"SUB-ZERO PREMIUM" (BIPA 606) M+C PLAN EVALUATION

FINAL REPORT

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Background

The Medicare program consists of Part A, which primarily covers inpatient hospital services, and Part B, which primarily covers outpatient medical services. Medicare Part A services are funded through a joint tax on employees and employers, while Medicare Part B is partially funded through federal general revenues (about three-fourths) and partially funded through beneficiary Part B premiums (about one-fourth). In 2003, all beneficiaries enrolled in Part B paid $58.70 a month for Part B services.

Medicare also has a Part C, which pertains to Medicare+Choice Organizations (M+COs). M+COs provide both Part A and Part B services to their enrollees in exchange for a fixed per member per month (PMPM) payment from the Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program. M+COs must provide supplemental services to enrollees or return excess payments to CMS if their PMPM payment is more than their "adjusted community rate" (ACR). For M+COs that serve both commercial and Medicare beneficiaries, the ACR reflects the amount non-Medicare enrollees would cost the M+CO for this same set of Part A and Part B benefits, adjusting for differences in demographic characteristics and utilization between Medicare and non-Medicare enrollees. In the spring of each year, M+COs learn the PMPM rates that will apply to enrollees in the following year. They then compare their average expected PMPM payment to their ACR. If the ACR is less than the expected PMPM payment, the M+CO must generally provide, at no cost to enrollees, supplemental benefits of a value equal to the difference or the excess funds can be retained in a stabilization fund for later use (until 2006). M+COs usually provide supplemental benefits in order to remain competitive or increase their competitiveness with other health plans offered in the market.

The most common supplemental benefits M+COs provide are waivers of beneficiary cost-sharing for Medicare-covered services that the organization would otherwise be permitted to charge. Many M+COs also cover additional health services that Medicare does not pay for, such as routine physical exams. Perhaps the most appealing of these benefits have been outpatient prescription drugs, although this coverage is often limited. Until 2003, however, M+COs were not allowed to reduce all or part of a beneficiary's Part B premium as a supplemental benefit.

Effective January 1, 2003, Section 606 of the Benefits Improvement and Protection Act ("BIPA 606") of 2000 permits M+COs to offer a full or partial reduction in the Medicare Part B premium as a supplemental benefit. M+COs may elect a reduction in their base payment by up to 125 percent of the Part B premium. Eighty percent of the payment reduction is applied to reduce the amount of the Part B premium, generally reflected as an increase in a beneficiary's Social

Security check.[1] The Medicare Trust Fund shares in the savings by retaining 20 percent of the payment reduction. Enrollees in an M+CO that elects to reduce its base payment by the full 125 percent pay no Part B premium. M+C plans offering a full or partial premium reduction benefit are variously referred to as "sub-zero premium plans," "BIPA 606 plans," or "Medicare Part B premium reduction plans."[2]

The new BIPA 606 rules have resulted in the availability of sub-zero premium plans to 1.75 million Medicare beneficiaries (about 4.3 percent of the Medicare population).[3] According to CMS records, enrollment as of June 2003 among all M+C plans that offer this benefit was reported at 6,835.[4] Two M+COs (Health Net and United Healthcare) in New York offer four benefit packages with a $20 to $30 premium reduction per member per month; three M+COs (CarePlus, Vista, and Well Care) in Florida offer six individual benefit packages with a sub-zero premium feature, five of which waive the full Part B premium for their members.[5]

Study Purpose

CMS contracted with BearingPoint to conduct a limited evaluation of the sub-zero premium plans to explore how Medicare beneficiaries and health plans have responded to the new option and to assess the initial impact on beneficiary benefits. One purpose of the evaluation was to learn why beneficiaries enrolled in these new M+C plans, which types of beneficiaries enrolled, and what their initial experiences have been. Another objective was to better understand the reasons that some M+COs decided to offer plans with this new benefit, whether they targeted the benefit to certain types of beneficiaries, whether they altered other health plan benefits, and their experiences to date. Specifically, the project was designed to answer the following primary research questions:

1. *What were the main reasons that M+COs decided to offer a premium reduction benefit? Would they have done so (be willing to do so) if the "lock-in" provisions were in effect?*[6]
2. *What are the characteristics of the M+COs that have chosen to offer this benefit?*
3. *What have been the experiences of the M+COs offering the premium reduction benefit (e.g., with respect to current and planned marketing strategy, enrollment goals, planned changes in future benefit packages) and has it met their expectations?*

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[1] Most beneficiaries pay the Part B premium through a monthly reduction in their Social Security check.
[2] M+C plans that offer a Part B premium reduction benefit are called "sub-zero premium plans" within the context of this report.
[3] CMS Project Scope of Work received January 31, 2003.
[4] CMS June 2003 "Monthly Payment Files." This figure includes retroactive enrollments and disenrollments, except for the month of June.
[5] Detailed review of the M+COs and sub-zero premium plans is included in Chapter 2 of this report.
[6] A "lock-in" provision dictates that a beneficiary can only change health plans a limited number of times in a calendar year and only during certain times of the year. Currently, beneficiaries can change health plans each month, with no limit on the number of health plan elections they can make during the year.

4. *What are the characteristics of Medicare beneficiaries who have enrolled in these plans?*
5. *Why did Medicare beneficiaries choose to enroll or not to enroll in an M+C plan offering a premium reduction as an additional benefit? Do they understand the particular benefit, as well as elements of the entire benefit package chosen?*
6. *What has been the experience of beneficiaries receiving the premium reduction benefit and has it met their expectations?*

Methodology

The project team used a three-fold approach to address the primary research questions through qualitative and quantitative data collection and analysis that included: (1) collecting and reviewing sub-zero premium plan marketing materials and reviewing health plan and enrollee data (as background information and to select key informants and focus group participants); (2) conducting semi-structured telephone interviews with key staff from M+COs that offer the sub-zero premium plans and M+COs in the same market areas that opted not to offer a sub-zero premium product; and (3) conducting focus groups with sub-zero premium plan enrollees, other health plan enrollees, and Original Medicare fee-for-service (FFS) beneficiaries in market areas where the plans are currently being offered.

Separate reports presenting detailed methodology for conducting each of these activities, as well as the findings from each of these three tasks, were previously submitted to CMS. They are also included as Chapters 1 through 4 in this report. This Executive Summary highlights key findings across the three tasks.

Summary of Findings

Primary Reasons for M+COs to Offer a Sub-Zero Premium Plan

A key research area for this project was an investigation of why M+COs decided to offer a premium reduction benefit, as well as to inquire whether they would have done so if the "lock-in" provisions for Medicare beneficiary health plan changes had been in effect in 2003. Semi-structured telephone interviews with key staff from participating plans (i.e., M+COs offering the benefit in 2003) revealed they chose to offer the benefit this year primarily to gain an early marketing advantage over their competitors and to try to attract Original Medicare FFS beneficiaries to an M+C product. As with any new product offering, M+COs that decided to offer a benefit package containing the Part B premium reduction estimated that the addition of this benefit in exchange for reducing other health benefits (particularly limiting prescription drug coverage and/or increasing co-payments) would be profitable in some of their markets. However, participating plan respondents did express concern about how the market would respond to their resulting benefit packages. Most of the participating plans did not believe that beneficiary "lock-in" provisions would have affected their decision, stating they would have offered the sub-zero premium product with or without the provisions. One M+CO interviewee estimated that beneficiary enrollment might have been lower than it is, however.

Non-participating M+COs (i.e., M+COs not offering the benefit in 2003 in the eight counties where the benefit is being offered by others) said the main reason for not offering the product was their desire to take a "wait and see" approach and reassess their decision for 2004 depending on participating plans' experiences this year. Non-participating M+COs also said they wanted to wait to reassess until after CMS had finalized its new health-status-based risk adjustment payment method. Specific key findings include:

- **Both participating and non-participating M+COs described the new product offering as "innovative" and regarded the premium reduction feature as a possible enticement to enroll Medicare FFS beneficiaries.** Participating plans cited the potential gain of a distinct marketing advantage over their competitors as a reason to offer the new product. Moreover, they cited their desire to test a "different" product in the marketplace to identify the existence of an interested niche within the Medicare FFS and, perhaps, M+C populations. Non-participating M+COs noted that they were initially very interested in offering the product, yet they chose to wait and re-evaluate their decision in 2004 for various reasons, including a desire to observe the initial market introduction of the benefit.
- **Non-participating M+COs also cited uncertainty with the funding of the Medicare program as a reason for not offering the product.** They commented that this product benefit was a "non-starter" at this time because CMS had not finalized its health-status-based risk adjustment payment method, making it difficult for them to adequately assess how their revenues would be affected by offering such a product.
- **For all plans, the most influential factors to affect the decision to offer the product were the determinations of actuarial analysis of the benefit package with a Part B premium reduction and whether that benefit package would sell well.** All of the non-participating M+COs noted that, in order to afford the offering, they would have had to reduce other benefits and/or raise beneficiary co-payments to such an extent that they did not believe the product would be marketable. Participating M+COs also determined they would have to reduce some benefits and/or increase co-payments, and were concerned about how the market would respond to their resulting benefit packages. Presumably, what distinguished the participating M+COs from those that opted not to offer the new product this year was the belief that their sub-zero premium product would appeal to a sufficient number of beneficiaries in their markets in order for the plan to be profitable.
- **Most of the participating plans stated they would have offered the sub-zero premium product with or without the 2003 beneficiary "lock-in" provisions in place.** One M+CO commented that "lock-in" is a phenomenon that some of its members have experienced in other settings (e.g., employer-based coverage) and, thus, would not have affected its decision to offer the new product. However, another M+CO suggested that Medicare beneficiary enrollment in sub-zero premium plans would have been even less in 2003 if the lock-in provision were in effect.

Characteristics of M+COs Offering a Sub-Zero Premium Plan

Another key research area for this project was to identify key characteristics of participating plans. United Healthcare of New York offers its sub-zero premium plan, "Medicare Give Back Plan," with a $30 per month reduction in the Part B premium in all five New York City counties. Health Net of New York offers a Smart*Choice* sub-zero premium plan, with a $20 premium reduction, in Bronx, Queens, and Richmond Counties. While each county's Smart*Choice* sub-zero premium plan has a unique plan identification number, these three plans are identical with respect to the plan attributes under consideration. CarePlus Health Plans and Vista Healthplan in Florida offer their sub-zero premium products – the CareFree Plan and the Medicare VALUE Advantage plan, respectively – in Dade and Broward Counties. Well Care Choice offers its Well Care Advantage plan in Dade and Hillsborough Counties. All sub-zero premium plans available in Dade and Broward Counties offer a full reduction in the Part B premium. The plan available in Hillsborough County offers a $25 reduction in the Part B premium.

A comparison of M+CO benefit packages offered in the eight counties in which sub-zero premium plans are available, based on CMS's Medicare Compare database, revealed that the sub-zero premium plans of participating M+COs generally have less generous other supplemental benefits than their non-sub-zero premium plans offered in the same counties. Similarly, compared to benefit packages offered by non-participating M+COs in those counties, the sub-zero premium products generally require higher co-payments and/or offer less generous other supplemental benefits, including no, or very limited, prescription drug coverage. Only two of the five M+COs offering a sub-zero premium plan, CarePlus and Health Net, have generated any notable (active) enrollment, perhaps due to a relatively more generous benefit package and greater advertising efforts than the other sub-zero premium plans. Specific key findings include:

Product Offerings

- **M+COs offer fewer supplemental benefits and/or require higher beneficiary co-payments for their sub-zero premium plans in comparison to their non-sub-zero premium plans offered in the same service areas.** Therefore, members of sub-zero premium plans may face greater financial risk than their counterparts in the same M+CO's non-sub-zero plans should they require services.
- **Compared to other M+C plans offered in the counties under study, the sub-zero premium products require higher co-payments and offer less generous other supplemental benefits, including no or very limited prescription drug coverage.** However, Health Net's Smart*Choice* requires market average co-pays for inpatient hospital care and specialist visits and no co-pay for skilled nursing facility (SNF) care[7] or routine physical exams. Along with approximately two-thirds of the other plans in these counties, the Smart*Choice* plans provide some outpatient drug coverage, though it is limited to formulary

[7] Assumes 100-day benefit period.

generics. Smart*Choice* plans offer some coverage of hearing aids, but do not cover dental services. In both Dade and Broward counties, the CarePlus CareFree Plans compare favorably with other M+C plans in their markets, with the only clear disadvantage being their very limited coverage of outpatient prescription drugs. Relative to the other sub-zero and non-sub-zero premium plans that no longer offer desired benefits such as dental, vision and hearing coverage, the CareFree benefit package is considered quite generous.

Marketing of Product

- **Low enrollment numbers may be due in part to limited advertising effort.** For some of the M+COs, offering the new product was a test to see how beneficiaries would react to it. These organizations chose to use their Summary of Benefits document and sales representatives to advertise the product in person, rather than investing in advertising efforts specific to the new product. Other M+COs opted to advertise their new product via direct mailings, newspaper advertisements, and posters. To date, only two of those M+COs using a more aggressive advertising campaign, CarePlus and Health Net, have realized a return on their investment in terms of active enrollment.

Relative Success

- **Only CarePlus's and Health Net's sub-zero premium plans have generated any notable active enrollment. This finding is most likely attributable to a more generous benefit package and greater advertising efforts than the other sub-zero premium plans.** With 1,035 members as of May 2003, the CarePlus CareFree Plan in Broward County has by far the highest enrollment; the Dade County version of the plan had 315 members in May. The remaining Florida sub-zero premium plans have no more than 25 members. In New York, United Healthcare's sub-zero premium plan had enrolled 13 people by May, compared with the approximately 267 (active) enrollees in Health Net's Smart*Choice* sub-zero premium plans.[8]

Experience versus Expectations of M+COs Offering a Sub-Zero Premium Plan

Another key area of investigation for this project was to understand the experiences of participating M+COs during the initial months of the product offering. Semi-structured telephone interviews with key staff from participating plans revealed that most M+COs did not have high enrollment expectations due to recent M+C market instability and concern about adequate physician participation and education expenses for the sub-zero premium product. They believed the plan had the potential to attract healthier beneficiaries, Medicaid/Medicare dual eligibles, and Original Medicare FFS beneficiaries previously reluctant to join a managed care plan. Despite their low expectations, many of the participating plans have been disappointed in the level of interest in the new offering to date, particularly among the beneficiary groups mentioned. The M+COs have found that most beneficiaries are risk averse and that high co-payments for

[8] The remainder of Health Net's May enrollment of 5,207 is considered "passive" because the enrollees were enrolled into the sub-zero premium plan from a previous Health Net plan that was discontinued in 2003.

services, such as an inpatient hospitalization, concerned even "healthy" beneficiaries for whom the premium reduction did not offset the risk of an unpredictable inpatient hospitalization. Additionally, as our beneficiary focus group research found, the most influential driver of health plan choice was the participation of one's personal physician(s) in the plan's provider network. In addition to low enrollment, participating M+COs also noted disappointment with the government's implementation of the product offering. Specific key findings include:

- **Most of the participating M+COs did not have high expectations for enrollment.** Their somewhat low expectations were due to a perception of the M+C market as volatile and financially risky, and their uncertainty as to whether the benefit tradeoffs (e.g., a reduction in prescription drug coverage in exchange for a Part B premium reduction) would be accepted in the market. The health plans were also concerned about physician participation in the sub-zero premium products and the potential for added M+CO expenses related to educating their provider network and members about the new products.[9]
- **Notwithstanding low enrollment expectations, many of the participating plans have been disappointed in the level of interest in the new offering.** Table 1.1 displays enrollment by M+CO sub-zero premium health plan for the first five months of this year, January through May 2003. The last line of the table presents the combined totals for Florida and New York. The CarePlus Carefree Plans in Florida are the only sub-zero premium plans with any significant enrollment increases during the year. Health Net's Smart*Choice* sub-zero premium plans show relatively high enrollment at the beginning of 2003, but this is because Health Net transferred its Medicare enrollees in Bronx, Queens, and Richmond Counties into its Smart*Choice* sub-zero premium plans from the health plans offered in the previous year that they replaced. Between January and May of this year, some 267 people actively enrolled in the Smart*Choice* sub-zero premium plans and 826 disenrolled. The plans' net enrollments decreased only slightly through May.[10]

[9] According to the CMS Project Scope of Work received January 31, 2003, the M+COs projected a cumulative enrollment of 18,000 for calendar year 2003.

[10] Health Net enrollment and disenrollment data come from CMS's Monthly Membership Data File. Discrepancies between this data and the information in Table 1.1 below are due to the fact that the former dataset does not take into account retroactive enrollments and disenrollments.

Table 1.1 Sub-Zero Premium Plan Enrollments, January – May 2003								
M+CO	Plan Name	Contract No. & Plan ID	County	January	February	March	April	May
FLORIDA								
CarePlus Health Plans	CareFree	H1019-004	Broward	289	491	696	896	1,035
CarePlus Health Plans	CareFree	H1019-005	Dade	59	96	194	262	315
Well Care	Advantage	H1032-026	Hillsborough	0	0	0	0	0
Well Care	Advantage	H1032-027	Dade	0	5	5	5	5
Vista Healthplan	Medicare Value Advantage	H1076-010	Dade	5	18	22	24	24
Vista Healthplan	Medicare Value Advantage	H1076-012	Broward	0	1	1	1	1
NEW YORK								
Health Net of New York	Smart*Choice*	H3366-001	Bronx	1,370	1,328	1,318	1,314	1,307
Health Net of New York	Smart*Choice*	H3366-007	Queens	682	661	655	675	678
Health Net of New York	Smart*Choice*	H3366-008	Richmond	3,339	3,273	3,248	3,234	3,222
United Healthcare of New York	Give Back	H3379-006	Bronx, Kings, New York, Queens, Richmond,	0	10	10	13	13
Total Enrollment				5,744	5,883	6,149	6,424	6,600
Source: CMS's Monthly Membership Data File.								

- **Many of the participating M+COs thought the new product would appeal to Original Medicare FFS enrollees, dual eligibles, and "healthy" beneficiaries.** Some participating M+COs anticipated that the new product offering might appeal to "healthy" beneficiaries who would be willing to trade some supplemental benefits for the Part B premium reduction.[11] They also noted that the sub-zero premium plans might appeal to FFS enrollees who are comfortable with limited health care coverage, would benefit from receiving coverage that is more comprehensive than their current plan, and are interested in the premium reduction benefit. One M+CO also thought a sub-zero premium product would be most beneficial for, and attractive to, Medicare/Medicaid dual eligibles, though this belief

[11] For the purposes of this study, the BearingPoint research team refers to "healthy" beneficiaries as individuals who do not utilize many health care services or take many prescription drugs.

was based on the misconception that the beneficiaries, rather than the State Medicaid program, would receive the premium reduction.[12] It should be noted that the M+COs did not necessarily target these populations when initially developing their products.

