration's lessons, they will need to be mindful of the participating firms' diversity, the range of markets they serve, and the distinct PPO products they offer. That is, demonstration experience may differ across the firms, markets, and products. Looking at the experience of subsets of demonstration plans could provide valuable insights into the conditions under which PPO products may or may not thrive in Medicare.

PPO Benefits and Premiums

Most PPOs in the demonstration appear to have carved out a niche in the Medicare market that permits them to attract individuals with the means to support higher premiums than those charged by traditional Medicare+Choice plans. (Group accounts as well as individuals are likely to be targeted.) Though PPO products will offer beneficiaries the flexibility to seek out-of-network care, products generally are designed to encourage enrollees to use in-network providers. Benefit structures vary, but the following facts provide a sense of the products offered:

- Under the demonstration, the average premium in 2003 is $84 per month for "basic plan options" (lowest-premium plan option when more than two plan options are offered by a plan in the same area) and $92 per month for all plan options. Five of the 31 PPO plans established in contracts effective February 1, 2003 offer multiple plan options. In total, the demonstration accounts for 43 basic (lowest premium) plan options and 53 total plan options. Despite some exceptions, premiums for PPO plan options are substantially higher than premiums for M+C products in the same markets.

- Though almost 80 percent of the offered plan options cover prescription drugs, 77 percent of the options limit coverage to generics only. As with M+C, annual limits are common, particularly when brand-name drugs are covered. Thus, drug coverage will continue to be a highly limited offering, especially if individuals enroll in the PPO on their own. (Employers may and often do supplement benefits in plans offered through a group.)

- Coinsurance is common in out-of-network benefits under the demonstration. Typically, the beneficiary is required to pay 20 percent of the plan's payment to out-of-network providers for physician and specialty care and for inpatient hospitalization. Some, but not all, of the PPO demonstration plans apply an out-of-pocket limit on cost sharing for out-of-network benefits, though the limit is typically much higher than for in-network benefits. (Beneficiaries are also usually responsible for fees higher than those paid by the PPO to out-of-network providers up to the Medicare limiting amount.) These provisions are similar to those in indemnity benefit packages and commercial PPOs. In-network cost sharing, in contrast, more typically involves fixed-dollar copayments, although the amounts can add up in some plans.

Payment Methods and Risk Sharing

Under the demonstration, payment in most counties is at the M+C level. However, the rate will be 99 percent of AAPCC (the local average traditional program cost) in 41 of the demonstration counties, which is where about a quarter of the Medicare beneficiaries in demonstration counties live. Twelve of the 41 counties paid this way are located in New Jersey. On average, the payments are 5 percent higher than M+C payments. While the option of 99 percent of the AAPCC appears not to have been a major incentive for participation in the demonstration, it could have expanded offerings in particular counties.

For the most part, the opportunity for firms to share risk with the federal government, rather than absorbing it entirely on their own, appears to be an attractive feature of the demonstration. Of the 17 participating firms, only five are assuming all the risk. (Risk-sharing arrangements are the same firmwide across affiliated plans; CMS asked for such uniformity in a firm but allowed firms to vary the medical loss ratio across their plans.)

Certain features are common to all risk-sharing arrangements. (CMS is sharing risk only for medical expenses, not for administrative costs.) Risk sharing is therefore specified in terms of gains or losses from a target medical loss ratio (the percentage of premium revenue that goes to fund health benefits). Risk sharing must also be symmetrical (gains and losses shared equally). Under all arrangements, plans are at risk for plus or minus 2 percentage points around the target medical loss ratio. The lowest amount of risk carried by a plan beyond the 2 percentage points differential arrangement is 20 percent of gains or losses outside that range; in practice, greater risk is common.

How easily CMS and plans will be able to reconcile revenue and expenses related to risk sharing in the 12 months after the close of the contract year should be monitored. Though commercial contracts also typically exclude risk sharing for administrative expenses, actuaries informed us that the structure of such contracts is often less detailed and more focused on protection from large losses, making retrospective adjustments less crucial to ultimate plan revenue.

While risk sharing therefore offers CMS (and firms) opportunities as well as losses, its full effect cannot be assessed until we have more information on who enrolls (e.g., a current M+C enrollee or not, group versus individual enrollment, and so forth) and how well plans manage care to meet their targeted medical loss ratio. Presumably, estimates of the effects of risk sharing are likely to be sound if they are developed by plans with more experience with Medicare and in the particular geographic markets where products are already offered.

Unfortunately, firms consider individual risk-sharing arrangements as proprietary; consequently, CMS is not releasing information about the firms to which the arrangements apply or the details of the arrangements associated with them. Without firm-specific information on the particular risk-sharing arrangements in place, it is difficult to interpret fully the implications of different benefit designs and what they imply about the strategies

firms pursue in the demonstration. Under the CMS demonstration, evaluators will speak with individual firms about these issues, perhaps leading to additional insights later .

IV. CONCLUSIONS

In sharp contrast to the experience with many previous Medicare managed care demonstrations, CMS has mounted a major payment demonstration over a short period and with a high degree of plan participation. This achievement is due, in large part, to the fact that the CMS administrator has indicated, to the extent feasible under the law (Scully 2002), an interest in working closely with private health plans to understand their concerns more fully and to structure payment arrangements that are congruent with key business practices.

Such an accomplishment, however, does not come without risks. Given the time frame in particular, CMS had little opportunity to review applicants' qualifications. The fact that this could have opened the door to unqualified participants could have both impeded demonstration success and jeopardized care for vulnerable Medicare beneficiaries. Yet, by establishing qualification criteria that required state licensure and stressed a firm's infrastructure and relevant experience, CMS sought to protect against risks to beneficiaries that would have undermined the demonstration. The fact that most firms have been involved in M+C also provided reassurance, though participation in M+C was not required. The downside, of course, is that the same selection criteria that minimized risk also may have limited CMS's ability to draw new firms or coverage enhancements into areas of the Medicare market in which choice is limited.

Indeed, the data presented in this report show that the demonstration has attracted a diverse group of firms offering PPO plans in a range of geographic areas. These products provide a possible alternative to beneficiaries seeking broader access to providers than is typically available in M+C HMOs and lower costs than are typical in many Medigap products. The demonstration has not, however, attracted new firms or elicited firm interest in products that would be available in areas where managed care has not already taken hold under the M+C program. But such an outcome is not surprising in light of M+C (and earlier Medicare risk) experience. For instance, it has proven to be exceptionally difficult to establish managed care models in rural and generally less urban areas.

It is not clear whether CMS structured the demonstration to generate such offerings in rural and other similar areas that do not already have extensive M+C offerings. Moreover, a three-year demonstration that begins less than six months after award is unlikely to draw applications for network-based products if a network needs to be established from scratch. In addition, by requiring plans to engage in risk sharing (and to demonstrate associated state licensure), CMS probably precluded participation by many major PPOs that had no Medicare experience and that, absent state licensure, were unable to contract directly with CMS. At the same time, plans without experience in risk arrangements may be less likely to have developed systems to manage risk and care. As a result, they may have little to add to CMS's already strong ability to set prices in ways that encourage cost containment.

Implications of Experience to Date

The demonstration experience is valuable for policymakers considering Medicare reform proposals that would use a new benefit (such as drug coverage) to attract beneficiaries from traditional Medicare to private plans. In particular, the products offered under the demonstration are testing various combinations of benefits and cost sharing in ways that are likely to build a richer understanding of beneficiary preferences, including the trade-offs beneficiaries make between provider choice (in-network and out-of-network benefits) and price.

Early experience with the demonstration's enhanced choice is not encouraging with respect to reducing the proportion of beneficiaries without supplemental coverage or alleviating the financial uncertainty of beneficiaries facing burdensome drug costs. While lower than Medigap premiums, PPO premiums under the demonstration are still high—a large share of beneficiaries must therefore pay approximately $1,000 a year or more. Even though the premiums could still attract some moderate-income beneficiaries unable to afford Medigap yet not wanting to relinquish provider choice in favor of an M+C plan, the demonstration products seem particularly likely to appeal to those already covered—either through an employer or their own Medigap coverage—thereby doing little to increase the proportion of beneficiaries without supplemental coverage.

In addition, while most demonstration plans include some drug coverage (an improvement over Medicare-only coverage or Medicare coverage with the Medigap plans in which most beneficiaries are enrolled), the PPO plans offer much less extensive coverage than that offered through common group benefits. Typically, the drug coverage offered by the PPO demonstration plans is restricted to generic drugs. In addition, many plans impose an annual limit (often $500 per year) on such coverage. Both premium prices and drug coverage policies provide additional evidence that choice, however valuable, is not a substitute for an expanded Medicare benefit package.

Issues to Monitor as the Demonstration Proceeds

The CMS-sponsored evaluation of the Medicare PPO demonstration should provide insight into the factors that influence beneficiary and plan interest in products, demonstration costs, and other areas. For instance, it will be important to monitor the number of beneficiaries who enroll in the products because this information will help to reveal how attractive PPO plans are to Medicare beneficiaries. CMS assumes a limited scope for the demonstration—150,000 enrollees from markets that include more than 10 million beneficiaries, implying CMS expected only moderate interest. (In April 2003, 58,000 were enrolled in the demonstration, most of them in New Jersey.)

As the demonstration proceeds, it also will be important to develop information on its cost effects, including Medicare expenditures for demonstration plans and out-of-pocket costs incurred by beneficiaries enrolled in the plans. By statute, CMS demonstrations must be budget neutral. However, the ultimate cost effects of the demonstration will depend on what transpires with regard to (1) payment rates in counties with the highest enrollment; (2) who enrolls, which will tell us whether the risk adjustment methods have left any selection

bias unaddressed; and (3) the extent to which PPOs can manage costs better relative to the plans in which beneficiaries were previously enrolled (especially traditional Medicare). Obviously, better management will reduce not only losses but also CMS exposure as a result of the demonstration's risk-sharing arrangements.

Beneficiaries' previous form of coverage (e.g., Medigap, employer supplement, M+C) will likely determine the "winners and losers" under the demonstration. Winners could be individuals who have a Medigap policy, experience lower premium costs in the PPO demonstration plans, and are satisfied with the PPO product. Those in employer-paid plans, however, may lose out to the extent that employers retain any savings arising from retirees' enrollment in the PPO demonstration instead of passing them along to retirees. On the other hand, these beneficiaries could gain if such savings induce employers otherwise inclined to reduce or drop retiree coverage to continue offering such coverage. If the demonstration draws heavily from beneficiaries already enrolled in M+C, CMS could experience losses, especially if those beneficiaries making the switch are sicker (more expensive) and enrolled in plans associated with firms that share risk under the PPO.

Historically, CMS has had little information on the source of M+C enrollment, that is, whether beneficiaries are enrolled individually or through employer groups although efforts have been made recently to gather more of this kind of information (G.R. Hileman et al. 2002). While most group enrollees in M+C plans are enrolled through products also available to individuals, some have recently enrolled through plans available only to employer groups. To fully understand the demonstration, it will be important to collect data that indicate whether enrollment is group-or individual-based as well as the source of the product. Information of this type is likely to be collected in the CMS evaluation (through surveys and interviews), but it also would be useful for CMS to provide more information on these issues through its traditional public data sources.

Relevance to Current Debate on Medicare Reform

The demonstration experience to date reinforces the fact that managed care models—whether HMOs or PPOs—tend to be easier to develop in urban areas than in rural ones and that, even in urban areas, their market strength varies. Current and earlier PPO demonstration experience highlights the long lead time needed to develop new products and offerings, particularly when they require creating new networks either in new areas of the country or by firms new to the market.

Accordingly, Medicare reform proposals that call for managed care models should not assume that reforms will be feasible nationwide. Even where reforms do prove feasible, implementation may require substantial lead time as well as a great willingness on the part of CMS to work closely with potential contractors to agree on terms that meet business needs. Determining what it feasible and where may involve trade-offs between these terms and beneficiary needs; an example could be waiving ACR requirements and actuarial tests.

In addition, the demonstration experience to date reinforces the importance of adequate funding for any expansion of Medicare benefits, whether in the traditional program or under

a competitive model offering different types of private health plans. It is instructive that the demonstration PPOs generally charge higher premiums than do HMOs. While demonstration PPO benefits are not uniformly less generous, and cost sharing in some PPOs is higher (at least for in-network care) than in HMOs, it remains true that, even on a shared-risk basis, the ability of demonstration plans to offer more benefits without increasing premiums has been modest. Clearly, adequate financing is therefore important not only to the feasibility of supporting benefit expansion but also to the ability to structure competitive models that will be attractive to private plans.

TABLES

FIGURES

CHAPTER I

INTRODUCTION

The Medicare Preferred Provider Organization (PPO) demonstration is intended to expand the choices available to Medicare beneficiaries by modifying some federal policies that, according to people associated with private managed care plans, limit participation in Medicare+Choice (M+C). The demonstration began on January 1, 2003. Though it is still far too early to assess the demonstration, policymakers are interested in knowing more about it, including which private firms it has attracted and in which types of markets, which plans are available to beneficiaries, how demonstration plans are paid, and other features that may inform the Medicare policy debate now and in the future.

Policy interest in the demonstration is especially intense because Congress is considering how to respond to Medicare beneficiaries' concerns about the limitations in Medicare's current benefit package—particularly the exclusion of most outpatient prescription drugs. In addition, some in Congress are interested in "reforming" Medicare by making it resemble the private sector. Some proposals, including the plan described by President Bush in his January 2003 State of the Union address, rely heavily on private plans to deliver such benefits.

Proposals to increase the involvement of private plans in Medicare are controversial not only because they involve a fundamental restructuring of the Medicare program but also because they appear, at least on the surface, to be inconsistent with recent experience with private plans in the M+C program (Gold 2001a; Gold 2003). In particular, M+C has failed to draw in significant numbers of the less heavily managed M+C products (like PPOs) authorized by the Balanced Budget Act of 1997, which initiated M+C. In addition, despite "floor payments" generating higher payment rates that are designed to encourage plans to participate in rural and less highly paid urbanized markets, such options have failed to materialize. Further, many plans have withdrawn from the M+C program while M+C premiums have increased and available benefits have eroded over time. Beneficiaries, as well as employers that purchase group coverage, have found this instability not only unsettling but also at odds with continuity of coverage and care. Accordingly, policymakers are especially interested in current PPO demonstration experience and what it may be able to tell

us about using private plans in Medicare under circumstances that are slightly different from those in M+C.

PURPOSE AND METHODS

This paper describes and analyzes the Medicare PPO demonstration. Its intent is to help policymakers understand the demonstration's features, draw early lessons, and identify questions that may be important to consider as the demonstration proceeds. Chapter II places the demonstration in the context of Medicare's history with health plan contracting. Chapters III through VII describe the demonstration (chapter III) and the PPOs offered under the demonstration, including the demonstration's geographic scope (chapter IV); plan sponsorship (chapter V), premiums, benefits, and cost sharing (chapter VI); and payment methods and risk sharing (chapter VII). Chapter VIII draws on previous chapters to answer questions that can be addressed at this stage of the demonstration and to consider potential lessons to be learned and questions to be asked as the demonstration progresses.

The paper is based largely on available documents on the demonstration we have obtained from public sources or, to a limited extent, from Centers for Medicare and Medicaid Services (CMS) staff. We draw on the extensive literature on Medicare's history with private plans and on evaluation studies, and we take advantage of data files we have constructed for other projects that are monitoring M+C.[1] These files merge CMS data on beneficiaries, plans, and enrollment across the nation. Benefits data are based on files from Medicare Compare. To gain insight into health plans' perspective on the financial and risk-sharing incentives underlying the program, we also talked with a few actuaries who consulted with firms that considered the PPO demonstration.

The paper is limited in at least two ways. First, while CMS cooperated in making information available, we did not have access to CMS's internal information on the demonstration, such as project applications, contracts, and budget estimates. Absent, for example, is applicants' narrative describing what they sought to accomplish or how their particular delivery systems are structured and how their networks compared with any other products offered by the same firm. CMS provided a summary of risk-sharing arrangements but not, for proprietary reasons, the names of the firms to which the arrangements applied or the specific terms of the arrangements. CMS has sponsored an evaluation of the PPO demonstration that includes an early report on the demonstration features. Some of the detail absent from this report may be included in the CMS report. Second, the demonstration is just now underway, so, it is far too early to assess beneficiaries' interest and level of enrollment in the plans offered under the demonstration or the sustainability of interest among participating plans.

[1] The Robert Wood Johnson Foundation, the Centers for Medicare and Medicaid Services, and the Henry J. Kaiser Family Foundation contributed to development of the databases used in this report. The Commonwealth Fund supported development of data from Medicare Compare.

DEFINITIONS OF TERMS

Readers may find the following definitions useful in understanding the types of entities involved in the PPO demonstration (see box).

Definitions of Terms Used in the Report on the Medicare PPO Demonstration

Firm or Sponsor: The organization that "owns" or sponsors the plans participating in the PPO demonstration. A given firm may sponsor one or more PPO plans in different geographic areas.

PPO Demonstration Plans: The individual plans offered to Medicare beneficiaries under the demonstration. Defined this way, PPO demonstration plans are the same as contracts under the M+C program. A PPO demonstration plan is a network-based product that includes a distinct, geographically contiguous service area comprising one or more counties. A given firm or sponsor may contract for one or more PPO demonstration plans. PPO demonstration plans have contracts with CMS and can offer multiple plan options (see below) with different benefits.

Product: Sometimes "product" is used interchangeably with plan, particularly when the firm sponsoring a PPO demonstration plan also sponsors an M+C HMO in the same area. In this case, the HMO and PPO demonstration plan are separate products for the Medicare line of business of the plan.

PPO Demonstration Plan Options: A plan option is a package of covered benefits, defined by a plan and offered to Medicare beneficiaries in a given geographic area. The plan option specifies the benefits, along with cost sharing that applies for in- and out-of-network services and a premium paid by the beneficiary. (This premium is in addition to the standard Medicare Part B premium.) Most PPO plans in the demonstration offer only one plan option. Others offer more than one, allowing beneficiaries in a given geographic area to choose the benefit package and associated premium that best meets their needs. In describing the benefits covered by PPO demonstration plans, we distinguish between a "basic option," which is either the only option or the option with the lowest premium offered by a plan, and "all options," which include all benefit packages.

SOURCE: Mathematica Policy Research, Inc.

CHAPTER II

CONTEXT: MEDICARE'S HISTORY WITH PRIVATE PLANS

As the marketplace has evolved, Medicare has attempted to accommodate to a changing environment. In particular, the program has sought to provide a role for some types of private health plans that departed from traditional fee-for-service delivery (particularly health maintenance organizations, HMOs). Enrollment in such plans has always been voluntary. Further, only a small minority of Medicare beneficiaries has ever participated in HMOs, which for a long time were the only type of private plan offered in Medicare. In fact, HMOs remain the predominant type of private health plan in the program.

This chapter briefly reviews Medicare's history with private plans, including the circumstances leading up to the M+C program, experience under that program, and the concerns that underlie development of the current Medicare PPO demonstration. Appendix A provides a more extensive description and analysis of this history.

EARLY HISTORY

The original Medicare program was structured to resemble health insurance arrangements common when Medicare was enacted in 1965: a basic indemnity health insurance plan covering institutional (mostly hospital) services—Part A and physician (and other professional) services—Part B (Gold 2002). Administered by the federal government, the nationwide insurance program offers a uniform set of benefits for a standard premium. From the outset, private contractors provided administrative support for claims payment and oversight. Though the program has evolved, the basic structure of today's Medicare is in many ways similar to that at the time of the program's original conception.

Over time, policymakers have made some accommodation for alternative forms of care delivery. In the early years (1966–1979), Medicare reimbursed private plans on a cost basis—first through prospective payment under Part B and, after 1972, on a reasonable cost basis as Group Practice Prepayment Plans (now Healthcare Prepayment Plans) (Rossiter 2001). The intent was to allow beneficiaries to continue the same care arrangements with Medicare as they had with private employer-paid coverage to Medicare.

As HMOs became more common in the late 1970s, Medicare began to experiment with risk-based (capitated) methods of paying private plans.[1] A 1980 Medicare capitation demonstration started with seven plans; a National Medicare Competition Demonstration with 27 plans operated between 1982 and 1985. Evaluations of the demonstrations showed that they saved money (largely by reducing inpatient use) and provided about the same quality of care as the traditional Medicare program. In addition, surveys indicated some reduction in overall enrollee satisfaction compared with fee-for-service care, with greater satisfaction with costs but less satisfaction with choice of physician (Rossiter 2001). However, some plans engaged in abusive enrollment and marketing practices, particularly in the south Florida market, where the federal government terminated the contract of a large HMO (Rossiter 2001).

THE MEDICARE RISK CONTRACTING PROGRAM

The Medicare risk program—authorized by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982—provided permanent authority for HMOs to participate in Medicare. As before, enrollment under the Medicare risk program was voluntary. Beneficiaries who did not elect to enroll in an HMO remained in traditional Medicare. The risk contracting program required plans to return any additional savings (beyond the 5 percent automatically retained by the federal government) to beneficiaries in the form of more benefits or lower premiums. The former included coverage for cost sharing and formerly noncovered benefits, such as various preventive services, eye and hearing care, and prescription drugs. The added benefits or savings were the main incentives for beneficiaries to join a private plan.

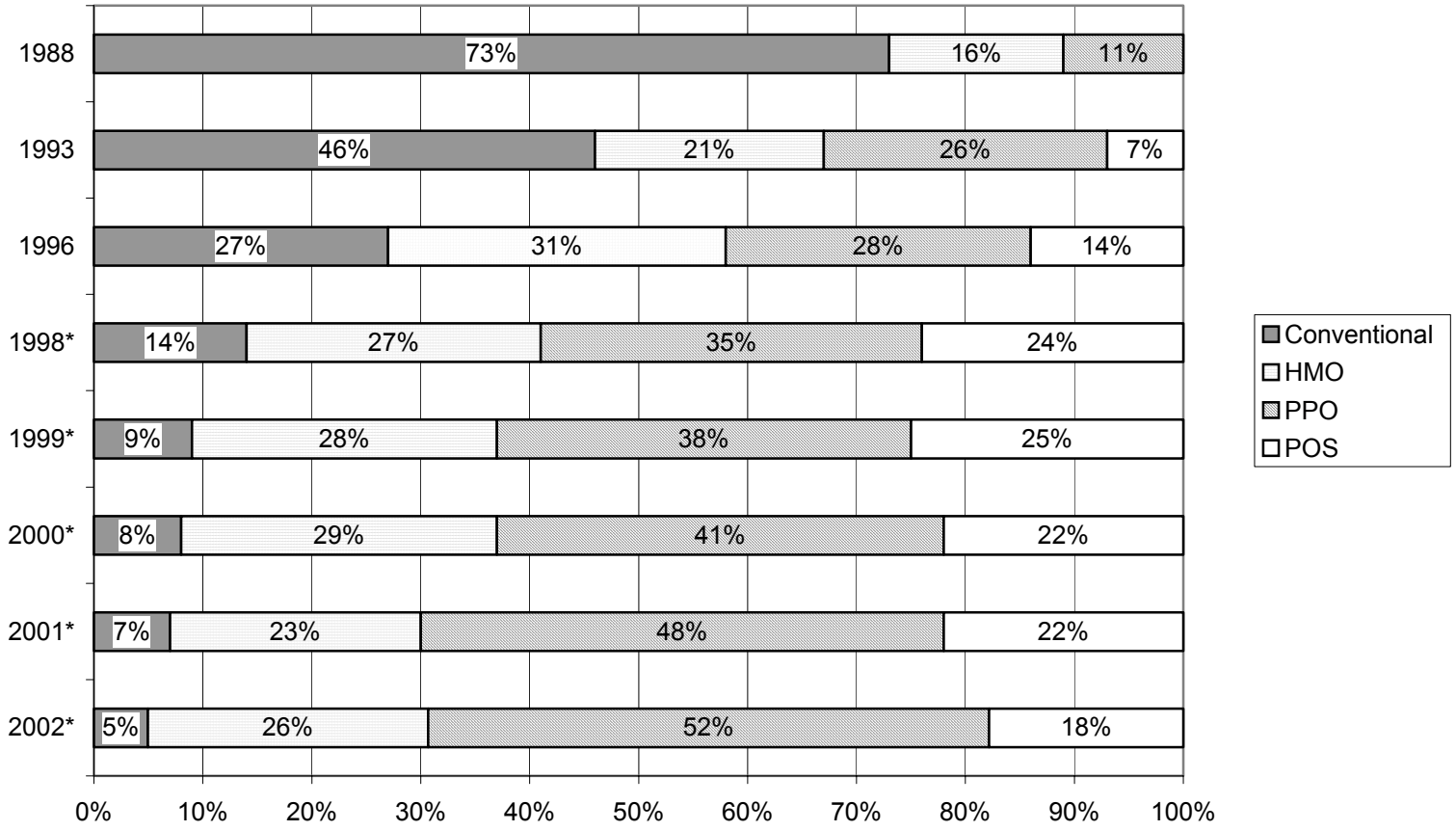
A Health Care Financing Administration (HCFA, now CMS)-sponsored evaluation of the Medicare risk program found that beneficiaries in HMOs received care of comparable quality to that received by beneficiaries in traditional Medicare. In addition, beneficiaries reported substantially lower out-of-pocket costs and enhanced benefits. However, while HMOs used fewer resources, the federal government did not save any money over fee-for-service care because the capitation system did not account adequately for the better health status of those who enrolled in the risk program (they used fewer services on average than did those in the traditional program) (Brown et al. 1993).

In the late 1980s, as employers attempted to control costs by offering HMO coverage, managed care expanded rapidly in the private market. Seventy-three percent of all active workers with insurance coverage were enrolled in conventional indemnity plans in 1988; the number declined to 46 percent by 1993, 27 percent by 1996, and 5 percent by 2002 (see figure II.1).

[1] By paying HMOs a fixed premium per member per month--regardless of the actual use of health care (capitation)—plans had no incentive to overuse services as they might have with fee-for-service payments.

FIGURE II.1

HEALTH PLAN ENROLLMENT FOR COVERED WORKERS, BY PLAN TYPE, 1988-2002



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996, 1998

*Distribution is statistically different from the previous year shown: 1996–1998, 1998–1999, 1999–2000, 2000–2001, 2001–2002.

To learn more about contracting with a range of managed care plans, HCFA used its demonstration authority in mid-1995 to create the Medicare Choices demonstration (Frazer et al. 1999). The demonstration encouraged development of new types of managed care organizations and products as well as new risk-based methods of payment. HCFA selected nine geographic areas where conditions favored managed care but where Medicare risk contracting had little or no presence. The demonstrations encouraged applicants to include rural areas within their service area; three of them drew substantially from rural areas.

Of the 13 demonstrations, 12 were sponsored by providers and one was sponsored by an insurer. Most offered HMO products, but three offered other forms of managed care alone or in addition to an HMO product.

Evaluators concluded that while the demonstration attracted plans that would not qualify under the Medicare risk-contracting program, demonstration participants nonetheless required substantial assistance in understanding and meeting requirements; collecting encounter data from providers was a particular problem for plans in the demonstration. In addition, establishing provider networks in rural areas proved to be challenging (Frazer et al. 1999).

THE MEDICARE+CHOICE PROGRAM

In an effort to expand Medicare enrollment further in managed care and other private plans, Congress enacted the M+C program (Christensen 1998) as part of the Balanced Budget Act (BBA) of 1997.

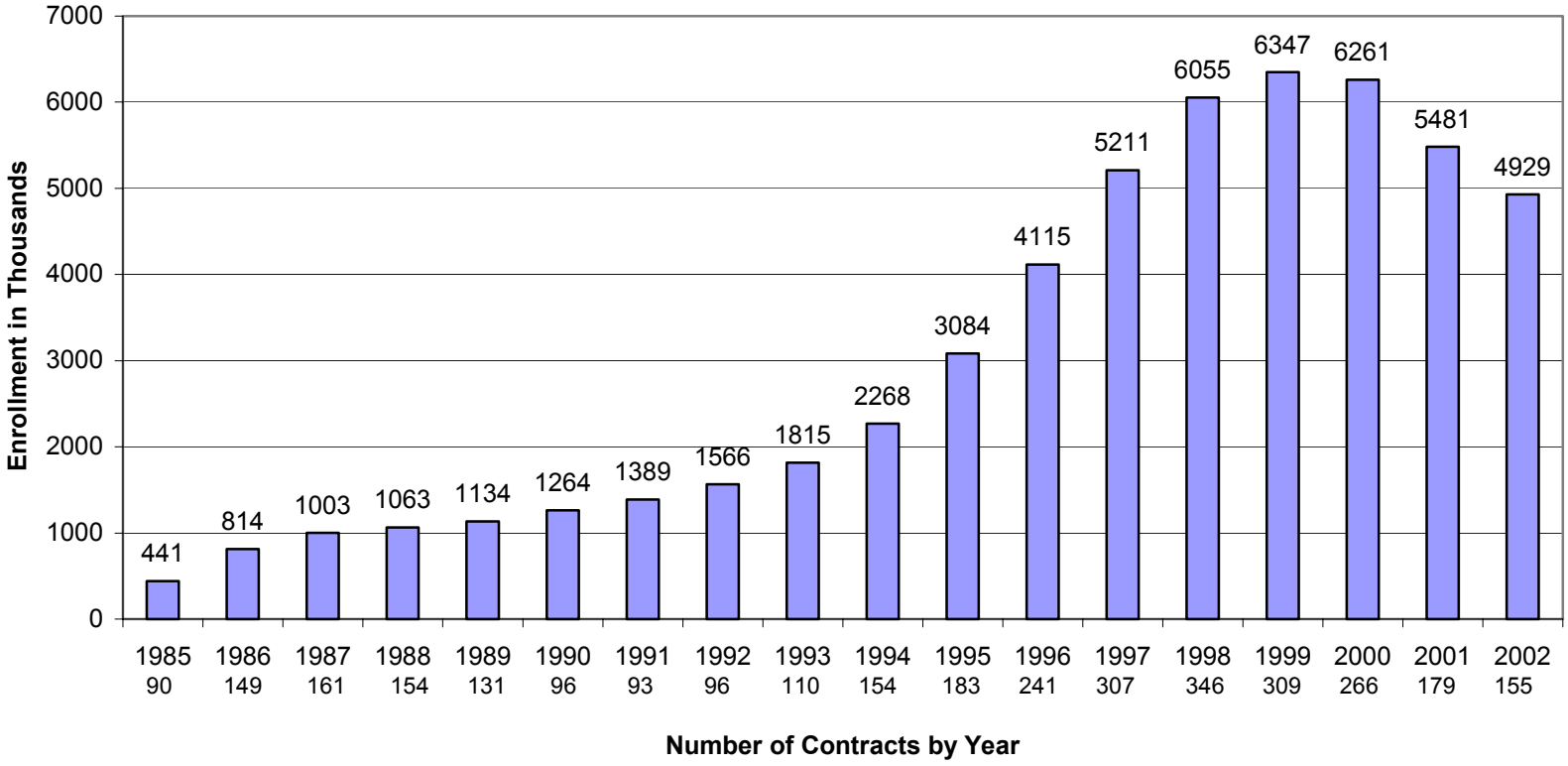
The program incorporated existing Medicare risk contracting programs and authorized a range of new plan options. One major feature was the coordinated care (i.e., managed care) program (CCP), which offered Medicare beneficiaries a choice of managed care plans. In addition to HMOs, the act provided for (1) PPO plans that allowed beneficiaries more opportunity to seek out-of-network care at higher cost-sharing levels and (2) provider-sponsored plans (PSOs) that encouraged provider organizations to sponsor their own managed care plan rather than merely contract with available HMOs and PPOs. Beyond the CCP options, the M+C program authorized (1) private fee-for-service plan indemnity offerings that did not restrict the beneficiary's access to providers and (2) limited enrollment in Medicare Savings Accounts (MSAs) with high deductibles.

Again, beneficiary enrollment in M+C plans was voluntary, and, as under the original Medicare risk contracting program, the federal payment formula was set by statute. HCFA paid M+C plans an administered price set with reference to Medicare fee-for-service spending. The amounts varied across counties to encourage enrollment in less heavily penetrated counties. The main incentive for beneficiary enrollment was more attractive benefits and/or premiums.

The M+C program has failed to meet expectations for expanded choice and enrollment growth (Gold 2001a) (see figure II.2). Only a few private fee-for-service plans are available, and enrollment remains low; no MSAs exist. Among coordinated care options, only of the

FIGURE II.2

MEDICARE RISK/MEDICARE+CHOICE ENROLLMENT, 1985–2002



SOURCE: Mathematica Policy Research (MPR) analysis of HCFA's Medicare Managed Care Contract Plans Monthly Summary Report

NOTE: All data are from December. Data for 1999–2002 are for enrollees in Medicare+Choice Coordinated Care Plans (CCPs). Data for earlier years are for enrollees in Medicare risk contracts.

155 contracts involve PPO products, and the one provider-sponsored plan has had an unstable history in the program. While new options, including PPOs, failed to materialize, plans already in the M+C program began to withdraw in 1999. Between 1999 and 2002, more than 2.2 million beneficiaries lived in counties where at least one of the plans withdrew from the program either entirely or from that county (Gold and McCoy 2002a).[2] Enrollment in private plans continued to grow briefly (reaching a high of 6.3 million beneficiaries in 1999), but the rate of growth slowed and ultimately reversed.

Instability in the plans offered to Medicare beneficiaries has been a major issue among policymakers and a concern to employers who offered M+C options to their retirees or were considering doing so. The M+C experience highlights the importance of minimizing instability but also points out the concomitant challenges (Gold 2001a; Gold 2003).

The M+C experience reinforces earlier experiences associated with attracting plans to rural areas, especially given that only 21 percent of beneficiaries in rural areas had access to a plan in 2000 (MedPAC 2001b). Under M+C, Congress guaranteed plans a minimum county payment of $367 in 1998, rising to $415 in 2001. In March 2001, Congress increased the "floor" payment to $525 in large urban areas (defined as 250,000 or more persons) and $475 elsewhere, but the increases were not sufficient to offset the barriers to developing managed care in rural areas and other markets inhospitable to managed care.

To counter criticism of the M+C program, Congress has made various incremental changes to the program (Gold 2001a). In 1999, the Balanced Budget Refinement Act (BBRA) relaxed the quality requirements for PPOs, for example, and authorized "new entry bonuses" to encourage organizations to enter areas without M+C. In 2002, the Benefits Improvement and Protection Act (BIPA) raised payment rates to M+C plans, particularly in lower-paid areas.

Because many of its provisions are set in statute, CMS has only limited authority to modify the M+C program in response to industry concerns. However, national firms report that CMS has been receptive to addressing administrative problems when feasible (Draper, Gold, and McCoy 2002). In late 2001, for example, the CMS administrator encouraged plans that were considering a 2002 withdrawal to talk with staff about ways of staying in the program and exploring how CMS could use its demonstration authority to provide needed flexibility.[3]

[2] Withdrawals continued at a slower rate in 2003.

[3] In 2002, CMS entered into demonstration agreements with six plans that otherwise would have disenrolled; five, with a combined enrollment of about 40,000, were in coordinated care plan demonstrations, and another, with less than 2,000 enrollees, was in a private fee-for-service plan demonstration.

LOOKING TO THE FUTURE

The Bush administration has been clear that, regardless of the M+C experience, it sees an important role for private plans in the Medicare program (Office of the Press Secretary 2002). Given the managed care backlash, it is unlikely that a program based on HMOs alone could ever be feasible nationwide. The obvious alternative is to look at looser forms of managed care—such as PPOs—that are common in the commercial market. What it will take to encourage such participation, however, is less clear. After all, the unsuccessful M+C experience is well known.

The PPO demonstration described in this report represents a more formal CMS effort to use its demonstration authority to expand experience with more flexible managed care plans in Medicare. The demonstration has modified some selected policies—related, for example, to payment, full risk sharing, and administrative reporting—that previously may have discouraged plan participation. With the current debate about whether to make a new Medicare drug benefit available only to those in private plans, the experience with the Medicare PPO demonstration is likely to be of considerable interest.

CHAPTER III

THE MEDICARE PPO DEMONSTRATION

The Medicare PPO demonstration intends to make the PPO health plan model more widely available to Medicare beneficiaries (CMS 2002a). The demonstration is being conducted under the authority of Section 402 of the Social Security Amendment of 1967, which authorizes demonstrations and allows CMS to waive requirements in the Medicare law that relate to reimbursement or payment.

PPO plans, which are common in the commercial market, offer beneficiaries additional benefits whose level is tied to use of a network provider. PPO plan enrollees are free to use out-of-network providers, although such use typically comes with higher cost sharing. While the financial incentives thus encourage reliance on network providers, enrollees—not the plan—make the choice. Given that PPO products are less managed than HMOs, they typically carry higher premiums.

In establishing a PPO demonstration, CMS set as a goal

> . . .ways to identify options for encouraging continued and expanded participation in the M+C program. The demonstration seeks to increase the number and variety of health plan choices available to Medicare beneficiaries and provide beneficiaries with greater opportunities to select a plan that best meets their individual needs. This project will test the impact of enhanced payment and risk sharing arrangements between CMS and plans on the range of options and benefits available to beneficiaries. The new plans will offer beneficiaries a wide variety of supplemental benefits including drug coverage and, most significant, the freedom to use out of network providers for a higher cost share (CMS 2002c).

The M+C program already provides for a PPO option but, as previously described, few PPO plans participate in it. To make Medicare more attractive to the PPO industry, the demonstration aims to provide CMS with additional flexibility in product design (such as shared risk between plans and CMS) while allowing licensed HMOs to offer a PPO product in Medicare (under M+C, licensed HMOs are not allowed to offer a PPO because fewer quality requirements in M+C apply to PPOs) (CMS 2002b).

SOLICITATION AND DEMONSTRATION DESIGN

CMS solicited applicants for its PPO demonstration via an April 15, 2002 *Federal Register* notice and responded to applicants' questions on May 14, 2002 (CMS 2002a, b). CMS selected a May 30, 2002 due date to ensure that the demonstration plans could be offered at the start of 2003. The solicitation indicated CMS's intent to enter into contracts of up to three years' duration, though contracts would run for a year at a time with annual renewals. The *Federal Register* notice stated that the government would award demonstrations in up to 12 geographic areas. In response to questions, CMS said it would interpret the limit flexibly.[1]

Applicants could ask for up to $100,000 per application for start-up funds, with a total $1.3 million available from CMS. Applicants could use the funds for implementation costs related to modifying existing network contracts, adapting claims processing systems to incorporate Medicare rates, preparing special education and outreach efforts for the PPO demonstration product, developing expense reporting forms for risk-sharing or reconciliation processes, and implementing data collection for quality or patient satisfaction unique to the demonstration.

Under the solicitation, participants needed to be licensed risk-bearing entities under state law. This requirement—one of the few on which CMS provided little flexibility—is important; it provides assurance that organizations offering plans are subject to state oversight with respect to their ability to handle financial risk. Many PPO plans in the commercial market do not bear medical risk, so they do not have the required license.

Demonstration PPOs had to cover all Medicare benefits but had the option to decide that out-of-network coverage would not necessarily be available for each benefit if the plan met appropriate standards of access for in-network benefits. In addition, PPOs were allowed, but not required, to offer richer in-network benefits, with coverage of prescription drugs not required. CMS accorded demonstration plans more flexibility in structuring cost sharing than under M+C as long as the structure did not discourage use of needed care. CMS structured the demonstration with at least five features that it expected might make the demonstration attractive to private plans:

---

[1] In its response to questions (CMS 2002b), CMS indicated that the 12 areas were not predetermined, that the agency did not have specific criteria for selecting such areas (e.g., current M+C penetration, likely enrollment size), and that more than one award in an area was possible. Service areas needed to be contiguous, though not necessarily restricted to a single state.

Applicants were allowed to submit demonstrations in multiple sites, though CMS did not intend to implement multiple-site demonstrations (CMS 2002b). Such applicants had to provide detail on specific product features in each market; in accordance with the selection criteria, they would not necessarily be awarded a demonstration for all of the markets. In response to a question on the competitiveness of the awards, CMS deferred but said that, in the past, competitiveness was a function of the number of applications received and the number assessed acceptable by a technical review panel. PPOs in a particular area could include more than one benefit design.

- **Payment Levels Modified from M+C.** Under the demonstration and subject to negotiation, plans in an area receive the greater of 99 percent of the fee-for-service payment amount or the M+C payment amount.

- **Modification of M+C Adjusted Community Rate (ACR) and Cost-Sharing Requirements**. Under M+C, plans are required to submit an ACR proposal that justifies their rates and confirms that any savings on delivery of Medicare benefits (less reasonable profit) are returned to beneficiaries in the form of added benefits or reduced costs; the ACR proposal is subject to an audit. The demonstration waives the ACR requirement. (CMS does require a revenue and expense statement that is reviewed by actuaries.) In addition, under the demonstration and in contrast to M+C, the actuarial value of the monthly premium and beneficiary cost sharing can exceed the actuarial value of deductibles and coinsurance in traditional Medicare. These last provisions reduce the demonstration's administrative burden and potentially give plans more discretion in structuring a benefit package consistent with Medicare's stipulated payment rates. Though flexibility in the demonstration does not mean that copayments in demonstration products will necessarily always exceed those in M+C (in fact, they could be lower); the provisions make it more important for individual beneficiaries to understand the benefits to which they are entitled and the cost-sharing arrangements to which they are held.

- **Ability to Share Risk.** Under M+C, plans are fully at risk for the cost of medical services under the contract. In the demonstration, CMS has entered into arrangements by which it shares risk with the health plan. Risk sharing is limited to medical benefits only such that CMS and plans have agreed to a minimum medical loss ratio (MLR) that specifies the share of total revenue (capitation and beneficiary premiums) spent for health care—also known as the medical expense ratio. Even though the demonstration excludes administrative expenses and profit, CMS indicated that administrative expenses must be reasonable and consistent with prior practices (CMS 2002a). (We understand that CMS later set the MLR at a minimum of 84 percent.) Risk sharing also must be symmetrical (i.e., gains as well as losses are shared) and involve substantial plan risk sharing. CMS indicated that while it preferred at least a 50/50 split of gains and losses, it was open to other alternatives and would consider the specific payment situation of each applicant (e.g., whether the plan's enrollment was likely to come from the traditional Medicare program or M+C; the potential for risk selection; the reasonableness of the financial estimates, especially for administrative costs; and special enhancements for beneficiaries, such as drug coverage, broad networks, commitment to quality).

- **Reduced Administrative Requirements.** Under the demonstration, CMS offered to reduce some administrative requirements. Ultimately, CMS decided to apply a consistent set of requirements for all demonstration plans. Unlike nondemonstration PPOs, demonstration PPOs are not required to conduct Quality Assurance Performance Improvement (QAPI) projects. These require

access to medical records, something PPOs are less likely to have than are HMOs. PPO demonstration plans will also be limited to reporting only selected HEDIS/CAHPS performance measures (breast cancer screening and select diabetes care) and information needed by CMS to examine satisfaction with the experience of care. Non-demonstration PPO plans also have a limited number of HEDIS/CAHPS measures to report.

- **Budget Neutrality**. As with all demonstrations, the Medicare PPO demonstration was required to be budget neutral. The expected cost of the demonstration cannot exceed the expected cost to Medicare in the absence of the demonstration. CMS required applicants to submit as part of their application a budget neutrality calculation that outlined the proposed risk-sharing arrangements, including cost computations under best-, expected-, and worst-case scenarios.

DEMONSTRATION AWARDS

A CMS review panel evaluated the demonstration proposals against a number of criteria, including evidence of a basic infrastructure necessary to offer the new demonstration product; the strength of the financial analysis; and special area characteristics (e.g., offerings in areas with limited options).

On August 27, 2002, CMS announced the selection of 17 organizations to offer PPO products in all or part of 23 states. Most, though not all, of the plans were to be available on January 1, 2003. The demonstration will eventually offer 35 plans, and over 11 million beneficiaries—one in three Medicare enrollees—will have at least one private plan option available to them.[2]

Between August and December 2002, CMS negotiated with the 17 entities, resulting in some changes in awards, products, and timing. Ultimately, CMS expected that about 150,000 beneficiaries would be enrolled in products under the demonstration (CMS 2002d), with premiums ranging somewhere between the levels charged by M+C and Medigap plans (CMS 2002c).

CAVEATS ON UNDERSTANDING THE DEMONSTRATION PRODUCTS

As the demonstration begins, it is important to understand what it represents. There is interest in knowing whether the demonstration has attracted plans to areas where they are in

[2] These counts exclude additional counties where PPO options are offered only to employer groups. Only three contracts provide such employer-only options: (1) Aetna's Pennsylvania PPO contract (H3914); (2) Coventry's Illinois/Missouri contract (H1412); and (3) Coventry's Ohio West Virginia contract (H3615). Employer group-only options are particularly extensive in Coventry's plans, especially in West Virginia. Medicare Compare does not include information on employer group-only products, and CMS materials typically do not refer to this component of the demonstration.

limited supply or do not exist and how the products differ from those already available across the country.[3] Which firms are offering the PPO demonstration plans, and what seem to be the most important features that make them attractive to beneficiaries? What effect, if any, does the PPO demonstration have on the traditional M+C program in counties where both are offered? Because the available information is limited, this paper cannot address many of these questions. However, CMS is funding a major evaluation of the PPO demonstration that should provide additional insights as the demonstration proceeds. Major constraints underlying this paper include the following.

Lack of Information on Network Composition. One major gap is the absence of information from proposals on how provider networks are structured and how they compare with existing M+C products. Some firms use a restricted network for their tightly managed HMO products versus their PPO products. Looser networks may be attractive to some enrollees, and beneficiaries may select a PPO demonstration product even though, on its surface, the HMO product may appear to be a better deal (e.g., lower premium and broader in-network benefits). Without information on the breadth of their corresponding networks, it is difficult to assess the competitive appeal of a PPO and an HMO.

Lack of Information on Plan Marketing Strategy. Another critical gap is the absence of information on plans' marketing strategies, especially their intent to use the Medicare PPO demonstration to attract employer group accounts (rather than just beneficiaries enrolling through the individual market). Although employer group-only plans exist in both M+C and the PPO demonstration, these typically are small in number, and information about them is limited. Further, many enrollees in M+C and the PPO demonstration probably are enrolled through products that are also available to individuals. This makes it hard to assess whether demonstration products offered to individuals were developed with the employer group market in mind as well. When group accounts offer retirees an M+C plan or any health plan, the employer typically pays part of the premium, thus making the individual Medicare beneficiary less sensitive to its cost.[4] Further, employers may supplement the Medicare PPO demonstration plan's benefits with other

[3] It is not clear how important CMS perceived the ability to attract options in new areas versus generally increasing the types of options available to Medicare beneficiaries across the country. CMS staff indicate that attracting products to new areas was not a stated goal of the demonstration. Readers should note that the demonstration time line made it unlikely that offerings in new areas would be feasible in the short time available to develop them, as we discuss later.

[4] In contrast, beneficiaries in the individual market typically trade off price for Medigap policies that often are more expensive than M+C options that cost less but limit enrollees' freedom to choose any provider. Unless a beneficiary has chosen a Medigap plan when he or she turns 65 and first enters the program, the individual's Medigap choices may be limited. In addition, only three of the 10 standardized options include a prescription drug benefit, and these plans tend to be expensive. Beneficiaries of modest means may find that the only affordable option is an M+C plan. A main issue is how PPO demonstration products will be positioned in relation to M+C and Medigap premiums. Positioning is likely to influence which beneficiaries are attracted by the plans in terms of income spread and type of coverage before enrollment (e.g. Medigap, none, M+C).

benefits they pay for separately. If such were the case, PPO demonstration products might appear particularly attractive to retirees.

Though some employers offer M+C, the program's appeal has been limited by instability in the M+C offerings and certain administrative incompatibilities that CMS has tried to reduce. Therefore, the PPO demonstration option could prove to be attractive for employers seeking consistency with their commercial products. On the other hand, the temporary status of the PPO demonstration authority, combined with M+C's history of instability, could dissuade employers seeking a stable set of plan choices for retirees.

Finally, despite considerable interest in the budgetary implications of the demonstration design, we do not have the types of information needed to speculate on budgetary matters. As CMS indicates in its response to applicants' questions, budget neutrality will vary with the source of new enrollees (e.g., M+C versus Medigap, individual versus employer group accounts). Ultimate expenses will vary with the size and management of the network, the soundness of the initial cost estimates, and the specific risk-sharing arrangement between the private plans in the demonstration and CMS. CMS's own internal evaluation will potentially provide more information on budget issues.

While these are important limitations, the following chapters discuss several aspects of the PPO demonstration.

CHAPTER IV

GEOGRAPHIC SCOPE OF PPO DEMONSTRATION

Plans participating in the PPO demonstration will ultimately be available to nearly 11 million eligible Medicare beneficiaries in 206 counties across the nation. At the beginning of 2003, nearly 9 million Medicare beneficiaries could enroll in a PPO demonstration plan.[1] However, due to start-up delays, some PPO plans were not yet accepting enrollment as of March 2003. Whether underway or still under development, the overwhelming majority of the PPO demonstrations will take place in areas with an existing M+C plan, so the PPO demonstration will not greatly expand the opportunity for beneficiaries to enroll in a private plan in areas not currently served by M+C plans.

This chapter looks at the geographic scope of the PPO demonstration, including the M+C choices already available to beneficiaries in the affected counties, the types of counties in which the demonstration plans will operate (i.e., urban/rural), and the stability of the markets (as represented by the counties) since 1999.

M+C CHOICES AVAILABLE IN COUNTIES WITH PPO DEMONSTRATIONS

As of March 2003, 31 PPO demonstration plans are available, with four scheduled to be added, for a total of 35 plans. Some of the PPO demonstration plans will compete within the same geographic areas. All together, 28 geographic areas will enjoy access to at least one plan,[2] exceeding CMS's original expectation of 12 geographic areas in the demonstration.

The PPO demonstrations are highly concentrated in areas with an existing M+C market; those markets typically offer an HMO plan sponsored by the same firm sponsoring

[1] PPO demonstrations were first available to Medicare beneficiaries in January 2003. In analyzing PPO availability and benefits, we include all plans offered then as well as the Group Health Insurance plan first offered in February 2003.

[2] A geographic area is defined here as an aggregation of counties where one or more PPO demonstration plans will operate. Of the 28 geographic areas that ultimately will be served by the demonstration, seven will have more than one PPO plan in at least a subset of the counties.

the PPO demonstration plan. Of the 10.7 million eligible Medicare beneficiaries who will be able to enroll in a PPO demonstration plan, only 3 percent, or 319,000, will not have access to an M+C coordinated care plan (CCP) in 2003 (see table IV.1). About two-thirds of these beneficiaries never had a CCP option under the M+C program. Of the 15 counties that will have a PPO demonstration plan in 2003 but no other M+C CCP plan, 10 have not had any M+C CCP available in the county since at least 1999 (see table IV.2). The counties in the demonstration without CCPs are located in seven states (Arizona, Illinois, Indiana, Maryland, Oregon, Pennsylvania, and Virginia). Seven of the 15 counties are rural.

The remaining 97 percent of Medicare beneficiaries living in a county with a PPO demonstration will have access to at least one M+C CCP plan in 2003. Just over 60 percent will have access to at least three CCP plans in 2003, reinforcing the argument that the PPO demonstrations are concentrated in already mature M+C markets. Judging from the markets selected by the firms participating in the demonstration, firms' primary interest appears not to be entry into new markets but rather identification of opportunities for enrolling beneficiaries who have heretofore declined enrollment in an M+C CCP.

URBAN/RURAL MIX

Much like the existing M+C program, the PPO demonstrations are heavily concentrated in urban areas. While roughly 24 percent of Medicare beneficiaries live in rural areas, only 4 percent of rural Medicare beneficiaries will ultimately have access to a PPO demonstration plan in 2003 (see table IV.3). The urban concentration of demonstration plans should not be surprising given the difficulty experienced by the broader M+C program in making inroads into rural areas. In November 2002, only 3 percent of M+C enrollees in coordinated care plans (CCPs) resided in rural areas.

Major urban central-city areas predominate within both the PPO demonstration and the broader M+C program.[3] Even though only 40 percent of the total Medicare population lives in the most urban of urbanized areas, that share accounts for 68 percent of the total population served by a PPO demonstration plan (see Table IV.3). In November 2002, urban central-city areas accounted for 72 percent of CCP enrollment within the M+C program. Again, it appears that PPO demonstration activity is not distinctly different from activity within the broader M+C program.

[3] The definitions of county urbanicity used here are based on the U.S. Department of Agriculture's Rural-Urban Continuum Codes for Metropolitan and Nonmetropolitan Counties. Urban central-city counties are central counties of metropolitan areas with populations of 1 million or more. Other urban counties are fringe counties of metropolitan areas with 1 million or more individuals and counties in metropolitan areas with populations less than 1 million. Rural-adjacent to MSA counties are counties adjacent to, but not included in, a metropolitan statistical area (MSA). All other counties are considered rural-other.

TABLE IV.1

M+C OPTIONS FOR MEDICARE BENEFICIARIES WITH ACCESS TO A PPO DEMONSTRATION IN 2003

	Beneficiaries in Counties with a PPO Available February 1, 2003		All Beneficiaries in Counties Expected to Have a PPO	
	(N)	(percent)	(N)	(percent)
Total Beneficiaries	9,014,346	100	10,678,039	100
No Coordinated Care Option	301,069	3.3	319,246	3.0
Any Coordinated Care Option	8,713,277	96.7	10,358,793	97.0
1 CCP	1,814,852	20.1	1,946,572	18.2
2 CCPs	1,830,198	20.3	1,979,906	18.5
3 or More CCPs	5,068,227	56.2	6,432,315	60.2
Private Fee-for-Service Plan Option	2,796,565	31.0	2,839,598	26.6
Private Fee-for-Service Only	195,477	2.2	195,477	1.8
Private Fee-for-Service and CCP Plan	2,601,088	28.9	2,644,121	24.8

Source: MPR Analysis of CMS data

COUNTIES SERVED BY PPO DEMONSTRATION WITH NO M+C CCP PLAN IN 2003

State	County	Medicare Eligibles	PPO Demonstration Contract County Number	Firm Serving County	Urban/Rural	Number of CCP Contracts in December 1999
AZ	Cochise	19,887	H0314	Health Net	Rural	1
AZ	Coconino	14,398	H0315	Health Net	Rural	0
AZ	Gila	11,876	H0316	Health Net	Rural	2
AZ	Mohave	37,338	H0317	Health Net	Urban	1
IL	Boone	5,128	H1408	Order of St. Francis	Urban	0
IL	Winnebago	42,508	H1409	Order of St. Francis	Urban	0
IN	Allen	44,638	H1508	Advantage	Urban	0
IN	St. Joseph	41,497	H1509	Advantage	Urban	0
MD	Calvert	8,190	H2110	Aetna	Urban	1
MD	Charles	11,267	H2111	Aetna	Urban	4
OR	Jackson	34,303	H3806	Health Net	Urban	0
OR	Josephine	18,427	H3806	Health Net	Rural	0
PA	Venango	11,612	H3913	UPMC	Rural	0
VA	Buchanan	7,094	H4907	Cariten	Rural	0
VA	Tazewell	11,083	H4907	Cariten	Rural	0
Total		319,246				

SOURCE: MPR analysis of CMS data

TABLE IV.3

CHARACTERISTICS OF COUNTIES SERVED BY PPO DEMONSTRATIONS

	Eligible Medicare Beneficiaries			CCP Enrollees			CCP Penetration Rate		
	United States	PPO Demonstrations Live on 2/1/2003	All PPO Demonstrations	United States	PPO Demonstrations Live on 2/1/2003	All PPO Demonstrations	United States	PPO Demonstrations Live on 2/1/2003	All PPO Demonstrations
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	12.0%	20.4%	21.9%
Urban Central City	40.4%	63.1%	68.1%	71.9%	70.7%	76.7%	21.3%	22.9%	24.7%
Other Urban	35.6%	32.3%	27.7%	25.5%	27.0%	21.5%	8.6%	17.1%	17.0%
Rural- Adjacent to MSA	13.3%	4.2%	3.7%	2.2%	2.3%	1.8%	2.0%	11.1%	10.8%
Rural-Other	10.7%	0.3%	0.6%	0.4%	0.0%	0.1%	0.5%	1.8%	2.2%
2003 Payment Rate									
99% FFS Higher	18.7%	28.5%	24.4%	18.9%	22.9%	18.1%	12.1%	16.5%	16.2%
M+C Rate Higher	81.3%	71.5%	75.6%	81.1%	77.1%	81.9%	11.9%	22.0%	23.7%
2003 M+C Rate									
$700 or more	9.0%	16.6%	23.9%	20.0%	19.2%	29.6%	26.5%	23.5%	27.2%
$600-699	16.8%	23.5%	22.9%	25.5%	23.2%	22.8%	18.2%	20.2%	21.8%
$550-599	45.8%	55.0%	48.9%	51.1%	55.3%	45.6%	13.4%	20.6%	20.4%
$510.38-549	28.4%	4.9%	4.2%	3.0%	2.4%	1.9%	1.3%	9.9%	9.6%
2003 Withdrawal in County[1]									
Yes	10.9%	13.3%	12.8%	14.2%	13.7%	12.4%	15.6%	21.1%	21.3%
No	89.1%	86.7%	87.2%	85.8%	86.3%	87.6%	11.5%	20.3%	13.1%
Change in Penetration Rate Since 1999									
Down 15.0% or more	5.0%	4.2%	3.9%	2.9%	0.9%	0.8%	7.0%	4.5%	4.8%
Down 5.0% - 14.9%	24.7%	29.5%	25.2%	31.8%	29.0%	23.0%	15.4%	20.0%	20.0%
Down 0.1% - 4.9%	25.3%	26.9%	37.0%	40.5%	29.0%	43.6%	19.1%	22.0%	25.8%
No Change	30.8%	3.1%	2.8%	0.5%	1.1%	0.9%	0.2%	7.2%	6.8%
Up 0.1%-5.0%	10.6%	29.3%	25.2%	16.2%	28.6%	22.6%	18.3%	19.9%	19.6%
Up 5.1% or more	3.6%	6.9%	5.9%	8.2%	11.5%	9.1%	27.4%	33.8%	33.7%
CMS Region: States Covered									
1: CT, ME, MA, NH, RI, VT	5.4%	1.7%	1.4%	6.0%	2.8%	2.2%	13.3%	33.8%	33.8%
2: NY, NJ	10.0%	32.5%	27.4%	10.6%	22.7%	17.9%	12.7%	14.3%	14.3%
3: DE, MD, PA, VA, WV, DC	10.6%	15.1%	13.4%	10.8%	16.8%	13.4%	12.2%	22.7%	21.8%
4: AL, NC, SC, FL, GA, KY, MS, TN	20.8%	22.8%	19.6%	15.3%	22.8%	18.2%	8.8%	20.5%	20.3%
5: IL, IN, MI, MN, OH, WI	18.0%	8.9%	7.9%	7.9%	6.2%	5.1%	5.3%	14.3%	14.3%
6: AR, LA, NM, OK, TX	10.5%	1.8%	1.5%	6.0%	2.9%	2.2%	6.8%	32.1%	32.1%
7: IA, KS, MO, NE	5.0%	3.4%	4.3%	3.7%	5.8%	6.1%	8.7%	34.9%	31.4%
8: CO, MT, ND, SD, UT, WY	2.9%	0.0%	0.0%	2.3%	0.0%	0.0%	9.8%	0.0%	0.0%
9: AZ, CA, HI, NV	13.1%	9.1%	20.5%	32.1%	12.8%	29.2%	29.4%	28.7%	31.3%
10: AK, ID, OR, WA	3.7%	4.7%	4.0%	5.3%	7.2%	5.7%	17.0%	31.2%	31.2%

SOURCE: MPR Analysis of CMS data

1. Counties counted as having a withdrawal include those where a health plan partially withdrew from the county.

COUNTY PAYMENT RATE

As might be expected, PPO demonstrations are concentrated in high-payment M+C areas relative to nationwide payment rates. Within the M+C program, plans contend that higher payment rates are needed if they are to offer lower premiums and supplemental benefits such as prescription drug coverage and low copayment/coinsurance requirements. The PPO demonstrations were even more attracted to high-payment areas than the broader M+C program. Nationwide, 20 percent of M+C CCP enrollees in November 2002 lived in a county with a 2003 M+C payment rate of $700 or higher (see table IV.3). However, by the time all of the PPO demonstrations are underway, 30 percent of the CCP enrollees in a county with a PPO demonstration will live in a county with a 2003 M+C payment rate of $700 or higher. In comparison, just 9 percent of eligible Medicare beneficiaries live in a county with a 2003 payment rate of $700 or higher. Conversely, 48 percent of CCP enrollees in a county that will ultimately have a PPO live in a county with a payment rate less than $600 compared with 54 percent of CCP enrollees nationwide.

The concentration of PPO demonstrations in areas with payment rates of $700 or higher is distorted by including Los Angeles and Orange counties in California, which have very large M+C enrollments and relatively high M+C payment rates ($708 and $653, respectively). Not yet underway, the demonstration in these counties is planned for later in 2003. The profile of currently active demonstrations by payment rate falls considerably more in line with the national profile of M+C enrollment by county payment rate. Of the M+C enrollees in currently operating Medicare PPO demonstrations, just 19 percent operate in a county with a payment rate of $700 or higher, much closer to the national mark of 20 percent for all CCP enrollees.

MARKET STABILITY

The M+C market has experienced considerable instability since 1999. From 1999 through 2003, plan withdrawals from the program have affected approximately 2.4 million M+C enrollees (Gold and McCoy 2002a; CMS 2003a, b).[4] During the same period, M+C market penetration dropped from about 15 percent in 1999 (Gold and McCoy 2002b) to about 12 percent in December 2002 (CMS 2003a). Yet, even amid the nationwide decline in M+C enrollment, the period between 1999 and 2002 may have seen individual markets hold steady or perhaps expand. For example, Rochester, New York experienced no withdrawals and saw its penetration rise from 15 percent to 23 percent over this period. M+C penetration increased from 43 percent to 46 percent in Miami and from 30 percent to 35 percent in Pittsburgh.

In terms of M+C market volatility, the PPO demonstrations appear to be serving relatively stable counties disproportionately. M+C enrollees in counties where M+C

[4] This figure, the cumulative count of beneficiaries in a plan that withdrew from the program, overstates the unduplicated count of affected beneficiaries because some beneficiaries were affected more than once during the time period.

enrollment increased from 1999 to 2002 account for 24 percent of CCP enrollment nationwide, but 32 percent of CCP enrollees who will have a PPO demonstration in their county in 2003 (see table IV.3). Further, while highly unstable markets (markets where the M+C penetration rate declined by at least 15 percent between 1999 and 2002) account for 3 percent of CCP enrollment in November 2002, these same markets account for only 1 percent of CCP enrollment in areas that will be served by a PPO demonstration plan.

Another way to look at the stability of the counties that will host PPO demonstrations is to consider the experience of these counties in 2003 only. In that year, 14 percent of M+C CCP enrollees lived in a county with at least one Medicare HMO withdrawal (see table IV.3).[5] For counties scheduled for a PPO demonstration, 12 percent of M+C CCP enrollees lived in a county with at least one Medicare HMO withdrawal.

It makes sense that health plans would target relatively stable markets for their PPO demonstration. Beneficiaries in highly volatile markets may be hesitant to enroll in a Medicare managed care plan after seeing numerous M+C plans come and go. In addition, plan-provider relations in stable markets are probably better than they are in highly volatile markets, making the creation of provider networks easier for health plans in stable areas.

REGIONAL VARIATION

While the location of PPO demonstrations generally appears to fall in line with where the broader M+C program already exists, a look at the regional placements of the demonstrations suggests some discrepancies. Most notably, the PPO demonstrations appear to be disproportionately represented along the East Coast—in the Northeastern, Mid-Atlantic, and Southeastern states (CMS regions 2, 3, 4). For instance, M+C enrollment in New York and New Jersey currently accounts for 11 percent of M+C enrollment nationwide (see Table IV.3). However, these two states will account for 18 percent of the M+C enrollment in counties served by a PPO demonstration as Medicare beneficiaries in the entire state of New Jersey and most of New York will have the opportunity to enroll in a PPO demonstration plan. Conversely, the Southwestern, Northwestern, and Pacific states appear to be underserved disproportionately by the PPO demonstration. Perhaps most surprising, only two counties in California, the state with the most mature M+C market, will have PPO demonstrations, and those are not scheduled to begin until later in 2003.

Traditional Medicare HMOs have historically had a harder time making inroads on the East Coast than on the West Coast. The key to increasing Medicare managed care enrollment on the East Coast could lie in allowing enrollees to access out-of-network providers. In fact, the opportunity for sharing risk may be attractive to firms in markets where HMOs have been slow to take root. If so, PPOs and other loosely managed care arrangements could provide the framework for increasing M+C penetration on the East Coast.

[5] Counties counted as having a withdrawal include those where a health plan partially withdrew from the county.

CONCLUSIONS

PPO plans under the demonstration are widely available across the nation but are generally available in the same areas where M+C choices already exist. The demonstration therefore offers the potential to expand the range of choices in many urban areas, but it may not shed light on what it would take to expand choices throughout the United States. The next chapters provide additional insight into the new choices available under the PPO demonstration and the types of beneficiaries they may attract.

CHAPTER V

PROFILE OF PLAN SPONSORS

The demonstration involves 17 firms or plan sponsors that eventually will lead to 35 contracts for PPO plans to be made available in a contiguous service area. In January 2003, 15 of the firms started offering products; another firm started in February 2003. The 16 participating firms cover all but four of the service areas that ultimately will be involved in the demonstration. This chapter profiles the firms participating in the demonstration and describes how the PPO plans appear to relate to the firms' other lines of business. Readers seeking additional information on the PPO offerings by market and competitors can refer to appendix B.