- **These populations (FFS enrollees, dual eligibles, and "healthy" beneficiaries) did not exhibit the interest in the sub-zero premium plans that the M+COs had predicted.** With respect to FFS beneficiaries, one M+CO found through its own focus group research that this group was very "anti-HMO" and concerned that they would not be able to see "their" doctor if they belonged to an M+C plan. Finally, as previously noted, the M+COs' prediction that the new product offering would appeal to dual eligibles was based on the misconception that this low-income population would financially benefit from a sub-zero premium plan.
- **In addition to low enrollment, participating M+COs also noted disappointment with the government's implementation of the product offering.** All of the plans commented that they received limited instruction from CMS about how the Part B premium reduction process would work. Moreover, many have had to deal with member complaints regarding significant delays in receiving the Part B premium reduction. M+CO interviewees said they have also received complaints that customer service representatives at the Social Security Administration and the 1-800 Medicare information call line have not been knowledgeable about the new product offering.[13]

Characteristics of Medicare Beneficiaries in Sub-Zero Premium Plans

A fourth objective of the project was to examine characteristics of Medicare beneficiaries who chose to enroll in the sub-zero premium plans. Using CMS's Medicare Enrollment Database (EDB), we compared selected socio-demographic characteristics of beneficiaries who actively enrolled in a sub-zero premium plan (active enrollees) or who were "passively" transferred to the plan from a previous M+CO offering (passive enrollees), with beneficiaries who either remained in Original Medicare FFS or enrolled in a non-sub-zero premium plan in the eight Florida and New York counties with sub-zero premium plans. Findings from the comparison with both FFS and M+CO enrollees revealed that active sub-zero premium plan enrollees, in the aggregate, were more likely to be under-age-65 disabled, ages 65-69, newly eligible for Medicare, White non-Hispanic, and not eligible for Medicaid benefits.[14] Except for the first listed beneficiary subgroup, the other findings are consistent with M+CO expectations and beneficiary focus group findings in the assertion that sub-zero premium plans may appeal to "healthier" beneficiaries.[15]

A comparison of selected enrollee characteristics among sub-zero premium plans with enrollment data from the EDB and CMS's Monthly Membership Data files revealed considerable

[12] The party that pays the Part B premium receives the premium reduction benefit.
[13] 1-800 Medicare customer service representatives were provided with a script regarding the sub-zero premium plans in Fall 2002.
[14] "Newly eligible" for Medicare is defined as an individual who obtained Part A or Part B after January 1, 2002.
[15] No direct health indicators are available from the EDB.

diversity among the sub-zero premium plans. The sub-zero premium plans offered in Dade County, Florida, in particular CarePlus's CareFree Plan, had a much higher percentage of beneficiaries who were ages 65 to 69, newly eligible for Medicare, male, African-American or Hispanic, Medicaid-eligible, and with below-average risk factors,[16] than the other sub-zero premium plans. Except for Medicaid eligibility, the other characteristics do not appear to be driven by differences in Dade County's demographics.

The four sub-zero premium plans with larger enrollments appeared to attract a significant percentage of their members from the Original Medicare FFS sector. However, Health Net, with the greatest number of former FFS beneficiaries, also had the highest percentage of disenrollments over the four-month period. Specific key findings include:

Comparison of Medicare Beneficiary Characteristics by Health Plan Type

- **Younger Medicare beneficiaries (ages 65-69) comprised a higher percentage of actively enrolled sub-zero premium plan beneficiaries in comparison to other M+C enrollees and Original Medicare FFS beneficiaries.** Since younger beneficiaries are often healthier, this finding supports participating M+COs' prediction that the sub-zero premium product would appeal to "healthier" beneficiaries. This difference is also consistent with findings from the focus groups conducted for this study that found that healthier beneficiaries are more likely to find the sub-zero premium plans attractive because the premium reduction outweighs less generous health care coverage under the plan.
- **Active sub-zero premium plan enrollees also include a slightly higher percentage of under-age-65 disabled beneficiaries compared to other M+CO enrollees (about 4 percentage points).**[17] However, under-age-65 disabled beneficiaries do not necessarily require more services than those ages 65 and over as one might assume.
- **The active sub-zero premium plan enrollee population has the lowest share of Medicaid-eligible members, and is less racially and ethnically diverse.** Sub-zero premium plan enrollees - both active and passive - do not have the same diversity as either other types of M+CO enrollees or even FFS beneficiaries. Less diversity appears to be partially linked to differences in Medicaid enrollment among plan types: both the FFS plan (20 percent) and the non-sub-zero M+CO plans (11 percent) have higher Medicaid enrollment than the sub-zero

[16] The Part A risk factor encompasses the Principal Inpatient Diagnostic Cost Group (PIP-DCG) factor, which adjusts M+C payments based on enrollee demographics and diagnoses associated with inpatient hospital stays occurring in the year prior to payment. Application of the model includes calculation of a relative risk factor using previous inpatient diagnoses, age, sex, originally-disabled criteria, and Medicaid eligibility to modify the appropriate county payment rate according to the characteristics of the individual M+C enrollee. Thus, the Part A risk factor is used as a proxy in this study to measure relative health status of sub-zero premium plan enrollees. A risk factor equal to 1 indicates average beneficiary "health status."

[17] The percentage of active sub-zero premium plan enrollees under age 65 (13.2 percent), however, is lower than for the Original Medicare FFS population in the eight counties (16.3 percent).

premium plans (less than 6 percent of enrollees). Studies have shown that Medicare beneficiaries who are dually-eligible for Medicaid benefits more frequently identify with a racial or ethnic minority. Dual-eligible enrollment in the sub-zero premium plans may be a lower share of total plan enrollment because dual-eligibles do not actually benefit from the premium reduction (although they may not all be aware of this).

Comparison of Medicare Beneficiary Characteristics by Sub-Zero Premium Plan

- **In comparison to the other sub-zero premium plans, CarePlus's sub-zero premium plan in Dade County has a much higher percentage of younger-aged beneficiaries (ages 65 to 69), newly eligible beneficiaries, males, and beneficiaries with below-average risk factors**. Vista Health Plan in Dade County also has a somewhat elevated male-to-female ratio and a higher percentage of newly eligible Medicare beneficiaries compared with sub-zero premium plans in the other seven counties. It is not clear why CarePlus and Vista attracted these particular populations. Neither differences in gender, age, new Medicare eligibility, or risk factors across the sub-zero premium plans appear to be caused by differences in general demographics among the counties in which they are offered. It could be that advertising in Dade County was more heavily targeted towards individuals first joining Medicare, which did not occur in New York or the other Florida counties.
- **With respect to race/ethnicity, Dade County sub-zero premium plans (CarePlus and Vista) had a much greater share of African-American enrollees and a somewhat higher share of Hispanic enrollees than other sub-zero premium plans.** Dade County's demographics indicate that a higher percentage of Hispanic Medicare beneficiaries live there than in the other sub-zero Florida and New York counties, but this is not true with respect to African-American Medicare beneficiaries. It is not clear why Dade county sub-zero premium plan enrollees, particularly in the CareFree Plan, are attracting a higher share of minority beneficiaries. Reflecting their county's demographics, both Dade County sub-zero health plans have higher percentages of dually-eligible beneficiaries compared with the other sub-zero premium plans.
- **The four sub-zero premium plans with larger enrollments appear to be attracting a significant portion of their members from the Original Medicare FFS sector.** About one-fourth to one-third of enrollees in the three Florida plans joined from Original Medicare FFS. Nearly 70 percent of Health Net's active enrollees were in FFS immediately prior to their enrollment in the sub-zero premium plan.
- **About 55 percent of Health Net's active enrollees disenrolled over the four-month period, whereas most beneficiaries who enrolled in a Florida sub-zero premium plan did not disenroll.** This finding may reflect Health Net's larger share of beneficiaries (69 percent) that joined from Original Medicare FFS, and consequently may have left the sub-zero premium plan because they felt uncomfortable in a Medicare managed care plan.

Beneficiaries' Reasons For and Against Enrollment in Sub-Zero Premium Plans and Understanding of Plan Benefits

Another project goal was to understand why Medicare beneficiaries chose to enroll or not enroll in a sub-zero premium plan, and to investigate whether they understood the Part B premium reduction benefit. A series of focus groups conducted in Florida and New York with sub-zero premium plan enrollees, disenrollees, and non-enrollees indicate that most beneficiaries, either currently or previously enrolled in a sub-zero premium plan in 2003, place the highest emphasis on the participation of their personal physician(s), rather than on the premium reduction feature, when choosing a health plan. However, Florida sub-zero plan enrollees, who receive the full Part B premium reduction, said this benefit motivates them to remain in the plan, at least until they develop more serious health problems or their personal physician leaves the plan. New York enrollees, who receive only partial premium reduction, did not find the benefit to be enough to keep them in the plan. Many sub-zero plan enrollees had also found other sources for obtaining prescription drug benefits. Specific key findings include:

- **The premium reduction feature was not the primary motivating factor behind most enrollees' initial decision to join a sub-zero premium plan.** Some Florida-based beneficiaries and low-income beneficiaries cited the premium reduction as a reason for choosing their sub-zero premium plan. For most beneficiaries either currently or previously enrolled in a sub-zero premium plan in 2003, the overwhelming driver of their health plan choice was the participation of their personal physician(s) in the plan. Other motivating factors ranged from one plan's dental coverage and low emergency room co-payment to increased prescription drug coverage when compared to Original Medicare FFS. However, beneficiaries in general appear to be sensitive to the costs and benefits of their choice of plan, also citing the perception of lower out-of-pocket expenses as one of their reasons for enrolling in any type of M+C plan.
- **For sub-zero premium plan members in Florida who receive the full premium reduction, the savings is an incentive to stay enrolled in the plan; New York-based sub-zero premium plan members consider the partial reduction insignificant.** Enrollees in Florida seemed to view the sub-zero premium plans as "interim" plans for healthy aged people until they develop more serious health concerns. For such people, the $60 per month in savings is a valuable plan benefit. In New York, where most enrollees had not actively selected the health plan and the reduction is $20 per month, enrollees considered the reduction insignificant and had not given it much consideration.
- **Across plans and enrollment type, beneficiaries' continued enrollment in the sub-zero premium plan is dependent on their physician's participation and the preservation of their current benefits.** Many sub-zero premium plan enrollees said they would likely sacrifice the premium reduction and seek out a different plan if their doctor no longer participated with the sub-zero premium plan or if their other benefits were significantly reduced.

- **Many sub-zero premium plan enrollees identified additional sources for receiving prescription drugs.** While some respondents indicated that they had experienced a small savings in the plan, they were likely to be enrolled in other programs that provided prescription drug coverage. For instance, several focus group participants from Florida received benefits through the Veterans Administration, including prescription drug coverage, thereby making it financially possible to take advantage of their sub-zero health plan's other features at no great financial burden. In New York, several beneficiaries mentioned EPIC, an income-based state program that assists with prescription drug costs. Additionally, in Florida, a number of beneficiaries were very satisfied with ordering prescriptions from Canada at "fantastic" prices.

- **Participants in the non-enrollee groups were generally unaware of the availability of plans with the premium reduction feature.** Upon receiving an explanation of the new product offering, some non-enrollees expressed curiosity about the plans, but few indicated interest in switching to a sub-zero premium plan. Original Medicare FFS participants seemed resistant to considering any type of M+CO for their health care coverage, and non-enrollees in New York City indicated that the $20 monthly premium reduction offered by Health Net was not sufficient incentive to join the plan in exchange for losing some of the benefits under their current plan.

- **Sub-zero premium plan members in Florida tended to be very much aware of their plan's premium reduction feature; some New York-based sub-zero premium plan members, particularly those who had passively enrolled, were unaware of this feature.** In many cases, passive enrollees only discovered changes to their health plan benefit during a service encounter.

- **There was a general consensus that both the plan and the premium reduction were not explained very well, and some enrollees indicated that they could benefit from a better understanding of their benefits.** Low-income participants were particularly likely to feel this way. Beneficiaries emphasized that they prefer to hear, rather than read, new information about plan benefits.

- **Generally, most beneficiaries appeared to be sensitive to the costs and benefits of their plan enrollment.** For example, all members of sub-zero premium plans recognized they would need to pay more for prescription drugs should they need them. However, for beneficiaries who had not yet required services such as hospital care or prescription medicine, it was difficult for them to determine whether they would pay more out-of-pocket with a sub-zero premium plan than with another plan.

- **Some participating M+COs reported that their members experienced significant delays receiving the reduction and encountered difficulty obtaining accurate information about the sub-zero premium offering.** In addition, many members were concerned and confused about the amount of their Social Security check because they were not aware of or did not understand the COLA made in January 2003. One M+CO also stated that some

members called the Social Security Administration and 1-800-Medicare customer service line and were told that the new product offering did not exist.

Experience versus Expectations of Beneficiaries in Sub-Zero Premium Plans

A final area of project inquiry was to examine beneficiary experiences with the premium reduction benefit. This set of issues was also explored through beneficiary focus groups in Florida and New York. Sub-zero premium plan enrollees generally recognized that they would have greater out-of-pocket costs for prescription drugs should they need them, and thus, the majority said they would apply their Part B premium savings towards prescription drug expenses if required. While most active sub-zero plan enrollees felt that they were not paying more out-of-pocket than under their previous plan, passively enrollees tended to say the opposite.

Across the board, satisfaction with membership in a sub-zero premium plan correlated with the need for services. Enrollees requiring increased health care services were less likely to be satisfied because they were more likely to have greater out-of-pocket expenses than "healthy" beneficiaries. Sub-zero plan disenrollees generally left their plan for perceived better benefits, lower out-of-pocket costs in other plans, or improved flexibility accessing physicians or other health services. Specific key findings include:

- **All sub-zero premium plan enrollees recognized that they would have greater out-of-pocket costs for prescription drugs should they need them; most active enrollees did not believe they are paying more now than they were with their previous plan.** However, it was difficult for those who had not yet required services such as hospital care or prescription medicine to determine if their out-of-pocket costs would likely be higher with a sub-zero premium plan.
- **When asked how they use, or intend to use, the savings from the premium reduction benefit, the majority of sub-zero premium plan enrollees said they would apply it towards their prescription drug expenses.** Answers varied by group and included paying bills and going to better restaurants.
- **Passive enrollees were more likely to note that they had paid more out-of-pocket under the new benefit structure than the old structure.** These additional costs were usually related to diabetes and asthma medications and hospital and physician visits. Many in this group also highlighted that they used their savings to cover prescription drug costs.
- **Only a few sub-zero premium plan members indicated that they had experienced a small savings.** These beneficiaries were likely to participate in other programs that provided prescription drug coverage, e.g., Veteran's Administration.
- **Although the majority of enrollees are generally satisfied with their plan, most reported ambivalent feelings regarding their enrollment.** Most indicated that the premium reduction was a nice benefit, but that it was not a reason to stay enrolled should other, more important, plan features change. For example, there was a general consensus to stay enrolled

as long as one's doctors remained with the plan, but to disenroll if the doctor were to leave the plan network.

- **"Healthy" plan members were more likely to describe themselves as satisfied.** Across the board, satisfaction with membership in a sub-zero premium plan correlated with the need for services. If a member required increased health care services, they were less likely to be satisfied because they were likely to have had to pay more out-of-pocket than expected.
- **Disenrollees from among those passively enrolled into Health Net, as well as some who had actively enrolled into CarePlus in Florida, were willing to incur greater out-of-pocket costs in exchange for increased flexibility in a health plan.** Other disenrollees believed that they had incurred higher out-of-pocket costs during their membership in a sub-zero premium plan. Others left their sub-zero premium plan for a plan that they believe provides improved access to physicians or because they were dissatisfied with what they considered to be an ongoing elimination of benefits from the sub-zero premium plan.

Chapter 1: Background & Study Purpose

Background

Medicare is the federal health insurance program for some 40 million Americans age 65 or older and those under age 65 who have end-stage renal disease or certain long-term disabilities. Medicare consists of Part A, which primarily covers inpatient hospital services, and Part B, which primarily covers outpatient medical services. Although most Medicare beneficiaries do not pay directly for Medicare Part A coverage (funded through employee and employer taxes), Medicare Part B is funded in part by Medicare beneficiary premium payments. For 1999 and later years, the Part B premium is fixed at 25 percent of the expected costs of providing Part B benefits. (In 2003 the Part B premium is $58.70 per month.) Beneficiaries may access Medicare services through the Original Medicare fee-for-service (FFS) system or through a managed care organization available in their service area. About 14 percent of beneficiaries are currently enrolled in managed care. Regardless of how beneficiaries choose to receive their health coverage – whether through Original Medicare, a Medicare+Choice (M+C) plan or other type of Medicare managed care plan – they, or someone on their behalf, must pay the Part B premium in order to receive Part B benefits.

Medicare+Choice Organizations (M+COs) must provide all covered Medicare Part A and Part B services in exchange for a fixed per member per month (PMPM) payment from the Medicare program. In the spring of each year, M+COs learn the federal payment rates that will apply for the following year. They then compare their average expected federal payments with an "adjusted community rate" (ACR) for a health plan that would include the minimum required set of Medicare benefits. The ACR is calculated to reflect what non-Medicare enrollees would cost the M+CO for the same set of benefits, adjusting for differences in demographic characteristics and utilization between Medicare and non-Medicare enrollees. If the ACR is less than the expected federal payments, the M+CO must generally provide, at no cost to enrollees, supplemental benefits of a value equal to the difference or the excess funds can be retained in a stabilization fund for later use (until 2006). M+COs most frequently develop health benefit packages (i.e., "health plans") with enhanced benefits rather than return the excess payment to Medicare as a way of competing for Medicare members. The most common supplement offered by M+COs has been a waiver or reduction of beneficiary cost-sharing for Medicare-covered services that the organization would otherwise be permitted to charge. Many M+COs also provide enhanced benefits that Medicare does not pay for, such as outpatient prescription drug coverage, vision and hearing benefits, routine health exams, and/or dental coverage.

In an effort to provide a more direct form of price competition between M+C health plans and Original Medicare, section 606 of the Benefits Improvement and Protection Act (BIPA) of 2000 amended the Social Security Act to allow M+COs to offer a reduction of the Medicare Part B premium as an additional member benefit, effective January 1, 2003. This new approach originated partly in response to concerns that Medicare regulations needed to be less restrictive to allow the offering of premium reductions to beneficiaries as an alternative to expanded benefit

packages.[18] As a result of BIPA 606, M+COs are allowed to elect a reduction in their base payment by up to 125 percent of the Part B premium. Eighty percent of the payment reduction is applied to reduce the amount of the Part B premium, generally reflected as an increase in a beneficiary's Social Security check (given that most beneficiaries pay the Part B premium through a monthly reduction in their check). The Medicare Trust Fund shares in the payment savings, by retaining 20 percent of the payment reduction. For an M+CO that elects to reduce their base payment by the full 125 percent reduction of the Part B premium, enrollees pay no Part B premium. Health plans offering this benefit are variously referred to as "sub-zero premium plans," "BIPA 606 plans," or "Medicare Part B premium reduction plans."[19]

To date, five M+COs with service areas in the New York City, Miami, and Tampa metropolitan areas have chosen to offer a total of ten health plans that include this benefit. Five of the six plans in Florida waive the full Part B premium for their members; the remaining Florida plan and the four plans in New York waive $20 to $30 per member per month. The health plans are offered in eight counties in which 1.75 million beneficiaries, or roughly 4.3 percent of the Medicare population, reside. The M+COs projected a cumulative enrollment of 18,000 for calendar year 2003.[20] As of June 2003, cumulative enrollment across all sub-zero premium plans was 6,835.[21]

Study Purpose

The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, is interested in the implementation of the "sub-zero premium" benefit in part to determine whether a reduction in the Part B premium appeals to a broader range of Medicare beneficiary than other managed care benefit packages currently offered. CMS contracted with BearingPoint to conduct a limited assessment of how Medicare beneficiaries and M+COs responded to the new sub-zero premium option during its initial offering. One purpose of the evaluation is to learn which types of beneficiaries enrolled in these new health plans and why, how they learned about the new option, whether they fully understand the benefit, and what their initial experiences have been. Another objective is to better understand the reasons that some M+COs decided to offer health plans with this new benefit and why some did not, how M+COs have marketed the product, whether they targeted the benefit to certain types of beneficiaries, whether they altered other aspects of the health plan benefit package, and their experiences to date.