PROFILE OF PARTICIPATING FIRMS

In its solicitation, CMS encouraged applications from "experienced organizations to contract. . .on a capitated basis [for] PPO products that will appeal to people with Medicare, both those already familiar with some form of managed care and those familiar only with fee-for-service" (CMS 2002a). Experience extends to commercial or Medicare products, with applications not limited to those currently in the M+C program (CMS 2002b). Applicants must be state licensed to bear risk for Medicare.

We conferred with actuaries and consultants who concluded that, given the magnitude of the Medicare market, many firms might be interested in capitalizing on an opportunity to gain experience with a new and potentially large product line for seniors. The experts thought that larger firms with existing M+C products or similar PPO products would be better positioned to assume the risk of a new business venture. In addition, the same experts believed that, because PPOs dominate employer offerings and are less restrictive than HMOs, the Medicare PPO could appeal to firms with a focus on retiree benefits.

Overall, the firms participating in the PPO demonstration appear to bear out the experts' observations, although the demonstration sponsors are also highly diverse and apparently bring different objectives to the demonstration. Not surprising, most of the 17 plan sponsors are entities whose main line of business is health insurance, with managed care products often dominant (see table V.1). The participating firms include many major M+C

TABLE V.1

FIRMS PARTICIPATING IN PPO DEMONSTRATION AND THEIR M+C ACTIVITY IN PPO DEMONSTRATION SITES

Firm Name	Total Firm M+C Enrollment in November 2002	Firm's M+C Enrollment in PPO Demonstration Sites	Share of Firm's M+C Enrollment in PPO Demonstration Sites	Total Number of Demonstration Contracts (February 1, 2003)	Number of Plan Options Offered in PPO Demonstration[a]
Total	1,927,414	720,402	37.4%	35(31)	53
Advantage[b]	1,636	0	0.0%	1(1)	1
Aetna	117,076	27,072	23.1%	3(2)	5
Anthem Blue Cross Blue Shield	11,551	4,943	42.8%	1(0)	unknown
Cariten Insurance Co.	11,881	9,327	78.5%	2(1)	1
Coventry Health and Life Insurance Co.	75,587	12,240	16.2%	4(3)	3
Group Health, Inc.	0	0	NA	1(1)	4
Health Net	178,646	36,724	20.6%	2(2)	4
Health Now	28,837	28,837	100.0%	1(1)	4
Health Spring	30,130	22,254	73.9%	1(1)	1
Horizon Blue Cross Blue Shield	62,115	62,115	100.0%	1(1)	2
Humana	341,320	21,119	6.2%	1(1)	1
Managed Health/Health First	21,636	15,341	70.9%	1(1)	2
Order of St. Francis	3,902	3,902	100.0%	1(1)	1
PacifiCare	766,708	264,649	34.5%	3(2)	3
Tenet Choices	26,832	26,832	100.0%	1(1)	1
United HealthCare	241,534	177,024	73.3%	10(10)	14
University of Pittsburgh Medical Center	8,023	8,023	100.0%	1(1)	6

SOURCE: MPR Analysis of CMS data

NOTE: M+C enrollment does not include enrollment in private fee-for-service plans or other demonstrations.

[a]Does not include products for PPO demonstrations starting after February 1, 2003, since we do not know how many products these contracts will offer.

[b]Advantage withdrew its sole HMO product in 2003.

firms as well as more geographically limited firms. Three organizations are licensed to offer Blue Cross-Blue Shield products.

Though insurance and managed care firms dominate the demonstration, four sponsors are provider organizations or organizations sponsored by providers. They represent different organizational types: the Catholic health system associated with the Order of St. Francis in Illinois; Tenet Choices, which is a large national health care provider; and the University of Pittsburgh Medical Center, whose system includes extensive teaching activity. A fourth sponsor (Cariten Insurance Company) was developed by Covenant Health and Mountain States Health Alliance and is a provider-owned company offering health insurance products.

Of the 17 firms, all but one had existing M+C contracts in 2002.[1] The exception is Group Health, Inc., which began to offer a Medicare PPO product in New York City in February 2003 (see box for a profile of the firm and the products it will offer).

Group Health, Inc. (GHI): New to the M+C Market

GHI is the only firm in the PPO demonstration that was not participating in M+C in 2002. Formed in 1937, GHI operates as a statewide health insurance plan in New York. In fact, with more than 3 million enrollees in its various products, it is the largest insurer in New York. GHI is the dominant insurer for New York City employees and describes itself as a large provider network and a subsidiary HMO. In 1998, it launched a triple-tiered PPO product in downstate New York. In addition, GHI is a Medicare Part B carrier and offers a range of Medigap products as well as other Medicare supplemental products for its group accounts (Group Health Insurance 2003).

Under the demonstration, GHI will offer its PPO product in the five boroughs of New York City and in nearby Rockland and Westchester counties. Two other firms (Managed Health Care/Health First and UnitedHealthCare) will also offer PPO demonstration products in New York City.

With its base of Medigap products and group retiree accounts, GHI may be aiming to create products that will allow the firm to offer a looser and possibly more attractive managed care product for its group accounts while providing a lower-priced alternative to its Medigap line of business. Whether GHI intends to expand its overall share of the Medicare market or mainly retain its current share across all products is not clear.

Plans already in M+C typically are sponsoring demonstrations in at least some of the same service areas in which they currently offer an HMO product under M+C (see table V.2). In a limited number of cases, firms are offering PPOs in a market in which they had no M+C enrollment in 2002. One of Aetna's PPO plans will be available in a New Jersey market from which the firm withdrew its M+C product in 2003.

[1] One of the 16 with existing contracts (Advantage) withdrew from its sole M+C contract in 2003. Horizon also dropped one of its M+C HMO plan options from the New Jersey market, although the company does still offer another M+C HMO plan option in the area.

TABLE V.2

PPO DEMONSTRATION SPONSORS AND CONTRACTS

Firm and Affiliated Contracts	Firm Had M+C Contract in 2002	Number of Demonstra-toin Contracts	Operational February 1, 2003	Total Medicare Beneficiaries in Demon-stration Sites	2002 M+C Enrollees in Demon-stration Sites	2002 Firm M+C Enrollment in Demonstra-tion Sites	2002 Firm Enrollment as Share of All M+C Enrollment in Demonstra-tion Sites	2002 M+C Enrollment for Firm in Demonstra-tion Sites/All Sites
Advantage Health Solutions, Inc.	Y	1		86,135	0	0	NA	NA
H1508: Allen/St. Joseph counties, IN			Yes	86,135	0	0	NA	NA
Aetna Health	Y	3		1,535,874	158,071	27,072	17.1%	23.1%
H2110: Baltimore, MD			Yes	326,300	7,201	0	0.0%	0.0%
H3108: New Jersey[a]			Yes	836,900	64,545	27,072[a]	41.9%	23.1%
H3914: Pennsylvania[b]			Yes	372,674	86,325	0	0.0%	0.0%
Anthem Blue Cross Blue Shield	Y	1		259,462	42,565	4,943	1.9%	42.8%
Pending: Kentucky-Ohio			No	259,462	42,565	4,943	1.9%	42.8%
Cariten Insurance Co.	Y	2		310,822	25,340	9,327	36.8%	78.5%
H4403: Tennessee			Yes	240,027	22,039	9,327	42.3%	78.5%
H4907: Virginia			No	70,795	3,301	0	0.0%	0.0%
Coventry Health and Life Insurance Co.	Y	4		786,343	213,040	12,240	5.7%	25.1%
H1412: St. Louis Area[c]			Yes	368,522	84,062	2,247	2.7%	4.6%
H1715: Johnson County, KS, and Jackson County, MO			No	149,708	36,084	8,026	22.2%	16.5%
H3615: Jefferson County, OH, and Hancock County, WV			Yes	24,177	2,017	1,967		NA
H3915: Allegheny County, PA			Yes	243,936	90,877	0	NA	NA
Group Health, Inc.	N	1		1,222,990	224,788	0	NA	NA
H3323: New York City			Yes	1,222,990	224,788	0	NA	NA

TABLE V.2 *(continued)*

Firm and Affiliated Contracts	Firm Had M+C Contract in 2002	Number of Demonstration Contracts	Operational February 1, 2003	Total Medicare Beneficiaries in Demonstration Sites	2002 M+C Enrollees in Demonstration Sites	2002 Firm M+C Enrollment in Demonstration Sites	2002 Firm Enrollment as Share of All M+C Enrollment in Demonstration Sites	2002 M+C Enrollment for Firm in Demonstration Sites/All Sites
Health Net	Y	2		1,063,356	340,297	36,724	10.8%	20.6%
H0314: Arizona			Yes	639,732	207,974	36,724	17.7%	20.6%
H3806: Oregon and Clark County, WA			Yes	423,624	132,323	0	NA	NA
Health Now	Y	1		455,435	94,407	28,837	30.5%	100.0%
H3324: Upstate New York			Yes	455,435	94,407	28,837	30.5%	100.0%
Health Spring	Y	1		162,824	22,254	22,254	100.0%	73.9%
H4404: Tennessee			Yes	162,824	22,254	22,254	100.0%	73.9%
Horizon Blue Cross Blue Shield	Y	1		1,249,885	99,188	62,115	62.6%	100.0%
H3109: New Jersey			Yes	1,249,885	99,188	62,115	62.6%	100.0%
Humana	Y	1		203,067	45,666	21,119	46.2%	6.2%
H1047: Pinellas County, FL			Yes	203,067	45,666	21,119	46.2%	6.2%
Managed Health/Health First	Y	1		1,037,160	200,873	15,341	7.6%	70.9%
H3325: New York City			Yes	1,037,160	200,873	15,341	7.6%	70.9%
Order of St. Francis	Y	1		143,802	5,061	3,902	77.1%	100.0%
H1408: Illinois			Yes	143,802	5,061	3,902	77.1%	100.0%
PacifiCare	Y	3		2,101,812	683,576	264,649	38.7%	34.5%
H0313: Arizonae			Yes	556,233	207,974	87,777	42.2%	11.4%
H0548: Los Angeles and Orange counties, CA			No	1,364,088	447,494	149,662	33.4%	19.5%
H2903: Clark County, NV[b]			Yes	181,491	28,108	27,210	96.8%	3.5%

TABLE V.2 *(continued)*

Firm and Affiliated Contracts	Firm Had M+C Contract in 2002	Number of Demonstration Contracts	Operational February 1, 2003	Total Medicare Beneficiaries in Demonstration Sites	2002 M+C Enrollees in Demonstration Sites	2002 Firm M+C Enrollment in Demonstration Sites	2002 Firm Enrollment as Share of All M+C Enrollment in Demonstration Sites	2002 M+C Enrollment for Firm in Demonstration Sites/All Sites
Tenet Choices	Y	1		163,542	52,575	26,832	16.4%	100.0%
H1901: New Orleans, LA[b]			Yes	163,542	52,575	26,832	16.4%	100.0%
UnitedHealthCare	Y	10		3,695,454	812,739	177,024	21.8%	73.3%
H0102: Alabama			Yes	148,563	31,568	14,721	46.6%	6.1%
H0103: Mobile, AL			Yes	60,673	12,871	12,871	100.0%	5.3%
H5400: Broward and Palm Beach counties, FL			Yes	502,416	183,210	110	0.1%	0.0%
H5401: South Florida			Yes	585,039	116,189	33,676	29.0%	13.9%
H1413: St. Louis area			Yes	384,630	87,429	58,822	67.3%	24.4%
H3403: North Carolina			Yes	353,744	32,172	9,273	28.8%	3.8%
H3326: New York City			Yes	1,037,160	200,873	9,572	4.8%	4.0%
H3616: Butler and Hamilton counties, OH			Yes	180,360	35,321	14,534	41.1%	6.0%
H3617: Cuyahoga and Mahoning counties, OH			Yes	289,679	61,257	8,024	13.1%	3.3%
H4103: Rhode Island			Yes	153,190	51,849	15,421	29.7%	6.4%
University of Pittsburgh Medical Center	Y	1		655,780	214,544	8,023	3.7%	100.0%
H3913: Pennsylvania			Yes	655,780	214,544	8,023	3.7%	100.0%

Note: 2002 M+C enrollees in site from November 2002 Geographic Service Area File. Includes all CCP contracts, even those that announced withdrawals as of January 2003.

SOURCE: Total Medicare beneficiaries in site from September State/County Market Penetration File.

[a] Aetna withdrew its M+C HMO plan from two of the nine counties in the PPO demonstration area for this contract.

[b] This plan is available in three additional counties to employer groups-only (Chester, Delaware, Philadelphia.)

[c] The plan is available to employer group-only in five additional counties in Illinois and 11 additional counties in Missouri.

[d] The plan is available to employer groups-only in 5 additional counties in Ohio and 55 additional counties in West Virginia.

[e] The contract includes at least one county with a partial service area. Eligible Medicare beneficiary and enrollment totals given for these counties are for the full county since information is not available at the subcounty level.

Participation by Major M+C Firms

Seven national firms account for more than half of M+C enrollment (see figure V.1) (Draper, Gold, and McCoy 2002): PacifiCare, Kaiser Permanente, Humana, UnitedHealthCare, Aetna, Health Net, and Cigna.

Only two of these firms are not participating in the PPO demonstration—Kaiser Permanente and Cigna. As a prepaid group practice, Kaiser Permanente tends not to offer looser managed care models involving out-of-network benefits that depart substantially from its tight internal network of providers and hospitals. For its part, Cigna has dramatically reduced its role in the M+C program, as evidenced by its offering only two contracts in 2003. Evidently, Cigna did not find the terms of the PPO demonstration sufficiently attractive to reverse course or offset the other reasons it has chosen not to focus on the M+C market.

Below, we briefly review the involvement of each of the remaining five major M+C firms in the demonstration.

PacifiCare. PacifiCare is the largest M+C contracting firm in the nation, with enrollment predominantly concentrated in eight western states. Medicare is a particularly important line of business for the firm (Draper, Gold, and McCoy 2002). In January 2003, the firm began its participation in the demonstration with PPO demonstrations in two areas—Clark County (Las Vegas, partial county coverage), Nevada, and Phoenix/Tucson, Arizona. The two sites account for 15 percent of PacifiCare's already existing M+C HMO business, which will more than double to 35 percent if PacifiCare succeeds in developing its planned PPO product for its large Los Angeles/Orange County service area.

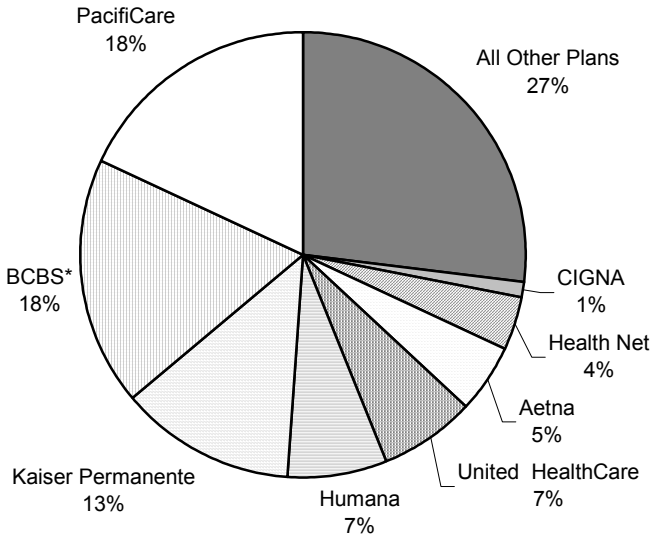
In the Las Vegas area, PacifiCare dominates the M+C market, with almost all of the area's enrollment. For 2003, it will receive 99 percent of the Medicare fee-for-service payment (about $41 more than the M+C rate). In the Phoenix/Tucson area, PacifiCare will receive the M+C payment rate. Health Net is also offering a PPO product in the Phoenix/Tucson area in a market that already offers several M+C products.

PacifiCare's Medicare PPO products in both markets will charge a substantially higher premium than its M+C HMO product. Cost sharing for out-of-network services in the PPO demonstration is extensive (e.g., 30 percent coinsurance), with no limit on out-of-pocket spending. In Nevada, the HMO product, but not the PPO demonstration product, covers $1,000 of brand-name drugs.

Given the dominance of M+C in PacifiCare's book of business, the firm has been seeking alternatives that will allow it to diversify its Medicare supplemental products and expand its commercial business by, for example, offering a commercial PPO (Draper, Gold, and McCoy 2002). The way PacifiCare has structured its PPO demonstration products could indicate that the firm sees the products less as a M+C competitors in the individual market and more as vehicles for contracting with employers for group accounts.

FIGURE V.1

M+C ENROLLMENT OF THE EIGHT NATIONAL MANAGED CARE FIRMS COMPARED WITH ALL OTHER PLANS, 2001



SOURCE: Draper, Gold, and McCoy 2002

*BCBS = Blue Cross and Blue Shield–affiliated organizations.

Such a strategy could prove to be attractive for PacifiCare. Accordingly, the employer typically would subsidize the PPO premium and costs for additional benefits not included under the Medicare PPO benefit. The PPO's design could mean that employers would bear most of the risk for potentially expensive services such as brand-name drug coverage and out-of-network care. Given that premiums for supplemental benefits with employer contracts can be negotiated more easily with employers than with CMS, and assuming employers remain willing to shoulder financial risk, PacifiCare could limit its financial exposure by concentrating on group accounts.

UnitedHealthCare. Operating in 44 markets, UnitedHealthCare was the nation's fifth-largest M+C firm in 2001 (Draper, Gold, and McCoy 2002). It accounts for 10 of the 31 demonstration plans operational in early 2003, making it the dominant firm in the demonstration. According to previous research, UnitedHealthCare is committed to the Medicare market but interested in exploring multiple product offerings (Draper, Gold, and McCoy 2002). Its heavy participation in the demonstration is consistent with the view reported in the earlier research.

The 10 areas where UnitedHealthCare will offer PPO demonstrations account for 73 percent of the firm's M+C enrollment, although the firm's market share in M+C varies substantially across the areas. In eight of the 10 markets, the firm will be paid the M+C rate. The two exceptions are the Tampa-St. Petersburg area and the Broward-Palm Beach County area, where 99 percent of fee-for-service yields a higher payment.[2] The latter market is the only one where the firm currently does not offer an M+C product, although it was considering the possibility of offering an M+C PPO in the area before announcement of the demonstration.

Though details of the firm's PPO product differ across markets, United's PPO premium typically is substantially higher than the premium for its M+C HMO. To encourage beneficiaries to seek in-network care, the PPO uses lower in-network cost sharing and imposes lower in-network out-of-pocket limits (than for the M+C product). It also offers $500 worth of generic drug coverage.

Humana. Humana is the nation's third-largest M+C contractor. In a strategic move, Humana has attempted to keep M+C premiums low for its target market (Draper, Gold, and McCoy 2002). It also began offering a private fee-for-service plan in five states in January 2003. Humana participates in the PPO demonstration, but only in one county (Pinellas County, Florida). While UnitedHealthCare also offers a PPO product in the same market along with WellCare, that market has lagged behind southern Florida with fewer available plans and more withdrawals (Gold and Aizer, 1998; Gold and McCoy 2002b).

The Humana PPO demonstration product costs substantially more than the zero-premium HMO product. In the PPO demonstration, cost sharing is substantially lower than in the HMO for those who stay in network ($15 less per physician visit and $5 less for

[2] The difference is minimal in Broward County but about $55 in Palm Beach County.

specialist visits; $150 versus $250 per day for hospital days one through five, $3 less for prescriptions under the $500 generic benefit in both the demonstration PPO and M+C HMO, and an $1,800 versus $2,300 out-of-pocket limit). Those who expect to make use of health care extensively but intend to remain in network could have an incentive to switch from the HMO to the PPO because they will benefit greatly from reduced cost sharing, which could offset higher premiums. Testing this form of benefit design could be attractive to Humana, especially if the firm is not at full risk for the PPO product (we lack firm-specific information on risk sharing). Humana also could have been seeking to attract those outside M+C, a market UnitedHealthCare also appears poised to target.[3]

Health Net. In 2001, Health Net was the nation's sixth-largest M+C contract; the plan reports that local circumstances drive its M+C products and strategies (Draper, Gold, and McCoy 2002). Under the demonstration, the firm is offering PPO products in two markets (Arizona and Oregon/Washington); the demonstration design suggests that motivation in each market might be different.

In Arizona, Health Net currently accounts for 18 percent of the M+C market, which, in turn, represents 21 percent of the firm's total M+C enrollment. Both Health Net and PacifiCare offer Medicare PPO products in the Phoenix market, but the Health Net option assesses a premium almost double that of the PacifiCare product ($144 versus $75). The PacifiCare product also permits lower cost sharing for those who stay in network (especially for hospital and specialist care). However, Health Net's PPO requires less cost sharing for out-of-network care. Clearly, Health Net could be positioning its product to attract those who wish broad access to providers and can afford such access either on their own or through an offering from their employer, which, presumably, would absorb the premium.

Health Net currently does not offer an M+C HMO product in Oregon and Clark County, Washington. PacifiCare, Regence HMO, Kaiser Permanente, and Providence all offer an M+C HMO product in many Oregon counties. In addition, Sterling offers a private fee-for-service plan in many Oregon counties and in Clark County, Washington, though the highest enrollment the plan garnered in any of the counties was 13 in 2002. The Health Net premium of $80 is not consistently higher than premiums under the M+C program. The diversity in M+C products offered across this multicounty area complicates any comparison of available plan options.

[3] The Humana PPO product compares favorably in premium to the UnitedHealthCare product ($65 per month versus $79 per month). The UnitedHealthCare product provides access to out-of-network services with lower cost sharing (generally 20 percent versus 30 percent with a $500 deductible). Though UnitedHealthCare's product imposes no limit for generic drugs (as opposed to Humana's $500) and no out-of-pocket limit for out-of-network services (as opposed to Humana's $5,000), it probably provides more affordable access to those seeking some use of out-of-network services. Out-of-network cost-sharing data are from CMS and are based on preliminary submissions of plan benefit packages. Plans have not verified the information independently.

Aetna. Aetna is a large insurance company that absorbed U.S. HealthCare, NYLCare, and Prudential. The firm's dominant line of business continues to be insurance for large national group accounts (Draper, Gold, and McCoy 2002). In contrast to most other PPO demonstration products, the Aetna PPO is a point-of-service product, which means that primary care physicians authorize referral to specialists. The Aetna PPO is similar to how most M+C products work except that, under the demonstration, PPO enrollees have access to out-of-network specialists without referral if they are willing to pay more cost sharing.

Once a major M+C contractor, Aetna has reduced its offerings steadily so that M+C enrollment totaled only about 117,000 beneficiaries in 2002. Aetna will participate in the demonstration in three markets; it had already withdrawn an M+C plan from two of these markets (Baltimore and Pennsylvania) and, in 2003, reduced its service area for its M+C HMO in another market (New Jersey).[4] It is possible that the demonstration offers Aetna a vehicle for maintaining some connection to the large Medicare market with less risk or fewer of the constraints associated with the M+C program.

Baltimore was hard hit by M+C withdrawals; as a result, the city has few M+C alternatives. Aetna's Baltimore PPO product carries a premium of $110 per month, includes a generic drug benefit, and imposes fixed-dollar copayments for in-network services. Out-of-network services carry a 20 percent coinsurance after a $150 deductible, with an out-of-pocket maximum of $2,500 for out-of-network services.[5] If Medigap products cost substantially more, Aetna's product could be attractive to those who can afford the charges, want to reduce their fixed premium costs, and are inclined to accept additional costs for out-of-network services. Beyond the individual market, these conditions could appeal to some employers as well, especially if they already cover retirees through Aetna.

The Aetna products offered in the two other markets are similar to Baltimore's products, though some details may vary. Premiums for the products typically are high (over $100 per month), but Aetna's M+C HMO products in New Jersey also involve premiums that are not always substantially lower ($75 or $85). The New Jersey PPO demonstration product offers generic drug coverage not offered in Aetna's M+C HMO products. Though cost sharing is extensive for out-of-network benefits, all of Aetna's PPO products include an out-of-pocket limit. Given that the Aetna demonstration sites include multiple counties with diverse M+C products, available information is insufficient for us to position the Aetna demonstration product in the marketplace.

[4] Aetna reduced its service area by withdrawing from Monmouth and Ocean counties.

[5] Out-of-network cost-sharing data are from CMS and are based on preliminary submissions of plan benefit packages. Plans have not verified the information independently.

Other Firms Participating in the Demonstration

Other firms participating in the PPO demonstration tend to be more locally based and to focus on a service area that often includes only a single market or state. Coventry Health and Life Insurance Company is one of two exceptions. Though it has accounts for only about 76,000 M+C enrollees, it operates in several markets and is sponsoring four demonstration sites (three operational in January 2003). A second, Anthem Blue Cross Blue Shield, has been expanding its service area and has one site pending for participation in the PPO demonstration later in 2003. We first review the two firms that are exceptions and then move on to the others. (Appendix B includes details on the individual PPO plan options and competition in the marketplace.)

Coventry. Coventry Health and Life Insurance Company had its origins in a Texas life insurance company acquired by Coventry HealthCare in 1998. Coventry HealthCare, the parent, is a managed health care company with a variety of subsidiaries, including Coventry Healthcare, Coventry Health and Life, Health America, and others (Coventry Health Care 2001). In 2001, it completed acquisition of HealthPartners of the MidWest (based in St. Louis) and the Kaiser Foundation Health Plan (based in Kansas City). Coventry's four PPO demonstration contracts are split between the Midwest (St. Louis; Johnson County, Kansas; and Jackson County, Missouri) and the Ohio-Pennsylvania area (Jefferson County, Ohio; Hancock County, West Virginia; and Allegheny County, Pennsylvania). One of the two Midwest contracts is still pending.[6]

Anthem Blue Cross Blue Shield. Based in Indiana, Anthem is the fifth-largest publicly traded health benefits company and, through acquisition, now holds a license from Blue Cross and Blue Shield to offer products in Colorado, Connecticut, Indiana, Kentucky, Maine, Nevada, New Hampshire, and Virginia (excluding the Washington, D.C., area) (Anthem 2003). Currently, Anthem has only about 13,000 M+C HMO enrollees, but its demonstration application is pending for a service area that includes Kentucky, where 43 percent of the firm's M+C enrollment lives and where Anthem is the only HMO offering in the county,[7] and Ohio, where the plan would be a new entrant into a market with more than 200,000 Medicare beneficiaries

Advantage Health Solutions. Offering HMO/POS products to employers, Advantage is a licensed HMO based in Indianapolis that serves Fort Wayne and South Bend counties (among other counties). The two counties account for more than 85,000 Medicare beneficiaries but lack any M+C contractors. Until it withdrew in 2003, Advantage operated an M+C contract with about 1,600 enrollees elsewhere in Ohio. Presumably, the demonstration is providing Advantage with a less risky or more attractive (to beneficiaries) means to participate in Medicare in a market near where it has experience.

[6] Coventry is notable in that is has gained approval for employer group-only arrangements in a number of counties surrounding its core PPO demonstration plans available to both individuals and groups.

[7] Sterling offers its private fee-for-service product in Anthem's service area.

Cariten Insurance Company. Cariten Insurance Company is based in Knoxville, Tennessee. Founded in 1985 and owned by Covenant Health and Mountain States Health Alliance, Cariten is a provider-owned organization offering health insurance products. The firm offers a demonstration PPO product in 19 east Tennessee counties (Covenant 2003). The company also offers an M+C HMO product in the same counties, which account for about 78 percent of the firm's M+C enrollment. In addition, Cariten has a contract pending to provide a PPO demonstration plan in Virginia. The firm offers no M+C product there now, and we have no information about the reasons for Cariten's move into that market.

Health Now. Health Now is a licensed HMO and nonprofit indemnity insurer in New York (*New York Consumer Guide to Health Insurance* 2002) that serves upstate New York (outside New York City and Long Island). It offers its PPO product in a service area that includes all of the firm's M+C HMO enrollees and accounts for 31 percent of the M+C market in that same service area. The firm is offering a PPO demonstration product in all the counties in which it currently has an M+C HMO product.

Health Spring. Health Spring is an insurance company headquartered in Nashville, Tennessee. It offers the only M+C plan in mid-Tennessee. (Sterling is available in some counties but has enrolled few beneficiaries.) Health Spring's PPO demonstration product will charge a $70 premium; its M+C HMO product does not charge any premium.

Horizon Blue Cross Blue Shield. This Newark-based nonprofit Blue Cross Blue Shield organization has been offering health insurance products in New Jersey since 1932. The company makes available a full spectrum of managed care and indemnity products and now claims to have more than 60,000 M+C HMO enrollees, with its products accounting for 62 percent of the M+C enrollment in the service area. Since Aetna's withdrawal of M+C products, Horizon has come to dominate the New Jersey market. In fact, the company's PPO demonstration includes all of the counties in which Horizon claims to have M+C enrollment. In many of these counties, payment rates will be at 99 percent of fee-for-service because they are higher than the M+C rate. The firm offers two PPO products, one with a higher premium and more benefits. Both assess premiums higher than does the Horizon M+C HMO product. Aetna will offer PPO demonstration products in some of the same New Jersey counties.

In 2002, Horizon offered two M+C HMO products in New Jersey but has since dropped one.[8] Enrollment in Horizon's HMO has recently declined dramatically, from more than 62,000 in November 2002 to under 11,000 in April 2003. At the same time, enrollment

[8] The remaining HMO product in New Jersey has a $51 premium (compared with $86 and $116 for the two PPO demonstration products offered by Horizon). The HMO does not cover prescription drugs and has a 15 percent coinsurance for inpatient hospital stays, outpatient hospital visits, diabetes supplies, and durable medical equipment. In contrast, the PPOs have a $750 deductible for inpatient hospital care, one of the PPO products offers prescription drug coverage, and neither has any enrollee cost sharing for outpatient hospital visits, diabetes supplies, or durable medical equipment.

in Horizon's PPO demonstration plan is significant, at nearly 45,000 as of April 2003.[9] It seems likely that Horizon's PPO demonstration is attracting many of the Medicare beneficiaries who left Horizon's M+C HMO plan.

Managed Health/Health First. Managed Health/Health First is an HMO that serving New York City and Long Island; with about 15,000 beneficiaries, its M+C enrollment is small. The HMO will offer a PPO demonstration in New York City, where 71 percent of the firm's M+C enrollment lives. Group Health, Inc., and UnitedHealthCare will also offer a PPO demonstration product in the same market; in addition, several M+C alternatives are available in the service area. While M+C payment rates in New York City are high, M+C penetration of the market has been lower than in some other highly paid markets (Gold and Aizer 1998). PPO products could prove to be attractive to New Yorkers who wish to retain provider choice. Many though not all M+C HMO products carry a zero premium, as does Group Health's PPO demonstration. In contrast, Managed Health's two PPO demonstration plan options charge a premium, though the firm's HMO products generally do not.

Order of St. Francis (OSF). This Catholic health system operates six acute care hospitals and a long-term care facility in Illinois. OSF Health Plans sponsors HMOs and PPOs. The system has developed a network of independent affiliate community hospitals with which it cooperates (OSF 2003). The HMO covers more than 94,000 enrollees. Though OSF's M+C HMO enrollment is small (under 4,000 enrollees), it accounts for more than three-quarters of the enrollment in the service area. The PPO demonstration plan's premium is only $15 per month higher than the HMO premium ($60), and the product provides a $100 per month generic drug benefit and in-network cost sharing that is almost the same as that offered by the HMO product. In addition to making the M+C plan available in the service area, OSF will offer the PPO demonstration product in one additional county that does not have an M+C plan (Winnebago, with about 43,000 Medicare beneficiaries and no other M+C alternatives).

Tenet Choices. Tenet Healthcare Corporation owns or operates 114 acute care hospitals and businesses serving communities in 16 states (Tenet 2003). Headquartered in Santa Barbara, California, Tenet is primarily a health care provider, and its sole M+C contract is though the affiliated Tenet Choices in the New Orleans area, where it also offers a PPO under the demonstration. In fact, Tenet is one of two current M+C contractors in the four-parish area around New Orleans. In contrast to the zero-premium M+C HMO product, Tenet's PPO demonstration product carries an $85 monthly premium but no cost sharing for in-network services and an out-of-network benefit with 20 percent coinsurance. The firm has been marketing the product actively, stressing that it is "hassle free" with no referrals or authorizations required (Young 2003).

[9] Enrollment in Horizon's PPO demonstration plan accounts for roughly 77 percent of all PPO demonstration enrollment in March 2003. Total enrollment under the demonstration in April 2003 is 58,459.