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[18] Feldman, R., B. Dowd, R. Coulam, L. Nichols and A. Mutti, "Premium Rebates and the Quiet Consensus on Market Reform for Medicare," *Health Care Financing Review*, Winter 2001 23(2), pp: 19-23.
[19] M+C health plans that include the Part B premium reduction benefit are called "sub-zero premium plans" within the context of this report.
[20] CMS Project Scope of Work received January 31, 2003.
[21] CMS Enrollment Report received June 4, 2003. Of the 6,835 enrollees in sub-zero premium plans, approximately 1,341 actively enrolled in the plans. The balance was rolled over from Health Net plans in Bronx, Queens and Richmond Counties that existed prior to January 2003.

BearingPoint's evaluation is based on a three-fold approach that includes:

- Task 1: A review of sub-zero premium plan marketing materials, CMS-housed M+CO and health plan data, and beneficiary data for sub-zero premium plan enrollees and non-enrollees;
- Task 2: Semi-structured telephone surveys with key individuals at M+COs offering a sub-zero premium plan ("participating M+COs"), key individuals at several M+COs in the same market areas that chose not to offer such a plan at this time ("non-participating M+COs"), Medicare beneficiary advocates, and Medicaid directors in Florida and New York; and
- Task 3: Focus groups with sub-zero premium plan enrollees and disenrollees, other Medicare managed care enrollees, and Original Medicare FFS plan enrollees located in market areas where the sub-zero premium plans are currently being offered.

Findings from each of these tasks were included in individual task reports prepared for CMS; the same findings are included in this report. Chapter Two provides a description of the marketing materials and outreach methods used by the five M+COs offering the new sub-zero premium benefit and of the markets in which the sub-zero plans are offered. Enrollment data for the sub-zero premium plans is included in addition to beneficiary profiling information for the sub-zero premium plan markets and an overview of how each M+CO's sub-zero premium product compares with its other products in the markets under study. Chapter Three provides findings from the key informant interviews with staff at participating M+COs, staff at several non-participating M+COs, Medicare beneficiary advocates, and Medicaid directors. Chapter 4 presents findings from the focus groups with Medicare beneficiaries.

Chapter 2. Market Profile and Marketing Material Review

This chapter describes the markets in which the sub-zero premium plans are offered. Enrollment data and beneficiary profiling of sub-zero plan enrollments and sub-zero premium product comparisons are included. The product comparisons help discern whether and how participating M+COs chose to differentiate their sub-zero premium plan from other health plans in the local market, including their own plans. The information also provides context for the project's Task 2 review of the M+COs' decision-making process with regard to offering and designing sub-zero premium plans.[22]

Research for this chapter was conducted via four methods: 1) a detailed analysis of beneficiary data from CMS's Medicare Enrollment Database (EDB) and Monthly Membership Data files; 2) a comparative review of health plan benefit package data available from CMS's Medicare Health Plan Compare website; 3) a critical review of CMS guidance on the CMS Part B premium reduction benefit, CMS marketing material guidelines, and sub-zero premium plan marketing materials; and 4) semi-structured interviews with marketing staff from M+COs in New York and Florida that are offering a sub-zero premium health plan this year. Details of these methods and respective findings are presented below.

Medicare Beneficiary Data Profiling

Methodology

Review of All Enrollee Types

We initially requested a random sample from CMS's Enrollment Data Base (EDB) files of Medicare beneficiaries residing at any time during January through April 2003 in the eight New York and Florida Counties in which sub-zero premium plans are offered: Broward, Hillsborough, and Dade Counties in Florida, and Bronx, Queens, Richmond, Kings, and New York Counties in New York. CMS drew a random sample of 10,000 beneficiaries enrolled in Original Medicare FFS in each county as of April 2003, and a random sample of 10,000 beneficiaries enrolled in an M+CO plan in each county as of April 2003. We next added to these samples all beneficiaries enrolled in the M+COs that offered a sub-zero premium plan but were not enrolled in the sub-zero plans. We then extracted variables indicating beneficiary age (as of January 1, 2003), gender, Medicaid status, race/ethnicity, health plan enrollment, and new Medicare eligibility status. Beneficiaries who were deceased, had End Stage Renal Disease (ESRD), were missing enrollment or disenrollment data, or did not have both Medicare Parts A and B were removed from the samples. We then categorized beneficiaries who had not been in an M+CO at any point during the four-month period as Original Medicare FFS; beneficiaries who had been enrolled in

[22] The analysis in this report is limited to plans that opted to offer a sub-zero premium plan, although the Task 2 analysis will also consider feedback from M+COs that chose not to offer such a plan.

an M+CO at any point during the four-month period were categorized as M+CO. The final sample sizes used in the analysis were 57,105 FFS beneficiaries and 126,180 M+CO enrollees.

We next used CMS's Monthly Membership Report files for January through April 2003 to identify M+CO enrollees in the sub-zero premium health plans. Non-sub-zero premium plan enrollees include beneficiaries participating in M+COs that offer a sub-zero premium plan but who chose other benefit packages offered by those M+COs. Sub-zero enrollees include all beneficiaries enrolled in a sub-zero premium plan at any point during the four-month period. We also divided New York's Health Net sub-zero premium plan enrollees into those who had been "passively" enrolled into the plan at the beginning of January 2003 and those who had "actively" chosen to enroll in the plan after January 1, 2003. Passive enrollees were identified by their enrollment in Health Net (H3366) prior to January 1, 2003, because the sub-zero premium plan was not offered before that date.

After file preparation, we compared beneficiary characteristics across the four groups of health plan enrollees: active sub-zero M+CO, passive sub-zero M+CO, FFS, and other M+CO. We only compared beneficiaries who were enrolled in both Medicare Parts A and B as of November 1, 2002, as these comprise the beneficiaries who had the option to enroll in a sub-zero premium plan during the 2002 Annual Enrollment Period and afterwards. A beneficiary was designated as "newly eligible" if his/her Part A or Part B begin date was on or after January 1, 2002. This designation includes beneficiaries newly eligible for Medicare due to age or disability status, and those newly eligible for Medicare Part B benefits due to delayed enrollment in Part B.[23]

Review of Sub-Zero Premium Plan Enrollees

In addition to comparing beneficiaries across plan types, we used data from CMS's Monthly Membership Report files for January through April 2003 to compare beneficiary characteristics among the sub-zero premium plans. The combined Monthly Membership Report file contains information on the following 10 sub-zero premium plans:

- CarePlus in Broward County, Florida (H1019-004);
- CarePlus in Dade County, Florida (H1019-005);
- Vista Health Plan in Dade County, Florida (H1076-012);
- Vista Health Plan in Broward County, Florida (H1076-010);
- Well Care Advantage Plan in Dade County, Florida (H1032-027);
- Well Care Advantage in Hillsborough County, Florida (H1032-026);

[23] We considered separating new eligibility categories by eligibility reason (i.e., under-age-65 disabled, newly turned age 65, or age 66 or older and newly enrolled in Medicare Part B) and by Part A/Part B or Part B eligibility only, but the sub-zero enrollment seemed too small to justify this, particularly for "active" enrollees.

- Health Net in Bronx County, New York (H3366-001);
- Health Net in Queens County, New York (H3366-007);
- Health Net in Richmond County, New York (H3366-008); and
- United Health Care in Richmond, Bronx, Kings, New York, and Queens Counties, New York (H3379-006).

Well Care Advantage of Hillsborough County had no enrollees during January through April and is not included in the sub-zero premium plan profiling tables. Health Net sub-zero premium plans in Bronx, Queens, and Richmond Counties in New York offer the same benefit package, so the three plans were combined into one for profiling purposes. In addition, the Health Net membership was separated into "active" and "passive" enrollees as in the previous section.

In profiling the plans, we examined differences in gender, age, race/ethnicity, number of months enrollees participated in a sub-zero premium plan from January through April, disenrollee percentages, Medicaid eligibility, new Medicare eligibility status, health status as measured by the Part A risk factor on the Monthly Membership Report files,[24] and type of previous plan enrollment (i.e., FFS or M+CO). In many cases, sub-zero premium plan enrollment for the first four months of 2003 was low, limiting comparisons among plans.

Findings

All Enrollee Types

Chi-squared tests of independence were used to assess statistical associations between beneficiary characteristics and health plan type. All characteristics in Table 2.1 below were found to be statistically significant at the 95 percent level of confidence, indicating potential important differences among plan types (sub-zero, FFS, and M+CO).

In particular, beneficiaries who actively joined a sub-zero premium plan appear to differ in several ways from other M+CO enrollees, including those passively enrolled in Health Net's sub-zero premium plan. First, the distribution of gender for sub-zero active enrollees is more even than in other M+CO and FFS plans, with the other plan types more likely to have a higher ratio of females to male participants (1.5 to 1). The sub-zero active enrollees also include a higher percentage of younger enrollees ages 65 to 69. This is the case even when compared with other M+CO plans, which research has indicated tend to enroll younger and healthier

[24] The Part A risk factor encompasses the Principal Inpatient Diagnostic Cost Group (PIP-DCG) factor, which adjusts M+C payments based on enrollee demographics and diagnoses associated with inpatient hospital stays occurring in the year prior to payment. Application of the model includes calculation of a relative risk factor using previous inpatient diagnoses, age, sex, originally-disabled criteria, and Medicaid eligibility to modify the appropriate county payment rate according to the characteristics of the individual M+C enrollee. Thus, the Part A risk factor is used as a proxy in this study to measure relative health status of sub-zero plan enrollees.

beneficiaries than FFS plans. This finding is also consistent with the findings from the focus groups conducted for this study that revealed healthier beneficiaries are more likely to find the sub-zero premium plans attractive because the Part B premium reduction feature outweighs other less generous health care benefits included in these plans. The active sub-zero premium plan enrollees also include a slightly higher percentage of under-age-65 disabled beneficiaries than other M+COs (including the passive enrollees in Health Net), which is interesting because these types of beneficiaries often have poor health status although they do not necessarily use more health services than aged beneficiaries.

Table 2.1 Comparison of Medicare Beneficiary Characteristics by Health Plan Type, 2003

Beneficiary Characteristic	Sub-Zero M+CO Plans[α]		Original Medicare Fee-for-Service Plan[β]	Other M+CO Plans[α]
	Passive Enrollment	Active Enrollment		
Enrollment	5,361	1,603	57,105	126,180
Gender				
Male	39.7%	50.5%	39.8%	41.8%
Female	60.3%	49.5%	60.2%	58.2%
Age				
64 or younger	9.5%	13.2%	16.3%	9.0%
65 – 69	21.9%	28.7%	19.0%	23.2%
70 – 74	27.4%	22.0%	17.3%	23.7%
75 – 79	19.0%	17.8%	15.8%	17.8%
80 or older	22.2%	18.3%	31.6%	26.3%
Newly Eligible[χ]				
Yes	3.4%	13.5%	9.0%	6.4%
No	96.6%	86.5%	91.0%	93.6%
Race/Ethnicity				
White	89.0%	82.0%	77.2%	70.0%
Black	6.8%	11.5%	12.1%	16.8%
Hispanic	2.2%	4.2%	6.4%	7.9%
Asian	0.5%	0.6%	1.4%	2.2%
Other	1.5%	1.7%	2.9%	3.1%
Medicaid Eligibility				
Yes	5.5%	5.4%	19.5%	10.9%
No	94.5%	94.6%	80.5%	89.1%

[α]CMS April 2003 "Monthly Payment Files." Includes retroactive enrollments and disenrollments except for the month of April 2003.
[β] BearingPoint analysis utilized CMS sample of April 2003 Medicare Enrollment Database File.
[χ]Obtained Part A or Part B after 1/1/02.

The age distribution among the plan types also reflects the greater percentage of sub-zero premium plan active enrollees who are newly eligible for Medicare benefits. Active sub-zero premium plan enrollment reflects the highest share of individuals newly eligible for Medicare at almost 14 percent of plan participation. Again, this may be a result of age and health characteristics, with younger new-eligibles likely to be in better health, thus finding the trade-off between Part B premium reduction and decreased health care coverage more attractive than older and less healthy beneficiaries.

Table 2.1 indicates that racial/ethnic minority enrollment is highest in the non-sub-zero M+CO plans. Sub-zero premium plan enrollees – both active and passive – do not reflect this diversity to the same extent, and even less so than FFS beneficiaries. Less diversity appears to be partially linked to differences in Medicaid enrollment among plan types: both the FFS plan (20 percent) and the non-sub-zero M+CO plans (11 percent) have higher Medicaid enrollment than both the active and passive-enrollee sub-zero premium plans (less than 6 percent of enrollees each).[25] Studies have shown that Medicare beneficiaries who are dually-eligible for Medicaid benefits more frequently identify with a racial or ethnic minority. Dual-eligible enrollment in the sub-zero premium plans may be a lower share of total plan enrollment because dual-eligibles do not actually benefit from the premium reduction (although they may not all be aware of this).

Sub-Zero Premium Plan Enrollees

Comparisons of beneficiary characteristics among the sub-zero premium plan enrollees with available data reveal several interesting differences (Table 2.2). The New York plan (i.e., Health Net) has a higher male-to-female ratio (60/40) than the Florida plans when combined. However, a Florida plan, CarePlus in Dade County, has the highest percentage of males at 62 percent of enrollees. Similarly, Vista Health Plan in Dade County also has a somewhat elevated male-to-female ratio. The majority of sub-zero premium plans have roughly equal percentages of enrollees in each of the four elderly age categories, although again CarePlus in Dade County has a much higher percentage of younger aged beneficiaries ages 65 to 69 (42 percent of enrollees). Neither differences in gender or ages across the plans appear to be caused by differences in general demographics among the counties. As displayed in Tables 2.3 and 2.4 at the end of this section, the same patterns for FFS and M+CO enrollees in Dade County are not apparent.

The significant portion of younger-aged enrollees participating in sub-zero premium plans in Dade County reflect their higher share of new Medicare eligibles joining these plans. Almost one-fourth of the enrollees in CarePlus and Vista Health Plan of Dade County were new to Medicare within the past year compared with 10 percent in CarePlus's Broward County plan and 13 percent among New York's Health Net active enrollees. Again, this pattern does not seem to be associated with Dade County demographics, with about the same percentage of newly eligible

[25] Additionally, although approximately 50 percent of non-sub-zero M+CO, FFS, and active sub-zero enrollees who are Medicaid eligible identify themselves as non-White, only 20 percent of passive sub-zero enrollees who are Medicaid eligible are non-White (data not shown).

beneficiaries in FFS and other M+CO plans in Dade County as in the other Florida and New York Counties (Tables 2.3 and 2.4). It could be that advertising in Dade County was more heavily targeted towards individuals first joining Medicare that did not occur in New York or the other Florida counties.

There are only small differences among the sub-zero premium plans on average with respect to Part A risk factors, with about three-fourths of enrollees having an average to below-average risk factor (PIP-DCG) score and one-fourth having an above-average risk factor score. However, CarePlus of Dade County again appears to attract a different set of beneficiaries than other sub-zero premium plans. It has a lower percentage of enrollees with above-average risk factor scores (17 percent compared with about 25 percent of other sub-zero premium plans), most likely reflecting its greater share of younger-aged beneficiaries.

With respect to race/ethnicity, Dade County sub-zero premium plans appear different than those in the other Florida and New York counties, with a much greater share of Black enrollees and a somewhat higher share of Hispanic beneficiaries. Tables 2.3 and 2.4 indicate that Dade County's demographics include a higher percentage of Hispanic Medicare beneficiaries than the other counties, but this is not true with respect to Black Medicare beneficiaries. It would be interesting to understand why Dade County sub-zero enrollees, particularly in CarePlus, are attracting a higher share of minority beneficiaries, perhaps due to targeted marketing. Dade County sub-zero premium plan enrollment with respect to race/ethnicity may also reflect its higher percentage of Medicaid recipients (Tables 2.3 and 2.4). Both Dade County sub-zero premium plans have higher percentages of dually-eligible beneficiaries compared with the other Florida and New York Counties.

Not surprisingly, Health Net's passive plan enrollment has the highest percentage of members who had been enrolled in a sub-zero premium plan for the entire January through April period (93 percent). About 65 percent of enrollees in Florida plans had participated in a sub-zero premium plan for two months or less and 65 percent of Health Net's active enrollees had participated for one month only. However, the pattern for the Florida plans appears to be more attributable to late plan enrollment than disenrollment patterns. The late plan enrollment is likely the result of the delayed approval of the marketing materials for use in Florida and, therefore, a later start in advertising the new product. Most beneficiaries who enrolled in a Florida sub-zero premium plan did not disenroll from the plan during the four-month period. In sharp contrast, a much higher percentage of Health Net's active enrollees disenrolled (55 percent), perhaps because a much greater share of beneficiaries joined from Original Medicare and may not have felt comfortable in a Medicare managed care plan. In general, the four sub-zero premium plans with larger enrollments appear to be attracting a significant percentage of their members from Original Medicare (about one-fourth to one-third of enrollees in the three Florida sub-zero premium plans). Almost 69 percent of Health Net's active enrollees were immediately in Original Medicare prior to their enrollment in Health Net.

Across all sub-zero premium plans, 67 enrollees were still working (7 in CarePlus Broward County, 5 in CarePlus Dade County, and 55 in Health Net), 12 enrollees had End Stage Renal Disease, and 3 enrollees were receiving hospice care.

Table 2.2 Beneficiary Characteristics by Sub-Zero Premium Plan, January – April 2003[δ]

	FLORIDA						NEW YORK				
Beneficiary Characteristic	**CarePlus** (Broward County)	**CarePlus** (Dade County)	**Well-Care Advantage** (Dade County)	**Vista Health Plan** (Dade County)	**Vista Health Plan** (Broward County)	**All Florida Sub-Zero Plans**	**Health Net Passive enrollees** (Bronx, Queens, and Richmond Counties)	**Health Net Active enrollees** (Bronx, Queens, and Richmond Counties)	**United Health Care** (Bronx, Queens, Kings, Richmond, and New York Counties)	**All New York Sub-Zero Plans**	**ALL SUB-ZERO PLANS**
Enrollment	897	243	5	22	1	1,168	5,361	422	13	5,796	6,964
% of total enrollment	12.9%	3.5%	N/A[ε]	0.3%	N/A[ε]	16.8%	77.0%	6.1%	N/A[ε]	83.2%	100%
Gender											
Male	50.7%	62.1%		54.5%		53.1%	39.4%	43.2%		40.0%	42.2%
Female	49.3%	37.9%		45.5%		46.9%	60.6%	56.8%		60.0%	57.8%
Age											
64 or younger	10.8%	15.6%		13.6%		11.9%	9.5%	16.8%		10.1%	10.4%
65 – 69	24.0%	42.0%		27.3%		27.8%	21.9%	30.1%		22.6%	23.4%
70 – 74	22.0%	18.5%		27.3%		21.5%	27.4%	23.7%		27.0%	26.1%
75 – 79	21.2%	11.5%		13.6%		19.0%	19.0%	14.9%		18.7%	18.8%
80 or older	22.0%	12.4%		18.2%		19.8%	22.2%	14.5%		21.6%	21.3%
Newly Eligible											
Yes	10.4%	23.0%		22.7%		13.4%	3.4%	13.3%		4.0%	5.6%
No	89.5%	77.0%		77.3%		86.6%	96.6%	86.7%		96.0%	94.4%

[δ]As of April 2003, Well Care Advantage Plan in Hillsborough, FL had no enrollees and is not included in the table. The three Health Net plans in Bronx, Queens, and Richmond, NY have been combined into one plan because they offer identical benefits; they have been separated into "Passive enrollees" and "Active enrollees" based on M+CO enrollment prior to January 1, 2003.

[ε] Plans with fewer than 20 enrollees are not included in the table.

Table 2.2 Beneficiary Characteristics by Sub-Zero Premium Plan, January – April 2003[δ]

	FLORIDA						NEW YORK				
Beneficiary Characteristic	**CarePlus** (Broward County)	**CarePlus** (Dade County)	**Well-Care Advantage** (Dade County)	**Vista Health Plan** (Dade County)	**Vista Health Plan** (Broward County)	**All Florida Sub-Zero Plans**	**Health Net Passive enrollees** (Bronx, Queens, and Richmond Counties)	**Health Net Active enrollees** (Bronx, Queens, and Richmond Counties)	**United Health Care** (Bronx, Queens, Kings, Richmond, and New York Counties)	**All New York Sub-Zero Plans**	**ALL SUB-ZERO PLANS**
Enrollment	897	243	5	22	1	1,168	5,361	422	13	5,796	6,964
% of total enrollment	12.9%	3.5%	N/A[ε]	0.3%	N/A[ε]	16.8%	77.0%	6.1%	N/A[ε]	83.2%	100%
Risk Factor											
Average or below average	73.6%	82.7%		72.7%		75.3%	73.7%	75.1%		73.8%	74.1%
Above Average	26.4%	17.3%		27.3%		24.7%	26.3%	24.9%		26.2%	25.9%
Race/Ethnicity											
White	88.2%	60.1%		27.3%		81.3%	89.0%	86.0%		88.6%	87.4%
Black	7.1%	25.5%		63.6%		12.0%	6.8%	8.3%		7.0%	7.9%
Hispanic	3.0%	10.3%		9.1%		4.6%	2.2%	3.1%		2.2%	2.6%
Asian	0.2%	0.4%		0.0%		0.3%	0.5%	1.4%		0.6%	0.6%
Other	1.5%	3.7%		0.0%		1.8%	1.5%	1.2%		1.6%	1.5%
Medicaid Eligibility											
Yes	3.3%	7.4%		13.6%		4.7%	3.6%	4.3%		3.7%	3.9%
No	96.7%	92.6%		86.4%		95.3%	96.4%	95.7%		96.3%	96.1%

[δ]As of April 2003, Well Care Advantage Plan in Hillsborough, FL had no enrollees and is not included in the table. The three Health Net plans in Bronx, Queens, and Richmond, NY have been combined into one plan because they offer identical benefits; they have been separated into "Passive enrollees" and "Active enrollees" based on M+CO enrollment prior to January 1, 2003.

[ε] Plans with fewer than 20 enrollees are not included in the table.

Table 2.2 Beneficiary Characteristics by Sub-Zero Premium Plan, January – April 2003[δ]

	FLORIDA						NEW YORK				
Beneficiary Characteristic	**CarePlus** (Broward County)	**CarePlus** (Dade County)	**Well-Care Advantage** (Dade County)	**Vista Health Plan** (Dade County)	**Vista Health Plan** (Broward County)	**All Florida Sub-Zero Plans**	**Health Net Passive enrollees** (Bronx, Queens, and Richmond Counties)	**Health Net Active enrollees** (Bronx, Queens, and Richmond Counties)	**United Health Care** (Bronx, Queens, Kings, Richmond, and New York Counties)	**All New York Sub-Zero Plans**	**ALL SUB-ZERO PLANS**
Enrollment	897	243	5	22	1	1,168	5,361	422	13	5,796	6,964
% of total enrollment	12.9%	3.5%	N/A[ε]	0.3%	N/A[ε]	16.8%	77.0%	6.1%	N/A[ε]	83.2%	100%
Months of Enrollee Plan Participation											
1	33.5%	44.8%		18.2%		35.4%	1.7%	64.5%		6.3%	11.2%
2	30.4%	24.7%		54.5%		30.0%	3.2%	15.4%		4.2%	8.5%
3	21.7%	20.6%		18.2%		21.3%	2.4%	16.6%		3.5%	6.5%
4	14.4%	9.9%		9.1%		13.3%	92.7%	3.5%		86.0%	73.8%
January to April 2003 Disenrollees											
Yes	8.8%	3.7%		4.5%		7.6%	6.9%	55.2%		10.4%	9.9%
No	91.2%	96.3%		95.5%		92.4%	93.1%	44.8%		89.6%	90.1%
Previous Plan Enrollment											
FFS	28.1%	32.1%		27.3%		28.9%	0%	69.4%		7.4%	11.0%
MCO	71.9%	67.9%		72.7%		71.1%	100%	30.6%		92.6%	89.0%

[δ]As of April 2003, Well Care Advantage Plan in Hillsborough, FL had no enrollees and is not included in the table. The three Health Net plans in Bronx, Queens, and Richmond, NY have been combined into one plan because they offer identical benefits; they have been separated into "Passive enrollees" and "Active enrollees" based on M+CO enrollment prior to January 1, 2003.

[ε]Plans with fewer than 20 enrollees are not included in the table.

Source: BearingPoint analysis of CMS's January – April 2003 Monthly Membership Report and Medicare Enrollment Database Files.

Table 2.3 Beneficiary Characteristics of Original Medicare Fee-for-Service Enrollees by County, January – April 2003

	FLORIDA				NEW YORK						
Beneficiary Characteristic	**Broward County**	**Dade County**	**Hillsborough County**	**All Florida Counties**	**Bronx County**	**Queens County**	**Richmond County**	**Kings County**	**New York County**	**All New York Counties**	**All Counties**
Enrollment	7,565	6,661	8,512	22,738	7,059	7,360	5,638	6,820	7,490	34,367	57,105
Gender											
Male	38.4%	39.1%	42.3%	40.0%	38.2%	39.3%	44.6%	38.1%	39.0%	39.6%	39.8%
Female	61.6%	60.9%	57.7%	60.0%	61.8%	60.7%	55.4%	61.9%	61.0%	60.4%	60.2%
Age											
64 or younger	9.8%	10.7%	18.0%	13.1%	22.6%	14.5%	24.8%	16.9%	15.2%	18.5%	16.3%
65 – 69	16.1%	19.7%	23.1%	19.8%	18.5%	17.4%	21.7%	15.4%	19.8%	18.5%	19.0%
70 – 74	14.4%	18.9%	20.3%	17.9%	16.2%	16.6%	17.3%	15.8%	18.6%	16.9%	17.3%
75 – 79	15.2%	18.2%	16.8%	16.7%	14.1%	15.0%	15.7%	14.4%	16.8%	15.2%	15.8%
80 or older	44.5%	32.5%	21.8%	32.5%	28.6%	36.5%	20.5%	37.5%	29.6%	30.9%	31.6%
Race/Ethnicity											
White	93.3%	75.2%	82.3%	83.9%	57.7%	79.8%	90.1%	72.5%	67.6%	72.8%	77.2%
Black	3.8%	6.6%	13.0%	8.1%	24.7%	9.9%	5.3%	18.2%	14.4%	14.8%	12.1%
Hispanic	1.7%	15.5%	3.4%	6.4%	12.4%	4.0%	1.7%	4.1%	9.1%	6.5%	6.4%
Asian	0.2%	0.2%	0.3%	0.3%	1.1%	2.5%	1.0%	2.3%	3.7%	2.2%	1.4%
Other	1.0%	2.5%	1.0%	1.3%	4.1%	3.8%	1.9%	2.9%	5.2%	3.7%	2.9%
Medicaid Eligibility											
Yes	8.7%	33.7%	18.9%	19.8%	25.8%	13.6%	13.0%	21.0%	22.2%	19.4%	19.5%
No	91.3%	66.3%	81.1%	80.2%	74.2%	86.4%	87.0%	79.0%	77.8%	80.6%	80.5%
Newly Eligible											
Yes	7.8%	8.4%	10.1%	8.8%	10.1%	8.3%	11.9%	7.6%	8.4%	9.2%	9.0%
No	92.2%	91.6%	89.9%	91.2%	89.9%	91.7%	88.1%	92.4%	91.6%	90.8%	91.0%

Source: BearingPoint analysis of CMS's January – April 2003 Medicare Enrollment Database Files.

Table 2.4 Beneficiary Characteristics of Non-Sub-Zero M+CO Plans by County, January – April 2003

	FLORIDA				NEW YORK						
Beneficiary Characteristic	**Broward County**	**Dade County**	**Hillsborough County**	**All Florida Counties**	**Bronx County**	**Queens County**	**Richmond County**	**Kings County**	**New York County**	**All New York Counties**	**All Counties**
Enrollment	20,111	28,277	13,855	62,243	12,361	13,593	12,036	13,615	12,332	63,937	126,180
Gender											
Male	42.1%	45.3%	42.8%	43.7%	37.5%	41.6%	39.2%	40.2%	41.3%	40.0%	41.8%
Female	57.9%	54.7%	57.2%	56.3%	62.5%	58.4%	60.8%	59.8%	58.7%	60.0%	58.2%
Age											
64 or younger	8.3%	7.8%	12.7%	9.0%	9.4%	7.2%	12.3%	8.8%	7.1%	8.9%	9.0%
65 – 69	22.0%	25.3%	23.1%	23.8%	22.3%	24.6%	22.8%	20.3%	23.1%	22.6%	23.2%
70 – 74	20.5%	26.1%	26.0%	24.2%	23.2%	23.8%	22.5%	22.0%	24.2%	23.1%	23.7%
75 – 79	17.0%	19.4%	18.0%	18.3%	17.5%	17.2%	17.5%	17.2%	17.4%	17.4%	17.8%
80 or older	32.2%	21.4%	20.2%	24.7%	27.6%	27.2%	24.9%	31.7%	28.2%	28.0%	26.3%
Race/Ethnicity											
White	85.4%	65.2%	81.8%	75.4%	53.0%	65.5%	91.9%	61.8%	52.1%	64.7%	70.0%
Black	10.8%	11.0%	12.0%	11.2%	34.5%	19.7%	4.4%	27.7%	23.9%	22.2%	16.8%
Hispanic	2.0%	21.0%	4.6%	11.2%	8.5%	3.9%	1.0%	2.8%	7.0%	4.6%	7.9%
Asian	0.5%	0.3%	0.4%	0.4%	1.0%	5.2%	1.0%	4.0%	8.8%	4.0%	2.2%
Other	1.3%	2.5%	1.2%	1.8%	3.0%	5.7%	1.7%	3.7%	8.2%	4.5%	3.1%
Medicaid Eligibility											
Yes	7.7%	19.6%	8.4%	13.2%	10.3%	6.4%	4.9%	8.7%	12.8%	8.6%	10.9%
No	92.3%	80.4%	91.6%	86.8%	89.7%	93.6%	95.1%	91.3%	87.2%	91.4%	89.1%
Newly Eligible											
Yes	6.5%	8.0%	5.0%	6.8%	5.8%	6.0%	6.7%	5.0%	6.0%	6.0%	6.4%
No	93.5%	92.0%	95.0%	93.2%	94.2%	94.0%	93.3%	95.0%	94.0%	94.0%	93.6%

Source: BearingPoint analysis of CMS's January – April 2003 Medicare Enrollment Database Files.

Review of M+COs' Plan Offerings and Marketing Materials and Methods

Methodology

Review of Plan Offerings

In order to understand the sub-zero premium plan markets, the project team conducted a detailed review of the M+C health plans available in the eight Florida and New York counties in which sub-zero premium plans are offered. Using information from CMS's Medicare Health Plan Compare database available at www.medicare.gov, the project team created a county-by-county matrix inclusive of selected benefits offered by the existing M+CO health plans.[26] For each county, these characterizations consist of tables and related text describing the following details:

- Number of available M+COs;
- Number and type of health plans offered by each M+CO;
- Characteristics of the health plan benefit packages offered in those markets (focusing on supplemental benefits). The benefits selected for inclusion are those known to meaningfully affect Medicare beneficiary selection of health plan options.

The data provide the foundation for the M+CO-level and county-level plan comparisons presented below and in Appendix B. In addition to analyzing Medicare Health Plan Compare data, the project team received monthly enrollment data from CMS, which is also presented in this chapter.

Review of Sub-Zero Premium Plan Marketing Materials

The project team conducted a critical review of the sub-zero premium plan marketing materials. The first step in the review process was to gain an understanding of the current CMS marketing material guidelines and the parameters in which materials are developed. This strategy helped to clarify the flexibility that the M+COs have to promote certain aspects of their health plans, such as the Part B premium reduction benefit.

CMS Marketing Material Guidelines and Review

All marketing materials and promotional activities related to an M+C plan must be reviewed by CMS.[27] According to the Medicare Managed Care Manual, marketing materials are defined as informational materials targeted to Medicare beneficiaries that promote a health plan/M+CO, or

[26] A copy of this matrix can be obtained from Vic McVicker at vmcvicker@cms.hhs.gov, or at Centers for Medicare & Medicaid Services, C3-20-17, 7500 Security Boulevard, Baltimore, MD, 21244-1850.

[27] CMS has waived all M+COs from having to follow the requirements under 42 CFR 422.80(a) for employer group members. This means that M+COs need not have CMS pre-approve marketing materials they prepare that are designed for members of employer groups.

communicate or explain an M+C plan.[28] They include "beneficiary notification materials," defined as advertising materials or pre-enrollment materials and may be sections of newsletters, notification forms and letters used to enroll, disenroll, or communicate with the member or potential member about membership operational policies and procedures.[29] They are intended primarily to attract or appeal to M+C eligible non-members and to promote membership retention by providing general information to enrollees about the health plan.[30, 31]

Included among beneficiary notification materials is the annual notice of change (ANOC), which is sent to current plan members informing them of any changes to their current plan.[32] Of the health plans offering the premium reduction benefit, only the Health Net of New York plans in Bronx, Queens, and Richmond Counties were in existence prior to January 2003. These plans' members were transferred into the plans offering the new premium reduction benefit and, as such, were sent an ANOC describing the new benefit. Other M+COs offering the new product did not send an ANOC because their plans were being offered for the first time in January 2003 as an additional product.

Pre-enrollment materials, a type of marketing material, include the standardized Summary of Benefits (SoB) document generated from the Plan Benefit Package database.[33] It is the primary pre-enrollment document that M+COs use to inform potential Medicare beneficiaries of their health plan details. In some cases, it is the only marketing document used to promote a plan. If the SoB lists only one plan, but other plans become available through the M+CO in the service area, the ANOC must notify beneficiaries of the new plans and include specific information on how to obtain more information.

CMS's Regional Offices (ROs) review the marketing materials, using Chapter 3 of the Medicare Managed Care Manual (Last Updated - Rev. 15, 09-27-02) as their main source of guidance. M+COs must submit one copy of the following to its CMS Central Office Plan Manager and one copy to the RO Plan Manager: outreach letters and other materials intended for potential and existing members; and telephone scripts or other outreach assistance scripts that will guide M+CO representatives in answering members' questions or discussing the assistance available to them.

Chapter 3 of the Medicare Managed Care Manual provides guidance to M+COs as they develop their marketing materials and activities. While no guidelines or model language particular to the sub-zero premium plans have been issued, the following guidelines appear to be most relevant:

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[28] Medicare Managed Care Manual (MMCM), Ch. 3, 10 – Introduction
[29] MMCM, Ch. 3, 4.40 – Guidelines for Beneficiary Notification Materials
[30] MMCM, Ch. 3, 30.1 – Guidelines for Advertising Materials
[31] MMCM, Ch. 3, 4.40 – Guidelines for Beneficiary Notification Materials
[32] MMCM, Ch. 3, 4.40 – Guidelines for Beneficiary Notification Materials
[33] MMCM, Ch. 3, 40.40 – Guidelines for Beneficiary Notification Materials

- Materials must disclose that beneficiaries must continue to pay the Part B premium and continue their Medicare Part B coverage while enrolled in the M+C Organization (Must Use/Can't Use/Can Use Chart).
- In addition to the targeted message, pre-enrollment materials must state "the plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area" (Section 30.1).
- Health plans/M+COs should make marketing materials available in any language that is the primary language of more than 10 percent of the population in a geographic area. In addition, basic enrollee information should be made available to the visually impaired (Section 60.4).

In most cases, M+COs must submit materials to CMS at least 45 days prior to distribution; the material can be used after 45 days or upon RO approval.

Marketing Material Collection and Review

Following conference calls with the Region II New York and Region IV Atlanta CMS Regional Offices, the project team contacted M+COs offering the Part B premium reduction benefit to request samples of the marketing materials circulated during the fall of 2002. Materials collected included flyers, posters, newspaper advertisements, and the ANOC sent to currently enrolled beneficiaries. Three of the five M+COs created advertising materials. The remaining two did not create additional materials for the new health plan. During interviews, these two M+COs were questioned about their decision not to create additional materials and whether or not any marketing efforts were conducted. Table 2.5 below details the materials collected by the project team.

Table 2.5 M+CO Marketing Materials Provided					
	CarePlus Health Plans, Inc.	**Vista Healthplan, Inc.**	**Well Care Choice**	**Health Net**	**United Healthcare of New York, Inc.**
Sub-zero premium plan	CareFree Plan	Medicare VALUE Advantage	Advantage Plan	Smart*Choice*	Give-Back Plan
Counties	Dade, Broward	Dade, Broward	Dade, Hillsborough	Bronx, Richmond, Queens	Bronx, Richmond, Queens, Kings, New York
Advertising Materials (Optional)	Color brochures detailing two plans, 7 flyers/posters, 3 newspaper clips (English & Spanish)	No materials or script available	No materials or script available	Poster, postcard, mailer w/business reply card, mailer with seminar details	Color brochure, seminar information (English & Spanish)
Summary of Benefits (Required)	Yes	Yes (English & Spanish)	Yes	Yes	Requested –Not received as of 6/16/03
Annual Notice of Change (ANOC) (Required for Existing Members)	New plan – ANOC not applicable	New plan – ANOC not applicable	New plan – ANOC not applicable	Yes	New plan – ANOC not applicable

Marketing material characteristics reviewed by the project team were selected based on an Internet search for instructive resources regarding development of marketing materials, complemented by the project team's experience in health plan marketing and health communications. In this section, the following characteristics of the marketing materials are described: message relating to premium reduction benefit, graphics, colors, and other benefits highlighted. This information is provided to inform CMS how the M+COs chose to explain the new benefit in their materials. In addition, this section includes information gleaned from the key informant interviews conducted during May and June 2003 regarding M+CO outreach methods and target audiences. CMS ROs had approved all materials received from the plans.