University of Pittsburgh Medical Center (UPMC). This nonprofit integrated delivery system in western Pennsylvania includes the only regional academic medical center in the area (UPMC 2003). Its health plan is structured around UPMC-affiliated hospitals and thus "provides reasonably priced insurance products that give access to the region's finest hospitals." UPMC has an existing M+C HMO product that has enrolled 10,000 beneficiaries in a 17-county area with more than half a million Medicare beneficiaries. UPMC's PPO demonstration product appears to offer the same in-network benefits as its higher-end M+C product, but at a higher premium ($156 versus $107) in exchange for an out-of-network benefit resembling indemnity insurance. Presumably, UPMC is seeking to attract those who can pay more and want the option of out-of-network care if so desired.

CONCLUSIONS

For the most part, the PPO demonstration has not attracted new firms to the M+C market, though it has provided a vehicle for existing firms to diversify their product lines and further their strategic objectives. The one exception is Group Health, Inc. in New York. It probably is not realistic to start up a managed care product at a rapid pace when existing infrastructure and Medicare experience are lacking. In addition, the requirement that PPO demonstration plans share risk and demonstrate state licensure to do so probably limited participation. (PPO plans are usually not at risk in the commercial market.)

Several types of organizations are participating in the PPO demonstration; however, as in the M+C program, a few may come to dominate the demonstration's enrollment. In drawing conclusions about the demonstration, it will be valuable to consider the differences among participating organizations as firm types. Further, their strategic objectives may prove to be important in explaining diverse experiences under the demonstration. For example, goals set forth by small, locally based sponsors may differ dramatically from firm to firm as well as from large national M+C firms with a larger stake in the M+C market.

Similarly, national firms participating in the demonstration appear to be positioning their demonstrations differently from one another. And, within firms that serve multiple markets, most, but not all, appear to be positioning their PPOs similarly in each market. In many cases, the PPO demonstration plans do not appear to be designed to compete with M+C as much as to attract enrollees from the traditional Medicare program who are drawn by the prospect of broader choice than in M+C HMOs and have the means to pay higher premiums. In some cases, though, the PPO demonstrations appear to be designed specifically to provide more expansive choice for those currently enrolled or considering participation in M+C.

If policymakers are to benefit fully from the lessons associated with the demonstration, they will need to be aware of the diversity of firms, the range of markets they serve, and the Medicare PPO products they offer. That is, demonstration experience may differ across firms, markets, and products. Looking at the experience of subsets of demonstration plans could provide valuable insights into the conditions under which PPO products may or may not thrive in Medicare.

CHAPTER VI

BENEFITS AND COST SHARING IN PPO DEMONSTRATIONS

Most PPO demonstration plans appear to have carved out a position in the M+C market that will permit them to attract individuals with the means to pay higher premiums than those charged by traditional Medicare HMOs. While the trade-off for beneficiaries is greater flexibility to seek out-of-network care, the PPO demonstrations have generally structured their benefits to provide substantial incentive to enrollees to use network providers. This chapter examines the benefits offered by the PPO demonstrations, their relationship to the traditional M+C products with which they are competing, and the differences between in-network and out-of-network coverage. Information on out-of-network benefits for the PPO demonstration plans is based on data provided by CMS taken from preliminary submissions of plan benefit packages. Plans have not verified the information independently.

PREMIUMS AND PRESCRIPTION DRUG COVERAGE

In terms of price, most PPO demonstrations appear to be positioning themselves between Medicare HMOs on the low side and Medigap plans on the high side. While most plans offer only one PPO plan option in the service area, some offer multiple PPO benefit packages to beneficiaries in the same area or divide their service area by offering one package in some counties and another in a second set of counties.[1] The PPO demonstration plans operate under the same rules regarding service areas and benefit packages as for plans in the broader M+C program. The average premium for basic PPO plans (those with the lowest premium)[2] operating in February 2003[3] is $84 (see table VI.1). When all PPO demonstration

[1] Among the 31 PPO demonstration plans operational on February 1, 2003, there are 43 basic plan options and 53 total plan options (distinct benefit packages). Group Health, Inc. (NY) and the University of Pittsburgh Medical Center—each sponsoring only a single PPO demonstration plan--are notable for offering multiple plan options (four and six, respectively).

[2] In cases where the premiums for plans offered by the same firm are equal, the plan with the more generous prescription drug coverage is considered to be the basic plan.

[3] No information was available from CMS or Medicare Compare about the benefits of PPO demonstrations that are not yet active.

plan options are taken together, the average premium is $92. In comparison, the average premium is $31 for basic coordinated care plan (CCP) options in the areas with active demonstrations. When all CCP packages are considered, the average monthly premium increases to $41, still considerably below the average PPO demonstration premiums. In addition, PPO demonstration plan options are more likely to assess premiums greater than $85 per month. Of all PPO demonstration plan options, 53 percent charge monthly premiums higher than $85 while just 22 percent of all CCP plans in areas served by a demonstration assess a monthly premium of more than $85. Only 28 percent of all PPO plan options have a premium less than or equal to $65, compared with 69 percent of all CCP plan options.

In relation to competing plans, a PPO demonstration may look much like Tenet's PPO demonstration in the New Orleans area, which charges an $85 monthly premium while its HMO plan in the same area charges no premium. Another HMO in the market, offered by Total Health, likewise charges no premium. Appendix B shows the market-by-market benefits and cost sharing for PPO demonstration plans and competing M+C plans in each service area.

Only two of the PPO demonstration plan options offer zero premiums, and both are available from Group Health, Inc. in the New York City area. Virtually all nine HMO plans in New York City offer at least one zero-premium plan option, and two HMOs offer plan options with reduced Part B premiums of $20 or $30. (This new option in the M+C program offers M+C plans the opportunity to refund part or all of an enrollee's Part B premium.[4]) While most PPO demonstration plans charge noticeably more than competing HMOs in any given area, there are some exceptions. Coventry's PPO demonstration plan in Jefferson County, Ohio and Hancock County, West Virginia charges a monthly premium of $87. Coventry-owned organizations operate HMOs in both of these counties as well, each with a monthly premium of $89, $2 per month higher than the PPO demonstration option.[5]

Currently, lower-income Medicare beneficiaries are disproportionately more likely to enroll in an M+C HMO (Thorpe et al. 2002; Gold and Mittler 2001). Given that PPOs generally charge higher premiums, it is unlikely many core M+C beneficiaries will enroll in a demonstration plan. In fact, one of the stated purposes of the demonstration was to avoid drawing beneficiaries from the current M+C enrollment. The demonstration plans will likely attract more middle-income beneficiaries who can afford the higher premiums and might save money by dropping their current Medigap coverage and switching to a PPO demonstration plan. If such enrollment trends prove to be true, the M+C program could develop into an economically stratified program, whereby middle-income beneficiaries choose

[4] This option, authorized in the Benefits Improvement and Protection Act (Section 606), became effective January 1, 2003.

[5] In Hancock, the one other competing M+C HMO charges a monthly premium of $79.

TABLE VI.1

MONTHLY PREMIUMS AND DRUG BENEFITS IN PPO DEMONSTRATION PLANS AND M+C CCP PRODUCTS IN DEMONSTRATION AREAS

	PPO Demonstration Plans		CCP Plans	
	Basic PPO Options	All PPO Options	Basic CCP Options	All CCP Options
Premium				
$0	2.3%	3.8%	50.0%	41.5%
$1–$65	30.2%	24.5%	28.4%	27.5%
$66–$85	23.3%	18.9%	11.2%	14.0%
$86–$105	25.6%	24.5%	8.2%	10.5%
$106–$130	11.6%	13.2%	3.0%	5.9%
$131–$150	4.7%	5.7%	0.0%	2.6%
$151 or higher	2.3%	9.4%	1.5%	2.6%
Mean	$84.00	$92.00	$30.56	$41.25
Drug Coverage				
No Drug Coverage	20.9%	20.8%	50.7%	45.1%
Generic: Annual Limit Equal to or Less than $500	37.2%	30.2%	7.5%	9.3%
Generic: Annual Limit Greater than $500	2.3%	1.9%	6.0%	5.7%
Generic Unlimited	37.2%	32.1%	16.4%	15.5%
Generic and Brand Name: Annual Limit Equal to or Less than $500	2.3%	1.9%	1.5%	3.6%
Generic and Brand Name: Annual Limit Greater than $500	0.0%	9.4%	6.7%	9.8%
Unlimited Generic and Limited Brand Name	0.0%	3.8%	11.2%	10.9%
Number of Plan Options	43	53	134	193

SOURCE: MPR analysis of files created from Medicare Compare

NOTE: Basic plans are those with the lowest premiums. In cases where two plans have the same premium, the plan with the more generous drug coverage is considered the basic plan. All plans include all offered plan options. This table includes only those plans offered as of February 2003.

loosely managed plans, and lower-income enrollees are relegated to tightly managed HMOs. (Such stratification already exists between M+C and those with Medigap.) CMS's evaluation of the Medicare PPO demonstration calls for a beneficiary survey that should provide information on beneficiary characteristics, beneficiary coverage before enrollment in the demonstration, and reasons for the switch to the demonstration plan.

PPO demonstration plans are likely to offer some, albeit limited, prescription drug coverage that imposes a low annual dollar limit, covers generic drugs only, or both. Clearly, the PPO is an improvement over both traditional Medicare, which offers no prescription benefits, and most Medigap plans (see table VI.1). Only 21 percent of PPO plan options did not offer any prescription drug coverage compared with 45 percent of all M+C CCP plan options in the same service areas. Most PPO demonstration plan options (64 percent) limit prescription drug coverage only to generic drugs. The remaining 15 percent covered brand-name drugs as well as generics, though always with a limit on coverage for brand-name drugs.

The limited drug coverage offered by the demonstration plans is not surprising given the financial constraints under which the plans operate. First, most of the demonstration plans receive the same payment as M+C plans in the same county, meaning there was generally little extra money to offer supplemental benefits not offered by the M+C plans. Second, while the demonstration does allow plans to share risk with CMS (as most have), the plans are at risk around the initial corridor and can be substantially at risk beyond the corridor as well. Finally, demonstration plans need to be able to fund out-of-network benefits, which will be costlier and less tightly controlled than the in-network benefits they offer. All of these conditions limit the amount of money available for supplemental benefits such as drug coverage. However, the fact that so many plans offer some drug coverage shows that they recognize the importance enrollees place on prescription benefits. (CMS also encouraged plans to offer such coverage.)

PRIMARY CARE PHYSICIAN AND SPECIALIST VISITS

PPO demonstration cost sharing for physician visits, both primary care and specialists, creates strong incentives for enrollees to visit in-network providers. Cost sharing for in-network physicians is much like cost sharing under traditional Medicare HMOs. All of the PPO demonstrations require fixed copayments for in-network primary care physician and specialist visits. It is interesting to note that copayments for in-network physician visits in PPO plan options are generally less costly than in competing M+C plans. For instance, 85 percent of all PPO plans require an in-network physician visit copayment of $10 or less compared with 64 percent of competing M+C CCP plans (see table VI.2). Similarly, 87 percent of all PPO plan options require specialist copayments of $20 or less compared with 62 percent of all M+C CCP plan options. Given that demonstration PPOs offer an out-of-network benefit, the plans may be relying on relatively lower in-network cost sharing as an incentive for beneficiaries to seek in-network care. At the same time, given that most M+C managed care options do not have an out-of-network benefit, in-network cost sharing may not need to be as low, though it obviously will have to be sufficiently low to attract enrollees.

TABLE VI.2

PRIMARY CARE PHYSICIAN AND SPECIALIST VISIT COST SHARING IN PPO DEMONSTRATION PLANS AND M+C CCP PRODUCTS IN DEMONSTRATION AREAS

	PPOs		CCPs	
	Basic PPO Options	All PPO Options	Basic CCP Options	All CCP Options
In-Network Primary Care Physician Visit				
$0	4.7%	5.7%	4.5%	9.3%
$1–$5	7.0%	5.7%	8.2%	9.3%
$6–$10	72.1%	73.6%	46.3%	45.6%
$11–$15	16.3%	13.2%	16.4%	15.5%
$16–$20	0.0%	1.9%	16.4%	14.0%
$21 or higher	0.0%	0.0%	6.7%	4.7%
Coinsurance	0.0%	0.0%	1.5%	1.6%
Out-of-Network Primary Care Physician Visit				
Coinsurance	74.4%	71.7%	NA	NA
20%	62.8%	62.3%	NA	NA
30%	11.6%	9.4%	NA	NA
Copayment	11.6%	9.4%	NA	NA
Deductible and Coinsurance	14.0%	18.9%	NA	NA
In-Network Specialist Visit				
$0	2.3%	1.9%	1.5%	4.7%
$1–$10	25.6%	22.6%	14.9%	16.1%
$11–$20	60.5%	62.3%	41.0%	41.5%
$21–$25	9.3%	9.4%	14.9%	12.4%
$26–$30	2.3%	3.8%	13.4%	14.5%
$31 or higher	0.0%	0.0%	12.7%	9.3%
Coinsurance	0.0%	0.0%	0.1%	1.6%
Out-of-Network Specialist Visit				
Coinsurance	74.4%	71.7%	NA	NA
20%	62.8%	62.3%	NA	NA
30%	11.6%	9.4%	NA	NA
Copayment	11.6%	18.9%	NA	NA
Deductible and Coinsurance	14.0%	9.4%	NA	NA
Number	43	53	134	193

Source: MPR analysis of files created from Medicare Compare for in-network benefits. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. Plans have not verified the information independently.

Note: Basic options are those with the lowest premiums. In cases where a plan has two options with the same premium, the plan option with the more generous drug coverage is considered the basic option. Table is limited to plans offered as of February 2003.

NA = not applicable

While the PPO plans offer fixed copayments for in-network providers, nearly all require coinsurance for out-of-network providers, placing beneficiaries at considerably greater risk for high payments by basing the enrollee's payment responsibility on a percentage of the fee instead of a fixed-dollar amount. Nearly 92 percent of all PPO plan options instituted coinsurance for out-of-network primary care physician visits (72 percent require coinsurance only, and 19 percent require coinsurance and an annual deductible) (see table VI.2). Similarly, 81 percent of all PPO plan options require coinsurance for out-of-network specialist visits (72 percent require coinsurance only, and 9 percent require coinsurance and an annual deductible). The majority of plans require enrollees to pay 20 percent coinsurance for out-of-network providers, although some require 30 percent. The few plans using copayments for out-of-network care charge between $25 and $35 per visit for both primary care and specialist physician visits.

INPATIENT AND OUTPATIENT HOSPITAL BENEFITS

Much like the cost-sharing structure for physician visits, the cost-sharing structures in the PPO demonstration plans for inpatient and outpatient hospital visits provide strong incentives for enrollees to use in-network providers. With respect to inpatient hospital benefits, in-network benefits vary (e.g., no cost sharing [26 percent of all PPO plans], a copayment per stay [34 percent], a copayment per day with a fixed cutoff [34 percent], or an annual deductible [6 percent]) (see table VI.3).

Much like the copayments for physician visits, the cost-sharing mechanisms usually impose a fixed limit on an enrollee's out-of-pocket outlays.[6] The cost-sharing requirements may be coupled with an out-of-pocket maximum, either exclusively for the inpatient hospital benefit or for all in-network services.

In comparison, out-of-network inpatient hospital benefits are much more likely to require coinsurance rather than copayments. Nearly 70 percent of all PPO demonstration plans require coinsurance for out-of-network inpatient hospital benefits (62 percent impose a coinsurance obligation only while 8 percent require coinsurance in addition to an annual deductible for out-of-network services) (see table VI.3). Again, coinsurance obligations typically range from 20 percent to 30 percent. Some PPO plans (9 percent) use the Medicare fee-for-service cost-sharing structure for out-of-network inpatient hospital services. (For 2003, the traditional Medicare program has imposed an $840 deductible per benefit period and $210 copayment per day for days 61 through 90 of each benefit period.[7])

[6] Even with a copayment per day, all copayments cover a specified period of time, for instance, $125 per day for days 1 through 15 or $100 per day for days 1 through 18, as is the case in many UnitedHealthCare PPO demonstration plans.

[7] A benefit period is defined as the time from when an individual enters a hospital or skilled nursing facility until 60 days after that individual no longer receives any care from a hospital or skilled nursing facility.

TABLE VI.3

INPATIENT AND OUTPATIENT HOSPITAL BENEFITS IN PPO DEMONSTRATION PLANS

	Basic PPO Options	All PPO Options
In-Network Inpatient Hospital		
No Cost Sharing	16.3%	26.4%
Copayment per Stay	37.2%	34.0%
$1–$150	11.6%	9.4%
$151 or higher	25.6%	24.5%
Coinsurance	0.0%	0.0%
Copayment per Day	41.9%	34.0%
Deductible	4.7%	5.7%
Out-of-Network Inpatient Hospital		
No Cost Sharing	7.0%[1]	11.3%[1]
Copayment per Stay	7.0%	5.7%
$1–$150	0.0%	0.0%
$151 or higher	7.0%	5.7%
Coinsurance	62.8%	62.3%
Copayment per Day	2.3%	1.9%
Deductible	2.3%	1.9%
Medicare Fee-for-Service Cost Sharing	11.6%	9.4%
Deductible and Coinsurance	7.0%	7.5%
In-Network Outpatient Hospital		
No Cost Sharing	30.2%	39.6%
Copayment per Visit	25.6%	24.5%
$1–$75	18.6%	18.9%
$76 or higher	7.0%	5.7%
Coinsurance	41.9%	34.0%
10%–15%	39.5%	32.1%
20%	2.3%	1.9%
30%	0.0%	0.0%
Deductible	2.3%	1.9%
Deductible and Coinsurance	0.0%	0.0%

TABLE VI.3 *(continued)*

	Basic PPO Options	All PPO Options
Out-of-Network Outpatient Hospital		
No Cost Sharing	0.0%	0.0%
Copayment per Stay	2.3%	1.9%
$1–$75	0.0%	0.0%
$76 or higher	2.3%	1.9%
Coinsurance	81.4%	77.4%
10%–15%	0.0%	1.9%
20%	69.8%	66.0%
30%	11.6%	9.4%
Deductible	0.0%	0.0%
Deductible and Coinsurance	16.3%	20.8%
Number	43	53

SOURCE: MPR analysis of data files created from Medicare Compare for in-network benefits. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. Plans have not verified the information independently.

NOTE: Basic plan options are those with the lowest premiums. In cases where two plan options have the same premium, the option with the more generous drug coverage is considered to be the basic plan. Table Includes all plans offered as of February 2003.

[1] All of UPMC's plan options have no copayment for out-of-network inpatient hospital coverage. The plans do have a 70-day limit on out-of-network inpatient hospital care, although the materials provided by CMS do not mention cost sharing.

UPMC's PPO demonstration plan options, which account for 11 percent of all PPO demonstration packages, are the only plans that do not require any cost sharing for out-of-network inpatient hospital stays. However, they do impose a coverage limit of 70 days for out-of-network inpatient care.

The remaining PPO demonstration plan options require a copayment per stay (6 percent), a copayment per day (2 percent), or an annual deductible for out-of-network care (2 percent). These charges are higher than those required by the same plan for in-network coverage. For instance, in-network cost sharing for inpatient hospital care in Health Spring's Tennessee PPO is $50 per day for days 1 through 10. Out-of-network cost sharing in the same plan option is $200 per day for the same hospitalization period.

Differences in cost sharing for in-network and out-of-network outpatient hospital benefits work much the same way as for inpatient hospital benefits. No cost sharing is required for in-network outpatient hospital visits in 40 percent of all PPO plan options (see Table VI.3). PPO demonstration plan options require copayments per visit in 25 percent of plan options and annual deductibles in another 2 percent of plans. Unlike the case with other benefits, some PPO demonstration plan options (34 percent) do impose coinsurance for in-network outpatient hospital visits. However, in the instance of coinsurance requirements, payments typically range from 10 percent to 15 percent rather than the 20 percent to 30 percent required for out-of-network providers.

In contrast, nearly all PPO demonstration plan options require coinsurance for out-of-network outpatient hospital benefits (77 percent require coinsurance only while 21 percent require coinsurance in addition to an annual deductible). None of the PPO demonstration plan options waives cost sharing for out-of-network outpatient hospital visits, and only 2 percent use a fixed copayment per visit.

OTHER FEATURES OF PPO PLANS

In addition to higher cost sharing for out-of-network services, PPO plans have adopted other mechanisms to encourage use of in-network providers. Many of the PPO plans set out-of-pocket maximums for in-network services, and some PPO plans also have established out-of-pocket maximums for out-of-network services that are higher than those for in-network care. For instance, all of UnitedHealthCare's PPO demonstrations carry an annual out-of-pocket maximum of $1,800 for in-network services and no out-of-pocket maximum for out-of-network services.

Another mechanism to encourage use of in-network providers is an annual out-of-network deductible in addition to higher cost sharing. For instance, Horizon Healthcare of New Jersey's two PPO plan options impose annual deductibles for out-of-network care of $1,000 and $2,000, after which services are covered at 80 percent and 70 percent, respectively. The plan options impose no such deductible for in-network services. Finally, some plans have instituted lifetime maximums of $1 million in coverage for out-of-network services. All of UPMC's PPO benefit packages carry the lifetime maximum, as does Cariten's PPO plan in Tennessee.

Taken together, the PPO demonstration plans have created significant incentives for enrollees to use in-network providers. Out-of-network benefits involve higher and more variable cost sharing for the enrollee and are more likely to be unlimited or subject to higher out-of-pocket maximums. However, the plans do accommodate enrollees willing to spend more for the privilege of seeking out-of-network providers; previously, the lack of such an opportunity may have constrained enrollment in traditional Medicare HMOs. Once the CMS evaluation reveals more information on the operational experience of the demonstration PPOs, it will be interesting to see the extent to which the demonstration plan enrollees use out-of-network services.

CONCLUSIONS

In sum, PPO plan options offered under the demonstration typically charge, as CMS expected, substantially higher premiums than those charged by M+C plans, although the premiums may not be as high as those charged by Medigap insurers. Positioning of the PPO product by market varies. Despite strong incentives for enrollees to remain in-network, higher premiums support access to out-of-network providers. Though demonstration PPOs usually provide some drug coverage, and are more likely to do so than Medicare M+C plans, coverage offered by the demonstration plans is highly limited in type (e.g., generic only) and maximum amount (e.g., $500).

The next chapter discusses federal payment for the PPO product. Clearly, the richness of the benefits offered by PPOs depends on the plans' ability to negotiate price with providers and to manage care. In the commercial market, most PPO savings are thought to stem from price negotiation, but PPOs competing with traditional Medicare may have less leverage than the federal government to strike a favorable bargain. At the same time, PPOs operating in commercial markets are not typically at financial risk, so they have little incentive to conduct care management activities. In Medicare, successful PPOs may have to initiate some management activities if they are to offset Medicare's potential per unit price advantage.

CHAPTER VII

PAYMENT METHODS AND RISK SHARING

Among the features that distinguish the PPO products offered under the demonstration from those offered as part of the regular M+C program are the PPOs' payment and risk-sharing provisions. In some cases, Medicare pays higher rates for PPO plans in the demonstration than for those in the regular M+C program. For some plans in the demonstration, Medicare also shares a portion of thier financial risk. This chapter briefly reviews the arrangements used in the PPO demonstration, discusses their implications, and identifies major payment and risk-sharing issues to be considered as the demonstration progresses.

HOW THE DEMONSTRATION HAS CHANGED PAYMENT AND RISK-SHARING METHODS

Payment at M+C Rate versus 99 Percent of Average Adjusted per Capita Cost

The PPO demonstration guarantees plans a payment equal to either the current M+C rate or 99 percent of the Medicare fee-for-service rate in the county (average adjusted per capita cost, or AAPCC), whichever is higher. The second option returns to the methods used in the Medicare risk program that predated M+C, except that payment is set at 99 percent versus 95 percent of what the plan would have received for similar beneficiaries in the affected geographic area. In effect, the two-option structure means that (1) some plans are paid at a higher rate in the demonstration than under M+C and (2) when plans receive the higher rate, the assumed 5 percent savings under the old system is reduced to 1 percent. Eliminating a specified savings to the government in private plan rates essentially puts rates for the demonstration and traditional Medicare option (i.e., the fee-for-service payment system) at parity if risk differences between enrollment in the two plans are adjusted properly.

The fee-for-service (or first) option addresses plans' concerns that M+C payments have been limited to a 2 percent annual increase, resulting in payments that perhaps are lower than what plans would have received under the old Medicare risk program. Under the first

payment option, plans can return to a fee-for-service–based local payment and receive 99 percent (versus 95 percent, as under Medicare risk) of that rate.

As shown in Table VII.1, M+C payments exceed 99 percent of fee-for-service payments in 84 percent of counties nationwide and in 82 percent of the counties in which demonstration plans will operate. Only 41 counties in the demonstration will be paid at 99 percent of the AAPCC, and they represent a heavy geographic concentration in New Jersey (12 of the 41 counties). About a quarter of all Medicare eligibles in the demonstration reside in counties where 99 percent of the AAPCC rate applies, exceeding the U.S. total of 19 percent.

Given Medicare's payment history, it is not surprising that the 99 percent of fee-for-service payment is not more dominant in the demonstration. Though a 2 percent minimum annual increase in M+C payments may be less than the increase in a plan's costs, recent years have seen significant constraints on Medicare fee-for-service payments. Given that these payments factor into the AAPCC, 99 percent of the AAPCC is now less than the M+C rate in many counties. The M+C floor (i.e., guaranteed minimum) rates also drive the M+C rates above 99 percent of the AAPCC in many counties.

While the option of 99 percent of fee-for-service payment does not appear to be a major influence on most demonstration plan participants, the dual-option payment structure under the demonstration is not necessarily irrelevant as a determinant of plan participation. Indeed, it provides an alternative in those counties where M+C payments may have been viewed as particularly problematic. Though these counties account for a minority share of the PPO demonstration, they may be important to the offerings in individual markets.

Of the demonstration plans, more than half (19 of 35) are located in counties where the 99 percent of AAPCC payment does not apply. Of the remaining 16, six have only a small share of beneficiaries in such counties, six have an extensive share of beneficiaries in such counties, and four are composed entirely of counties paid at 99 percent of AAPPC (see table VII. 2).

TABLE VII.1

DISTRIBUTION OF COUNTIES, BENEFICIARIES, AND ENROLLEES
BY DEMONSTRATION PAYMENT CATEGORIES*

Higher Payment Level	U.S. Counties	Medicare Beneficiaries	Beneficiaries in PPO Counties	PPO Demonstration Counties
99% of AAPCC	16%	19%	24%	18%**
Current M+C	84%	81%	76%	82%

SOURCE: MPR analysis of CMS data
* Three contracts include additional counties available only to employer groups. These are not included in the analysis.
**Includes 41 of 206 counties, 12 of which are located in New Jersey.

TABLE VII.2

PROFILE OF PPO CONTRACTS BY PAYMENT LEVEL

Geographic Area, Firm, Contract Number	Date of Operation	Total Number of Counties (M+C rate)	Percent Payment at M+C Rate	
			Beneficiaries in Service Area	Current M+C Enrollees in Service Area
Entirely 99% of AAPCC				
Pinellas County, FL Humana (H1047)	1/2003	1 (0)	0.0	0.0
Broward/Palm Beach County, FL United-HealthCare (H5400)	1/2003	2 (0)	0.0	0.0
Clark County (Las Vegas), NV PacifiCare (H5400)	1/2003	1 (0)	0.0	0.0
Nine-County Area in New Jersey Aetna (H3108)	1/1/2003	9 (0)	0.0	0.0
Primarily 99% of AAPCC				
Tampa-St. Petersburg, FL UnitedHealthCare (H5401)	1/1/2003	5 (3)[a]	57.9	55.0
New Orleans, LA Tenet Choices (H1901)	1/1/2003	4 (2)[b]	42.6	48.5
Baltimore, MD Aetna (H2110)	1/1/2003	6 (1)[c]	30.7	44.4
New Jersey Horizon (H3109)	1/2/2003	21 (9)[d]	24.9	29.4
Ohio/West Virginia Area Coventry (H3615)	1/1/2003	2 (1)[e]	32.0	64.3
Virginia Cariten (H4907)	(Delayed)	11 (5)[f]	40.2	71.6

TABLE VII.2 *(continued)*

Geographic Area, Firm, Contract Number	Date of Operation	Total Number of Counties (M+C rate)	Percent Payment at M+C Rate	
			Beneficiaries in Service Area	Current M+C Enrollees in Service Area
Limited 99% of AAPCC				
St. Louis Area Coventry (H1412)	1/1/2003	7 (6)[g]	93.9	94.8
St. Louis Area UnitedHealthCare (H1413)	1/1/2003	10 (9)[g]	94.1	94.9
New York City Area Group Health, Inc. (H3323)	2/1/2003	7 (5)[h]	84.8	89.4
Oregon/Clark, WA Health Net (H3806)	1/1/2003	14 (13)[i]	95.7	98.1
Pennsylvania Aetna (H3914)	1/1/2003	6 (4)[j]	85.6	94.0
Pittsburgh UPMC (H3913)	1/1/2003	17 (13)[k]	87.3	90.7
No AAPCC				
Birmingham, AL, Area UnitedHealthCare (H0102)	1/1/2003	5 (5)	100.0	100.0
Mobile, AL UnitedHealthCare(H0103)	1/1/2003	1 (5)	100.0	100.0
Arizona Health Net (H3014)	1/1/2003	7 (7)	100.0	100.0
Arizona PacifiCare (H0313)	1/1/2003	3 (3)	100.0	100.0
Los Angeles and Orange counties, CA PacifiCare (H0548)	Delayed	2 (2)	100.0	100.0

TABLE VII.2 *(continued)*

Geographic Area, Firm, Contract Number	Date of Operation	Total Number of Counties (M+C rate)*	Percent Payment at M+C Rate	
			Beneficiaries in Service Area	Current M+C Enrollees in Service Area
Illinois Order of St. Francis (H1408)	1/1/2003	10 (10)	100.0	100.0
Indiana Advantage (H1508)	1/1/2003	2 (2)	100.0	100.0
Kansas, Missouri Coventry (H1715)	Delayed	2 (2)	100.0	100.0
Kentucky-Ohio Anthem (pending)	Delayed	7 (7)	100.0	100.0
North Carolina UnitedHealthCare (H3403)	1/1/2003	10 (10)	100.0	100.0
Upstate New York HealthNow (H3324)	1/1/2003	16 (16)	100.0	100.0
New York City Managed Health/ Health First (H3325)	1/1/2003	5 (5)	100.0	100.0
New York City UnitedHealthCare (H3326)	1/1/2003	5 (5)	100.0	100.0
Two-County Area, Ohio UnitedHealthCare (H3616)	1/1/2003	2 (2)	100.0	100.0
Cleveland, OH, Area UnitedHealthCare (H3617)	1/1/2003	2 (2)	100.0	100.0
Allegheny, PA Coventry (H3915)	1/1/2003	1 (1)	100.0	100.0
Rhode Island UnitedHealthCare (H4103)	1/1/2003	3 (3)	100.0	100.0

TABLE VII.2 *(continued)*

Geographic Area, Firm, Contract Number	Date of Operation	Total Number of Counties (M+C rate)	Percent Payment at M+C Rate	
			Beneficiaries in Service Area	Current M+C Enrollees in Service Area
Western Tennessee Cariten (H4403)	1/1/2003	19 (19)	100.0	100.0
Eastern Tennessee Health Spring (H4404)	1/1/2003	13 (13)	100.0	100.0

SOURCE: MPR analysis of CMS data.

*Three contracts include additional counties available only to employer groups. These are not included in the analysis.

[a] Ninety-nine percent includes Hernando ($66 more) and Pinellas ($33 more) counties.

[b] Orleans Parish (New Orleans) is paid at 99 percent of AAPCC ($746 versus $698 per month), as is Saint Tammany Parish ($724 versus $718 per month).

[c] Baltimore City is paid at 99 percent of AAPCC ($628 versus $615 per month).

[d] Ninety-nine percent includes Bergen ($41 more), Cape May ($19 more), Essex ($55 more), Gloucester ($55 more), Hudson ($42 more), Mercer ($28 more), Monmouth ($34 more), Morris ($18 more), Ocean ($135 more), Passaic ($26 more), Union ($23 more), and Warren ($60 more) counties.

[J] Jefferson County, Ohio, is paid at 99 percent of AAPCC ($627 versus $569).

[f] Ninety-nine percent includes Buchanan ($70 more), Dickenson ($73 more), Lee ($31 more), Russell ($2 more), Tazewell ($26 more), and Wise ($29 more) counties.

[g] St. Charles County, Missouri, is paid at 99 percent of FFS ($592 versus $565).

[h] Ninety-nine percent includes Rockland ($4 more) and Westchester ($4 more) counties.

[l] Jackson River, Oregon, is paid at 99 percent of AAPCC ($647 versus $510 per month).

[j] Ninety-nine percent in Monroe ($2 more) and Schuylkill ($9 more) counties.

[k] Ninety-nine percent in Butler ($59 more), Lawrence ($6 more), Venango ($17 more), and Mercer ($6 more) counties.

Risk Sharing under the Demonstration

Under the demonstration, CMS offered to share risk with PPO plans subject to certain requirements described previously. In brief, all plans are required to bear "substantial" risk, and any sharing of risk between the government and the plan must be symmetrical (sharing gains as well as losses in the same proportion). Under these arrangements, plans bear responsibility for full risk within a certain range of percentage points of the target medical loss ratio (MLR). Beyond that, CMS and the health plan share the risk with specified shares. Under the demonstration, risk-sharing arrangements are consistent for each firm, even though firms may operate multiple contracts and serve different areas. CMS asked firms for uniformity in risk sharing across the firm's demonstration contracts but allowed them to vary the medical loss ratio across contracts.

For the most part, the opportunity to share risk with the federal government (rather than the firm's absorbing risk entirely on its own) appears to be attractive to firms participating in the demonstration. Of the 17 firms in the demonstration, only five are assuming all the risk, as would be the case under M+C.[1] The remaining 12 are sharing at least some risk with CMS rather than assuming it all themselves.

Under the demonstration, the plan is at risk for its administrative costs and for all gains and losses within a 2 percentage point corridor on either side of the target medical loss ratio. The most CMS will pay outside that corridor is 80 percent of the gains or losses, although both the amount of risk retained by plans and the structure of the risk-sharing arrangement vary.

Example of Risk Sharing

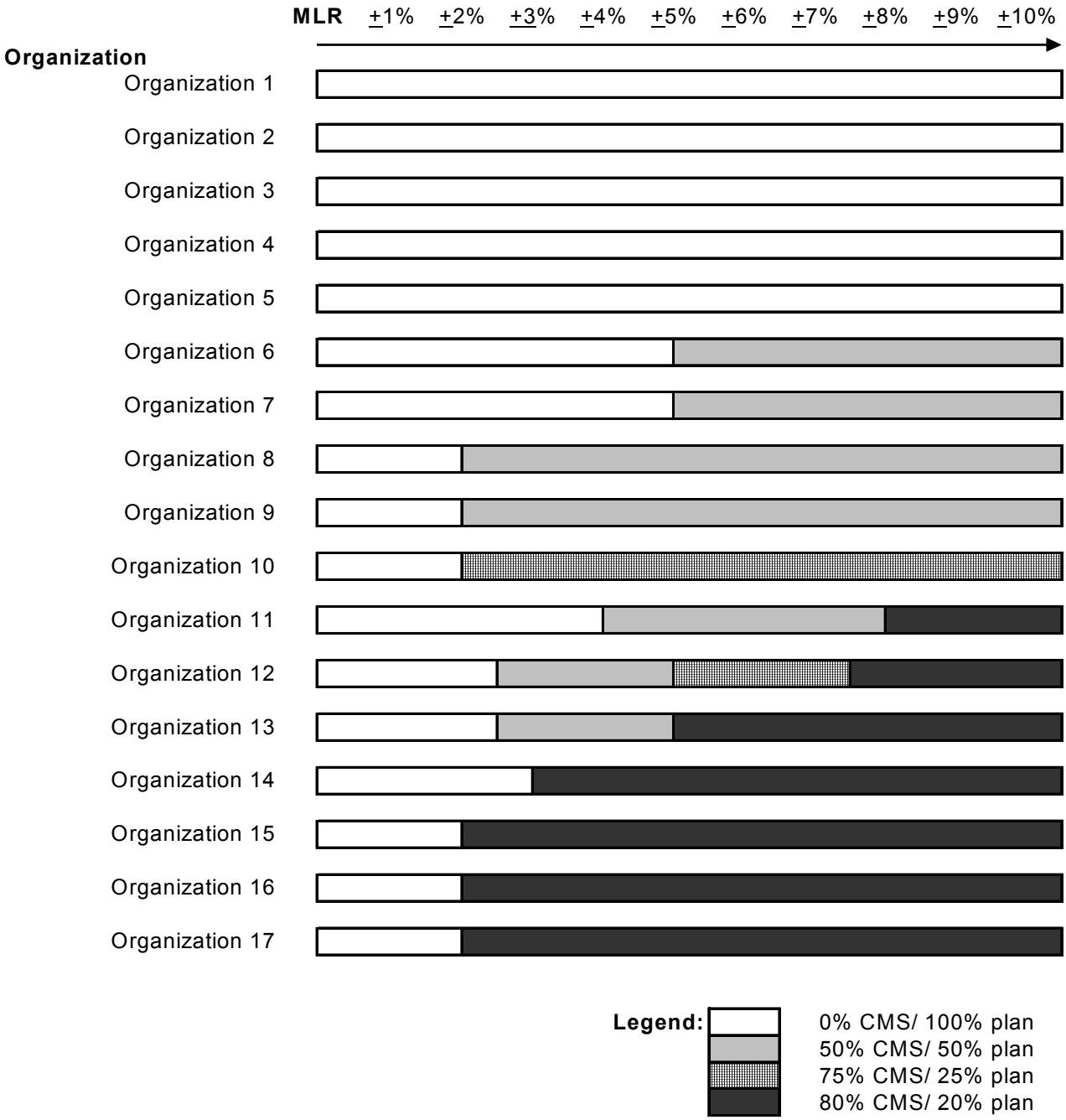
If a firm has a targeted MLR equal to 84 percent of total plan revenue, it would be responsible for 100 percent of any loss if expenses are higher than projected within a 2 percent corridor, i.e., up to an MLR of 86 percent. CMS and the firm would then share losses in the agreed upon proportion in excess of the amount equal to 86 percent, (for example, with CMS absorbing 80 percent and the firm the other 20 percent). Risk-sharing arrangements in the demonstration must be symmetrical; therefore, in this example, the plan would keep all of the gains until the MLR dropped to 82 percent, after which it would have to share further gains with CMS on the same percentage basis as the losses. CMS would retain 80 percent of the gain, and the plan would retain the balance.

[1] To avoid releasing what it viewed as firms' proprietary information, CMS did not provide us with specifics on risk-sharing arrangements or with the firm names with which the different arrangements are associated. We have generally showed whether the unnamed firm shared risk with CMS, the corridor around which it shared risk (i.e., the percentage plus or minus the target medical loss ratio), and the shared-risk split between CMS and the plan (see figure VII.1).

As discussed further below, plans have proposed and CMS has approved a variety of risk-sharing arrangements that follow the same general approach as in the example, with various portions of the risk above and below the MLR corridor shared on 0/100, 50/50, 75/25, and 80/20 bases between CMS and the plans. Figure VII.1 shows the distribution of risk sharing as summarized by CMS. Under the demonstration, the least risk a plan bears in relation to the medical loss ratio is the full risk for 2 percentage points above or below the target MLR and for 20 percent of the excess in medical expenses outside that range.

FIGURE VII.1

PPO DEMONSTRATION RISK-SHARING ARRANGEMENTS



SOURCE: CMS communication, December 13, 2002

Organization: PPO parent firm offering PPO demonstration plans.
MLR: Difference from the target medical loss ratio (MLR) (all organizations are fully at risk for a spread of +/- 2 percentage points' variance from the target).

Absence of Adjusted Community Rate Submission Requirements

As noted earlier, without additional information, we are not able to judge the effect of eliminating the requirement for submission of an adjusted community rate (ACR) for an audit. Such a waiver obviously reduces the administrative burden for the plans, a matter of great concern to M+C plans (Fried and Ziegler 2000; Draper, Gold, and McCoy 2002).

Elimination of such a requirement also gives the plans greater flexibility in the level of benefits (or premiums savings) they might offer to Medicare enrollees. At the same time, though, eliminating the ACR requirement may place a greater onus on CMS to ensure that the plan presents reasonable and accurate assumptions in support of its MLR calculations. Further, under the waiver, plans can allow the actuarial value of monthly premiums and beneficiary cost sharing to exceed the actuarial value of deductibles and coinsurance in the traditional Medicare program, thus facilitating higher out-of-network cost sharing in the PPO plans and providing flexibility in organizational design. These provisions probably make the Medicare PPO plan more attractive as a business line and increase the chances firms will stay with the program. Such stability is likely to come, however, from either a reduction in the value of the products provided to Medicare beneficiaries or an increase in the premiums charged for such products.

ISSUES FOR CONSIDERATION

Risk versus Management Potential in the PPO Model

Unlike HMOs that have historically been at risk for the full cost of medical care, PPOs are less likely to carry such risk because, at least in theory, their structure makes them less able to manage care. More specifically, there are at least four reasons to explain the differences in how HMOs and PPOs manage risk.

First, compared with HMOs PPOs, may have more extensive networks for attracting enrollees; as a result, they account for only a small share of patients in any practice so they may be less able to influence the behavior of their network physicians.

Second, PPOs typically do not require enrollees to select a primary care physician (gatekeeper model), without which it is not clear who is responsible for the enrollees' care. As a result, it becomes much more difficult to hold physicians accountable both in reality and in terms of performance monitoring. (If a PPO is a point-of- service model—as is the case with some PPOs in the demonstration—the lack of gatekeeper designation is less of an issue.)

Third, compared with HMOs, PPOs tend to be more expensive. The fact that enrollees may seek out-of-network care makes it difficult to manage beneficiaries' overall care and to control costs. Care sought out-of-network may carry a higher unit price (because the physician is not paid on a discounted fee basis), perhaps translating into higher PPO costs, depending on payment policies for out-of-network care. If network inclusion is based in part on practice profiling data on, out-of-network physicians could show more expensive practice patterns. Out-of-network care also may be more expensive because the mix of

services received is harder to control. Fourth, the added flexibility of the out-of-network option could attract either frequent users or individuals with greater health care needs who require flexibility (at least in relation to M+C).

To limit out-of-network use, PPOs generally establish significant differentials in beneficiary cost sharing between in-network and out-of-network services.[2] As discussed earlier, the PPOs in the demonstration follow the same approach but vary considerably in how they apply it. Particularly critical is the spread in cost sharing between in-network and out-of-network care, fee levels for in-network versus out-of-network care (which affects ultimate cost sharing by beneficiaries likely to be at risk for out-of-network fees above the plan's payment level as well as for the cost-sharing level that applies to it), and the extent to which out-of-pocket limits exist.

In addition to the way benefits are structured, the risk for the PPO product varies with the firm's experience in the particular markets in which it offers products and with the Medicare population generally. If, for example, a plan has operated a non–Medicare PPO in a particular market and is familiar with the providers, the population, and market operations, it is likely to face fewer uncertainties and lower risks with a Medicare PPO in the same market. Similarly, if a plan has served the Medicare population in a particular market through an M+C HMO, it will be familiar with the population and know more of its use patterns and needs than if it lacked that experience.

Commercial versus Medicare Products

CMS payments to demonstration plans are generally no higher than the payments the plans would receive in the regular M+C program, and the provisions for in-network versus out-of-network beneficiary cost sharing appear similar to those typical of a commercial PPO. Demonstration plans presumably will manage utilization in much the same way as in their commercial PPOs. Accordingly, the demonstration's payment arrangements, in-network versus out-of-network cost sharing, and utilization management are not likely to have unusual or unexpected effects. However, differences between PPO products in the commercial and Medicare markets are relevant in interpreting the results of the demonstration.

First, according to the actuaries we consulted, the risk-structuring arrangements used in Medicare differ from those used in commercial products. While commercial PPO products, like the Medicare PPO, typically exclude administrative costs from any risk-sharing arrangements, the structure of risk sharing in the demonstration differs from that in the commercial market. In the Medicare PPO demonstration, risk sharing between the purchaser and the plan is shared around a predicted corridor of plan costs, with retroactive

[2] Through their offer of point-of-service products, full-risk HMOs also allow out-of-network service use if enrollees are willing to pay a greater share of the cost, but the option to use out-of-network care is much less important in the HMO model design than it is in the PPO model, where it is a main feature used to attract enrollees.

settling up at the end of the year. Such an arrangement, we were told, is uncommon in the commercial sector.

In the commercial sector, large-employer purchasers may assume 100 percent of the risk if they self-insure. Smaller employers seek more predictability for their health costs, so they may share risk with plans, primarily for unexpectedly high health expenditures for individual enrollees or their enrollees in aggregate.[3] Private purchasers may be reluctant to enter into arrangements that involve retroactive reconciliation based on actual health expenditures in the previous year. Retrospective reconciliation just adds to the uncertainty and unpredictability of costs.

Second, the nature of plan risk in Medicare and in commercial products may differ. Medicare beneficiaries tend to use much more care on average, and chronic illness accounts for a potentially larger share of the costs of such care, especially compared with active workers. The ability to manage care (and thereby manage costs) may be more crucial in Medicare than in commercial markets, thereby making risk in a PPO substantially greater in Medicare.

Cost Implications for Medicare

As a large public purchaser, CMS is in a good position to assume a large portion of the risk—indeed, it does so for the vast majority of beneficiaries in the traditional Medicare program. For CMS, a major question is the nature of the beneficiaries enrolled in the plan with which it shares risk and the degree of management (beyond the traditional Medicare product) that plan exercises.

To the extent that Medicare PPO demonstration plans attract beneficiaries who would otherwise have been enrolled in the full-risk M+C program, Medicare potentially will incur greater costs because it shares a portion of the risk for the enrolled population. Of course, Medicare can share risk only to the extent that plans are also willing to assume a measure of that risk; therefore, shared risk could be a good "second best" alternative to no risk at all if no entities actually manage care and are willing to absorb risk (and be paid appropriately for it). In addition, most beneficiaries are enrolled in the traditional Medicare program whereby Medicare is fully at risk for costs associated with Medicare benefits. However, the accuracy of risk adjustment is critical. Any shortcomings in the adjustment methodology could be costly to CMS if PPO beneficiaries are healthier than those in the traditional program.

The risk corridor approach could be especially useful in encouraging plan participation in new programs in which past health care cost and utilization experience may not be sufficient to predict future costs with reasonable confidence. Whether using the corridor approach in the context of the PPO demonstration serves this purpose is not yet clear. Will risk-sharing arrangements, for example, encourage firms to develop more experience with

[3] Either party may purchase separate reinsurance from the secondary market for particularly high and unusual expenses and/or losses.

the Medicare population and with the specific geographic market in which they operate? If so, plans may learn to manage care and gain confidence in assuming a greater share of risk.

Risk-Sharing Mechanics and Implementation

The starting point for all of the risk-sharing arrangements between CMS and each of the demonstration plans is a specific medical loss ratio for each plan—information that is highly sensitive and considered proprietary by the firms. CMS has disclosed neither the ratio for individual demonstration plans nor the predicted plan revenue or expenses on which the MLR is based. CMS will reconcile the risk-sharing arrangements 12 months after the close of the contract year, at which time it will establish the actual MLR and, with the plans, make payments as appropriate.

While the MLR is a standard financial measure in the health insurance industry, using it for risk sharing raises some difficulties. In particular, calculating an MLR requires two important figures, both of which are subject to uncertainty and may not always be firm and unambiguous, even in retrospect: (1) the plan's annual premium revenue and (2) the plan's annual medical expenses. Annual premium revenue, though difficult to predict, especially for a new program, is reasonably easy to establish in retrospect after delayed and uncollectible premiums and over- and underpayments are sorted out. However, medical expenses must be distinguished from administrative expenses to calculate the MLR. Without standard definitions of what constitute administrative versus clinical expenses, it is difficult to calculate MLRs consistently.[4] If, for example, a plan delegates some utilization management and quality assurance functions to provider groups, do those functions represent medical or administrative expenses? If an organization operates plans in more than one county, how are central office expenses allocated among the plans?

In practice, the lack of predictability and clarity that appears to be associated with the risk-sharing arrangement developed by CMS for the PPO demonstration may not pose difficulties for the plans and CMS; the plans and, to a lesser extent, CMS are experienced in dealing with the MLR. Nonetheless, it is important to monitor how the risk-sharing aspect of the demonstration plays out, especially if CMS is considering the use of similar arrangements in other parts of the M+C program. It is also important to assess the factors that lead demonstration plans to assume more or less risk as they gain experience in specific geographic markets and with the Medicare population.

CONCLUSIONS

Payment rates to the participating PPOs under the demonstration are not generally higher than those under M+C. Thus, it is likely that firms' interest in the demonstration can

[4] For an instructive discussion of these ambiguities, see Robinson, 1997.

be explained by (1) the opportunity to share some of the risk with CMS; (2) greater flexibility in setting benefits that match payments; and (3) incentive for tapping new and potentially lucrative markets (e.g., higher-income beneficiaries with Medigap or employment-based group benefits). A major issue for the demonstration as it proceeds will be to learn how it affects Medicare's and other participants' costs, particularly out-of-pocket costs for beneficiaries and the financial viability of plans.

CHAPTER VIII

CONCLUSIONS

OVERVIEW OF KEY FINDINGS

In sharp contrast to the experience with many previous Medicare managed care demonstrations, in the PPO demonstration, CMS has mounted a major initiative in a short period and with a high degree of plan participation. This achievement is due, in large part, to the fact that the CMS administrator has indicated, to the extent feasible under the law (Scully 2000), an interest in working closely with private plans to understand their concerns more fully and to structure payment arrangements that are more congruent with key business practices.

Such an accomplishment, however, does not come without risks. Given the particular time frame, CMS had little opportunity to review the applicants' qualifications. The fact that this could have opened the door to unqualified participants could have impeded the demonstration's success and jeopardized care for vulnerable Medicare beneficiaries. By establishing qualification criteria that required state licensure and stressed a firm's infrastructure and relevant experience, CMS sought to protect against risks to beneficiaries that would have undermined the demonstration. The fact that most of the participating firms have been involved in M+C also provided reassurance, though participation in M+C was not required. The downside, of course, is that the same selection criteria that minimized risk may also have limited CMS's ability to draw new firms or coverage enhancements into areas of the Medicare market in which choice is limited.

Indeed, the data presented in this report show that the demonstration has attracted a diverse group of firms offering PPO plans in a range of geographic areas. It has not, however, attracted new firms or elicited firm interest in products that would be available in areas where managed care has not already taken hold under the M+C program. But such an outcome is not surprising in light of M+C (and earlier Medicare risk) experience. For instance, it has proven to be exceptionally difficult to establish managed care models in rural and generally less urban areas.

It is not clear whether CMS structured the demonstration to generate such offerings in rural and other similar areas that do not already have extensive M+C offerings. Moreover, a three-year demonstration that begins less than six months after award is unlikely to draw

applications for network-based products if a network must be established from scratch. In addition, by requiring plans to engage in risk sharing (and to demonstrate associated state licensure), CMS probably precluded participation of many major PPOs that had no Medicare experience and that, absent state licensure, were unable to contract directly with CMS. At the same time, plans without experience in risk arrangements may be less likely to have developed systems to manage risk and care. As a result, they may have little to add to CMS's already strong ability to set prices in ways that encourage cost containment.

IMPLICATIONS OF EXPERIENCE TO DATE

The demonstration experience provides valuable information for policymakers considering Medicare reform proposals that would use a new benefit (such as drug coverage) to attract beneficiaries from traditional Medicare to private plans. In particular, the products offered under the demonstration are testing various combinations of benefits and cost sharing in ways that are likely to build a better understanding of beneficiary preferences and behavior, including the trade-offs they make between provider choice (in- and out-of-network benefits) and price.

Early experience with the demonstration's enhanced choice is not encouraging with respect to reducing the share of beneficiaries without supplemental coverage or alleviating the financial uncertainty of beneficiaries facing burdensome drug costs. While lower than Medigap premiums, PPO premiums under the demonstration are still high—the large share of beneficiaries must pay $1,000 a year or more. Even though the premiums could still attract some moderate-income beneficiaries unable to afford Medigap but not wanting to relinquish provider choice in favor of an M+C plan, the demonstration products seem particularly likely to appeal to those already covered—through either an employer or their own Medigap coverage.

In addition, while most demonstration plans include some drug coverage (an improvement on Medicare-only coverage or on Medicare coverage with the Medigap plans in which most beneficiaries are enrolled), the PPO demonstration plans offer much less extensive coverage than that offered through common group benefits. Typically, drug coverage offered by the PPO demonstration plans is restricted to generics. In addition, many plans impose an annual limit (often $500 per year). Both premium prices and drug coverage policies provide additional evidence that choice, however valuable, is not a substitute for an expanded Medicare benefit package.

ISSUES TO MONITOR AS THE DEMONSTRATION PROCEEDS

The CMS-sponsored evaluation of the Medicare PPO demonstration should provide insight into the factors that influence beneficiary and plan interest in products, demonstration costs, and other areas of interest. For instance, it is important to monitor the number of beneficiaries who enroll in the products because this information will help to determine how attractive PPO plans are to Medicare beneficiaries. CMS assumes a limited scope for the demonstration—150,000 enrollees from markets that include more than 10

million beneficiaries—implying that CMS expected only moderate interest. As of April 2003, nearly 58,000 Medicare beneficiaries had enrolled.

As the demonstration proceeds, it is also important to develop information on its cost effects, including Medicare expenditures for demonstration plans and out-of-pocket costs incurred by beneficiaries enrolled in the plans. By statute, CMS demonstrations must be budget neutral. However, the ultimate cost effects of the demonstration will depend on what transpires with regard to (1) payment rates in counties with the highest enrollment; (2) who enrolls, which will reveal whether the risk-adjustment methods have left any selection bias unaddressed; and (3) the extent to which PPOs can manage costs better than the plans in which beneficiaries were previously enrolled (especially traditional Medicare). Obviously, better management will reduce losses, as well as CMS exposure, as a result of the demonstration's risk-sharing arrangements.

Beneficiaries' previous form of coverage (e.g., Medigap, employer supplement, M+C) will likely determine the "winners and losers" under the demonstration. The former could be individuals who have a Medigap policy, experience lower premium costs in the PPO demonstration plans, and are satisfied with the PPO product. Those in employer-paid plans, however, may lose out to the extent that any savings arising from retirees' enrollment in the PPO demonstration are retained by the employer instead of being passed along to retirees. On the other hand, these beneficiaries could gain if such savings induce employers otherwise inclined to reduce or drop retiree coverage to retain such coverage. If the demonstration draws heavily from beneficiaries already enrolled in M+C, CMS could experience losses, especially if those switching are sicker (more expensive) and are enrolled in plans associated with firms that share risk under the PPO.

Historically, CMS has had little information on the source of M+C enrollment, that is, whether beneficiaries are enrolled individually or through employer groups, although efforts have been made recently to gather more of this kind of information (G.R. Hileman et al. 2002). While most group enrollees in M+C plans are enrolled through products also available to individuals, some have recently enrolled through plans available only to employer groups. To fully understand the demonstration, it will be important to collect data that indicate whether enrollment is group- or individual-based as well as the source of the product. Information of this type is likely to be collected in the CMS evaluation (through surveys and interviews), but it also would be useful for CMS to provide more information on these issues through its traditional public data sources.

The scope of the demonstration and the speed with CMS which initiated it should serve policymakers well, potentially providing timely feedback not only on beneficiary preferences but also on what the shift to private plans costs Medicare.

RELEVANCE TO CURRENT DEBATE ON MEDICARE REFORM

In the meantime, the demonstration experience to date reinforces the fact that managed care models—whether HMO or PPO—tend to be easier to develop in urban than in rural areas and that, even in urban areas, their market strength varies. Current and earlier PPO

demonstration experience highlights the long lead time needed to develop new products and offerings, particularly when they require creation of new networks either in new areas of the country or by firms new to the market.

Accordingly, Medicare reform proposals that call for managed care models should not assume that reforms will be feasible nationwide. Even where reforms do prove to be feasible, implementation may require substantial lead time as well as a great willingness on the part of CMS to work closely with potential contractors to agree on terms that meet business needs. Determining what is feasible and where may involve trade-offs between these terms and beneficiary needs; an example could be the case with regard to waiving ACR requirements and actuarial tests.

In addition, the demonstration experience to date reinforces the importance of adequate funding for any expansion of Medicare benefits, whether in the traditional program or under a competitive model in which different types of private health plans are offered. It is instructive that the demonstration PPOs generally charge higher premiums than do HMOs. While demonstration PPO benefits are not uniformly less generous, and cost sharing is higher (at least for in-network care) than with HMOs, it remains true that, even on a shared-risk basis, the ability of demonstration plans to expand benefits without increasing premiums has been modest. Clearly, adequate financing is important to the feasibility of supporting benefit expansion and to the ability to structure competitive models that will be attractive to private plans.

REFERENCES

Achman, Lori, and Marsha Gold. "Trends in Medicare+Choice Benefits and Premiums 1999-2000." New York: The Commonwealth Fund, November 2002.

Achman, Lori, and Marsha Gold. "Medicare+Choice and Medicare Beneficiaries: Monthly Tracking Report for December 2002." Washington, DC: Mathematica Policy Research.

Anthem Blue Cross-Blue Shield. Available at [www.80.anthem.com/jsp/antiphoa/corp/primary.psp?secp=About Us]. Accessed February 13, 2003.

Brown, Randall S., Dolores Gurnick Clement, Jerrold W. Hill, Sheldon M. Retchin, and Jeanette W. Bergeron. "Do Health Maintenance Organizations Work for Medicare?" *Health Care Financing Review* 15(1):7-23, Fall 1993.

Centers for Medicare and Medicaid Services (CMS). "Medicare Managed Care Contract Plans Monthly Summary Report December 2002." Baltimore, MD: CMS, January 2003. Available at [www.cms.hhs.gov/healthplans/statistics/mmcc/]. Accessed February 16, 2003a.

_____. "Medicare+Choice Non-Renewal Reports CY2003." Baltimore, MD: CMS, September 2002. Available at [www.cms.hhs.gov/healthplans/nonrenewal/nrrepts.asp]. Accessed February 16, 2003b.

_____. "Medicare Program: Solicitation for Proposals for the Medicare Preferred Provider Organization (PPO) Demonstration." CMS-4042-N. RIN 0938-ZA32. Baltimore, MD, April 15, 2002a.

_____. Applicant Questions, updated May 14, 2002b. Baltimore, MD.

_____. Medicare Preferred Provider Demonstration Fact Sheet. Available at [www. Hcfa.gov/research/ppdemo.htm]. Accessed May 16, 2002c.

_____. Medicare Preferred Provider Organization (PPO) Demonstration, Presentation to the Medicare+Choice Research and Policy Analysis Network Meeting, Washington, DC, November 1, 2002d.

Christensen, Sandra. "Medicare+Choice: Provisions in the Balanced Budget Act of 1997." *Health Affairs,* July/August 1998: pp 224-231.

Covenant States and Mountain Health Alliance/Cariten Insurance Company. Available at [www.covenanthealth.com/AboutUs/Cariten?CaritenNews/CFML/About/Default.cfm]. Accessed February 13, 2003.

Coventry Health Care, Inc. Quarterly Report SEC form 10Q, May 14, 2001.

Draper, Debra, Marsha Gold, and John McCoy. "The Role of National Firms in Medicare+Choice." Washington, DC: Henry J. Kaiser Family Foundation, June 2002.

Frazer, Hilary, Anna Aizer, Lyle Nelson, Jessica Mittler, and Amanda Smith. "The Implementation of the Medicare Choices Demonstration." Washington, DC: Mathematica Policy Research, Inc., September 13, 1999.

Fried, R. M., and J. Ziegler. "The Medicare+Choice Program: Is it Code Blue?" Washington, DC: Shaw Pittman, for the Health Insurance Association of America, June 8, 2000.

General Accounting Office. "Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings." HEHS-00-183, Washington, DC: General Accounting Office, September 2000.

Gold, Marsha. "Can Managed Care and Competition Control Medicare Costs? *Health Affairs Web Exclusive,* April 2, 2003 (WB-176-188).

Gold, Marsha. "Trends in Medical Coverage That Active Workers Receive from Employers: Implications for Reforming the Medicare Benefit Package." *MedPAC Contract Research Series No. 02-1.* Washington, DC: Medicare Payment Advisory Commission, May 2002.

Gold, Marsha. "Medicare+Choice: An Interim Report Card." *Health Affairs*, July/August 2001a, pp. 120-138.

Gold, Marsha. "Medicare's Private Fee-for-Service Plan: Sterling's Structure, Opportunities and Risks." *Monitoring Medicare+Choice Operational Insights #4.* Washington, DC: Mathematica Policy Research, Inc., July 2001b.

Gold, Marsha. "Understanding the Roots: Health Maintenance Organizations in Historical Context." In M. Gold, ed., *Contemporary Managed Care: Readings in Structure, Operations and Public Policy.* Chicago: Health Administration Press, 1998.

Gold, Marsha, and Lori Achman. "Raising Payment Rates: Initial Effects of BIPA 2000." *Monitoring Medicare+Choice Fast Facts #6.* Washington, DC: Mathematica Policy Research, Inc., June 2001.

Gold, Marsha, and Anna Aizer. "Medicare Beneficiaries in HMOs: A Case Study of the Tampa Florida Market." Washington DC: Henry J. Kaiser Family Foundation, July 1998.

Gold, Marsha and Anna Aizer. "Medicare Beneficiaries in HMOs: A Case Study of the New York City Market." Washington, DC: Henry J. Kaiser Family Foundation, January 1998.

Gold, Marsha, and Timothy Lake. "Medicare+Choice in California: Lessons and Insights." Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2002.

Gold, Marsha, and John McCoy. "Medicare+Choice Withdrawals: Experiences in Major Metropolitan Areas." *Monitoring Medicare+Choice Operational Insights #8*. Washington, DC: Mathematica Policy Research, Inc., September 2002b.

_____. "Choice Continues to Erode in 2002." *Monitoring Medicare+Choice Fast Facts* #7. Washington, DC: Mathematica Policy Research, Inc., January 2002a.

Gold, Marsha, and Jessica Mittler. "The Structure of Supplemental Insurance for Medicare Beneficiaries." *Monitoring Medicare+Choice Operational Insights #3*. Washington, DC: Mathematica Policy Research, June 2001.

Group Health Insurance. Available at [www.ghi.com/about/ahhist.htm]. Accessed February 13, 2003.

Hileman, Geoffrey R., Kerry E. Moroz, C. William Wrighton and Suhn K. Kim. "Medicare+Choice Individual and Group Enrollment: 2001 and 2000. *Health Care Financing Review* vol.24, no.1, pp 145-153, Fall 2002.

Kaiser Family Foundation/Health Research and Educational Trust. "Employer Health Benefits, 2002 Annual Survey." Menlo Park, CA: September 2002.

Kornfield, Thomas, and Marsha Gold. "Is There More or Less Choice?" *Monitoring Medicare+Choice Fast Facts #1*. Washington, DC: Mathematica Policy Research, Inc., December 1999.

Lake, Timothy, and Randall Brown. "Medicare+Choice Withdrawals: Understanding the Key Factors." Washington, DC: Henry J. Kaiser Family Foundation, June 2002.

Medicare Payment Advisory Commission (MedPAC). "Medicare+Choice: Trends Since the Balanced Budget Act." In *Annual Report to the Congress: Medicare Payment Policy* (chapter 5). Washington, DC, March 2002.

_____. "Report to the Congress: Medicare Payment Policy." Washington, DC, March 2001a.

_____. "Report to Congress: Medicare in Rural America." Washington DC, June 2001b.

_____. "Report to Congress: Medical Savings Accounts and the Medicare Program" Washington DC, November 2000, p. 11.

New York Consumer Guide to Health Insurance 2002. New York State Department of Health, August 1, 2000.

Office of the Press Secretary. "Fact Sheet: President Outlines Agenda for Improving Health Security in the Best Health Care System in the World." February 11, 2002. Available at [www.whitehouse.gov/news/released/2002/02/20020211.html]. Accessed February 20, 2003.

Order of St. Francis. Available at [www.osfhealthcare.org/facts.html]. Accessed February 13, 2003.

Robinson, James C. "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance." *Health Affairs*, 16, (4), July/August 1997: pp. 176-187.

Rossiter, Louis. *Understanding Medicare Managed Care: Meeting Economic, Strategic and Policy Challenges*. Chicago: Health Administration Press, 2001.

Scully, Thomas. Speech at 2002 National Policy Conference sponsored by Academy for Health Services Research and Health Policy. Washington, DC, January 16, 2002.

Tenet Healthcare Corporation. Available at [www.etenet.com/generalinfo/aboutus.asp]. Accessed February 13, 2003.

Thorpe, Kenneth, Adam Atherly, and Kelly Howell. "Medicare+Choice: Who Enrolls?" Washington, DC: Blue Cross Blue Shield Association, April 25, 2002.

University of Pittsburgh Medical Center (UPMC). Available at [www.upmc.com/Overview.htm]. Accessed February 14, 2003.

Young, Cheryl. "Markets Stagnate: Views from the Field." *Monitoring Medicare+Choice Operational Insights #10*. Washington, DC: Mathematica Policy Research, forthcoming.