Although several of the five M+COs provided BearingPoint with comparable materials for other plans they offer, as requested, we found that marketing materials for both the sub-zero and non-sub-zero premium plans were very similar. Additionally, some M+COs provided samples of various Evidence of Coverage documents. However, since this is a required document not typically shared with a potential member until after enrollment, the project team, with guidance from CMS, did not review these documents.

Interviews with Marketing Staff

During May 2003, the project team conducted semi-structured interviews with staff at the M+COs offering a sub-zero premium health plan. Marketing staff members were asked about their decision to create and use promotional materials specific to the new sub-zero premium

plans. The findings from these interviews are included with the discussion of the marketing materials in this chapter.

Findings

This section of the report provides context for evaluating participating M+COs' sub-zero premium products and their efforts to market these products. Medicare beneficiary data and detailed analysis of market and plan profile is presented and for each M+CO, the following information is provided:

- Enrollment in the sub-zero premium plans;
- An overview of the plans it offers in the markets under study, with an emphasis on how its sub-zero premium plan compares with its other products;
- A brief description of how the sub-zero premium plans compare with other M+C plans in the local market; and
- A description of its marketing materials and outreach methods for the sub-zero premium plans.

For a characterization of each county's plans and more detail on how the sub-zero premium plans differ from other plans in each county, see Appendix B.

Sub-Zero Premium Plan Enrollment: January – May 2003

As indicated by Table 1.1 in the Executive Summary, the CarePlus Carefree Plans in Florida are the only sub-zero premium plans with any significant enrollment increases during the year. Health Net's Smart*Choice* sub-zero premium plan shows relatively high enrollment at the beginning of 2003, but this is because Health Net transferred its Medicare enrollees in Bronx, Queens, and Richmond Counties into its Smart*Choice* sub-zero premium plan from the previously offered health plan it replaced.[34] Between January and May of 2003, 267 people actively enrolled in the Smart*Choice* sub-zero premium plans and 826 disenrolled. The plans' net enrollments decreased only slightly through May.[35]

Review of M+COs' Plan Offerings and Marketing Materials and Methods

New York M+COs

Two M+COs in New York offer sub-zero premium plans, United Healthcare of New York, Inc., and Health Net of New York (Table 2.6). The former offers its sub-zero premium plan, the Medicare Complete Plan 4 or Medicare Give Back Plan, in all five New York City counties,

[34] Health Net also offers a Smart*Choice* plan in Kings County that does not offer the Part B premium reduction benefit.

[35] Health Net enrollment and disenrollment data come from CMS's Monthly Membership Data File. Discrepancies between this data and the information in Table 3.1 are due to the fact that the former data does not take into account retroactive enrollments and disenrollments.

whereas Health Net offers a Smart*Choice* sub-zero premium plan only in Bronx, Queens, and Richmond Counties. While each county's Health Net sub-zero premium plan has a unique plan identification number, these three plans are identical with respect to the plan attributes under consideration.

Table 2.6 Availability of Sub-Zero Premium Plans, by County

Bronx	Kings	New York	Queens	Richmond
▪ Medicare Complete Plan 4 ▪ Smart*Choice* for Bronx County	▪ Medicare Complete Plan 4	▪ Medicare Complete Plan 4	▪ Medicare Complete (Plan 4) ▪ Smart*Choice* for Queens County	▪ Medicare Complete (Plan 4) ▪ Smart*Choice* for Richmond County

United Healthcare of New York, Inc.

Benefits

United Healthcare of New York, Inc. offers three HMO products to the general Medicare population, Medicare Complete Plans 1, 3, and 4, in the five counties in which they offer their sub-zero premium plan.[36] Plan 4, also named the Medicare Give Back Plan, is the organization's sub-zero premium product and is offered in all five counties. The other two plans require no premium in addition to the monthly Part B premium, and Plan 1 is offered in all of the counties while Plan 3 is offered only in Kings, New York, and Queens Counties (Table 2.7).

Table 2.7 Availability of United Healthcare of New York's Medicare Health Plans, By County

Bronx	Kings	New York	Queens	Richmond
▪ Medicare Complete Plan 1 ▪ Medicare Complete Plan 4	▪ Medicare Complete Plan 1 ▪ Medicare Complete Plan 3 ▪ Medicare Complete Plan 4	▪ Medicare Complete Plan 1 ▪ Medicare Complete Plan 3 ▪ Medicare Complete Plan 4	▪ Medicare Complete Plan 1 ▪ Medicare Complete Plan 3 ▪ Medicare Complete Plan 4	▪ Medicare Complete Plan 1 ▪ Medicare Complete Plan 4

Since the three plans are standardized across the counties, comparisons among the United Healthcare of New York plans are not county-specific. With respect to the different Medicare Complete plans, Plan 3 has the lowest co-pays for basic services like inpatient hospital care and physician visits. It offers the most generous vision benefit, but no coverage of outpatient prescription drugs. Plan 1 charges higher co-pays than Plan 3 for basic services, but it does provide coverage of outpatient generic drugs. Plan 4, in exchange for the reduction in the Part B premium, exposes its enrollees to the most financial risk by having no prescription drug

[36] United Healthcare also offers its Evercare product in these counties. Because preliminary research suggests that the plan is limited to nursing home patients, it has been excluded from the analysis. Queries directed to United Healthcare staff regarding this issue had not been answered as of June 16, 2003.

coverage, a higher maximum limit on enrollees' out-of-pocket expenses, and the highest co-pays. Specifically, Plan 4 charges higher co-pays for the following services:

- Inpatient hospital care
- Skilled nursing facility (SNF) care
- Primary care physician (PCP) and specialist visits
- Some hearing and vision services
- Routine physical exams.

The differences in co-pays for inpatient hospital care and SNF care are significant, meaning that an enrollee would have to avoid all but the briefest of stays in these facilities to financially benefit from enrolling in the sub-zero premium plan.

Similar findings about how United Healthcare's sub-zero premium plan compares with other health plans offered in the local markets apply across the five counties. First, compared with other plans in these markets, including Health Net's Smart*Choice* plans, United Healthcare's Medicare Give Back Plan requires higher co-pays and offers less generous benefits than its competitors. For instance, it has much higher co-pays for inpatient hospital stays and SNF care, the highest co-pays for specialist visits, and the second highest co-pays for routine physical exams.[37] In contrast to the majority of other plans in the five New York counties, this plan also offers no coverage of any type for outpatient prescription drugs, dental services, or hearing aids, and co-pays for vision and hearing exams are comparatively high. In exchange for these higher co-pays and less generous benefits, United Healthcare's Medicare Give Back Plan offers a reduction in the Part B premium of up to $30 per month, $10 more than the reduction offered by the Smart*Choice* plans. Moreover, the Medicare Give Back Plan, along with United Healthcare's other plans offered in these counties, are the only HMO plans that do not require members to obtain a referral to visit (network) specialists.

United Healthcare Marketing Materials Review

To market their Medicare Give Back Plan of New York, United Healthcare created a colorful booklet and flyers in English and Spanish listing "free community meetings." In addition to the booklet for the Give Back Plan, the M+CO provided BearingPoint with a similar one for their Medicare Complete Choice product, a PPO plan offered in the five New York counties under review.[38] Both are created in similar styles, colors, and layout and use many of the same pictures.

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[37] For example, most of the plans cap enrollees' out-of-pocket contribution toward the cost of an inpatient hospital stay (up to 90 days) at $750 or less. The Medicare Give Back Plan requires a co-pay of $265 per day for days 1-19, and $0 per day for days 20-90.

[38] The Medicare Complete Choice product is a PPO plan that is offered by the United Healthcare Insurance Co. of New York, Inc. This entity has a different H-number (H3326) than United Healthcare of New York, Inc. (H3379), and is thus counted as a separate M+CO in the county-level analyses in Appendix B.

The booklet cover notes that the Give Back Plan offers "more benefits than Medicare alone plus up to $30 each month off your Medicare Part B premium." This is something that may appeal to those in Original Medicare who would like to maintain the same benefits as they have in the fee-for-service environment yet reduce their Part B payment. Throughout the booklet, text emphasizes that enrollees will receive all of the benefits and services outlined in the booklet and, in addition, will gain up to $30 more each month in their Social Security check. More detail is provided in this booklet regarding the M+C program and the premium reduction than in any of the other M+CO marketing materials provided by any of the five participating M+COs. The following paragraph is provided in conjunction with an explanation that United Healthcare affiliates contract with CMS to provide enrollees with health care coverage:

> *"Our contract with CMS also enables people who sign up for the Medicare Give Back Plan to receive up to $30 off their Medicare Part B Premium. Meaning you actually pay less money overall and still get more benefits and services than Medicare alone."*

A table in the booklet highlights the advantages of the plan as compared to a traditional Medicare supplement (Medigap) policy. They include covered preventive care, no monthly premium, little or no paperwork, and no deductibles. Provision of this type of information reinforces the supposition that this plan is created with the Medicare fee-for-service beneficiary in mind.

The flyer has a banner and tag line that reads, "Wish you could have more money in your social security check? How does **$30** sound?" Other plan benefits noted include "coverage for hospitalization when treatment is medically necessary," worldwide emergency care, United Healthcare's Care Coordination program, and access to a "large network of contracted physicians and specialists, who you can always see without a referral." At the bottom of the flyer, phone numbers and community meeting details are listed. Meetings take place on Tuesday and Thursday mornings at restaurants in the New York area. A note at the bottom of the page states:

> *"(For most Medicare beneficiaries, the Medicare Part B premium is automatically deducted from your Social Security check); these beneficiaries would see an increase in their Social Security check if they join Medicare Give Back Plan. Medicare Complete is available to persons entitled to Medicare Part A by age or disability and enrolled in Medicare Part B. You must continue to pay Medicare for your Part B premium and receive all routine care from contracted Medicare Complete providers, except for emergency or urgently needed services. Some limitations, restrictions and/or co-payments/coinsurance apply. Medicare Complete is a Medicare+Choice plan offered by United Healthcare of New York."*

Health Net of New York.

Benefits

Health Net of New York offers a Smart*Choice* plan in four of the counties under study, Bronx, Kings, Queens and Richmond. Across these counties, the plan attributes under consideration are

identical, except that in Kings County the plan does not reduce any of the monthly Part B premium, and in the other three counties it offers a reduction of up to $20 per month. Compared with other plans offered in these four counties, Smart*Choice* plans require comparatively mid-range co-pays for inpatient hospital care and specialist visits and no co-pay for SNF care or routine physical exams.[39] Along with approximately two-thirds of the plans in these counties, the Smart*Choice* plans provide some outpatient drug coverage, though it is limited to formulary generics. Smart*Choice* plans offer some coverage of hearing aids, but do not cover dental services. Table 2.8 below provides context for evaluating the Health Net and the United Healthcare sub-zero premium plan benefit packages with those of their competitors.

Table 2.8 Percentage of Plans Offering Additional Benefits[φ] and M+C Market Penetration[γ] by County

	Bronx	Kings	New York	Queens	Richmond
Generic drugs	77%	65%	63%	65%	65%
Brand name drugs	36%	42%	42%	35%	39%
Dental services	59%	62%	63%	62%	61%
Vision services[η]	86%	88%	88%	88%	87%
Hearing aids	36%	65%	63%	65%	65%
M+C Market Penetration	22%	21%	13%	25%	34%

[φ] Additional benefit information from the online Medicare Health Plan Compare is available at www.medicare.gov.
[γ] M+C market penetration data for May 2003 was obtained from CMS's Geographic Service Area Report.
[η] According to Medicare Health Plan Compare, "Coverage for Vision Services" is understood to mean at least partial coverage of a vision service or material that is not covered at all by Medicare. Thus, a plan offering some coverage of a routine eye exam would qualify, but a plan that requires enrollees to pay 100% of non-Medicare-covered services or materials – even if it covers some portion of beneficiaries' share of the cost of a Medicare-covered vision service – would not.

Of the five participating M+COs in New York and Florida, only Health Net rolled over enrollees from a non-sub-zero premium product to its new offering, effective January 1, 2003. As noted in the Annual Notice of Change that was sent in Fall 2002 to plan members residing in Bronx, Queens, and Richmond Counties, Health Net made a number of changes to the benefit packages in these counties. Generally speaking, co-pays for preventive care services decreased, while co-pays for mental health services increased, along with certain services and equipment required by people with chronic conditions. For example, co-pays for routine eye exams and routine and diagnostic hearing exams were reduced from $15 to $0. However, co-pays for inpatient mental health care at a network psychiatric hospital were increased from $0 per admission to $500 per admission, and co-pays for diabetes monitoring, training, and supplies changed from $0 to a 20 percent coinsurance. Co-pays for generic prescription drugs increased from $7 to $12 per prescription and from $14 to $30 per mail order prescription. Brand name drugs are no longer covered.

[39] Assumes 100-day benefit period.

The Smart*Choice* plan has a two-tier inpatient hospital co-payment structure in Bronx and Richmond Counties. Tier 1 includes Health Net designated facilities with a lower co-pay than hospitals in Tier 2. Tier 1 has a $0 per admission co-pay versus $500 per admission for each benefit period in Tier 2, with no annual out-of-pocket maximum for either. The other counties only offer one hospital Tier, which has the same co-pay and out-of-pocket maximum as the Tier 2 hospitals in Bronx and Richmond Counties.[40]

Health Net Marketing Materials Review

Health Net markets its Smart*Choice* product through direct mail efforts, newspaper advertisements, and posters placed in the diners in which the M+CO conducts informational seminars. Advertisements encourage interested parties to schedule in-home appointments or attend marketing seminars. Potential members may also call a toll-free number to order an enrollment kit or to schedule an appointment. Additionally, the M+CO has conducted quarterly town hall meetings in diners and senior centers for current and prospective members.

Direct mail materials include a brochure with a business reply card encouraging readers to respond to obtain more information. The cover of the brochure has the message: "If you could increase your Social Security check up to $20 every month, wouldn't you?" next to a photograph of dollar bills with a $20 bill on top. Inside the brochure is a photograph of a couple in their fifties or early sixties and a single woman in her mid to late sixties. At the top of the page the message is "What is your health plan doing for you?" Readers are told to "Make the Smart*Choice*" and "See how a bigger check can lead to big benefits." Benefits highlighted in the brochure include: coverage for generic prescription drugs, $10 primary care office visit co-pay, and a $0 monthly health plan premium.

Another mailer with the same cover as described above includes details of informational seminars conducted at several diners in Richmond County. According to the brochure, "representatives will explain the plan and answer questions" at the informational seminars. Inside the mailer, the tag line reads "The Smart*Choice* advantage. A bigger check and bigger benefits." The same plan benefits as noted above are listed in this mailer. A phone number is provided for more information.

Other marketing materials include a postcard and poster with the same graphics and text as the seminar mailers. The plan's Summary of Benefits is a simple, black and white document. The premium reduction benefit is described as follows and is likely to be difficult to interpret for many beneficiaries:

> *"You pay $0 each month. You also continue to pay the Medicare Part B premium of $58.70 each month. Please note that Health Net of NY, Inc., is reducing your monthly*

[40] Medicare Health Plan Compare makes no mention of the tier system. According to that data source, Health Net's Smart*Choice* plans require a $500 co-pay per inpatient hospital stay in a network facility.

Medicare Part B premium by up to $20 (This may be a rounded number.) Please contact Health Net of NY, Inc., for details."

All existing Health Net members were mailed an ANOC explaining the change in their benefits. The description of the premium reduction benefit is as follows:

"Due to a new law passed by Congress, Health Net of New York, Inc., is now offering you a reduction in the amount that you pay for your monthly Medicare Part B premium. The amount that you will continue to pay for your Part B premium reduction will depend upon the total amount that you owe the Medicare program for your Part B benefits. This reduction will be effective for all Medicare beneficiaries who are members of Health Net SmartChoice in [Richmond, Queens, and Bronx] County. The reduced monthly Medicare Part B premium will continue at least through December 31, 2003."

Florida M+COs

In Florida, three M+COs offer sub-zero premium products: CarePlus Health Plans, Inc., Vista Healthplan, Inc., and Well Care Choice. CarePlus Health Plans and Vista Healthplan offer their sub-zero premium products, the CareFree Plan and the Medicare VALUE Advantage plan, respectively, in Dade and Broward Counties. Well Care Choice offers its Well Care Advantage plan in Dade and Hillsborough Counties (Table 2.9).

Table 2.9 Availability of Sub-Zero Premium Plans, by County

Dade	Broward	Hillsborough
▪ CareFree Plan ▪ Medicare VALUE Advantage plan ▪ Advantage plan	▪ CareFree Plan ▪ Medicare VALUE Advantage plan	▪ Advantage plan

Table 2.10 below provides a context for evaluating the sub-zero premium plans with the plan benefit packages of other plans in Broward, Dade and Hillsborough Counties.

Table 2.10 Percentage of Plans Offering Additional Benefits[ι] and M+C Market Penetration[φ] by County			
	Broward	Dade	Hillsborough
Generic drugs	77%	85%	60%
Brand name drugs	23%	75%	-
Dental services	31%	45%	80%
Vision services[κ]	100%	100%	100%
Hearing aids	23%	50%	60%
M+C Market Penetration	**43%**	**45%**	**23%**

[ι] Additional benefit information from the online Medicare Health Plan Compare is available at www.medicare.gov.
[φ] M+C market penetration data for May 2003 from the Geographic Service Area Report.
[κ] "Coverage for Vision Services" in Medicare Health Plan Compare is understood to mean at least partial coverage of a vision service or material that is not covered at all by Medicare. Thus, a plan offering some coverage of a routine eye exam would qualify, but a plan that requires enrollees to pay 100% of non-Medicare-covered services or materials—even if it covers some portion of beneficiaries' share of the cost of a Medicare-covered vision service—would not.

CarePlus Health Plans, Inc.

Benefits

CarePlus Health Plans operates in two of the Florida counties under study, Broward and Dade, and in each of these counties, it offers two products, the CareFree and the CarePlus plan. The CareFree Plan is the M+CO's sub-zero premium product, while the CarePlus plan is its zero premium product, meaning that it requires no premium in addition to the Part B monthly premium. Within each county, the two plans are nearly identical, differing only in premium amounts and levels of outpatient prescription drug coverage. The CareFree Plan in both counties offers very limited drug benefits, with no coverage of brand name or non-formulary generic drugs and a maximum monthly drug benefit of $25. By contrast, the CarePlus plans offer coverage of formulary and non-formulary brand name drugs and much higher drug benefit limits.[41]

The two plans offered in Dade County are more generous than their counterparts in Broward County, mainly with respect to inpatient hospital care co-pays, outpatient facility co-pays, specialist visit co-pays, and outpatient prescription coverage. This difference between the two counties is consistent with findings for the other M+COs in these markets. However, in both counties, the CareFree Plans compare favorably with other M+C plans, with the only clear disadvantage being their very limited coverage of outpatient prescription drugs. Relative to the

[41] In Dade County, the CarePlus plan has a semi-annual benefit limit of $750 on brand name drugs and no limit on generic drugs. In Broward County, this plan has a semi-annual limit of $500 for generic drugs and $300 for brand name drugs. This benefit information is from the plans' Summary of Benefits document dated 10/25/02.

other plans, the dental, vision, and hearing coverage offered by the CareFree Plans is quite generous.