APPENDIX A

MEDICARE'S HISTORY WITH PRIVATE PLANS

As the marketplace has evolved, Medicare has attempted to accommodate to a changing environment. In particular, the program has sought to provide a role for some types of private health plans that departed from traditional fee-for-service delivery (particularly HMOs). Enrollment in such plans has always been voluntary. Further, only than a small minority of Medicare beneficiaries has ever participated in HMOs, which for a long time were the only type of private plan offered in Medicare. In fact, HMOs remain the predominant type of private health plan in the program.

This appendix reviews Medicare's history with private plans, including its early history, the Medicare risk-contracting (HMO) program, the Medicare+Choice (M+C) program, and the concerns that underlie development of the current Medicare PPO demonstration.

EARLY HISTORY

The original Medicare program was structured to resemble health insurance arrangements common when Medicare was enacted in 1965: a basic indemnity heath insurance plan covering institutional (mostly hospital) services—Part A and physician (and other professional) services—Part B (Gold 2002). Administered by the federal government, the nationwide insurance program offers a uniform set of benefits for a standard premium. From the outset, private contractors provided administrative support for claims payment and oversight. Though the program has evolved, the basic structure of today's Medicare is in many ways similar to that at the time of the program's original conception.

Over time, policymakers have made some accommodation for alternative forms of care delivery. Initially, the most common of these arrangements was prepaid group practices,

such as Kaiser-Permanente.[1] In 1977, only 4.3 percent of all those with private employer-paid insurance participated in such a plan (Gold 2002).

In the early years (1966–1979), Medicare reimbursed private plans on a cost basis—first through prospective payment under Part B and, after 1972, on a reasonable cost basis as Group Practice Prepayment Plans (now Healthcare Prepayment Plans) (Rossiter 2001). The intent was to allow beneficiaries to continue with the same care arrangements with Medicare as they had with private employer-paid coverage to Medicare.

By the middle of this period (after the HMO Act of 1973 and the competitive era that followed the act's phase out), HMOs became more common in private insurance. Newer forms of HMOs (individual practice associations, or IPAs) joined the prepaid group practice model and provided a more expansive choice of providers. Prepaid group practices used a tight provider network that made them less attractive to individuals who already enjoyed an established relationship with community providers or preferred access to those providers. Provider networks affiliated with IPA-model HMOs were broader and included community-based physicians who practiced outside large-group settings. Given that many doctors in the community participated in IPAs and individuals could join IPAs/HMOs without changing their physician, development of the IPA model gradually led to an increase in HMO enrollment.

As HMOs became more common in the late 1970s, Medicare began to experiment with risk-based (capitated) ways of paying private plans.[2] A Medicare capitation demonstration started in 1980 with seven plans; a National Medicare Competition Demonstration with 27 plans operated between 1982 and 1985. In each of these demonstrations, Medicare paid HMOs a prepaid capitated amount per enrollee and put the plan at risk for delivering and paying for the individual's care. Evaluations of the demonstrations showed that they saved money (largely by reducing inpatient use) and provided about the same quality of care as the traditional Medicare program. In addition, surveys indicated some reduction in overall enrollee satisfaction compared to fee-for-service, with greater satisfaction with costs but less satisfaction with choice of physician (Rossiter 2001). However, some plans engaged in abusive practices. For example, because plans were paid a fixed amount per member they had an incentive to enroll members, and some marketing abuses were reported among certain plans (e.g., enrolling people without their knowledge or providing misleading information). Reports of abuses were common in the south Florida market where the contract of a large HMO was terminated by the federal government (Rossiter 2001).

---

[1] Prepaid group health practices are integrated systems that assume responsibility for providing care to a specified population at a fixed price per member per month (capitation). In 1970, nationwide enrollment in health maintenance organizations, as these plans came to be known, totaled 3 million people in the United States across all payers of care. Although there were 236 HMOs nationwide in 1980, only 9.1 million people were enrolled in them (Gold 1998).

[2] By paying HMOs a fixed premium per member per month--regardless of the actual use of health care (capitation)—plans received no incentive to overuse services as they might have with fee-for-service payment.

The experience of the demonstrations highlights the importance of defining eligibility requirements for any private plans participating in the Medicare program and providing continued oversight of plan practices (such as in marketing, network sufficiency, and quality of care). The challenge for Medicare has always been how to establish such requirements to protect beneficiaries while avoiding micromanagement of plans and of requirements that add excessively to administrative burdens and discourage participation by the types of plans Medicare may want to attract to the program.

THE MEDICARE RISK CONTRACTING PROGRAM

As HMOs became more pervasive nationally in the private sector, Medicare made it easier for HMOs to participate in the risk program permanently rather than on a demonstration basis alone. Specifically, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 established the Medicare risk program, which began in April 1985 (Brown et al. 1993). Under the program, Medicare required HMOs to assume responsibility for providing all Medicare-covered services to beneficiaries in return for a capitated payment. The capitation payment to an HMO for an enrollee living in a given county was set equal to 95 percent of what the Health Care Financing Administration (HCFA, now CMS) estimated it would have spent if the same Medicare beneficiary remained in the traditional Medicare program (i.e., the fee-for-service program).

Enrollment in the Medicare risk program was voluntary. Beneficiaries who did not enroll in an HMO remained in traditional Medicare. The risk-contracting program required plans to return any additional savings (beyond the 5 percent automatically retained by the federal government) to beneficiaries in the form of more benefits or lower premiums. (More benefits included coverage of Medicare's cost sharing and noncovered benefits, such as various preventive services, eye and hearing care, and prescription drugs.) The added benefits or savings were the main incentives for encouraging beneficiaries to join a private plan. Strong incentives were important; in exchange for the potential to pay less and receive enhanced benefits, a beneficiary had to be willing to accept the constraints inherent in an HMO, i.e., a restricted set of providers.

Even though their market share was still small, Medicare risk plans accounted for higher enrollment than under previous Medicare programs for private plans. Fewer than half a million Medicare beneficiaries were enrolled in private plans in 1985 (the year the risk program began operating (Gold 2001)). Enrollment grew steadily but slowly until about 1993, when fewer than 1.8 million beneficiaries, or 5 percent of all Medicare beneficiaries were enrolled. A HCFA-sponsored evaluation of the program found that beneficiaries in HMOs received care comparable to that received by beneficiaries in the traditional Medicare program. In addition, beneficiaries reported substantially lower out-of-pocket costs and an enhanced set of benefits. However, while HMOs used fewer resources, the federal government did not save any money over fee-for-service care because the capitation system did not adequately account for the better health status of those who enrolled in the risk program (they used fewer services on average than those in the traditional program) (Brown et al. 1993).

In the late 1980s, managed care started to expand in the private market as many employers attempted to control costs by offering coverage in HMOs. Employers encouraged workers to enroll in managed care plans by offering them models that had more provider choice and flexibility. Although these looser models were appealing to enrollees, their potential to help manage costs was lacking (Gold 2002). Seventy-three percent of all active workers with insurance coverage were enrolled in conventional indemnity plans in 1988; that proportion declined to 46 percent by 1993, 27 percent by 1996, and 5 percent by 2002 (see figure II.1).

Medicare did not evidence the same trends as the private sector, though enrollment in Medicare HMOs expanded greatly during the 1990s, from 1.8 million in 1993 to more than 5.2 million in 1997. At this point, 14 percent of Medicare beneficiaries were enrolled in Medicare HMOs. Until enactment of the BBA, Medicare did not offer PPO plans, which were beginning to dominate private insurance coverage.

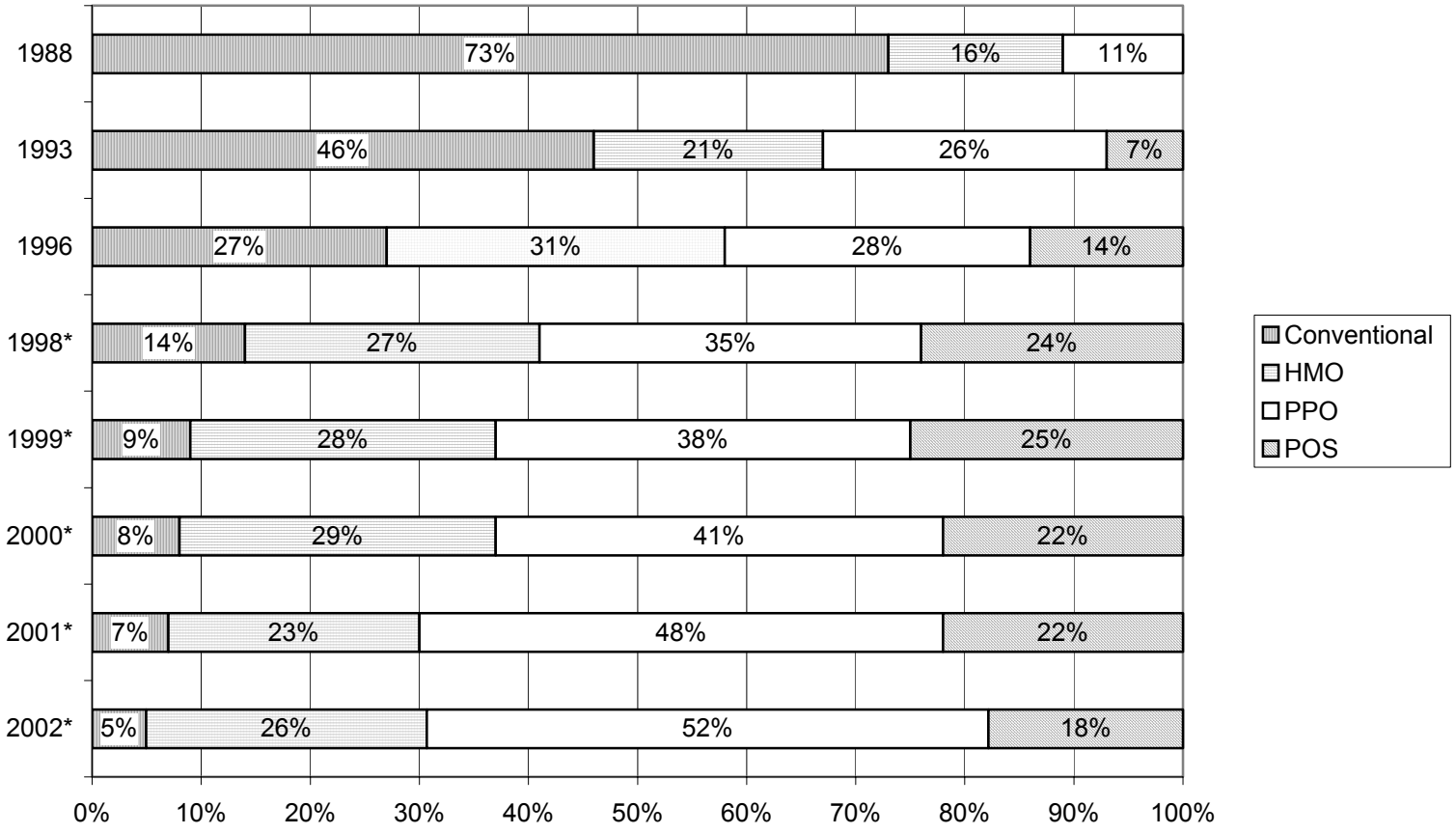
To learn more about contracting with a range of managed care plans, HCFA used its demonstration authority in mid-1995 to create the Medicare Choices demonstration (Frazer et al. 1999), which encouraged development of new types of managed care organizations and products as well as new risk-based methods of payment. HCFA selected nine geographic areas where conditions favored managed care but where Medicare risk contracting had little or no presence. The demonstrations encouraged applicants to include rural areas within their service area; three drew substantially from rural areas. Of the 52 organizations selected competitively to submit proposals, HCFA chose 25 to participate in the demonstration. Ultimately, 13 participated after nine withdrew and three others decided to participate in the regular M+C program. The demonstrations encouraged applicants to include rural areas within their service area, and three applicants drew substantially from these areas.

Demonstration plans began operating in 1997-1998, although two of the 13 withdrew in 1999. Of the 13, providers sponsored 12, and an insurer sponsored one. Most offered HMO products, but 3 offered other forms of managed care alone or in addition to an HMO product. Independence Blue Cross offered the most extensive set of options. In addition to its existing Medicare supplemental plans and Medicare HMO options (both traditional closed-panel models and "point of service" models that provide an out-of-network benefit for enrollees willing to pay more out of pocket), Independence offered a PPO alternative under the demonstration. (When the demonstration ended, Independence's PPO product became a regular PPO under the M+C program, which by that time had replaced the Medicare risk-contracting program.)

Evaluators concluded that while the demonstration attracted plans that would not qualify under the Medicare risk-contracting program, applicants under the demonstration required substantial assistance to understand and meet requirements; collecting encounter data was a particular problem. In addition, establishing provider networks in rural areas proved to be challenging (Frazer et al. 1999). These findings are relevant because they highlight the problems associated with expanding even loosely formed managed care plans to rural areas. The findings also underscore the challenges

FIGURE A.1

HEALTH PLAN ENROLLMENT FOR COVERED WORKERS, BY PLAN TYPE, 1988-2002



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits; 1999, 2000, 2001, 2002; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996, 1998

*Distribution is statistically different form the previous year shown: 1996-1998, 1998-1999, 1999-2000, 2000-2001, 2001-2002.

involved in starting up new plans rather than expanding the product line in forms that already offer similar plans elsewhere. Challenges could be particularly daunting for provider organizations with no insurance experience and traditional insurers inexperienced in network-based managed care.

The M+C program (described below) was enacted just as the Medicare Choices demonstration went "live" and provided legislative authority for many, though not all, of the options to be tested in the demonstration. For example, M+C authorized PPOs but required that all managed care plans be fully at risk for the cost of care, unlike the Medicare Choices demonstration, which allowed risk sharing with HCFA.

THE MEDICARE+CHOICE PROGRAM

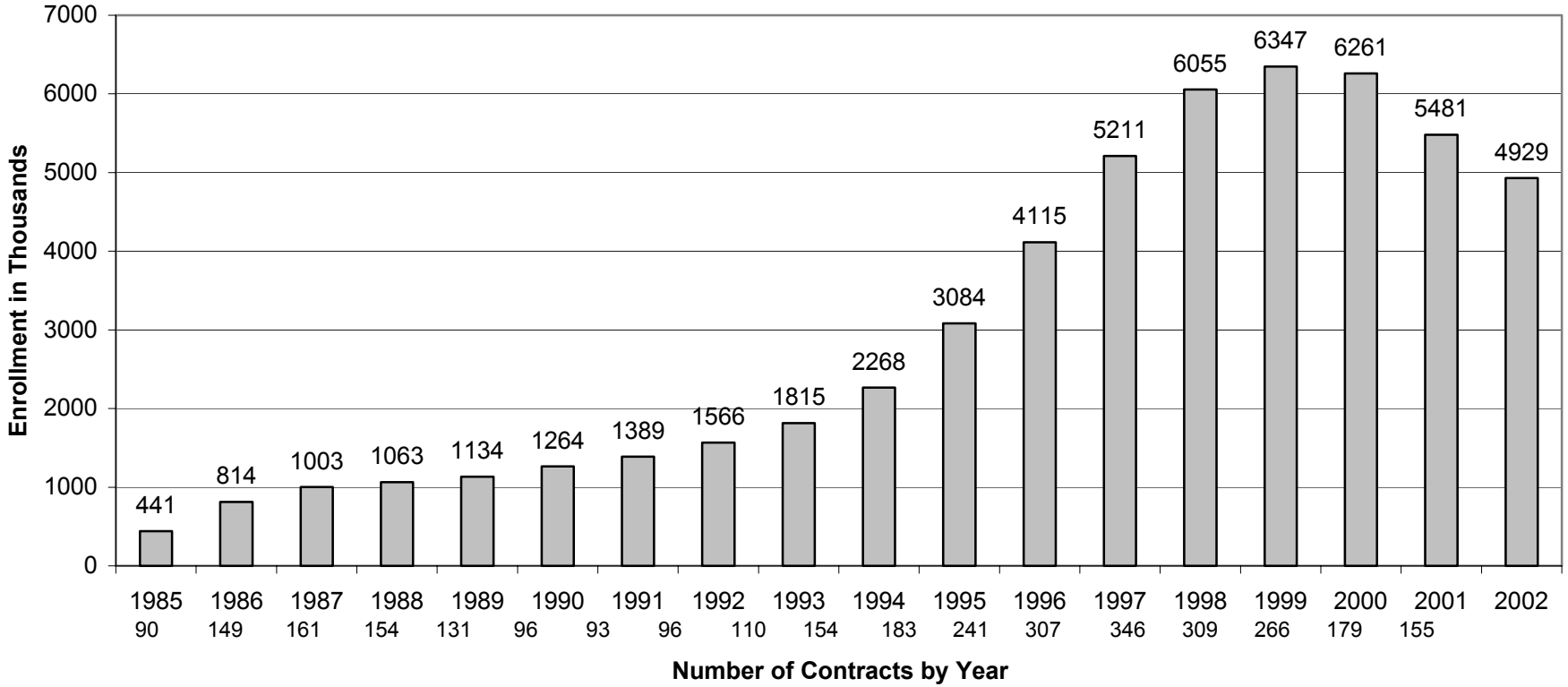
To further expand Medicare enrollment in managed care and other private plans, Congress enacted the M+C program (Christensen 1998) as part of the Balanced Budget Act (BBA) of 1997. The M+C program was intended to provide more alternatives to traditional Medicare by expanding the health plan choices available to beneficiaries and encouraging them to be more active in considering their choices. Whereas previous efforts had focused on creating a role for HMOs in the Medicare program, the M+C program represented the first attempt to encourage growth and competition among other types of private plans.

The program incorporated the existing Medicare risk contracting programs and authorized a range of new plan options. One major feature was the coordinated care (i.e., managed care) program (CCP), which offered Medicare beneficiaries a choice of managed care plans. In addition to HMOs, the act provided for (1) PPO plans that allowed beneficiaries more opportunity to seek out-of-network care at higher cost-sharing levels and (2) provider-sponsored plans (PSOs) that encouraged provider organizations to sponsor their own managed care plan rather than merely contract with available HMOs and PPOs. Beyond the CCP options, the M+C program authorized (1) private fee-for-service plan indemnity offerings that did not restrict the beneficiary's access to providers and (2) limited enrollment in Medicare Savings Accounts (MSAs) with high deductibles. Enrollment in M+C plans was voluntary, and the default remained the traditional Medicare program with its statutorily fixed premium and set of benefits. And, as under the original Medicare risk-contracting program, the federal payment formula was set by statute. HCFA paid M+C plans an administered price set based on Medicare fee-for-service spending. The amounts varied across counties to encourage enrollment in less heavily penetrated counties. The main incentive for beneficiary enrollment was more attractive benefits and/or premiums.

The M+C program has failed to meet expectations for expanded choice and growth in enrollment (Gold 2001a) (see figure II.2). Although enrollment in private plans continued to grow briefly (reaching a high of 6.3 million beneficiaries in 1999), the rate of growth slowed and ultimately reversed. Since 2000, the number of Medicare beneficiaries covered under the M+C option has declined. At year-end 2002, enrollment stood at 4.9 million--5 million if the count extends to all alternatives to traditional Medicare, including demonstrations

FIGURE A.2

MEDICARE RISK/MEDICARE+CHOICE ENROLLMENT, 1985-2002



SOURCE: Mathematica Policy Research (MPR) analysis of HCFA's Medicare Managed Care Contract Plans Monthly Summary Report

NOTE: All data are from December. Data for 1999-2002 are for enrollees in Medicare+Choice Coordinated Care Plans (CCPs). Data for prior years are for enrollees in Medicare risk contracts.

(Achman and Gold 2002). The decline in contracts for private plans is even more dramatic. In contrast to the 347 risk contracts in 1998, year-end 2002 saw only 155 coordinated care plan contracts in M+C. This decline reflects several trends: overall consolidation in the managed care industry; firms withdrawing from the Medicare market across the board or in specific areas or counties; and the M+C program's failure to attract new types of plans.

Instability in the plans offered to Medicare beneficiaries has been a major issue among policymakers, as plans have withdrawn from the program and beneficiaries have been forced to change their health plans and, potentially, their providers as well. Instability has also been a concern for employers who either offered M+C options to their retirees or were considering doing so. The M+C experience highlights the importance of minimizing such instability, but it also points to the challenges in doing so (Gold 2001a).

Experience with new plan choices. While the M+C program sought to encourage plan diversity in Medicare, almost all choices were limited to HMO products similar to those offered under the Medicare risk program.[3] Only two of the 155 contracts for coordinated care plans covered PPO products, and the one provider-sponsored plan (in Albuquerque) has had an unstable history in the program.[4]

Reasons for the limited development of PPO products under M+C are subject to dispute. PPOs are common in employer-paid plans, where they have largely replaced the traditional indemnity option. A Medicare PPO option, however, could be less attractive to Medicare beneficiaries, who are more financially risk-adverse and seek first-dollar coverage.[5] Managed care firms assert that they have rejected PPOs because the associated requirements make such plans financially unattractive as a business proposition. Specifically, the statute originally placed the same quality requirements on PPOs as on HMOs, although PPOs do not exercise the same control over care delivery.[6] In addition, PPO offerings may be limited

[3] The Medicare+Choice program formalized the authority for managed care plans to offer point-of-service (POS) options, which provide limited coverage when beneficiaries seek care from out-of-network providers without a plan referral. In 2002, 11 plans offered such an option. Though CMS does not track enrollment at this level of detail, total enrollment in POS options is likely small.

[4] The program announced a withdrawal in 2001 but reversed course after Congress raised the minimum payment rates to plans in late 2000. St. Joseph Health System, which operated the PSO, was purchased by Ardent and is now the Sandia Health System. The M+C product is being merged with one from Lovelace, also purchased by Ardent.

[5] Medicare HMOs have been particularly attractive to lower-income seniors willing to give up their choice of provider for what historically have been low premiums and out-of-pocket costs and enhanced benefits (Achman and Gold 2002). PPO products have been more expensive because they are less tightly managed and allow beneficiaries to go outside the network for care if they are willing to pay more. The main question for PPO products is, Whom do they attract? That is, are they sufficiently less expensive than Medigap to encourage individuals to join a plan that encourages them, based on financial considerations, to limit the providers they see? On the other hand, are they sufficiently close in price to an HMO that beneficiaries will be willing to pay somewhat more for access to a broader range of providers, albeit at a higher price?

[6] As discussed later, Congress subsequently exempted PPOs from a number of quality requirements (42CFR 422.152(b)(2)

if firms do not feel this loosely managed care product can compete successfully with traditional Medicare, which offers open choice of provider at a cost kept low by Medicare's purchasing power (in establishing provider fees).

M+C also gave private-fee-for-service (PFFS) plans the option to participate in the Medicare program. Such plans, like traditional Medicare, do not use a network or financial incentives to restrict access to subsets of providers. However, PFFS plans may redesign Medicare benefits in ways that integrate traditional Medicare benefits with supplemental Medigap plans to cover some of the costs and benefits that Medicare does not. The Sterling Life Insurance Company offered the first PFFS plan in Medicare (Gold 2001b) in July 2000 in all or part of 25 states, although it had only 22,738 enrollees by year-end 2002. CMS currently is evaluating Sterling's experience with its PFFS product. Humana began operating a second PFFS plan in five states in January 2003, after experience in 2002 with a demonstration.

In addition, the BBA provided authority through M+C for a January 1999 demonstration of Medical Savings Account plans. The nationwide demonstration, limited to 390,000 beneficiaries, was scheduled to expire in 2002. When no firms applied to offer such a product, the Medicare Payment Advisory Commission (MedPAC) reviewed the reasons for nonparticipation and concluded that (1) the private market perceived little demand for the product from risk-averse Medicare beneficiaries, and (2) it was difficult to market such a complex product to a fragmented and limited number of potential enrollees (MedPAC 2000). MedPAC also concluded that these barriers would limit growth of MSAs even if Congress removed some of the legislative constraints (such as the time limit) that applied to the particular demonstration.

The M+C experience highlights the challenges associated with expanding the range of private plan choices available in Medicare. As the current program is structured, incentives for private firms to offer such Medicare plans are limited, as are incentives for enrollment.

Experience with geographic availability of choice. In designing M+C, Congress sought also to address some of the geographic disparities evident in the distribution of choices under the Medicare risk contracting program. In 1997 when M+C was enacted, 67 percent of Medicare beneficiaries had access to a Medicare risk plan (MedPAC 2001), but they were highly concentrated in large urban areas and certain other areas of the country.

Choice is especially limited in rural areas, where only 21 percent of beneficiaries had access to a plan in 2000 (MedPAC 2001). Congress hoped that some of the new products might be more acceptable in rural areas where network-based care, particularly in the case of more tightly managed products, is less feasible because of limited provider supply and competition, low payment rates, and the inefficiencies associated with small populations living across large distances. Under M+C, plans were guaranteed a minimum county payment of $367 in 1998, rising to $415 in 2001. In March 2001, Congress amended the legislation to increase this "floor" payment to $525 in large urban areas (defined as 250,000 or more persons) and $475 elsewhere.

Despite increased payment and authority for greater choice, private plans remain rare outside the most heavily urbanized areas. In 2002, 95 percent of beneficiaries in central urban counties had at least one M+C plan option, as did 82 percent of those in other urban areas.[7] However, fewer than half (46 percent) of beneficiaries in rural counties adjacent to urban areas had at least one plan option in contrast to only 5 percent in other rural counties. Even in California where, in 2001, 35 percent of beneficiaries were enrolled in a M+C plan (compared with 14 percent in other states), only 1 percent of Medicare beneficiaries in counties outside metropolitan areas participated in an M+C plan—down from 3 percent in 1997 (Gold and Lake 2002).

The above figures exclude availability of the PFFS option. In 2001, half of those with access to Sterling's PFFS plan had no other available plan. Sterling has been available in some rural areas but is apparently not popular in those areas or elsewhere in the country as evidenced by a total enrollment that, though growing slowly, remains very small.

The M+C experience reinforces earlier experiences associated with attracting plans to rural areas (MedPAC 2001). Currently, traditional Medicare offers a uniform set of benefits for a specified premium nationwide. Under M+C, plans been required to mirror Medicare benefits, but they have had flexibility in the supplementary benefits offered and premiums charged for them. Because practice patterns and costs vary across the country, such benefits and premiums have varied substantially nationwide, has generated great concern among beneficiaries in counties where benefits are less extensive or premiums higher, and even more so where no such plans exist at all. Both theory and current experience indicate that national uniformity issues will be at least as controversial should Medicare expand its use of private plans that vary on a market-by market basis.

HMO withdrawals and the reasons for them. While new options, including PPOs, failed to materialize, plans already in the M+C program began to withdraw in 1999 and continued to withdraw through 2002. From 1999 through 2002, more than 2.2 million beneficiaries lived in counties where at least one plan withdrew from the program entirely or at least from that county (Gold and McCoy 2002).[8]

Many argue that the main reason for the withdrawals has been the payment rates enacted in the Balanced Budget Act of 1997 (BBA).[9] The act enumerated several provisions

[7] Central urban areas are defined by the U.S. Department of Agriculture as central counties of metropolitan areas of 1 million population or more.

[8] Withdrawals continued, at a slower rate, in 2003.

[9] Before passage of the Balanced Budget Act of 1997, which established the M+C program, Medicare paid risk-based plans an amount equal to 95 percent of what Medicare would have paid for the same type of enrollee in the same county under the traditional fee-for-service (FFS) program. The BBA and subsequent legislation in 1999 and 2000 uncoupled the link to FFS payments, at least at the local level. Though, M+C payments nationally are still constrained in aggregate by spending in the traditional program, Congress established "floors" for the level atwhich payments are set in a county, with the floors particularly relevant to payment in rural and less urbanized areas. Congress also aimed to reduce geographic variation in "nonfloor" counties by phasing in a blend of national and local rates to the extent that such a blend could be carried out

designed to hold down spending in the traditional Medicare program; the resulting reductions translated into much lower increases in capitation rates for managed care plans than were permitted in previous years. In addition, the act sought to reduce some of the geographic disparities in payments by both setting a floor on payments in lower-paid counties (to encourage growth in rural areas) and blending local and national experience (to smooth the variation in payment between the high- and low-payment-rate areas).

The ultimate effect of all these changes has been to limit payment growth in most years of the program to 2 percent per year in counties where most M+C enrollees reside. This rate has been less than what plans perceive to be the underlying rate of growth in health care costs and much less than their providers demand in the way of increases. Under these circumstances, plans typically have begun charging or increasing premiums and reducing benefits (potentially making the product less attractive) and/or withdrawing from the program entirely or in certain counties where payment has been deemed to be most problematic. Such withdrawals have been particularly common in counties where the underlying rate of payment was lower to begin with, making the 2 percent increase a strong reason for withdrawal.

Payment rates, however, are only one of the reasons for withdrawals, and withdrawals have occurred in both high and lower payment areas (GAO 2000). In a recent analysis of withdrawals from 1999 through 2001, Lake and Brown (2002) highlight the role of plan characteristics and local market forces in explaining plan withdrawals from the program. For-profit plans, nationally owned plans, and plans with low enrollments were most likely to withdraw. Plans in rural areas were twice as likely to withdraw as those in central urban areas, all else being equal. Withdrawal was higher in areas of high competition and high health care costs. Identifying the role played by payment levels proved to be challenging because of the complexity and breadth of the changes across the nation. In general, plans receiving a 2 percent increase in payment were less likely to withdraw if their initial payment was higher at the outset. Analogously, rural plans that experienced the largest increase in payments between 1997 and 1998 were least likely to withdraw.

(*continued*)
under budget neutrality (these conditions were met only in 2000). To avoid disproportionately hurting plans in the highest-cost counties, Congress agreed that no plan would receive less than a minimum 2 percent annual update. Blended payments were to be authorized only in years when they were budget neutral. The net effect of these changes has been that most nonfloor counties have seen their payments limited to a 2 percent increase annually. (Special legislation provided a 3 percent increase from March-December 2001). Since most enrollees live in counties without the floor, the program generally has been limited to a 2 percent annual increase since 1998. In 2000, CMS also began to phase in a new risk adjustment system for M+C payments that reduced payments to plans. In addition, plans in counties that rely heavily on indirect graduate medical education (GME) payments have seen their payments reduced.

REVISIONS TO THE MEDICARE+CHOICE PROGRAM

In an effort to counter criticism of the M+C program, Congress has made various incremental changes to the program (Gold 2001a). In 1999, the Balanced Budget Refinement Act (BBRA) modified the earlier intent to phase out by 2002 cost contracts for risk-based M+C contracts and instead extended authority until 2004. The new law relaxed reentry barriers for exiting plans and provided exceptions. It also authorized "new entry bonuses" involving higher payments in the early years to encourage organizations to enter areas without M+C. Further, the BBRA eliminated some of the requirements for health plans—by, for example, relaxing quality requirements for PPOs and shifting reporting dates for M+C plans' benefits and premiums in the upcoming year)—so that plans would have more time to identify cost trends. In 2002, the Benefits Improvement and Protection Act (BIPA) raised payment rates to M+C plans, particularly in lower-paid areas. (The law granted other plans a one-time minimum increase rate of 3 percent, up from 2 percent, from March through December 2001.)

Because many of its provisions are set in statute, CMS has only limited authority to modify the M+C program in response to industry concerns. However, national firms report that CMS has been receptive to addressing administrative problems when feasible (Draper, Gold, and McCoy 2002). In late 2001, for example, the CMS administrator encouraged plans that were considering a 2002 withdrawal to talk with staff about ways of staying in the program and exploring how CMS could use its demonstration authority to provide needed flexibility.[10]

LOOKING TO THE FUTURE

The Bush administration has been clear that, regardless of the M+C experience, it sees an important role for private plans in the Medicare program (Office of the Press Secretary 2002). Given the managed care backlash, it is unlikely that a program based on HMOs alone could ever be feasible nationwide. The obvious alternative is to look at looser forms of managed care—such as PPOs—that are common in the commercial market. What it will take to encourage such participation, however, is less clear. After all, the M+C experience is well known—withdrawals by plans, failure to attract plans to rural areas despite higher payments, and lack of substantial private options beyond traditional HMOs.

The PPO demonstration described in this report represents a more formal CMS effort to use its demonstration authority to expand experience with more flexible managed care plans in Medicare. The demonstration has modified some selected policies—related, for example, to payment, full risk sharing, and administrative reporting—that may have previously discouraged plan participation. With the current debate about whether to make a

[10] In 2002, CMS entered into demonstration agreements with six plans that otherwise would have disenrolled; five, with a combined enrollment of about 40,000, were in coordinated care plan demonstrations, and another with fewer than 2,000 enrollees was in a private fee-for-service plan demonstration.

new Medicare drug benefit available only to those in private plans, experience with the Medicare PPO demonstration is likely to be of considerable interest.

APPENDIX B

PPO DEMONSTRATION MARKETS: BENEFITS AND PREMIUMS FOR PPOS AND COMPETING M+C PLANS

(Note: Includes areas with active contracts in February 2003.)