CarePlus Health Plans Marketing Materials Review

CarePlus M+CO provided a number of advertising materials. Of the three M+COs offering the new sub-zero premium benefit in Florida, it is the only one that has actively advertised the new product. This is likely to be a major contributing factor to their significantly higher enrollment than the other two sub-zero premium plans.

Print advertisements and mailers in English and Spanish were provided to the BearingPoint project team. Print advertisements include one from The Herald in English and two from the El Nuevo Herald in Spanish. The English ad reads "Attention: Medicare Recipients. Take the CarePlus Test." Below the text is a color picture of a clipboard with a checklist with the following questions:

- *Are you currently enrolled in Medicare Part B, and entitled to Part A?*
- *Are you presently looking for a health plan that provides you with additional benefits, including dental coverage?*
- *Are you presently looking for a health plan that gives unlimited generic prescription drugs?*
- *Would you like to put an additional $59 in your pocket from Social Security?*

The questions apply to benefits of both the CareFree and CarePlus plans. This is somewhat misleading since readers may assume that all of these benefits are available through both plans. However, some of the benefits apply to only one of the plans. For example, the "unlimited generic prescription drug" benefit is a feature of the CarePlus Plan only. The CareFree Plan offers the premium reduction benefit, but has a monthly benefit limit of $25 for generic prescription drugs that is not noted on the print ad. The advertisement does, however, note that there is no co-pay for prescription drugs for the CarePlus plan and a $5 co-pay for the CareFree Plan.

Smaller print highlights access to an "extensive roster of caring physicians," medical centers and hospitals. As noted in several of the project team's interviews with various M+COs, access to specific providers is the primary concern for the majority of potential members.

The two Spanish print ads highlight features of both the CarePlus and CareFree Plans. For the CarePlus plan, the key feature highlighted is the unlimited generic prescription drug benefit. CareFree Plan descriptions highlight the $59 added to one's Social Security check. One ad notes that this is an increase in income of $700, and the other highlights the benefit following a note that this benefit may be appropriate for people who only require a monthly prescription drug benefit of $25. This technique targets the reader's need for prescription drugs and encourages him or her to assess this need when choosing a health plan.

Two flyers in Spanish also highlight the benefits of both health plans. In addition to the unlimited generic prescription benefit, the dental benefits are highlighted for the CarePlus Plan. Pictures on one flyer include those of a female and male physician with a couple in between. Another has a picture of an apple.

Flyers in English include similar messages. Graphics include the following:

- Hand dropping a coin into a piggy bank;
- Female hand placing a stack of dollar bills into a male outstretched hand;
- Stethoscope laying on top of a pile of dollar bills with four prescription medicine bottles next to it;
- A clenched fist of dollar bills.

Text displayed with the graphics include:

- *What's better than a Health Plan that costs you nothing? How about one that puts $59 a month in your bank?*
- *What's better than a Health Plan that offers you all your Medicare Benefits and more? How about one that increases your income by $59 a month?*
- *Make Money on your Health Insurance. Increase your Social Security Check by $59 a Month.*

Each flyer has a header that reads: "Attention Medicare Recipients." All list the services offered and benefits such as prescription drug coverage, with a monthly limit of $25, and a free membership to HSC, the health and wellness savings card. As with the newspaper advertisements, all describe the premium reduction as over $700 per year in additional income.

A major marketing piece is a large colorful booklet with information tailored by region (Dade and Broward). With a shiny red and white front cover and blue back cover, it is the most colorful document from among those provided by the five M+COs. Pictures on both sides show a man and a young boy fishing; two couples sitting on a couch; a woman with a younger, middle-aged women in the kitchen, a couple reading with two young boys on their laps; a man smiling; and three woman in the kitchen. All appear to be healthy, middle to upper-middle class senior citizens, excluding the children and middle-aged woman. The inside is also very colorful with color blocks and multiple photographs of happy and active people.

Unlike the Summary of Benefits document, the benefit chart in the booklet does not include a row describing premiums. Instead, it is highlighted on the third page with a catch phrase of "Introducing The New CareFree Plan!" The text describing the product is as follows:

> *"CarePlus Health Plans, Inc., now offers their members another benefit package – the CareFree Plan. The CareFree Plan offers all your Medicare benefits and more,* ***and***

reduces the amount you pay for your Medicare Part B premium by up to $59 per month. This reduction of $59 will appear as an increase in your Social Security check every month – an increase in over $700 a year in income!

The CareFree Plan covers many important benefits – Doctors and Specialists visits, hospitalization, dental benefits, $25 worth of generic prescription medications per month, and the HSC Card that provides additional pharmacy discounts. You can compare these two plans and the Original Medicare Plan using the benefit chart in this brochure."

Similar to those of other health plans, the CarePlus Summary of Benefits is a simple black and white document with the standard benefit chart. The chart uses similar wording to that of the other sub-zero premium plans and describes the new benefit as follows:

*"You pay **$0** each month. You also continue to pay the Medicare Part B premium of $58.70 each month. Please note that CarePlus Health Plans, Inc., is reducing your monthly Medicare Part B premium by up to $58.70. (This may be a rounded number.) Please contact CarePlus Health Plans, Inc., for details."*

CarePlus did not need to send an ANOC to its members describing the new benefit because it is offered through a new product. The CareFree Plan's availability is, however, noted in the ANOC sent in November 2002 to existing members of the CarePlus Plan. It does not provide a description of the plan or the premium reduction benefit.

Vista Healthplan, Inc.

Benefits

Vista operates three plans in both Broward and Dade Counties, the Medicare Advantage plan ("Advantage plan"), the Medicare CHOICE Advantage plan ("Choice plan"), and the Medicare VALUE Advantage plan ("Value plan").[42] The Value plan offers the sub-zero premium benefit, while the other plans require no premium in addition to the monthly Part B premium.

Within each county, the Advantage plan and Choice plan are very similar, with the only differences among the considered attributes being in the areas of dental and prescription drug coverage. The Advantage plans offer outpatient prescription drug coverage but no dental benefits, while the Choice plans do not offer any outpatient prescription drug coverage but do provide dental coverage. Thus, for people with Medicare, the choice between these two plans is a straightforward decision as to whether they prefer prescription drug or dental coverage. By contrast, the Value plans offer a distinct option to potential enrollees, namely one with which they would save up to $58.70 per month, but would expose themselves to much greater risk with

[42] Another M+CO named Vista Healthplan, Inc., operates in Dade County, and an M+CO named Vista Healthplan of South Florida, Inc., operates in both Dade and Broward Counties. According to information available at the writing of this report, these organizations operate independently of the Vista Healthplan, Inc., that offers the sub-zero premium product. The M+CO under study is identified by H-number H1076, while the other two organizations are identified by H1027 and H1013, respectively. According to a representative from the Vista Healthplan under study, the three organizations are undergoing a consolidation that will be complete within the next year.

respect to out-of-pocket costs. Some of the differences in co-pays and benefits between the Value plans and the other two Vista plans are listed in Table 2.11.

Table 2.11 Summary of Differences between the VALUE Advantage and Other Vista Plans

Broward County	Dade County
▪ Higher maximum limit for out-of-pocket spending ($4,000 compared to $2,500) ▪ Higher inpatient hospital care co-pay ▪ Significantly higher SNF daily co-pay and maximum per stay limit ▪ Co-pay for PCP visits ▪ Higher co-pay for specialist visits ▪ Higher co-pays for ambulatory surgical centers and outpatient facilities ▪ Higher co-pay for outpatient prescription drugs, and like the Advantage plan, covers only generics ▪ Less generous vision benefit	▪ Co-pay for inpatient hospital care ▪ Co-pay for SNF care ▪ Co-pay for specialist visits ▪ Co-pays for ambulatory surgical centers and outpatient facilities ▪ Higher co-pay for outpatient prescription drugs, and like the Advantage plan, covers only generics ▪ Less generous vision benefit

For each plan type and across most plan attributes, the product offered in Dade County is more generous than its counterpart in Broward County. One exception is that the plans offered in Broward County have a maximum out-of-pocket limit (on certain services) ranging from $2,500 to $4,000, while the plans in Dade County do not similarly cap enrollees' expenditures. In both counties, the Value plan is less generous in terms of benefits and cost-sharing than its competitors. For example, unlike most plans available in Dade County, Vista Healthplan's sub-zero premium plan requires co-pays for inpatient hospital care, SNF care, specialist visits, and outpatient surgery. Relative to the other plans in the Broward County market, the Value plan requires much higher co-pays for inpatient hospital care, specialist visits, and outpatient surgery. Moreover, its drug benefit is limited, covering only formulary generics and capping its monthly benefit at $50, and it does not cover dental services or non-Medicare covered hearing services.

Vista Healthplan Marketing Materials Review

Vista Healthplan does not actively advertise their various products. Instead, their Medicare Marketing representatives use the Standardized Summary of Benefits as the primary tool for their presentations. The document is a simple piece with a white and green shaded cover with three photographs: 1) a clinical worker with a woman and a cane; 2) a smiling couple; and 3) two clinical staff in a hospital setting. Inside is the usual information about choices in health care, comparing options, service areas, provider choice, out-of-network service, supplemental insurance, and coverage protection.

The premium reduction benefit in their Medicare VALUE Advantage plan is mentioned in two places in the document. First, the deduction is mentioned in the first row of the table entitled "Premium and Other Important Information." Following references to a $0 monthly premium for Vista Medicare VALUE Advantage and the requirement to pay the $58.70 Medicare Part B premium is this reference to the deduction: "Please note that Vista Healthplan is reducing your monthly Medicare Part B premium by up to $58.70." The reader is referred to a later page in the

document for more information. The information on that page is more detailed than that provided in the other Summary of Benefits we received:

> *"Members of Vista Medicare VALUE Advantage will have their monthly Medicare Part B premium reduced by up to $58.70. In 2003, the monthly Part B premium for most people is $58.70 (some pay different amounts, and people whose Medicare Part B premiums are paid by a third party will not see an increase in their monthly check since the money will go to the payer of the Medicare Part B premium). Medicare beneficiaries typically have their Part B premium deducted from their Social Security or OPM annuity checks; however, some pay Medicare directly for their Part B benefits.*
>
> *You do not have to do anything to receive this benefit. The deduction for your Part B premium will be reduced by up to $58.70 beginning in your third month of membership. You will be reimbursed by Social Security for the two months prior to the discontinuation of your premium. If you pay Medicare directly for your Part B benefits, Medicare will reduce your bill by up to $58.70."*

Vista has a large team of sales people who market the M+CO's various products. They conduct in-home presentations, group presentations and lunch seminars. They have a limited advertising budget and have not conducted any marketing efforts unique to their sub-zero premium plan. Instead, the sales representatives describe the various health plans during presentations and seminars, pointing out their various strengths and weaknesses and explaining the trade-off in benefits from plan to plan.

Well Care Choice

Benefits

Well Care Choice offers two products, the Choice and Advantage plans, in Dade and Hillsborough Counties. Advantage offers the sub-zero premium benefit, while the Choice plan charges no premium in addition to the monthly Part B premium. Within each county, a comparison of Well Care Choice's two plans reveals differences akin to those found among Vista Healthplan's offerings. In short, in exchange for the Part B premium reduction benefit and a $5,000 limit on out-of-pocket spending for certain plan services, enrollees in the Advantage plans potentially face much higher out-of-pocket costs for inpatient care, SNF care, specialist visits, outpatient surgery, and outpatient prescription drugs.

Across counties and plan attributes, as with Vista Healthplan and CarePlus plans, the Well Care Choice plans offered in Dade County are more generous than those available in Hillsborough Counties. For example, the Advantage plan in Hillsborough County offers only a partial reduction in the Part B premium, compared with a full reduction in the Dade County plan, and does not offer any outpatient prescription drug benefit, while its counterpart in Dade County does provide such a benefit, including some coverage of brand name drugs. In both counties, the Advantage plan is generally less generous in terms of benefits and cost-sharing than its competitors. For example, unlike most plans available in Dade County, Well Care Choice's sub-zero premium plan requires co-pays for inpatient hospital care, SNF care, specialist visits, and

outpatient surgery. In Hillsborough County, the Advantage plan requires higher co-pays for basic services than do three of the other four plans, and it does not offer any outpatient prescription drug coverage. However, it does offer relatively generous coverage of vision and hearing services.

Well Care Choice Marketing Materials Review

Well Care Choice does not actively market the Advantage plan separately from its other health plans. This M+CO's advertising approach is not specific to any one product and only the benefits and characteristics that apply to all products are discussed in advertising materials. Marketing representatives use the Summary of Benefits document to present the various products available to potential members. The document mentions the premium reduction benefit only in the table of benefits. The following reference is made in the document for Hillsborough County:

> *"You also continue to pay the Medicare Part B premium of $58.70 each month. Please note that Well Care Advantage is reducing your monthly premium by up to $25. (This may be a rounded number.) Please contact Well Care Choice for details."*

The same information is provided for Dade County with the monthly premium reduction amount at $58.70.

Feedback from Interviews with Marketing Staff

Several of the five M+COs told the project team that they had hoped to gain a distinct marketing advantage by offering the premium reduction benefit. The idea was that the new sub-zero premium plan would appeal to healthier fee-for-service, or Original Medicare, beneficiaries who do not use a significant amount of health care services and for whom the premium reduction benefit might be an incentive to join a health plan. One M+CO representative said, "From the marketing perspective, the appeal to a benefit like this is that there are a reasonable amount of eligibles that do not have an HMO because they view themselves as relatively healthy." Such beneficiaries include those that do not visit doctors often, do not take prescription drugs, and to a large degree do not see the need to enroll in an M+C product. Essentially, this new type of product might motivate "low-users" to enroll in a Medicare managed care product. One interviewee commented that beneficiaries in this target audience are likely to say, "If I am going to make money by joining, then I'll do it."

In order to offer the new benefit, most M+COs designed a benefit package that reduced coverage for certain services such as skilled nursing facilities and inpatient hospital stays. The reduction may have been in the form of decreased limits or increased co-pays or deductibles. Another common target was the outpatient prescription drug benefit—the reduction usually resulted in the coverage of generic drugs only or no coverage or at all.

Experience with the new product to date has led some of the M+COs to acknowledge that Medicare beneficiaries seem to prefer other, perhaps more tangible, benefits to the premium reduction. One M+CO noted that in order for the product to be attractive to more beneficiaries, other benefits would have to remain the same as in other existing plans. The M+CO's

assumption had been that the healthier people who would be attracted to this plan would accept these increased co-pays. However, many of the M+COs have learned that beneficiaries are not willing to take the risk of incurring higher out-of-pocket costs by joining the sub-zero premium plans.

For beneficiaries considering the sub-zero premium plan, the M+CO interviewees told us that sales representatives assist them in determining whether the increased co-pays would be offset by the reduced premium. For the majority, a simple math calculation illustrates that the new product is not appropriate for them. For example, a person taking 10 prescriptions per month would pay $60 in co-payments. This is more than the $58.70 Part B premium reduction, which would not make the Medicare VALUE Advantage plan an attractive choice.

For some of the M+COs, offering the new product was a test to see how beneficiaries would react to it. These organizations did not conduct advertising specific to the new product, instead choosing to explain the product in full to beneficiaries in person. One M+CO representative stated that advertising the benefit without having a sales representative present to respond to questions would be partial disclosure and the M+CO was not comfortable with that. These M+COs chose to simply use their Summary of Benefits document and invest in sales representatives instead of advertising efforts. Enrollment numbers to date indicate that this approach has had limited success. Alternatively, only one of the three M+COs that opted to advertise has realized a return on their investment to date in terms of increased enrollment. Thus, all M+COs will need to assess and, perhaps, modify their advertising efforts. Some M+COs have acknowledged that it is unlikely that they will offer the benefit again in 2004.

Chapter 3. Interviews with M+COs, SHIPS, and State Medicaid Directors

Key informant interviews were conducted via telephone with representatives from the following: M+COs that offer a sub-zero premium plan in 2003 ("participating M+COs"); M+COs with health plans in the eight counties in which the sub-zero premium plans are available and are not offering the product ("non-participating M+COs"); the CMS-sponsored State Health Insurance Assistance Programs (SHIPs) in Florida; the Medicare Rights Center (MRC) in New York; and the State Medicaid Offices in Florida and New York. The purpose of these interviews was to address the following primary research questions:

- What are the reasons why some M+COs decided to offer this option and others did not? Would participating M+COs have offered the product if the beneficiary "lock-in" rules had been in effect for 2003?
- Did participating M+COs target and market the option to specific types of beneficiaries in their service area?
- Did participating M+COs alter other health plan benefits in exchange for the Part B premium reductions?
- What is the overall experience that the participating M+COs have had with the option to date? Has it met their expectations?

This chapter presents the approach used by the project team in structuring and conducting interviews and key research findings.

Methodology

Members of the BearingPoint project team conducted 19 interviews with key individuals at the five participating M+COs in order to obtain the organizations' perspectives on the sub-zero premium benefit. For comparison purposes, the project team conducted six interviews with representatives of four "non-participating" M+COs. Non-participating M+COs were selected to be as comparable as possible with the participating M+COs with respect to the following variables: plan type, tax status, total size of M+CO enrollment, and co-payment/deductible requirements.

In addition, the project team conducted interviews with representatives of the Florida SHIP and the New York Medicare Rights Center[43]. The purpose of these interviews was to first learn if the representatives and beneficiaries in their area were aware of the new product offering; secondly, to learn how beneficiaries had reacted to the new benefit (if at all); and, lastly, to investigate the types of questions beneficiaries or beneficiary advocates had about the new product.

[43] The New York SHIP, also known as the Health Insurance Information & Counseling Assistance Program (HIICAP), referred the project team to the Medicare Rights Center for the New York SHIP interview.

In addition, the project team interviewed staff at the Florida and New York State Medicaid Offices to learn about any relevant payment issues concerning members who are dually eligible for Medicare and Medicaid benefits ("dual eligibles"). Specifically, the team interviewed key Medicaid staff to determine their level of awareness about the Part B premium reduction benefit and whether the Medicaid program had, or was expecting, to receive the premium reduction benefit for Medicaid recipients in the new plans.

For each participating and non-participating M+CO, the project team intended to conduct approximately five separate interviews per M+CO to include the chief executive officer, chief operating officer, director of sales and marketing, government affairs officer, and director of member services. A letter of introduction signed by CMS explaining the purpose and objectives of the study was sent to all participating/non-participating plans and other organizations described above (see Appendix C for "Introductory Letters"). The project team conducted follow-up telephone calls to schedule interviews with the identified key informants. In most instances, the M+COs noted that there were only two or three staff members who were familiar with the sub-zero premium option. In most instances the project team interviewed approximately three key informants per organization, although these interviews were often supplemented with information obtained from other staff within the organization. Some of these interviews occurred with small groups of participants, but most were with individual staff members.

Each interview was approximately 45 to 60 minutes and followed an interview guide[44] that had been previously developed by the project team and approved by the CMS Project Officers. At least two members of the project team were present at each interview. Members of the project team explained the objectives of the study and that the discussion was confidential. After receiving verbal permission from the participants, each interview was tape-recorded; written summaries were produced at the conclusion of each interview.

Qualitative research methods were used to accomplish the research objectives for this particular task, which are not necessarily conducive to generalizing. However, using qualitative research methods allowed the project team to explore and understand the attitudes, opinions, and behaviors of the organizations under study from key individuals.

Findings

This section of the report describes cross-cutting themes and key findings about participating and non-participating M+COs', SHIPs', and the Medicare Rights Center's level of awareness of the sub-zero premium product offering, decision to offer/not to offer, product development, outreach efforts, issues around implementation, future participation, and insights from beneficiary advocates about factors affecting beneficiary acceptance of a sub-zero premium product and the

[44] Separate interview guides were developed for participating plans, non-participating plans, and SHIPs. For copies of the interview guide, contact Vic McVicker at vmcvicker@cms.hhs.gov or at Centers for Medicare & Medicaid Services, C3-20-17, 7500 Security Boulevard, Baltimore, MD, 21244-1850.

Medicare program in general. In addition, the status of findings about the Florida and New York State Medicaid Offices' level of awareness about the product offering is discussed.

Cross-Cutting Themes

Level of Awareness

Both participating and non-participating M+COs became aware of the new sub-zero premium product option offering via a posting on CMS's website, through Medicare and Medicaid trade journals, and an announcement in the ACR (Adjusted Community Rate) filing instructions. All of the M+COs, however, discussed the lack of direction they received about the implementation of the product offering, and the subsequent necessity to contact their CMS Regional Office (RO) with questions.

Both the Florida SHIP and the MRC reported that they had not received any formal announcement about the product, either from CMS or participating M+COs. Consequently, they reported they had not received any inquiries from beneficiaries about the offering. The Florida SHIP commented, however, that there would potentially be greater interest and enrollment into the product if beneficiaries were made aware of it.

The Florida and New York State Medicaid Offices reported that they were not aware of the sub-zero product offering, but expressed an interest in finding out more about it from CMS.

Decision to Offer/Not Offer

There was widespread agreement among participating and non-participating M+COs that the new sub-zero premium product offering was innovative. However, an actuarial assessment determined that it would not be profitable, or even cost-prohibitive, for some M+COs, which led to their decision not to offer the Part B premium reduction benefit.

Currently, each month beneficiaries may opt out of their M+C plans. However, when M+COs were asked if they would have offered the product if the "lock-in" provisions were in effect for 2003, most replied 'yes.' Interestingly, one M+CO pointed out that fewer Medicare beneficiaries would have adopted the new offering if the lock-in provision had been in effect in 2003.

Product Development

Participating M+COs used similar tactics when marketing the sub-zero premium product. These tactics primarily consisted of direct mailings, newspaper advertisements, and community-based and in-home presentations.

When considering a specific "type" of Medicare beneficiary that might be attracted to the sub-zero premium product offering, some M+COs discussed three possible "types," including Original Medicare FFS beneficiaries, "healthy" beneficiaries, and "dual eligible" beneficiaries.

Original Medicare: Interviewees from two of the five M+COs commented that the Part B premium benefit might be attractive to individuals who are comfortable with a more limited benefit package than that offered by other health plans, but who would like more coverage than Original Medicare provides.

"Healthy" beneficiaries: Although M+COs did not necessarily target "healthy" beneficiaries, some believed that a sub-zero premium plan might appeal to these "types" of beneficiaries who otherwise would not join an HMO or purchase a Medigap supplemental policy because they view themselves as relatively healthy in terms of using health care services and/or requiring prescription drugs.

Dual Eligibles: Although one M+CO thought that a sub-zero premium product would be most beneficial for, and attractive to, dual eligibles, their understanding of the Part B premium reduction benefit, and its application to Medicaid recipients, was inaccurate. This finding was confirmed by discussions with the CMS Project Officers. For example, one M+CO explained that an eligible Qualified Medicare Beneficiary with full Medicaid benefits[45] (QMB Plus) would receive the full Part B premium reduction benefit as a lump sum payment for the entire year following their qualification as QMB. The state then continues to pay the Part B premium as long as the person remains QMB-eligible.

Outreach Efforts and Implementation

Although they did not have high expectations for enrollment due to the volatility and financial risk of the M+C marketplace, the level of beneficiary interest in their sub-zero premium plan disappointed the majority of participating M+COs at the time of their interviews.

In reference to implementation, members of some participating M+COs have experienced significant delays receiving the benefit and requisite adjustments in their Social Security check. Many members were further concerned and confused about the amount of their Social Security check as a result of the Cost of Living Adjustments (COLA) made in January 2003.

Future Participation

At the time of the interviews, most M+COs had not begun discussing whether they would offer a sub-zero premium plan in 2004. However, most of the M+COs commented that they probably would not offer one for several reasons, including: 1) concern about under-funding of the Medicare program in general; 2) the overall financial benefit is too low to beneficiaries to make the plan benefit package attractive; and 3) the product is a "non-starter," which means it is not something that the M+CO would consider since CMS has not finalized its health status-based risk-adjustment payment method.

[45] QMB Plus is a category of Medicare beneficiaries who are entitled to Medicare Part A, have an income of 100% of the Federal poverty level or less, have resources that do not exceed twice the limit for Supplemental Security Income (SSI), and are eligible for the full Medicaid benefit.

Some M+COs commented that they might be more likely to offer a sub-zero premium product if CMS provided an incentive to do so. The purpose of the incentive would be to alleviate M+CO concerns with start-up costs associated with educating providers and members and implementation, as well as to minimize concerns regarding the regulatory uncertainty of government-funded programs.

Factors Affecting Beneficiary Acceptance of a Sub-Zero Premium Product

According to the M+COs interviewed, Medicare beneficiaries are less interested in receiving immediate, relatively small financial benefits. Whether or not the plan offers a Part B reduction of $20 or the full amount of the Part B premium, beneficiaries generally do not want to forgo benefits for costly services, such as prescription drug coverage and hospitalizations, in exchange for a premium reduction.

M+COs reported that, in general, Medicare beneficiaries are a risk-averse population and dislike uncertainty about health care coverage. They understand that they are likely to have future health care needs and want to be prepared for both routine, relatively affordable care in addition to catastrophic and prohibitively expensive care. For beneficiaries, this means feeling confident that they can access providers, services, and supplies for any unpredicted health event and yet they will not incur extraordinary medical expenses as a result. Participating M+COs have reduced certain plan benefits in order to offer the Part B premium reduction, thereby increasing beneficiaries' uncertainty about their level of coverage in the event of a costly health event.

M+CO sales and marketing experience has shown that hospital-physician participation in a health plan's network is the "deal breaker" for Medicare beneficiaries. If a beneficiary's doctor and/or preferred hospital is not included in the plan's provider network, he or she is less likely to enroll in that health plan. Therefore, the Part B premium reduction alone is not likely to be a determining factor in health plan choice for most beneficiaries.

Participating M+COs

The project team interviewed 19 individuals from five M+COs in New York and Florida that chose to offer a sub-zero premium product. The New York M+COs offering the sub-zero premium product are United Health Care of New York, Inc. and Health Net of New York. The latter M+CO offers a Smart*Choice* sub-zero premium plan in Bronx, Queens, and Richmond Counties. United Health Care of New York offers its sub-zero premium product -- the Medicare Complete Plan 4 or Medicare Give Back Plan -- in Bronx, Kings, New York, Queens, and Richmond Counties. In Florida, three M+COs offer sub-zero premium products: CarePlus Health Plans, Inc., Vista Healthplan, Inc., and Well Care Choice. CarePlus Health Plans and Vista Healthplan offer their respective sub-zero premium products, the CareFree Plan and the Medicare VALUE Advantage plan, in Dade and Broward Counties. Well Care Choice offers its Well Care Advantage plan in Dade and Hillsborough Counties. These offerings are summarized in Table 3.1.

Table 3.1 Summary of Participating M+COs			
State	**Medicare + Choice Organization (M+CO)**	**Sub-Zero Premium Plan**	**Counties (H Number and Plan ID)**
Florida	CarePlus Health Plans, Inc.	CareFree Plan	Dade (H1019-004), Broward (H1019-005)
Florida	Vista Healthplan, Inc.	Medicare VALUE Advantage	Dade (H1076-010), Broward (H1076-012)
Florida	Well Care Choice	Advantage Plan	Dade (H1032-027), Hillsborough (H1032-026)
New York	Health Net	Smart*Choice*	Bronx (H3366-001), Richmond (H3366-008), Queens (H3366-007)
New York	United Healthcare of New York, Inc.	Give-Back Plan	Bronx (H3379-006), Richmond (H3379-006), Queens (H3379-006), Kings (H3379-006), New York (H3379-006)

Level of Awareness

Most participating M+COs became aware of the sub-zero premium product offering via a posting on CMS's website and through Medicare and Medicaid trade journals. It was also announced in the ACR (Adjusted Community Rate) filing instructions. However, all participating plans commented that they received limited instruction from CMS about how the premium reduction process would work, thus necessitating several phone calls to the CMS ROs to obtain this information. This information was particularly important for member education purposes.

Decision to Offer

Participating M+COs made the decision to offer the product for three main reasons. First, the sub-zero premium product was something different and innovative to offer Medicare beneficiaries. Developing health plan choices attractive to beneficiaries is a priority for the M+COs that decided to test it in the marketplace to find out if there might be a niche within the Medicare population for this type of offering. Secondly, these M+COs determined that returning a portion, if not the full amount, of the Medicare Part B premium to beneficiaries would provide a distinct marketing advantage over their competitors. Finally, M+COs offered the sub-zero premium product only if it met their actuarial test. As one M+CO spokesperson noted, "The decision to offer was really mathematical. If plans are required to reduce what they will receive from CMS by 125%, then putting co-payments (co-pays) on providers and prescriptions drugs was the way for them to find dollars to afford it." It was important to this M+CO to offer a reduction of the entire Part B premium to the beneficiary in conjunction with earning a profit, upon which, they emphasized, their decision to offer the product was contingent. The M+CO believed it was important to offer the full amount of the Part B premium because waiving only a portion of the premium would be "self-defeating." According to the M+CO, "offering only a little wouldn't have as large an impact because the beneficiaries' perception would be that 'you're only giving me a little, why not the whole thing.'"

Following their explanation of their decision-making for offering the new product, M+COs discussed the product's potential drawbacks. Uncertainty about how the market might respond to the new sub-zero premium plans was the biggest concern among participating M+COs. It was unclear if Medicare beneficiaries would accept substituting the Part B premium reduction for a decrease in benefits such as prescription drug coverage. Physician participation in these plans was another concern, as well as the potential for added M+CO expenses related to educating their provider network and members about the product.

Finally, when asked about whether or not M+COs would have offered the product with or without the final 2003 "lock-in" provisions in place, most interviewees replied "yes." However, one M+CO pointed out that the adoption of the new offering by Medicare beneficiaries would be even less than the enrollment its M+CO had experienced to date. Most beneficiaries can make monthly elections of health plans until at least December 31, 2004, if so desired. However, another M+CO commented that "lock-in" or "lock-in" equivalents is a phenomenon that some beneficiaries have experienced in other settings, such as in employer-sponsored plans. Therefore, this M+CO believed that these beneficiaries would not be affected or bothered by committing to one health plan for the full calendar year.

Product Development

Several M+COs remarked that Medicare beneficiaries do not want to pay for their prescription drugs nor do they want to have co-pays. However in today's market, M+COs explained, the benefit structure of sub-zero premium plans would not allow for this level of coverage and remain financially viable. In general, an M+CO's sub-zero premium plan's benefit package was not as rich as that of its other M+C products. Most M+COs that had generous prescription drug benefits for their non-sub-zero premium health plan were forced to limit them for the sub-zero premium offering. For example, members of Well Care's Advantage plan, in Dade County, Florida, have a co-pay of $5 for generic drugs, $15 for formulary preferred brands, $30 for non-formulary drugs, and have a combined $100 monthly limit on all brand prescription drugs that Well Care will cover. However, Well Care's Choice Plan, also in Dade County, has no co-pays, a combined monthly limit of $250 on formulary drugs, and a $250 monthly limit on non-formulary drugs. Most of the M+COs also introduced higher co-pays on inpatient hospitalizations for their sub-zero premium plans, up to $265 per day, as compared to no co-pays for the non-sub-zero plans.

Health Net's Smart*Choice* benefit package reduced its durable medical equipment and vision coverage. Additionally, its second tier (non-preferred) hospitals raised the deductible to $500 per stay and the prescription drug co-pays increased from $7 to $12. Vista's Medicare VALUE Advantage plan increased co-pays to specialists from $0 to $20, and added ambulatory care co-pays and $10 co-pay on generic prescriptions. CarePlus's Carefree product significantly reduced its prescription drug benefit, but was able to maintain its physician, dental, inpatient, outpatient, and vision services. As a result, the M+CO said its enrollment has been greater than expected.

When developing the product, most of the plans did not have a specific "type" of Medicare beneficiary in mind. The majority of M+COs planned to focus on identifying their target audience later in the year. However, some M+COs mentioned Original Medicare members, dual eligibles, and "low-utilizers" or "healthy" Medicare beneficiaries as groups that might be attracted to the new product offering.

- *Original Medicare*: Interviewees from two of the five M+COs commented that they had thought a sub-zero premium plan would be attractive to individuals who are comfortable with limited health care coverage, but desire something more comprehensive than what Original Medicare alone provides. One of the M+COs that conducted market research after the decision was made to offer the product provided findings that Original Medicare members were not very interested in a sub-zero premium plan after all. Focus group research found this group to be very "anti-HMO" in general and to have the basic sentiment that they want to see "their" doctor. When the M+COs explained that "their" doctor was in the network, the respondents from the Original Medicare group replied, "Well, my doctor might leave." The M+CO noted that the "myth" regarding "not being able to choose your doctor if you are enrolled in an HMO" still exists among Medicare beneficiaries. Additionally, during a focus group meeting with Original Medicare members, when the M+CO presented its sub-zero premium product, the seniors replied, "I don't understand this. What is $59? I want my drugs."
- *Dual Eligibles*: One M+CO mistakenly assumed a sub-zero premium product would be most beneficial for and attractive to dual eligibles as evidenced by the following comment:

  > *"This is the way it works: You are QMB-eligible [QMB Plus] and you join my plan in May and find out that this is true. The next step is to get QMB-certified. Once you do, the state should backtrack and make you eligible for one year (retroactively). So, QMB eligibles get back their Part B premium in one lump sum for that year. The state then continues to pay Part B as long as the person remains QMB-eligible. Then, the $58 comes back [to the beneficiary] in June for the next year [year 2]. With this population, plans can offer a better product because the capitation rate is higher and [I] think it would be more attractive to them."*

  Based on discussions with CMS Project Officers about how the benefit applies to this type of dual eligible beneficiary, the explanation above illustrates the confusion that M+COs have about how the Part B premium reduction benefit applies to this sub-group of Medicare beneficiaries. Since the state, rather than the beneficiary, pays the Part B premium for dual eligibles, the state would receive the financial benefit of the premium reduction.
- *"Low utilizers"/"Healthy" Medicare beneficiaries*: Although M+COs did not necessarily target "healthy" beneficiaries, some believed that a sub-zero premium product might appeal to these "types" of beneficiaries who otherwise would not choose to join an HMO (or purchase a Medigap supplemental policy) because they view themselves as relatively healthy and do not envision the need for regular provider visits and/or do not take many prescription

drugs. M+COs also referred to this group of Medicare beneficiaries as "low-utilizers" of health care. M+COs thought the Part B premium reduction would be enough of an incentive for these beneficiaries to enroll in the product even if it meant having a reduced plan benefit package. However, based on M+CO feedback from beneficiaries, it is clear most beneficiaries dislike uncertainty and that high co-pays for an inpatient hospitalization concerned even "healthy" Medicare beneficiaries. For these beneficiaries, a reduction in their monthly Part B premium did not outweigh the financial repercussions of a potential unpredictable inpatient hospitalization.

Outreach Efforts and Implementation

Most of the M+COs use similar approaches to market their sub-zero premium product, which consist of direct mail, newspaper advertisements, and community-based and in-home presentations.

One M+CO uses benefit consultants to market its M+C products, including its sub-zero premium product. These consultants primarily conduct in-home presentations. They also conduct group presentations and lunch seminars from time to time. Presentations are advertised using print media. Consultants offer a side-by-side analysis of its M+CO's products so that potential members can choose the product that best fits their health care needs. Explaining the sub-zero premium product to beneficiaries can become mathematical and complicated, but the M+CO's benefits consultants explain it in detail.

To announce its new sub-zero premium product, one M+CO simultaneously used direct mailing, newspaper advertisements, and a press release for its marketing launch. Initially, the M+CO actively marketed the offering to introduce it to the marketplace. As a result, the M+CO received a call from one of its competitors inquiring about the product. The M+CO responded, "CMS is allowing this to happen. They made a formal announcement." After the initial launch, the M+CO now uses sales representatives to talk to potential members at community meetings and/or during in-home visits. They also have a sales kit that can be mailed upon request.

Another M+CO uses direct mail and print advertising as its marketing vehicles to advertise in-home appointments and seminars. It supplies a toll-free telephone number for beneficiaries to call to order an enrollment kit by mail or to schedule an in-home visit. In addition, it conducts town hall meetings that take place mostly in diners on a quarterly basis. This M+CO also visits senior centers and participates in community events to find potential members.

Lastly, one M+CO did not market its sub-zero premium product through mass communication. Instead, it ran some newspaper advertisements and sent direct mail, but did not explicitly market its sub-zero product. When a Medicare-eligible individual contacts the M+CO for information, it sends a cover letter that provides a summary of benefits for both of its M+C products. To follow-up, a sales representative will make a visit to the potential member and explain both of its M+C products if requested.

M+COs said they have faced two significant issues with regard to implementing the sub-zero premium product. First, one M+CO noted that the CMS RO informed them that the Inspector General was investigating the sub-zero premium product as a potential violation of the Federal Anti-Kickback rule sometime in January or February of 2003. As soon as it heard this news, the M+CO pulled back its marketing and implementation efforts. However, the RO notified the M+CO in April that the Inspector General would not impose a fine on M+COs offering the benefit and that everything was "O.K. to move forward." The individuals interviewed never saw a formal report about the investigation, but did receive an e-mail from their RO that the investigation was unsubstantiated.

The second issue that M+COs faced with the Part B premium reduction benefit was the significant delay members encountered in receiving their Part B reduction, which resulted in an uncomfortable situation for at least one M+CO. This M+CO commented that members called to complain and ask questions about the premium reduction, which they had not been receiving in their Social Security check. Members called the Social Security Administration and 1-800-Medicare customer service representatives, who reportedly told Medicare beneficiaries that they "don't know what they are talking about. There is no such M+C product that rebates part or all of their Medicare Part B premium." In addition, CMS's third-party vendor responsible for processing new members in one state retroactively disenrolled members, affecting more than 200 beneficiaries who should have been enrolled in one particular sub-zero premium plan. The affected M+CO said that it had contacted CMS and was sent a letter to mail to its members on CMS's behalf. The purpose of the letter is to verify member enrollment in the plan and address the Part B premium reduction process. The letter reads as follows:

> *"This letter is to inform you that CMS has verified that you are enrolled into a plan that offers a reduction in your Medicare Part B premium. Since the Social Security Administration (SSA) is responsible for this reduction, we have also verified that their records reflect the correct status.*
>
> *You should be aware that because CMS and SSA systems are involved, it often takes from 60 – 90 days from your enrollment into the plan for you to see the reduction in your Part B premium on the Social Security check. By the time that your enrollment is processed by CMS, SSA is already 1 –2 months ahead in processing the Social Security checks. This time difference results in the delay that you are experiencing.*
>
> *Again, we have verified that there is no problem in reflecting your enrollment and you will be seeing the premium reduction (including all of the months owed to you) very soon."*

Another M+CO having trouble commented, "Members were concerned and confused about the amount of their Social Security check given the COLA in January 2003." According to the

M+CO interviewees, CMS did not provide any instructions on how to address or explain this to members.