Birmingham, AL, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0102	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Blount, Chilton, Jefferson, Saint Clair, and Shelby, AL**	**$39.00**	**Covers generic up to $500 annually, $12 copay**	**In-Network: $100/day for days 1–18; Out-of-Network: 20% coinsurance**	**In-Network: $5 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**$1800 annual out-of-pocket maximum for in-network services; no out-of-pocket maximum for out-of-network services**
H0151	001	UnitedHealthcare Medicare Complete	HMO M+C	Blount, Chilton, Jefferson, Saint Clair, and Shelby, AL	$0.00	Not covered	$260/day for days 1-10	$10.00	$15.00	$2500 annual out-of-pocket maximum
H0154	001	VIVA Medicare Plus	HMO M+C	Blount, Jefferson, Saint Clair and Shelby, AL	$0.00	Not covered	$250/stay	$5.00	$15.00	
H0150	001	The Oath-Seniors First	HMO M+C	Jefferson and Shelby, AL	$0.00	Unlimited Generic with $10 copay	$75/stay and $75/day for days 1-10	$10.00	$20.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Mobile, AL

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0103	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Mobile, AL**	**$65.00**	**Generic only with $500 annual limit, $12 copay**	**In-Network: $125/day for days 1–15; Out-of-Network: 20% coinsurance**	**In-Network: $10 copayment; Out-of-Network: 20% coinsurance**	**In-Network: $20 copayment; Out-of-Network: 20% coinsurance**	**$1800 annual out-of-pocket maximum for In-Network services; no out-of-pocket maximum for Out-of-Network services**
H0151	002	UnitedHealthCare Medicare Complete	HMO M+C	Mobile, AL	$0.00	Not Covered	$225/day for days 1–22	$10.00	$25.00	$4,800 annual out-of-pocket maximum on certain plan services

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Arizona

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0313	**001**	**PacifiCare of Arizona/Secure Horizons Medicare POS**	**PPO Demo-POS**	**Maricopa and Pinal, AZ**	**$75.00**	**Unlimited generic with $10 copay**	**In-Network: no copayment; Out-of-Network: $812 copay per admission for days 1–150**	**In-Network: $10 copay; Out-of-Network: 30% coinsurance**	**In-Network: $10 copay; Out-of-Network: 30% coinsurance**	**Initial $100 deductible for certain outpatient services, both In- and Out-of-Network**
H0314	**002**	**Health Net Options Plus**	**PPO Demo-PPO**	**Maricopa and Pinal, AZ**	**$144.00**	**Unlimited generic with $10–$20 copay**	**In-Network: $50/stay and $50/day for days 1–5, $500 out-of-pocket maximum per year; Out-of-Network: $750 copay per admission with no out-of-pocket maximum**	**In-Network: $10 copay; Out-of-Network: $35 copay**	**In-Network: $20 copay; Out-of-Network: $35 copay**	
H0307	004	Humana Gold Plus	HMO M+C	Maricopa and Pinal, AZ	$19.00	Unlimited generic with a $15–30 copay	$300/day for days 1–5	$20.00	$40.00	$2,300 annual out-of-pocket maximum

Arizona

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0354	001	CIGNA HealthCare for Seniors	HMO M+C	Maricopa and Pinal, AZ	$0.00	Unlimited generic drugs, and $500 annual limit on brand-name drugs. Copays of $10 for generic and $30 for brand-name.	$300/stay	$15.00	$25.00	
H0303	015	Secure Horizons Classic Plan	HMO M+C	Maricopa and Pinal, AZ	$20.00	Unlimited generic with $15 copay	$300/stay	$10.00	$30.00	
H0351	014	SeniorCare	HMO M+C	Maricopa and Pinal, AZ	$39.00	Unlimited Generic with $12.50 copay	$100/stay and $100/day for days 1–5, $1,000 out-of-pocket maximum per year	$15.00	$40.00	
H0302	001	MediSunONE	HMO M+C	Maricopa, AZ	$29.50	$250 deductible, then unlimited generic and a combined $2,000 limit on preferred brand and brand-name drugs with $12 generic copay, $20 preferred brand-name copay, and $30 brand copay	$150/stay	$5–$10	$20–$30	Initial deductible of $250 for certain plan services

Arizona

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0350	001	Maricopa Senior Select Plan	HMO M+C	Maricopa, AZ	$0.00	$100 monthly combined limit on brand-name and generic drugs. $10 copay for both brand-name and generic drugs	No copayment	$15.00	$25.00	
H0351	023	Senior Care	HMO M+C	Pinal, AZ	$49.00	Unlimited generic with $12.50 copay	$100/stay and $100/day for days 1–5, $1000 out-of-pocket maximum per year	$15.00	$40.00	
H5006	001	Sterling Option 1	PFFS	Maricopa and Pinal, AZ	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

Arizona

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0314	**001**	**Health Net Options Plus**	**PPO Demo-PPO**	**Pima, AZ**	**$94.00**	**Unlimited generic with $10 copay**	**In-Network: $50/stay and $50/day for days 1–5, $500 out-of-pocket maximum per year; Out-of-Network: $750 copay per admission with no out-of-pocket maximum**	**In-Network: $10 copay; Out-of-Network: $35 copay**	**In-Network: $20 copay; Out-of-Network: $35 copay**	
H0313	**002**	**Pacificare of Arizona/Secure Horizons Medicare POS**	**PPO Demo-POS**	**Pima, AZ**	**$75.00**	**Unlimited generic with $10 copay**	**In-Network: No copayment; Out-of-Network: $812 copay per admission for days 1–150**	**In-Network: $10 copay; Out-of-Network: 30% coinsurance**	**In-Network: $10 copay; Out-of-Network: 30% coinsurance**	**Initial $100 deductible for certain outpatient services, both In- and Out-of-Network**
H0303	013	Secure Horizons Classic Plan	HMO M+C	Pima, AZ	$0.00	Unlimited generic with $15 copay	$300/stay	$10.00	$30.00	

Arizona

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H0351	007	SeniorCare	HMO M+C	Pima, AZ	$29.00	Unlimited generic with $12.50 copay	$100/stay and $100/day for days 1–5, $1,000 out-of-pocket maximum per year	$15.00	$40.00	
H5006	001	Sterling Option 1	PFFS	Pima, AZ	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	
H0314	**003**	**Health Net Options Plus**	**PPO Demo-PPO**	**Cochise, Coconino, Gila, and Mohave, AZ**	**$174.00**	**Unlimited generic with $10 copay**	**In-Network: $50/stay and $50/day for days 1–5, $500 out-of-pocket maximum per year; Out-of-Network: $750 copay per admission with no out-of-pocket maximum**	**In-Network: $10 copay; Out-of-Network: $35 copay**	**In-Network: $20 copay; Out-of-Network: $35 copay**	
H5006	001	Sterling Option 1	PFFS	Cochise, Coconino, Gila, and Mohave, AZ	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Broward and Palm Beach, FL

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H5400	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Broward, FL**	**$105.00**	**$500 annual limit for generic; $10 copay**	**In-Network: $25/day for days 1-72; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No annual out-of-pocket maximum**
H1013	012	Senior Value Medicare Plan	HMO M+C	Broward, FL	$0.00	Generic with $50 monthly limit and $10 copay	$250/day for days 1–5	$0.00	$30.00	$2500 annual out-of-pocket maximum
H1016	002	AvMed Medicare Preferred	HMO M+C	Broward, FL	$0.00	Unlimited generic with $10 copay	$200/stay and $200/day for days 1–5	$10.00	$0-$150	
H1019	001	CarePlus Plan	HMO M+C	Broward, FL	$0.00	$800 combined semiannual limit for generic and preferred brand drugs (separate semiannual limits of $500 for generic and $300 preferred brand); $0 copay for generic, $20 copay for preferred brand drugs	$50/stay and $50/day for days 1–5, $250 out-of-pocket maximum per year	$0.00	$10.00	
H1019	004	CareFree Plan	HMO M+C	Broward, FL	-$56.90	Not covered	$50/stay and $50/day for days 1–5, $250 out-of-pocket maximum per year	$0.00	$10.00	
H1026	001	Medicare & More	HMO M+C	Broward, FL	$0.00	Not Covered	No copayment	$5.00	$15.00	

Broward and Palm Beach, FL

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1036	011	Humana Gold Plus	HMO M+C	Broward, FL	$0.00	Unlimited generic with $0 copay; $100 monthly limit for preferred brand-name drugs with $25-$50 copay	$200/day for days 1–5	$0.00	$25.00	$2300 annual out-of-pocket maximum
H1036	053	Humana Gold Classic Standard	HMO M+C	Broward, FL	$0.00	Not covered	No copayment	$0.00	$0.00	$2500 annual out-of-pocket maximum
H1076	003	Medicare Advantage	HMO M+C	Broward, FL	$0.00	$50 monthly limit for generic drugs, with $10 copay	$250/day for days 1–5	$0.00	$30.00	$2500 annual out-of-pocket maximum
H1076	012	Medicare VALUE Advantage	HMO M+C	Broward, FL	-$56.90	$50 monthly limit for generic drugs, with $15 copay	$400/day for days 1–2 and $150/day for days 3–90 with $4,000 annual out-of-pocket maximum	$10.00	$40.00	$4000 annual out-of-pocket maximum
H1076	013	Medicare CHOICE Advantage	HMO M+C	Broward, FL	$0.00	Not covered	$250/day for days 1–5	$0.00	$30.00	$2500 annual out-of-pocket maximum
H1078	003	NHP Medicare-Broward	HMO M+C	Broward, FL	$45.00	Quarterly limit of $250 combined for generic and brand-name; $5 generic copay and $30 brand-name copay	$500/stay	$20.00	$20.00	$2500 annual out-of-pocket maximum

Broward and Palm Beach, FL

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H5400	**002**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Palm Beach, FL**	**$130.00**	**$500 annual limit for generic; $10 copay**	**In-Network: $25/day for days 1–72; Out of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No annual out-of-pocket maximum**
H1013	013	Senior Value Medicare Plan	HMO M+C	Palm Beach, FL	$45.00	Not covered	$300/day for days 1–5	$20.00	$30.00	$300 annual out-of-pocket maximum
H1026	004	Medicare & More	HMO M+C	Palm Beach, FL	$45.00	Not covered	$150/stay and $150/day for days 1–5	$10.00	$25.00	
H1032	010	Well Care Choice Plan	HMO M+C	Palm Beach, FL	$0.00	Covers generic with a monthly $100 limit, $15 copay	$200/day for days 1–8	$10.00	$30.00	
H1034	003	America's Health Choice Palm Beach County	HMO M+C	Palm Beach, FL	$0.00	$150 combined monthly limit; $20 copay for preferred brand-name, $40 copay for brand name drugs	$200/stay and $150/day for days 61–90	$0-$20	$0.00	
H1036	035	Humana Gold Plus	HMO M+C	Palm Beach, FL	$0.00	Unlimited generic with $10 copay	$250/day for days 1–5	$0.00	$30.00	$2300 annual out-of-pocket maximum
H1076	002	Medicare Advantage	HMO M+C	Palm Beach, FL	$99.00	Not covered	$300/day for days 1–5	$20.00	$30.00	$3000 annual out-of-pocket maximum
H1076	016	Medicare PRIME Advantage	HMO M+C	Palm Beach, FL	$0.00	No limit on generic drugs, $100 monthly limit on brand-name drugs, $5 generic copay and $25 brand-name copay	$200/day for days 1–5	$5.00	$20.00	

Broward and Palm Beach, FL

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1078	005	NHP Medicare- Palm Beach	HMO M+C	Palm Beach, FL	$70.00	Not covered	$100/day for days 1–5	$10.00	$20.00	$2,500 annual out-of-pocket maximum

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Florida

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H5401	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Hillsborough and Pinellas, FL**	**$65.00**	**$500 annual limit for generic; $12 copay**	**In-Network: $100/day for days 1–18; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $25 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H1047	**001**	**Humana Gold PPO**	**PPO Demo-PPO**	**Pinellas, FL**	**$79.00**	**Unlimited generic with $10 copay**	**In-Network: $150/day for days 1–5; Out-of-Network: $500 annual deductible, then 30% coinsurance**	**In-Network: $5 copay; Out-of-Network: $500 annual deductible, then 30% coinsurance**	**In-Network: $30 copay; Out-of-Network: $500 annual deductible, then 30% coinsurance**	**In-Network: $2,500 annual out-of-pocket maximum; Out-of-Network: For covered services, there is a $500 deductible and 30% coinsurance. There is a $5,000 annual out-of-pocket maximum for covered inpatient and outpatient services.**
H1080	004	UnitedHealthCare Medicare Complete	HMO M+C	Hillsborough and Pinellas, FL	$0.00	Not covered	$265/day for days 1–19	$25.00	$35.00	$4,800 annual out-of-pocket maximum
H1032	012	Well Care Choice Plan	HMO M+C	Hillsborough, FL	$0.00	Covers generic with a monthly $100 limit, $15 copay	$200/day for days 1–5	$10.00	$30.00	
H1032	014	Well Care Choice Plan	HMO M+C	Pinellas, FL	$0.00	Covers generic with a monthly $100 limit, $15 copay	$200/day for days 1–5	$10.00	$30.00	

Florida

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1032	026	WellCare Advantage Plan	HMO M+C	Hillsborough, FL	-$25.00	Not covered	$375/day for days 1–10 with $3,750 out-of-pocket maximum per year	$10.00	$35.00	$500 annual out-of-pocket maximum
H1036	025	Humana Gold Classic	HMO M+C	Hillsborough, FL	$0.00	Unlimited generic with $15 copay	$250/day for days 1–5	$20.00	$35.00	$2,300 annual out-of-pocket maximum
H1036	052	Humana Gold Classic	HMO M+C	Pinellas, FL	$0.00	Unlimited generic with $15 copay	$250/day for days 1–5	$20.00	$35.00	$2,300 annual out-of-pocket maximum
H5401	**003**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Lee, FL**	**$65.00**	**$500 annual limit for generic; $12 copay**	**In-Network: $125/day for days 1–15; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1,800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H1080	011	UnitedHealthCare Medicare Complete	HMO M+C	Lee, FL	$0.00	$500 annual limit for generic, $15 copay	$200/day for day 1–24	$25.00	$25.00	$4,800 out-of-pocket maximum
H5401	**002**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Hernando and Pasco, FL**	**$65.00**	**$500 annual limit for generic; $12 copay**	**In-Network: $125/day for days 1–15; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1,800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H1080	013	UnitedHealthCare Medicare Complete	HMO M+C	Hernando and Pasco, FL	$0.00	$200 annual limit for generic; $15 copay	$265/day for days 1–19	$20.00	$25.00	$4800 annual out-of-pocket maximum

Florida

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1032	019	Well Care Choice Plan	HMO M+C	Hernando, FL	$0.00	$150 combined quarterly limit; $10 copay for generic, $40 copay for preferred brand; $50 copay for brand-name	$150/day for days 1–5	$10.00	$20.00	
H1032	021	Well Care Choice Plan	HMO M+C	Pasco, FL	$0.00	Covers generic with a monthly $100 limit, $15 copay	$200/day for days 1–5	$10.00	$30.00	
H1036	040	Humana Gold Classic	HMO M+C	Pasco, FL	$0.00	Unlimited generic with $15 copay	$250/day for days 1–5	$20.00	$35.00	$2300 annual out-of-pocket maximum

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Illinois

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1408	**001**	**OSF Care Preferred**	**PPO Demo-PPO**	**Boone, Knox, Livingston, McClean, Marshall, Peoria, Stark, Tazewell, Winnebago, and Woodford, IL**	**$75.00**	**$100 monthly limit for generic, $10 copay**	**In-Network: $150/stay; Out-of-Network: $812 deductible**	**In-Network: $10 copay; Out-of-Network: $100 annual deductible, then 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: $100 annual deductible, then 20% coinsurance**	**In-Network: $800 annual out-of-pocket maximum; Out-of-Network: $2,400 annual out-of-pocket maximum**
H1468	004	OSF Care Advantage	HMO M+C	Knox, Livingston, McClean, Marshall, Peoria, Stark, Tazewell, and Woodford, IL	$60.00	Not covered	$150/stay	$10.00	$10.00	
H1463	001	Health Alliance Premier Choice	HMO M+C	McClean and Woodford, IL	$60.00	Not covered	No copayment	$20.00	$20.00	$500 annual out-of-pocket maximum
H5006	001	Sterling Option	PFFS	Boone, Knox, Livingston, McClean, Marshall, Peoria, Stark, Tazewell, Winnebago, and Woodford, IL	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Fort Wayne, IN, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1508	**001**	**ADVANTAGE Preferred Plus**	**PPO Demo-PPO**	**Allen and St. Joseph, IN**	**$95.00**	**$125 quarterly limit for generic; $5 copay**	**In-Network: $100/stay; Out-of-Network: Original Medicare cost sharing**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

New Orleans, LA area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1901	**001**	**Tenet Choices HealthCare Select**	**PPO Demo-PPO**	**Jefferson, Orleans, Plaquemines, and St. Tammany, LA**	**$85.00**	**Unlimited generic with $10 copay**	**In-Network: No copayment; Out-of-Network: 20% coinsurance**	**In-Network: No copayment; Out-of-Network: 20% coinsurance**	**In-Network: No copayment; Out-of-Network: 20% coinsurance**	
H1951	001	Total Health 65	HMO M+C	Jefferson, Orleans, and Plaquemines, LA	$0.00	Unlimited generic with $10 copay	$150/day for days 1–5	$10.00	$30.00	
H1961	001	Tenet Choices 65	HMO M+C	Jefferson, Orleans, Plaquemines, and St. Tammany, LA	$0.00	Unlimited generic, $1,200 annual limit on brand; $10 generic copay and $25 brand-name copay	No copayment	$10.00	$10.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Baltimore, MD area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H2110	**001**	**Golden Choice Plan**	**PPO Demo-POS**	**Anne Arundel, Baltimore, Baltimore City, Calvert, Charles, and Harford, MD**	**$110.00**	**Unlimited generic with $15 copay**	**In-Network: $75/day for days 1–5; Out-of-Network: 20% coinsurance**	**In-Network: $10-$20 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: Annual $150 deductible and maximum $2,500 annual coinsurance**
H2108	002	MediChoice Maryland	HMO M+C	Anne Arundel, Baltimore, and Harford, MD	$0.00	Not covered	$812 deductible and $203/day for days 61–90 of a stay	20%	20%	Initial deductible of $100 for certain plan services
H2108	001	MediChoice Baltimore	HMO M+C	Baltimore City, MD	$0.00	Not covered	$812 deductible and $203/day for days 61–90 of a stay	20%	20%	Initial deductible of $100 for certain plan services

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

St. Louis, MO, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H1413	**001**	**United HealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Madison, Monroe; St. Clair, IL, and Crawford, Franklin, Jefferson, St. Charles, St. Louis, St. Louis City, and Warren, MO**	**$65.00**	**$500 annual limit for generic; $12 copay**	**In-Network: $125/day for days 1–15; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Netowrk: $1800 annual out-of-pocket maximum; Out-of-Network: No annual out-of-pocket maximum**
H1412	**001**	**Coventry Advantra PPO**	**PPO Demo-PPO**	**Madison and St. Clair, IL; and Jefferson, St. Charles, St. Louis, St. Louis City, MO**	**$46.00**	**$500 combined annual limit; $15 generic copay and $40 brand-name copay**	**In-Network: $250/day for days 1–5; Out-of-Network: 30% coinsurance**	**In-Network: $15 copay; Out-of-Network: 30% coinsurance**	**In-Network: $20 copay; Out-of-Network: 30% coinsurance**	**Out-of-Network: $500 annual deductible**
H2654	005	UnitedHealthCare Medicare Complete	HMO M+C	Madison, Monroe, and St. Clair, IL	$0.00	Not covered	$265/day for days 1–19	$18.00	$28.00	$4,800 annual out-of-pocket maximum
H2654	004	UnitedHealthCare Medicare Complete	HMO M+C	Crawford, Franklin, Jefferson, St. Charles, St. Louis, St. Louis City, and Warren, Missouri	$0.00	$300 annual limit on generic with $12 copay	$265/day for days 1–19	$18.00	$28.00	$4,800 annual out-of-pocket maximum
H2667	005	PremierPlus	HMO M+C	Madison, Monroe, and St. Clair, IL	$79.00	$250 annual limit on generic with $15 copay	$300/day for days 1–90 with $5,000 annual out-of-pocket maximum	$15.00	$25.00	
H2667	003	PremierPlus	HMO M+C	Franklin, Jefferson, St. Charles, St. Louis, St. Louis City, and Warren, MO	$59.00	$250 annual limit on generic with $15 copay	$300/day for days 1–90 with $5,000 annual out-of-pocket maximum	$15.00	$25.00	
H2663	002	GHP Advantra	HMO M+C	St. Clair and Madison, IL; and Jefferson, St. Louis, St. Louis City, and St. Charles, MO	$66.00	$500 combined annual limit; $15 generic copay and $40 brand-name copay	$250/day for days 1–5	$15.00	$20.00	$5,000 annual out-of-pocket maximum

St. Louis, MO, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H2663	005	GHP Gold Advantage	HMO M+C	St. Clair, IL, and Jefferson, St. Charles, St. Louis, and St. Louis City, Missouri	$0.00	$750 annual combined limit with $15 generic copay and $40 brand-name copay	$300/day for days 1–5	$10.00	$20.00	$4,500 annual out-of-pocket maximum
H5006	001	Sterling Option 1	PFFS	Madison, Monroe, and St. Clair, IL	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Clark, NV

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H2903	**001**	**PacifiCare of Nevada/ Secure Horizons Medicare POS**	**PPO Demo-POS**	**Clark, NV**	**$55.00**	**Unlimited generic with $10 copay**	**In-Network: No copayment; Out-of-Network: $812 per admission for days 1–150**		**In-Network: $10 copay; Out-of-Network: 30% coinsurance**	**$100 annual deductible for both In- and Out-of-Network services**
H2931	002	Sr. Dimensions Southern Nevada Plan	HMO POS	Clark, NV	$0.00	Unlimited generic and $500 combined quarterly limit on brand-name drugs; $10 generic copay and $35 brand-name copay	$200/stay	$10.00	$20.00	$1500 annual out-of-pocket maximum
H2949	002	Secure Horizons Classic Plan	HMO M+C	Clark, NV	$0.00	Unlimited generic and $1,000 annual limit on brand-name drugs; $10 generic copay and $40 brand-name copay	$200/stay	$10.00	$20.00	
H5006	001	Sterling Option 1	PFFS	Clark, NV	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

New Jersey

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3109	**001**	**Horizon Medicare Blue**	**PPO Demo-POS**	**Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren, NJ**	**$86.40**	**Not covered**	**In-Network: $750 annual deductible; Out-of-Network: $1,000 annual deductible, 20% coinsurance with a $2,000 coinsurance out-of-pocket maximum**	**In-Network: $15 copay; Out-of-Network: $1,000 annual deductible, 20% coinsurance, with a $2,000 coinsurance out-of-pocket maximum**	**In-Network: $20 copay; Out-of-Network: $1,000 annual deductible, 20% coinsurance, with a $2,000 coinsurance out-of-pocket maximum**	**Out-of-Network: Annual $1,000 deductible, 20% coinsurance and $2,500 coinsurance out-of-pocket maximum**
H3109	**002**	**Horizon Medicare Blue Plus**	**PPO Demo-POS**	**Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren, NJ**	**$115.70**	**$100 deductible; unlimited generic and $150 quarterly limit on brand; $10 generic copay and $20 brand-name copay**	**In-Network: $750 annual deductible; Out-of-Network: $2,000 annual deductible, 30% coinsurance with a $3,000 coinsurance out-of-pocket maximum**	**In-Network: $20 copay; Out-of-Network: $2,000 annual deductible, 30% coinsurance, with a $3,000 coinsurance out-of-pocket maximum**	**In-Network: $30 copay; Out-of-Network: $2,000 annual deductible, 30% coinsurance, with a $3,000 coinsurance out-of-pocket maximum**	**Out-of-Network: Annual $2,000 deductible, 30% coinsurance and $3,000 coinsurance out-of-pocket maximum**

New Jersey

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3108	**001**	**Aetna Golden Choice Plan**	**PPO Demo-POS**	**Bergen, Essex, Hudson, Passaic, and Union, NJ**	**$95.00**	**Unlimited generic with $15 copay**	**In-Network: $350/stay; Out-of-Network: 20% coinsurance**	**In-Network: $10-$20 copay: Out-of-Network: 20% coinsurance**	**In-Network: $20 copay: Out-of-Network: 20% coinsurance**	**Out-of-Network: Annual $150 deductible and maximum $2,500 annual coinsurance**
H3108	**002**	**Golden Choice Plan**	**PPO Demo-POS**	**Mercer, Middlesex, Monmouth, and Ocean, NJ**	**$125.00**	**Unlimited Generic with $15 copay**	**In-Network: $350/stay; Out-of-Network: 20% coinsurance**	**In-Network: $10-$20 copay: Out-of-Network: 20% coinsurance**	**In-Network: $20 copay: Out-of-Network: 20% coinsurance**	**Out-of-Network: Annual $150 deductible and maximum $2,500 annual coinsurance**
H3154	003	Horizon Medicare Blue Value	HMO M+C	Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren, NJ	$51.31	Not covered	15% of the cost of each day	$10.00	$10.00	$3000 annual out-of-pocket maximum
H3152	029	Golden Medicare Plan	HMO M+C	Bergen, Essex, Hudson, Passaic, Sussex, and Union, NJ	$75.00	Not covered	$150/day for days 1–5	$20–$25	$30.00	
H3152	022	Golden Medicare Plan	HMO M+C	Camden, NJ	$80.00	Not covered	$150/day for days 1–5	$15–$20	$25.00	

New Jersey

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3164	003	AmeriChoice Personal Care Plus	HMO M+C	Essex, Hudson, Passaic, and Union, NJ	$0.00	Not covered	$700 deductible	$20.00	$20.00	
H3107	001	Oxford Medicare Advantage	HMO M+C	Hudson, NJ	$0.00	Not covered	$810/stay	$25.00	$35.00	
H3156	021	AmeriHealth 65 Standard	HMO M+C	Salem, NJ	$125.00	$1500 annual limit for generics with $15 copay	$750 deductible	$15.00	$25.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Upstate New York

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3324	**001**	**HealthNow New York Medicare PPO 201 Plus**	**PPO Demo-PPO**	**Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, and Washington, NY**	**$86.82**	**Not covered**	**In-Network: $100/stay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Annual $250 deductible for In- and Out-of-Network services**
H3324	**003**	**HealthNow New York Medicare PPO 202 Plus**	**PPO Demo-PPO**	**Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, and Washington, NY**	**$166.49**	**Unlimited generic and $125 quarterly limit on brand-name; $7 generic copay and $25 brand-name copay**	**In-Network: No copayment; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Annual $250 deductible for In- and Out-of-Network services**
H3384	013	Senior Blue 402	HMO M+C	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, and Washington, NY	$70.00	Unlimited generic with $7 copay	$100/stay	$15.00	$15.00	
H3384	014	Senior Blue 403	HMO M+C	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, and Washington, NY	$130.00	Unlimited generic and $125 quarterly limit on brand-name; $7 generic copay and $20 brand-name copay	No copayment	$10.00	$10.00	

Upstate New York

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3384	015	Senior Blue 401	HMO M+C	Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, and Washington, NY	$35.00	Not covered	$100/stay	$15.00	$15.00	
H3361	010	WellCare Choice Plan	HMO M+C	Albany, Greene, and Rensselaer, NY	$29.00	$100 monthly limit on generic with $15 copay	$150/day for days 1–5	$10.00	$25.00	
H3388	001	CDPHP	HMO M+C	Albany, Rensselaer, Saratoga and Schenectady, NY	$35.00	Not covered	$250/stay	$10.00	$10.00	
H3324	**004**	**HealthNow New York Medicare PPO 202 Plus**	**PPO Demo-PPO**	**Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming, NY**	**$182.88**	**Unlimited generic and $125 quarterly limit on brand-name; $7 generic copay and $25 brand-name copay**	**In-Network: No copayment; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Annual $250 deductible for In- and Out-of-Network services**
H3324	**002**	**HealthNow New York Medicare PPO 201 Plus**	**PPO Demo-PPO**	**Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming, NY**	**$108.62**	**Not covered**	**In-Network: $100/stay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Annual $250 deductible for In- and Out-of-Network services**
H3305	001	Preferred Care Gold	HMO M+C	Genesee, Orleans, and Wyoming, NY	$59.00	Not covered	No copayment	$10.00	$15.00	

Upstate New York

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3351	001	Senior Choice	HMO M+C	Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming, NY	$34.90	Not covered	10% of the cost of each stay	$5.00	$5.00	$2500 annual out-of-pocket maximum
H3351	002	SeniorChoice	HMO M+C	Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming, NY	$74.90	$125 combined quarterly limit; 50% brand-name coinsurance	$375/stay with $1125 annual out-of-pocket maximum	$16.00	$16.00	
H3362	003	Encompass 65	HMO M+C	Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming, NY	$42.00	Not covered	$375/stay with $2500 annual out-of-pocket maximum	$5.00	$20.00	
H3362	004	Encompass 65 with 50% Rx Max $500	HMO M+C	Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming, NY	$78.00	$125 combined quarterly limit; 50% coinsurance for all drugs	$500/stay with $2500 annual out-of-pocket maximum	$10.00	$20.00	
H3384	019	Senior Blue 402	HMO M+C	Chautauqua, Erie, Genesee, Niagara, and Wyoming, NY	$55.00	Unlimited generic with $7 copay	No copayment	$10.00	$15.00	
H3384	020	Senior Blue 403	HMO M+C	Chautauqua, Erie, Genesee, Niagara, and Wyoming, NY	$130.00	Unlimited generic and $125 quarterly limit on brand-name; $7 generic copay and $20 brand-name copay	$250/stay	$10.00	$15.00	

Upstate New York

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3384	022	Senior Blue 401	HMO M+C	Chautauqua, Erie, Genesee, Niagara, and Wyoming, NY	$0.00	Not covered	No copayment	$10.00	$15.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3323	**001**	**Group Health Inc. Medicare Choice PPO I**	**PPO Demo-PPO**	**Bronx, Kings, New York, Queens, and Richmond, NY**	**$0.00**	**Not covered**	**In-Network: No copayment; Out-of-Network: 20% coinsurance with $7,500 out-of-pocket maximum per stay**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $150 annual deductible**
H3323	**002**	**Group Health Inc. Medicare Choice PPO II**	**PPO Demo-PPO**	**Bronx, Kings, New York, Queens, and Richmond, NY**	**$0.00**	**Unlimited generic with $15 copay**	**In-Network: $250/stay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	
H3325	**001**	**Managed Health HealthFirst PPO Select**	**PPO Demo-PPO**	**Bronx, Kings, New York, Queens, and Richmond, NY**	**$32.00**	**Not covered**	**In-Network: $250/stay; Out-of-Network: Same as original Medicare**	**In-Network: No copay; Out-of-Network: Greater of original Medicare or $25 copay**	**In-Network: $25 copay; Out-of-Network: Greater of original Medicare or $25 copay**	

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3325	**002**	**Managed Health HealthFirst PPO Complete Benefits**	**PPO Demo-PPO**	**Bronx, Kings, New York, Queens, and Richmond, NY**	**$103.00**	**Unlimited generic and $50 monthly limit on brand-name; $5 generic copay and $25 brand-name copay**	**In-Network: $250/stay; Out-of-Network: Greater of 10% cost sharing of Medicare allowable charges or $250**	**In-Network: No copay; Out-of-Network: Greater of original Medicare or $25 copay**	**In-Network: $25 copay; Out-of-Network: Greater of original Medicare or $25 copay**	
H3326	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Bronx, Kings, New York, Queens, and Richmond, NY**	**$55.00**	**Unlimited generic with $9 copay**	**In-Network: $75/day for days 1-24; Out-of-Network: 20% coinsurance**	**In-Network: $5 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1,800 annual out-of-pocket maximum; Out-of-Network: No annual out-of-pocket maximum**
H3307	002	Oxford Medicare Advantage Signature	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Unlimited generic and $500 annual limit on brand-name; 50% coinsurance on all drugs	$500/stay	$15.00	$25.00	
H3307	004	Oxford Medicare Advantage Plus	HMO POS	Bronx, Kings, New York, Queens, and Richmond, NY	$125.00	Unlimited generic and $750 annual limit on brand-name; 50% coinsurance on all drugs	$500/stay	$10.00	$25.00	Initial deductible of $200 for certain services

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3307	010	Oxford Medicare Advantage Essential	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Unlimited generic with 50% coinsurance	No copayment	$0.00	$10.00	
H3307	011	Oxford Medicare Advantage Balance	HMO M+C	Kings, New York, Queens, and Richmond, NY	$0.00	Unlimited generic and $500 annual limit on brand-name; 50% coinsurance on all drugs	No copayment	$5.00	$10.00	Initial deductible of $1000 for certain services
H3312	002	Golden Medicare Plan Option 1	HMO M+C	Bronx, Kings, New York, and Richmond, NY	$0.00	Not covered	$150/day for days 1–5	$20-$25	$30.00	
H3312	025	Golden Medicare Plan Option 2	HMO M+C	Bronx, Kings, New York, and Richmond, NY	$25.00	Unlimited generic with $10 copay	$150/day for days 1–5	$10-$15	$20.00	
H3312	026	Golden Medicare Plan Option 1	HMO M+C	Queens, NY	$40.00	Unlimited generic with $10 copay	$150/day for days 1–5	$20-$25	$30.00	
H3312	027	Golden Medicare Plan Option 2	HMO M+C	Queens, NY	$40.00	Not covered	$50/day for days 1–5	$10-$15	$20.00	
H3330	003	HIP Health Plan of New York	HMO M+C	Bronx, Kings, New York, and Richmond, NY	$0.00	Unlimited generic and $250 semi-annual limit on brand-name; $10 generic copay and $20 brand-name copay	$200/stay and $50/day for days 1–4	$10.00	$20.00	

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3330	006	HIP Health Plan of New York	HMO M+C	Bronx, Kings, New York, and Richmond, NY	$65.00	$250 combined semiannual limit; $10 generic copay and $20 brand copay	No copayment	$0.00	$0.00	
H3330	009	HIP Health Plan of New York	HMO M+C	Queens, NY	$0.00	Unlimited generic with $10 copay	$200/stay and $50/day for days 1–4	$10.00	$20.00	
H3330	010	HIP Health Plan of New York	HMO M+C	Queens, NY	$65.00	Unlimited generic with $10 copay	No copayment	$0.00	$0.00	
H3359	001	HealthFirst 65 Plus	HMO M+C	Bronx, Kings, New York, and Richmond, NY	$0.00	Unlimited generic and $50 monthly limit on brand-name; $5 generic copay and $25 brand-name copay	$250/stay	$0.00	$25.00	
H3359	019	HealthFirst 65 Plus Increased Benefit Plan	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Not covered	$250/stay	$0.00	$25.00	
H3359	020	HealthFirst 65 Plus Enhanced LTC Plan	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Not covered	No copayment	$0.00	$0.00	
H3359	021	HealthFirst 65 Plus Life Improvement Plan	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Not covered	$840 deductible; $210/day for days 61–90 and $420/day for days 91–150	20%	20%	Initial deductible of $100 for certain services

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3359	022	HealthFirst 65 Plus Queens	HMO M+C	Queens, NY	$15.00	Unlimited generic and $50 monthly limit on brand-name; $5 generic copay and $25 brand-name copay	$250/stay	$5.00	$25.00	
H3361	016	WellCare Choice Plan	HMO M+C	Bronx, Kings, New York, and Queens, NY	$0.00	$150 combined monthly limit; $15 generic copay and $30 brand-name copay	$150/day for days 1–5	$10.00	$25.00	
H3366	001	Health Net SmartChoice for Bronx County	HMO M+C	Bronx, NY	-$20.00	Unlimited generic with $12 copay	$500/stay	$10.00	$15.00	
H3366	005	Health Net SmartChoice for Kings County	HMO M+C	Kings, NY	$0.00	Unlimited generic with $12 copay	$500/stay	$10.00	$15.00	
H3366	007	Health Net SmartChoice for Queens County	HMO M+C	Queens, NY	-$20.00	Unlimited generic with $12 copay	$500/stay	$10.00	$15.00	
H3366	008	Health Net SmartChoice for Richmond County	HMO M+C	Richmond, NY	-$20.00	Unlimited generic with $12 copay	$500/stay	$10.00	$15.00	
H3370	001	Senior Plan	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Unlimited generic and $750 annual limit on brand-name; $10 generic copay and $25 brand-name copay	$300/stay	$10.00	$25.00	

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3379	001	UnitedHealthCare Medicare Complete-Plan 1	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Unlimited generic with $15 copay	$175/day for days 1–20	$5.00	$15.00	$3,500 annual out-of-pocket maximum
H3379	002	UnitedHealthCare Evercare	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	$0.00	Not covered	$175/day for days 1–90	$0–$25	$0–$25	$3,500 annual out-of-pocket maximum
H3379	005	UnitedHealthCare Medicare Complete-Plan 3	HMO M+C	Kings, New York, and Queens, NY	$0.00	Not covered	$25/day for days 1–20	$0.00	$0.00	$500 annual out-of-pocket maximum
H3379	006	UnitedHealthCare Medicare Complete-Plan 4	HMO M+C	Bronx, Kings, New York, Queens, and Richmond, NY	-$30.00	Not covered	$265/day for days 1–19	$15.00	$30.00	$4,800 annual out-of-pocket maximum
H3387	005	AmeriChoice Personal Care Plus	HMO M+C	Kings and Queens, NY	$0.00	$250 combined semiannual limit; $10 generic copay and $20 brand-name copay	$700 deductible	$10.00	$10.00	

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3323	**003**	**Group Health Inc. Medicare Choice PPO I**	**PPO Demo-PPO**	**Rockland and Westchester, NY**	**$100.00**	**Not covered**	**In-Network: No copayment; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $150 annual deductible**
H3323	**004**	**Group Health Inc. Medicare Choice PPO II**	**PPO Demo-PPO**	**Rockland and Westchester, NY**	**$100.00**	**Unlimited generic with $15 copay**	**In-Network: $250/stay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $150 annual deductible**
H3312	018	Aetna Golden Medicare Plan	HMO	Rockland and Westchester, NY	$90.00	Unlimited generic with $10 copay	$200/day for days 1–5	$20–$25	$30.00	
H3370	002	Empire HealthChoice HMO Senior Plan	HMO	Rockland and Westchester, NY	$85.00	Unlimited generic and $250 annual limit on brand-name; $10 generic copay and $25 brand-name copay	$500/stay	$10.00	$25.00	
H3330	008	HIP Health Plan of New York	HMO	Westchester, NY	$184.00	Unlimited generic with $10 copay	No copayment	$0.00	$0.00	

New York City Area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3330	005	HIP Health Plan of New York	HMO	Westchester, NY	$119.00	Unlimited generic with $10 copay	$700/stay or $250 for day 1 and $50/day for days 2–10, with $700 out-of-pocket maximum each benefit period	$10.00	$20.00	
H3361	014	WellCare Choice Plan	HMO	Rockland and Westchester, NY	$69.00	$100 monthly limit on generic with $15 copay	$150 each day for days 1–5	$10.00	$25.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

North Carolina

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3403	**001**	**United HealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham, and Wake, NC**	**$60.00**	**$500 annual limit on generic with $10 copay**	**In-Network: $100/day for days 1–18; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H3456	001	UnitedHealthCare Medicare Complete	HMO M+C	Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham, and Wake, NC	$0.00	$500 annual limit on generic with $15 copay	$265/day for days 1–19	$10.00	$20.00	$4,800 annual out-of-pocket maximum
H3449	005	PARTNERS Medicare Choice	HMO M+C	Alamance, Forsyth, Guilford, Mecklenburg, Orange, Rockingham, and Wake, NC	$45.00	Not covered	$150/day for days 1–10 with $1,500 annual out-of-pocket maximum	$15.00	$15.00	$2,500 annual out-of-pocket maximum

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Cincinnati, OH, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3616	**001**	**United HealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Butler and Hamilton, OH**	**$70.00**	**$500 annual limit for generics with $12 copay**	**In-Network: $150/day for days 1–11; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H3659	001	UnitedHealthCare Medicare Complete	HMO-M+C	Butler, OH	$0.00	Not covered	$295/day for days 1–19	$25.00	$35.00	$4,800 annual out-of-pocket maximum
H3659	018	UnitedHealthCare Medicare Complete	HMO-M+C	Hamilton, OH	$0.00	Not covered	$265/day for days 1–19	$25.00	$35.00	$4,800 annual out-of-pocket maximum
H3655	012	Anthem Senior Advantage-Standard 2	HMO-M+C	Butler, OH	$40.00	$500 annual limit for generics with $15 copay	$750/stay	$20.00	$30.00	
H3655	013	Anthem Senior Advantage-Premier 2	HMO-M+C	Butler, OH	$80.00	$500 annual limit for generics with $15 copay	$375/stay	$10.00	$20.00	
H3655	016	Anthem Senior Advantage - Basic 2	HMO-M+C	Butler, OH	$0.00	Not covered	$750/stay	$25.00	$35.00	
H3655	001	Anthem Senior Advantage-Standard 1	HMO-M+C	Hamilton, OH	$25.00	$500 annual limit for generics with $15 copay	$750/stay	$20.00	$30.00	
H3655	011	Anthem Senior Advantage-Premier 1	HMO-M+C	Hamilton, OH	$65.00	$500 annual limit for generics with $15 copay	$375/stay	$10.00	$20.00	
H3655	017	Anthem Senior Advantage-Basic 1	HMO-M+C	Hamilton, OH	$0.00	Not covered	$750/stay	$25.00	$35.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Cuyahoga and Mahoning, OH

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3617	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Cuyahoga, OH**	**$74.00**	**$500 annual limit on generic with $12 copay**	**In-Network: $175/day for days 1-11; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $25 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H3655	012	Anthem Senior Advantage-Standard 2	HMO M+C	Cuyahoga, OH	$40.00	$500 annual limit on generic with $15 copay	$750/stay	$20.00	$30.00	
H3655	013	Anthem Senior Advantage-Premier 2	HMO M+C	Cuyahoga, OH	$80.00	$500 annual limit on feneric with $15 copay	$375/stay	$10.00	$20.00	
H3655	016	Anthem Senior Advantage-Basic 2	HMO M+C	Cuyahoga, OH	$0.00	Not covered	$750/stay	$25.00	$35.00	
H3657	001	QualChoice Medicare Prime	HMO M+C	Cuyahoga, OH	$0.00	Not covered	$200/stay and $200/day	$15.00	$30.00	
H3659	003	UnitedHealthCare Medicare Complete	HMO M+C	Cuyahoga, OH	$0.00	$500 annual limit on generic with $15 copay	$265/day for days 1–19	$15.00	$30.00	$4800 annual out-of-pocket maximum
H3617	**002**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Mahoning, OH**	**$69.00**	**$500 annual limit on generic with $12 copay**	**In-Network: $150/day for days 1-11; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $25 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**

Cuyahoga and Mahoning, OH

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3655	001	Anthem Senior Advantage-Standard 1	HMO M+C	Mahoning, OH	$25.00	$500 annual limit on generic with $15 copay	$750/stay	$20.00	$30.00	
H3655	011	Anthem Senior Advantage-Premier 1	HMO M+C	Mahoning, OH	$65.00	$500 annual limit on generic with $15 copay	$375/stay	$10.00	$20.00	
H3655	017	Anthem Senior Advantage-Basic 1	HMO M+C	Mahoning, OH	$0.00	Not covered	$750/stay	$25.00	$35.00	
H3659	017	UnitedHealthCare Medicare Complete	HMO M+C	Mahoning, OH	$0.00	$500 annual limit on generic with $15 copay	$250/day for days 1–20	$15.00	$35.00	$4,800 annual out-of-pocket maximum

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Jefferson, OH, and Hancock, WV

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3615	**001**	**Coventry Health Advantra PPO**	**PPO Demo-PPO**	**Jefferson, OH; Hancock, WV**	**$87.00**	**$500 annual generic limit with $10 copay**	**In-Network: $250/stay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $300 annual deductible**
H3673	004	Coventry HealthAssurance Advantra HMO	HMO M+C	Jefferson, OH	$89.00	Not covered	$250/stay	$10.00	$20.00	
H5149	001	Coventry Advantra HMO	HMO M+C	Hancock, WV	$89.00	Not covered	$250/stay	$10.00	$20.00	
H5151	002	Health Plan Medicare+Choice	HMO M+C	Hancock, WV	$79.00	Not covered	$50/day	$15.00	$15.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Portland, OR, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3806	**001**	**Health Net of Oregon PPO**	**PPO Demo-PPO**	**Benton, Clackamas, Columbia, Hood River, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill, OR; Clark, WA**	**$80.00**	**Not covered**	**In-Network: $100 annual deductible; Out-of-Network: $250 annual deductible, then 30% coinsurance**	**In-Network: $10 copay; Out-of-Network: $35 copay**	**In-Network: $10 copay; Out-of-Network: $35 copay**	**In-Network: $100 deductible and $5,000 annual out-of-pocket maximum; Out-of-Network: $10,000 annual copayment maximum and $3,000 annual coinsurance maximum**
H3805	001	Secure Horizons Standard Plan	HMO M+C	Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, and Washington, OR	$65.00	Not covered	No copayment	$10.00	$10.00	
H3856	010	First Choice Sixty-Five	HMO M+C	Clackamas, Columbia, Marion, Multnomah, Polk, and Washington, OR	$72.00	Not covered	No copayment	$10.00	$10.00	
H3864	001	Clear Choice Traditional Plan	HMO M+C	Hood River, OR	$75.00	Not covered	No copayment	$10.00	$10.00	
H3864	002	Clear Choice Value Plan	HMO M+C	Hood River, OR	$55.00	Not covered	$100/day for days 1-5	$15.00	$15.00	$1200 annual out-of-pocket maximum
H3864	005	Clear Choice Traditional Plus Plan	HMO POS	Hood River, OR	$85.00	Not covered	No copayment	$10.00	$20.00	
H9003	001	Senior Advantage	HMO M+C	Clackamas, Multnomah, and Washington, OR; Clark, WA	$93.00	Unlimited generic and brand-name coverage with 70% coinsurance	$200/stay	$15.00	$15.00	$1,000 annual out-of-pocket maximum

Portland, OR, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H9003	002	Senior Advantage	HMO M+C	Columbia, OR	$118.00	Unlimited generic and brand-name coverage with 70% coinsurance	$200/stay	$15.00	$15.00	$1,000 annual out-of-pocket maximum
H9003	005	Senior Advantage	HMO M+C	Benton, Linn, Marion, Polk, and Yamhill, OR	$93.00	Unlimited generic and brand-name coverage with 70% coinsurance	$200/stay	$15.00	$15.00	$1,000 annual out-of-pocket maximum
H9047	001	Providence Medicare Extra Plan 1	HMO M+C	Clackamas, Columbia, Multnomah, and Washington, OR	$79.00	Not covered	$250/stay with $500 annual out-of-pocket maximum	$15.00	$15.00	$2,500 annual out-of-pocket maximum
H9047	019	Providence Medicare Extra Plan 1	HMO M+C	Yamhill, OR	$84.00	Not covered	$250/stay with $500 annual out-of-pocket maximum	$15.00	$15.00	
H9047	020	Providence Medicare Extra Plan 1	HMO M+C	Marion and Polk, OR	$81.00	Not covered	$250/stay with $500 annual out-of-pocket maximum	$15.00	$15.00	
H9047	022	Providence Medicare Extra Plan 1	HMO M+C	Lane, OR	$89.00	Not covered	$250/stay with $500 annual out-of-pocket maximum	$15.00	$15.00	
H9047	024	Providence Medicare Extra Plan 2	HMO M+C	Clackamas, Columbia, Multnomah, and Washington, OR	$56.00	Not covered	$325/stay	$20.00	$20.00	$2,500 annual out-of-pocket maximum
H9047	025	Providence Medicare Extra Plan 2	HMO M+C	Yamhill, OR	$61.00	Not covered	$325/stay	$20.00	$20.00	$2,500 annual out-of-pocket maximum

Portland, OR, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H9047	026	Providence Medicare Extra Plan 2	HMO M+C	Marion and Polk, OR	$58.00	Not covered	$325/stay	$20.00	$20.00	$2,500 annual out-of-pocket maximum
H9047	027	Providence Medicare Extra Plan 2	HMO M+C	Lane, OR	$66.00	Not covered	$325/stay	$20.00	$20.00	$2500 annual out-of-pocket maximum
H9049	001	First Choice Sixty Five	HMO M+C	Clark, WA	$72.00	Not covered	No copayment	$10.00	$10.00	
H5005	001	Secure Horizons Standard Plan	HMO M+C	Clark, WA	$79.00	Not covered	$200/stay	$10.00	$10.00	
H5006	001	**Sterling Option 1**	**PFFS**	**Benton, Clackamas, Columbia, Hood River, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill, OR; Clark, WA**	**$88.00**	**Not covered**	**$100/day for days 1–5**	**$15.00**	**$30.00**	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independenly by plans

Allentown-Behtelehem, PA, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3914	**001**	**Aetna Golden Choice Plan**	**PPO Demo-POS**	**Lehigh, Monroe, Northhampton, and Schuylkill, PA**	**$105.00**	**Unlimited generic with $15 copay**	**In-Network: $350/stay; Out-of-Network: 30% coinsurance**	**In-Network: $10-$20 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $150 annual deductible and $2,500 annual coinsurance maximum**
H3954	003	Geisinger Health Plan Gold Classic	HMO M+C	Schuylkill, PA	$82.00	Not covered	No copayment	$5.00	$5.00	
H3954	009	Geisinger Health Plan Gold Select	HMO M+C	Schuylkill, PA	$36.00	Not covered	10% of the cost of each stay	$5.00	$5.00	$2000 annual out-of-pocket maximum
H3954	004	Geisinger Health Plan Gold Classic	HMO M+C	Monroe, PA	$95.00	Not covered	No copayment	$5.00	$5.00	
H3954	010	Geisinger Health Plan Gold Select	HMO M+C	Monroe, PA	$43.00	Not covered	10% of the cost of each stay	$5.00	$5.00	$2000 annual out-of-pocket maximum
H3962	001	SeniorBlue-1	HMO M+C	Lehigh and Northampton, PA	$167.00	$250 combined quarterly limit; 50% coinsurance on all drugs	No copayment	$10.00	$10.00	
H3962	002	SeniorBlue-2	HMO M+C	Schuylkill, PA	$94.00	Not covered	No copayment	$10.00	$10.00	
H5006	001	Sterling Option	PFFS	Lehigh, Monroe, Northhampton, and Schuylkill, PA	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

Allentown-Behtelehem, PA, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3914	**002**	**Aetna Golden Choice Plan**	**PPO Demo-POS**	**Bucks and Montgomery, PA**	**$130.00**	**Unlimited generic with $15 copay**	**In-Network: $350/stay; Out-of-Network: 30% coinsurance**	**In-Network: $10-$20 copay; Out-of-Network: 20% coinsurance**	**In-Network: $20 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $150 annual deductible and $2,500 annual coinsurance maximum**
H3909	001	Americhoice Personal Choice 65	PPO-Alternative Payment Demo	Bucks and Montgomery, PA	$179.00	Unlimited generic with $15 copay	$50/stay and $50/day for days 1–8 with $400 annual out-of-pocket maximum	$10.00	$25.00	
H3952	009	Keystone 65 Standard-Suburbs	HMO POS	Bucks and Montgomery, PA	$94.00	Not covered	$50/stay and $50/day for days 1–8 with $400 annual out-of-pocket maximum	$10.00	$15.00	
H3952	022	Keystone 65 Brand-Suburbs	HMO POS	Bucks and Montgomery, PA	$183.00	$600 combined semiannual limit; $15 generic copay and $20 brand-name copay	$100/stay and $100/day for days 1–8, with $800 annual out-of-pocket maximum	$10.00	$25.00	

Allentown-Behtelehem, PA, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3952	024	Keystone 65 Generic-Suburbs	HMO POS	Bucks and Montgomery, PA	$138.00	$1500 annual limit for generics with $15 copay	$75/stay and $75/day for days 1–8 with $600 annual out-of-pocket maximum	$10.00	$20.00	

Allentown-Behtelehem, PA, area

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3972	001	AmeriChoice Personal Care Plus	HMO M+C	Montgomery, PA	$0.00	Not covered	No copayment	$5.00	$5.00	
H5006	001	Sterling Option	PFFS	Bucks and Montgomery, PA	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3913	**001**	**UPMC for Life PPO Deluxe**	**PPO Demo-PPO**	**Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Indiana, Lawrence, Washington, and Westmoreland, PA**	**$156.00**	**$350 combined quarterly limit; $10 generic copay, $20 preferred brand copay; $40 brand-name copay**	**In-Network: No copayment; Out-of-Network: 20% coinsurance limited to 70 days annually**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $500 annual deductible and lifetime maximum out-of-network coverage of $1 million**
H3913	**002**	**UPMC for Life PPO Standard**	**PPO Demo - PPO**	**Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Indiana, Lawrence, Washington, and Westmoreland, PA**	**$96.00**	**Not covered**	**In-Network: No copayment; Out-of-Network: 20% coinsurance limited to 70 days annually**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $500 annual deductible and lifetime maximum out-of-network coverage of $1 million**
H3915	**001**	**Coventry Advantra M+C PPO**	**PPO Demo-PPO**	**Allegheny, PA**	**$105.00**	**$500 annual generic limit with $10 copay**	**In-Network: $50/stay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $300 annual deductible**
H3907	009	UPMC for Life Standard	HMO M+C	Allegheny, Armstrong, Beaver, Butler, Washington, and Westmoreland, PA	$44.00	Not covered	No copayment	$10.00	$15–$25	

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3907	010	UPMC for Life Deluxe	HMO M+C	Allegheny, Armstrong, Beaver, Butler, Washington, and Westmoreland, PA	$107.00	$350 combined quarterly limit; $10 generic copay, $20 preferred brand copay; $40 brand-name copay	No copayment	$10.00	$15–$25	
H3907	002	UPMC for Life Standard	HMO M+C	Cambria and Fayette, PA	$37.00	Not covered	No copayment	$10.00	$15–$25	
H3907	004	UPMC for Life Standard	HMO M+C	Lawrence, PA	$38.00	Not covered	No copayment	$10.00	$15–$25	
H3907	006	UPMC for Life Deluxe	HMO M+C	Cambria and Fayette, PA	$101.00	$350 combined quarterly limit; $10 generic copay, $20 preferred brand copay; $40 brand-name copay	No copayment	$10.00	$15–$25	
H3907	008	UPMC for Life Deluxe	HMO M+C	Lawrence, PA	$102.00	$350 combined quarterly limit; $10 generic copay, $20 preferred brand copay; $40 brand-name copay	No copayment	$10.00	$15–$25	
H3957	003	SecurityBlue Basic Southwestern PA	HMO M+C	Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Indiana, Lawrence, Washington, and Westmoreland, PA	$36.00	Not covered	No copayment	$10.00	$20.00	

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3957	017	SecurityBlue Direct Southwestern PA	HMO M+C	Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Indiana, Lawrence, Washington, and Westmoreland, PA	$127.00	$350 combined quarterly limit; $12 generic copay, $20 preferred brand copay; $30 brand-name copay	No copayment	$10.00	$30.00	
H3959	001	Advantra	HMO M+C	Allegheny, PA	$35.00	$1000 combined annual limit; $12 generic copay and $25 brand-name copay	$50/stay	$10.00	$20.00	

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3959	002	Advantra	HMO M+C	Fayette, Lawrence, and Westmoreland, PA	$25.00	$500 combined annual limit; $12 generic copay and $25 brand copay	$50/stay	$10.00	$20.00	
H3959	004	Advantra	HMO M+C	Washington, PA	$115.00	Not covered	$500/stay	$20.00	$20.00	
H3959	008	Advantra	HMO M+C	Armstrong, Beaver, and Butler, PA	$75.00	Not covered	$500/stay	$20.00	$20.00	
H3954	007	Geisinger Health Plan Gold Classic	HMO M+C	Cambria, PA	$68.00	Not covered	No copayment	$5.00	$5.00	
H3954	013	Geisinger Health Plan Gold Select	HMO M+C	Cambria, PA	$21.00	Not covered	10% of the cost of each stay	$5.00	$5.00	$2000 annual out-of-pocket maximum
H5006	001	Sterling Option	PFFS	Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Indiana, Lawrence, Washington, and Westmoreland, PA	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	
H3913	**003**	**UPMC for Life PPO Deluxe**	**PPO Demo-PPO**	**Bedford, Blair, Crawford, Huntingdon, Somerset and Venango, PA**	**$143.00**	**$150 combined quarterly limit; $10 copay for generic, $20 copay for preferred brand; $40 copay for brand-name**	**In-Network: No copayment; Out-of-Network: 20% coinsurance limited to 70 days annually**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $500 annual deductible and lifetime maximum out-of-network coverage of $1 million**

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3913	**004**	**UPMC for Life PPO Standard**	**PPO Demo-PPO**	**Bedford, Blair, Crawford, Huntingdon, Somerset, and Venango, PA**	**$107.00**	**Not covered**	**In-Network: No copayment; Out-of-Network: 20% coinsurance limited to 70 days annually**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $500 annual deductible and lifetime maximum out-of-network coverage of $1 million**
H3907	005	UPMC for Life Deluxe	HMO M+C	Bedford, Blair, and Somerset, PA	$96.00	$150 combined quarterly limit; $10 copay for generic, $20 copay for preferred brand; $40 copay for brand-name	No copayment	$10.00	$15–$25	
H3954	007	Geisinger Health Plan Gold Classic	HMO M+C	Blair, Huntingdon, and Somerset, PA	$68.00	Not covered	No copayment	$5.00	$5.00	
H3954	013	Geisinger Health Plan Gold Select	HMO M+C	Blair, Huntingdon and Somerset, PA	$21.00	Not covered	10% of the cost of each stay	$5.00	$5.00	$2,000 annual out-of-pocket maximum
H3957	006	SecurityBlue Basic Bedford/Blair/ Somerset	HMO M+C	Bedford, Blair, and Somerset, PA	$62.00	Not covered	No copayment	$10.00	$20.00	
H3957	008	SecurityBlue Basic Crawford/Mercer	HMO M+C	Crawford, PA	$99.00	Not covered	No copayment	$10.00	$20.00	

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3957	018	SecurityBlue Direct Bedford/Blair/ Somerset	HMO M+C	Bedford, Blair, and Somerset, PA	$132.00	$150 combined quarterly limit; $12 generic copay, $20 preferred brand copay, and $30 brand-name copay	No copayment	$10.00	$30.00	
H5006	001	Sterling Option	PFFS	Bedford, Blair, Crawford, Huntingdon, Somerset and Venango, PA	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	
H3913	**005**	**UPMC for Life PPO Deluxe**	**PPO Demo-PPO**	**Mercer, PA**	**$184.00**	**$150 combined quarterly limit; $10 copay for generic, $20 copay for preferred brand; $40 copay for brand-name**	**In-Network: No copayment; Out-of-Network: 20% coinsurance limited to 70 days annually**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $500 annual deductible and lifetime maximum out-of-network coverage of $1 million**
H3913	**006**	**UPMC for Life PPO Standard**	**PPO Demo-PPO**	**Mercer, PA**	**$148.00**	**Not covered**	**In-Network: No copayment; Out-of-Network: 20% coinsurance limited to 70 days annually**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $15 copay; Out-of-Network: 20% coinsurance**	**Out-of-Network: $500 annual deductible and lifetime maximum out-of-network coverage of $1 million**
H3907	003	UPMC for Life Standard	HMO M+C	Mercer, PA	$98.00	Not covered	No copayment	$10.00	$15–$25	

Pennsylvania

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H3907	007	UPMC for Life Deluxe	HMO M+C	Mercer, PA	$136.00	$150 combined quarterly limit; $10 copay for generic, $20 copay for preferred brand; $40 copay for brand-name	No copayment	$10.00	$15–$25	
H3957	008	SecurityBlue Basic Crawford/Mercer	HMO M+C	Mercer, PA	$99.00	Not covered	No copayment	$10.00	$20.00	
H5006	001	Sterling Option	PFFS	Mercer, PA	$88.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Rhode Island

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H4103	**001**	**UnitedHealthCare Medicare Complete Choice**	**PPO Demo-PPO**	**Kent, Providence, and Washington, RI**	**$65.00**	**$500 annual limit on generic with $10 copay**	**In-Network: $125/day for days 1–15; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $10 copay; Out-of-Network: 20% coinsurance**	**In-Network: $1800 annual out-of-pocket maximum; Out-of-Network: No out-of-pocket maximum**
H4152	004	BlueCHiP for Medicare Standard	HMO M+C	Kent, Providence, and Washington, RI	$0.00	Not covered	$200/day for days 1–10 with $2000 annual out-of-pocket maximum	$10.00	$20.00	
H4152	005	BlueCHiP for Medicare Plus	HMO M+C	Kent, Providence, and Washington, RI	$74.00	$500 combined annual limit; $7 copay on generic, $25 copay on preferred brand; $40 copay on brand	$150/day for days 1-10 with $1500 annual out-of-pocket maximum	$10.00	$20.00	
H4152	007	BlueCHiP for Medicare Preferred	HMO M+C	Kent, Providence, and Washington, RI	$148.00	$5,000 annual limit on generic and $1,000 annual limit on preferred brand and brand-name; $7 copay on generic, $25 copay on preferred brand, $40 copay on brand-name	$75/day for days 1–10 with $750 annual out-of-pocket maximum	$10.00	$20.00	
H4102	002	UnitedHealthCare Medicare Complete	HMO M+C	Kent and Washington, RI	$0.00	$500 annual limit on generic with $10 copay	$265/day for days 1–14	$15.00	$20.00	$3,500 annual out-of-pocket maximum

H4102	001	UnitedHealthCare Medicare Complete	HMO M+C	Providence, RI	$0.00	$500 annual limit on generic with $10 copay	$265/day for days 1–14	$15.00	$20.00	$3,500 annual out-of-pocket maximum

SOURCE: Medicare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Tennessee 1

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H4404	**001**	**HealthSpring Medicare+Choice PPO Plan**	**PPO Demo-PPO**	**Cannon, Cheatham, Davidson, De Kalb, Macon, Marshall, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson, and Wilson, TN**	**$70.00**	**Unlimited generic with $15 copay**	**In-Network: $50/day for days 1–10; Out-of-Network: $200/day for days 1–10**	**In-Network: $10 copay; Out-of-Network: $25 copay**	**In-Network: $15-$25 copay; Out-of-Network: $25 copay**	
H4454	002	HealthSpring Medicare Plus Plan	HMO M+C	Cannon, Cheatham, Davidson, De Kalb, Macon, Marshall, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson, and Wilson, TN	$0.00	Unlimited generic with $15 copay	$100/day for days 1–10	$20.00	$25.00	
H5006	004	Sterling Option	PFFS	Cannon, Cheatham, De Kalb, Macon, Marshall, Robertson, Smith, Sumner, Trousdale, and Wilson, TN	$98.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.

Tennessee 2

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H4403	**001**	**Cariten Senior Health PPO**	**PPO Demo-PPO**	**Anderson, Blount, Campbell, Carter, Cocke, Grainger, Hamblen, Jefferson, Johnson, Knox, Loudon, Morgan, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington, TN**	**$63.00**	**Not covered**	**In-Network: $250/stay; Out-of-Network: 30% coinsurance with 70-day annual limit**	**In-Network: $15 copay; Out-of-Network: 30% coinsurance**	**In-Network: $15 copay; Out-of-Network: 30% coinsurance**	**Out-of-Network: $750 annual deductible then generally 30% coinsurance. Lifetime maximum benefit is $1 million.**
H4461	001	Cariten Senior Health Advantage Plus	HMO	Anderson, Blount, Campbell, Grainger, Jefferson, Knox, Loudon, Roane, Sevier, and Union, TN	$60.00	$175 combined quarterly limit, with $10 generic copay and $25 brand-name copay	No copayment	$10.00	$10.00	
H4461	004	Cariten Senior Health Advantage	HMO	Anderson, Blount, Campbell, Grainger, Jefferson, Knox, Loudon, Roane, Sevier, and Union, TN	$25.00	Not covered	No copayment	$10.00	$10.00	
H4456	005	John Deere Secure Plus Basic	HMO	Anderson, Blount, Campbell, Carter, Cocke, Grainger, Hamblen, Jefferson, Johnson, Knox, Loudon, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington, TN	$25.00	Not covered	$250/stay	$10.00	$10.00	

Tennessee 2

Contract #	Plan ID	Plan Name	Plan Type	Service Area	Premium	Prescription Drug Benefit	Inpatient Hospital Benefit	Physician Visit Copayment	Specialist Visit Copayment	Other Features
H4456	006	John Deere Secure Plus Choice	HMO	Anderson, Blount, Campbell, Carter, Cocke, Grainger, Hamblen, Jefferson, Johnson, Knox, Loudon, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington, TN	$63.00	$800 combined annual limit with $7 generic copay, $7 preferred brand copay, and $7 brand-name copay	No copayment	$10.00	$10.00	
H5006	004	Sterling Option	PFFS	Anderson, Blount, Campbell, Carter, Cocke, Grainger, Hamblen, Jefferson, Johnson, Knox, Loudon, Roane, Scott, Sevier, Sullivan, Unicoi, Union, and Washington, TN	$98.00	Not covered	$100/day for days 1–5	$15.00	$30.00	

SOURCE: Medicare Compare provided in-network benefit information for all plans. Data on out-of-network benefits for the PPO demonstration plans are based on data provided by CMS taken from preliminary submissions of plan benefit packages. This information has not been verified independently by plans.