None of the M+COs targeted employer groups. The M+COs commented that, based on their experience, employer groups are hard to reach. Employer benefit plans are typically so rich that an M+C option that reduces the Part B premium entirely is unlikely to be attractive to its retirees.

Future Participation

Most of the participating M+COs interviewed said they have not yet begun to discuss internally whether or not they will offer a sub-zero premium product in 2004. With the exception of one M+CO, however, most commented that they plan to first examine how all M+COs that offered the sub-zero premium product fared, but probably would not offer the product in 2004 for two main reasons.

First, although they did not have high enrollment expectations due to the volatility and financial risk of the M+C marketplace, the majority of participating M+COs have been disappointed in the level of interest in the sub-zero premium product offering. Most of the M+COs said they would prefer to look into new CMS M+C options such as the Preferred Provider Organization (PPOs) option that will allow them to provide richer benefits in the future. Secondly, the administrative costs to actually implement the product increases the cost for the M+CO by up to $7 per beneficiary, which makes offering a sub-zero premium product financially difficult. Overall, M+COs commented that they are better off providing the "status quo," which is a plan benefit package without the Part B premium reduction, but with enhanced services and/or lower co-pays and deductibles.

Despite these comments, however, several M+COs did say that they expect more M+COs to offer a sub-zero premium product in the future, "...because it is a 'me too' kind of business." Another M+CO also commented that it would consider participating again if the plans themselves could provide the reduction to their members. This particular M+CO representative said, "Allowing the plans to give back the money themselves would make the process less obtuse to the member. As it is, plans are explaining a premium reduction process to a person who does not necessarily understand his or her Medicare benefits already. Some don't even realize they are paying a premium." The M+CO also commented that with more education and a better incentive for M+COs to offer the product, it might become a viable option in the future. Right now, the sub-zero premium offering is a new product in a "confusing space." If CMS were to provide a financial incentive to M+COs to offer the product, it might help to alleviate concerns regarding start-up costs associated with educating providers and members and implementation. It might also decrease the regulatory uncertainty that comes with government-funded programs. The representative from this M+CO said, "[I] would most likely not encourage re-filing in 2004 in order to cut down our own administrative costs. However, if CMS came out and said: 1) 'Instead of taking 20 percent from the plans, we will subsidize the program for the next two years; and 2) We will let you pay seniors,' then this would make all the difference in the world." Another M+CO commented that it would like to talk with CMS about revisiting the amount of their base

payment that M+COs are expected to waive to CMS for this product offering. If they were able to scale back this amount, co-pays could be reduced and the overall success of the program might change.

M+COs interviewed said that when it comes to their health care, Medicare beneficiaries are generally looking for more protection, not less. Most seniors want to pay as little as possible for their health care and want dollar coverage for all of the health care services they potentially need. This is likely to limit beneficiary interest in a sub-zero premium product that must reduce services and increase co-payments and deductibles to make the product financially viable.

In addition, M+COs said that their business is driven by hospital and physician participation. These issues are always the "deal breaker" for Medicare beneficiaries even when offering to pay for part or all of their Medicare Part B premium. As one beneficiary commented to an M+CO, "$20 is incidental. This is a cab ride across town." Although there may be a very small percentage of the population that will decide to join a sub-zero premium plan based on the Part B premium reduction, M+COs said that in the end it is always the same issue that will keep them happy when it comes to their health: "their doctor." "If their physician is there, then life is good," said an M+CO representative. In general, Medicare beneficiaries know they are likely to have health care needs in the future and want to be prepared. This means assurance they will have access to providers, coverage for all services, and supplies for any unpredicted health event.

Factors Affecting Beneficiary Acceptance of a Sub-Zero Premium Product

One participating M+CO that is enjoying successful enrollment efforts with the sub-zero premium product felt quite strongly that beneficiaries would be more willing to join a sub-zero premium plan if the current 90-day lag period between enrollment and receipt of the benefit in their Social Security check could be reduced to 30 or 60 days.

Non-Participating M+COs

The project team interviewed a total of six individuals from four non-participating M+COs in the eight relevant counties These include interviews with Aetna, Inc., and Empire HealthCare HMO, Inc., both of New York, and United Health Care of Florida, Inc., and Neighborhood Health Partnership, Inc., of Florida (See Table 3.2). Non-participating M+COs were selected to approximate the characteristics of participating M+COs. Variables considered in this process were tax status (for profit/non-profit); the size of M+CO membership as of March 2003; zero premium versus partial premium status of health plans offered by the M+CO; co-pays and deductibles for inpatient care, primary care, specialist care; and presence or absence of dental benefits; prescription drug benefits; and vision benefits.

Table 3.2 Summary of Non-Participating M+COs			
State	**Medicare + Choice Organization**	**Plan Type**	**Counties (H number and Plan ID)**
Florida	Neighborhood Health Partnership, Inc.	HMO	Dade (H1078-009)/(H1078-007)/(H1078-008)/(H1078-001), Broward (H1078-003)
Florida	United Health Care of Florida, Inc.	HMO	Dade (H9011-003)/(H9011-009), Hillsborough (H5401-001)/(H1080-004)
New York	Aetna, Inc.	HMO	Bronx (H3312-002)/(H3312-025), Kings (H3312-002)/ (H3312-0025), New York (H3312-002)/(H3312-025), Queens (H3312-002)/(H3312-0025), Richmond (H3312-0025)/(H3312-001)
New York	Empire HealthCare HMO Inc.	HMO	Bronx (H3370-001), Kings (H3370-001), New York (H3370-001), Queens (H3370-001), Richmond (H3370-001)

Level of Awareness

The non-participating M+COs interviewed reported that they routinely monitor CMS's website for new M+C offerings and recall seeing an early announcement about the availability of the premium reduction option in June 2002. Similar to the participating M+COs interviewed, these M+COs said the announcement was vague and that CMS did not provide much detail. According to one M+CO, "[the announcement] was something along the lines of 'Medicare will be offering a new product for beneficiaries to receive cash rebates,' but that was about it."

Decision Not to Offer

All of the non-participating M+COs interviewed said they were initially very interested in offering the product, as it was an innovative idea. One M+CO remarked that, from a policy perspective, it is an appropriate option for M+COs, but said there is a general consensus that the Medicare program has to be more adequately funded before M+COs can actually exercise an option like a Medicare Part B premium reduction benefit.

Once CMS provided more details about how the product would work, several interviewees said that the risk to their M+CO was too difficult to calculate, rendering the proposition less interesting. Most of the M+COs assessed the level of premium reduction that they would be able to offer through an actuarial analysis; the findings of this analysis became the main driver behind their decision to not offer the product. All non-participating M+COs commented that in order to afford the offering, they would have to reduce plan benefits and/or raise co-pays, which would have made the product unattractive to most beneficiaries in their markets. The one benefit that all M+COs said they would have had to undoubtedly give up was prescription drug coverage. "[Offering a sub-zero premium product] is not relevant to a real life discussion because actuarial limits have been met, [making it difficult to give back some of the Part B premium to the beneficiary," said one M+CO representative. This M+CO expressed concern that CMS's recent change in payment methodology makes it very difficult to offset the full amount of the Medicare Part B premium and still have an attractive product to offer to Medicare beneficiaries.

Future Participation

Most non-participating M+COs do not anticipate offering a Medicare Part B premium reduction benefit in the near future for several reasons. The main reason is that M+COs are concerned about under-funding of the Medicare program in general. One M+CO commented that offering such a product is not a remote possibility because it is barely maintaining its Medicare members with its current product offerings. The M+CO said that it is already balancing the offering of benefits like prescription drug coverage while also introducing "serious" co-pays for services.

Another reason M+COs do not plan to offer a premium reduction benefit is because the overall financial benefit to beneficiaries is too low. Whether or not the plan reduces $20 or the full amount of the Part B premium to beneficiaries, seniors do not want to forego other necessary benefits, such as prescription drug coverage, that are often required on a regular basis.

Lastly, these M+COs suggest that this product benefit is a "non-starter" since CMS has not finalized its health status-based risk-adjustment payment method. When asked if M+COs would consider offering the product when CMS finalizes the risk-adjustment method, they replied it might be a possibility because it would be easier for them to assess how their revenues would be affected by offering such a product.

One M+CO, however, commented that it was neutral about future participation because it needs to better understand the pros and cons and would like to explore them with potential members.

Factors Affecting Beneficiary Acceptance of a Sub-Zero Premium Product

None of the non-participating M+COs interviewed recalled receiving any inquiries about sub-zero premium product offerings. In light of this, their views about factors affecting beneficiary acceptance of a sub-zero premium product are based on previous surveys conducted with the Medicare population and their own experiences from working in the industry. One M+CO commented that it is possible to make certain assumptions about a beneficiary's potential level of interest in such a product based on its observation that most of the Medicare population does not like uncertainty. As a result, the M+CO assumes that most beneficiaries would rather pay the Part B premium than have it reduced in place of lower co-pays and out-of-pocket expenses for services such as inpatient hospitalization stays.

State Health Insurance Assistance Programs (SHIPs) & Medicare Rights Center (MRC)

To understand the SHIPs' experiences related to the new sub-zero premium product offering, the project team interviewed representatives from Florida's SHIP program, Serving Health Information Needs for Elderly (SHINE), and the Medicare Rights Center (MRC) in New York.

SHINE, funded through a grant from CMS and administered by the Florida Department of Elder Affairs, is a statewide, volunteer-based program offering free Medicare and health insurance education, counseling, and assistance to Medicare beneficiaries and their families and caregivers. Volunteers in the SHINE program provide information, counseling and assistance for questions

regarding Medicare, Medicaid, M+C plans, Medicare supplemental insurance, long-term care insurance, and Medicare fraud. In southwest Florida, Senior Solutions of Southwest Florida and other local partners, provide support to SHINE.[46]

MRC is a national not-for-profit, non-governmental organization that helps to ensure that older adults and people with disabilities receive good, affordable health care. MRC accomplishes this goal by maintaining telephone hotline services, an education department, and public policy efforts. MRC also works closely with local and national media outlets to ensure public awareness and understanding of Medicare issues.[47, 48]

Level of Awareness

Both the Florida SHIP and the MRC representative commented that earlier in the year they were unaware that health plans could offer the sub-zero premium plan and also could not recall seeing any formal announcement about it from CMS. However, each individual said they eventually become aware of the offering.

The Florida SHIP representative recalled seeing "something" about the option on CMS's website and also discussed it with the state's Quality Improvement Organization (QIO). This individual commented that no additional information about the offering has "trickled down" from either CMS's Central Office or from the M+COs, but if information were available it should be included in the SHIP's HMO training module. The interviewee's perception about the sub-zero premium plan, given her limited knowledge, was that as beneficiaries and caregivers become aware of the product, significant interest and enrollment will most likely ensue. However, the representative commented, "There must be a prescription package and co-pays that are non-existent or very low."

The MRC representative reported that information eventually reached its office via a letter from its RO and the information is now included in an M+C plan table that volunteers use to educate Medicare beneficiaries about the different M+C products available in New York. However, this individual noted that health care costs are the most significant issue facing beneficiaries. Increasingly, health care is not affordable to people with Medicare and thus higher co-pays are not attractive to them. As a result, it is not entirely clear that a sub-zero premium product that would most likely require increased co-pays would appeal to beneficiaries. This individual

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[46] Serving Health Insurance Needs of the Elderly (SHINE). http://www.seniorsolutions.org/shine.html. Website accessed on June 16, 2003.

[47] About MRC. http://www.medicarerights.org/aboutmrcframeset.html. Website accessed on June 16, 2003.

[48] During the interview with the MRC representative, the project team inquired about the usefulness of contacting a representative from New York's HIICAP program for an additional interview. However, the representative noted that it would not be worthwhile for the project team to make this contact on the issue of "sub-zero premium" plans since MRC and HIICAP work very closely together and had discussed some of the research questions prior to the interview.

expressed concern about such an offering, commenting, "The majority of Medicare beneficiaries do not understand their Part B anyway, so an offering like this further complicates this aspect of Medicare. Medicare is dizzying and beyond confusing, even for someone like me whose job is to fully understand the program and explain it to others. Changing the [Medicare] system again and again by adding a benefit package like this only further complicates matters and confuses the beneficiary."

Factors Affecting Beneficiary Acceptance of a Sub-Zero Premium Product

The SHINE program has not received any feedback from Medicare beneficiaries interested in or enrolled in sub-zero premium products, but SHINE is the program that would be responsible for educating seniors if they inquired about this offering. The interviewee also noted that M+COs must understand that beneficiaries perceive that an M+C product is "good" and "worth it" when it offers a prescription drug benefit and a beneficiary's doctor is included in the M+CO's network.

The MRC representative commented that most beneficiaries understand the concept of health insurance as "financial and medical protection for a group of people who are largely healthy, but ultimately susceptible to catastrophic diseases." The lack of response MRC has received about this offering is attributed to the fact that, in MRC's experience, beneficiaries want their health insurance to work for and protect them when they need it. People who have Medicare are much less interested in receiving immediate, relatively small financial benefits. They would prefer to have peace of mind that the Medicare program and their health plan will adequately cover their future health care costs, whether they are moderate or catastrophic.

State Medicaid Offices

The project team interviewed individuals from the Florida and New York State Medicaid Offices. Representatives from the New York State Medicaid Office, Office of Medicaid Management, and the Florida State Medicaid Office, Agency for Health care Administration, commented that they were not familiar with the product offering. However, representatives expressed an interest in receiving information from CMS about the product offering.

Chapter 4: Beneficiary Focus Groups

This chapter presents the approach used by the project team in structuring and conducting the focus groups and key research findings from the focus groups. The general research objectives for the focus groups were to:

- Compare characteristics of Medicare beneficiaries who do or do not enroll in, or who disenroll from, sub-zero premium plans;
- Determine beneficiaries' awareness and understanding of the sub-zero premium plans in which they are enrolled, as well as the benefit structure of other health plans available to them;
- Determine why sub-zero premium plans do or do not appeal to Medicare beneficiaries, and the factors involved in beneficiary choice of such plans; and
- Describe beneficiaries' overall satisfaction with the sub-zero premium plans and investigate reasons for dissatisfaction and disenrollment.

Methodology

Focus Group Recruitment and Screening

The goal of the focus group recruitment process was to recruit a mix of beneficiaries to best represent the diversity of the Medicare beneficiary population in the eight Florida and New York counties in terms of gender, age, income, race/ethnicity, Spanish/bilingual populations, high utilizers of medical services (identified in this analysis as "high-risk" beneficiaries), and formal education. To comprehensively evaluate the communication challenges associated with health care provision and reimbursement mechanisms in the Medicare population, it was important to also recruit beneficiaries new to the Medicare program, as well as beneficiaries with several years of Medicare program experience.

Recruiting screener materials were designed to ensure that focus group participants met certain criteria, including length of time enrolled in the M+CO (to ensure a mix of some participants who have switched from one of the M+CO's prior plan offerings and some who have newly joined the M+CO), income level, ability to speak English and Spanish (i.e., we recruited some bilingual focus group participants to reflect the Hispanic Medicare population in the Florida and New York areas where the health plans are being offered), and whether their plan is employer-sponsored, which would transfer the incentive for participation from the beneficiary to the employer.[49]

[49] For copies of the recruiting screeners, contact Vic McVicker at vmcvicker@cms.hhs.gov or at Centers for Medicare & Medicaid Services, C3-20-17, 7500 Security Boulevard, Baltimore, MD, 21244-1850.

Participants were recruited by telephone by professional research facilities using enrollee and non-enrollee beneficiary lists provided to them by the project team, as it would have been prohibitively expensive for the facilities to develop the sampling frames (e.g., they would need to screen a potentially very large sample of people age 65 or over to find beneficiaries enrolled in a particular health plan). Two sets of beneficiary lists (one with current and former sub-zero premium plan enrollees and one with members of other M+C plan enrollees and Original Medicare FFS beneficiaries), derived from CMS files, reduced recruiting costs significantly and allowed for under-age-65 disabled beneficiaries to be included in the focus groups.

Each beneficiary participating in a focus group was paid a cash incentive between $65 and $100 to cover travel expenses. The state (Florida or New York) where the focus group occurred, in conjunction with the distance of the beneficiary's residence from the facility, determined the amount of the cash incentive. The incentive also ensures that we did not only recruit lower income beneficiaries, but also moderate-income beneficiaries, so that focus group responses may be income-independent.

Focus Groups

During June, July, and August of 2003, the project team conducted a total of nine focus groups in New York and Florida, with five held in New York and four in Florida. Due to difficulty recruiting for the 10th focus group – high-risk sub-zero premium plan enrollees in New York – eight telephone interviews with beneficiaries from this population were conducted. The New York area focus group participants were recruited from among residents of Bronx, Queens, and Richmond Counties; the four Florida focus groups were conducted with residents of Dade and Broward Counties.

Seven focus groups were held with present and former members of Health Net's Smart*Choice* health plan in New York and CarePlus's CareFree health plan in Florida. These two health plans were selected because their larger membership size enabled the project team to conduct several groups with members of the same plan, allowing for comparison across audience-types while controlling for plan differences. Each enrollee focus group included only members of a single health plan, rather than drawing from two or more plans because differences in plans' benefit packages and other M+CO characteristics may produce different enrollment reasons across the health plans. In addition, mixing enrollees from one or more health plans in a single focus group may have obscured these important differences.

In addition to research with present and former members of the sub-zero premium plans, the project team conducted focus groups with non-sub-zero premium plan beneficiaries. Non-enrollees were drawn from the service areas in which the sub-zero plans are offered. Members of M+COs not offering the premium reduction benefit and beneficiaries in Original Medicare FFS population were also included.

An initial health plan and beneficiary-type selection matrix was submitted to CMS for review and final selection was determined after examining the beneficiary, M+CO, and plan

characteristics data gathered for Task 1 of the project. The final matrices and target demographics of the focus groups are presented in Appendices B and C. Table 4.1 summarizes this information.

Table 4.1 Focus Group Locations and Target Audiences

Focus Group	Type of Coverage	Location	Target Audience
1	CarePlus CareFree	Broward County, Florida	High-Risk Enrollees
2	CarePlus CareFree	Broward County, Florida	Low Income Enrollees
3	Fee-for-Service and Non-Sub-Zero M+C Plans	Dade County, Florida	Non-enrollees
4	CarePlus CareFree	Dade County, Florida	Enrollees
5	Health Net Smart*Choice*	Bronx, Queens, & Richmond Counties, New York	Rollover/Passive Enrollees
6	Health Net Smart*Choice*	Bronx, Queens, & Richmond Counties, New York	Non-Rollover/Active Enrollees
7	Health Net Smart*Choice*	Bronx, Queens, & Richmond Counties, New York	Dual Eligible Enrollees
8 (Telephone interviews)[λ]	Health Net Smart*Choice*	Bronx, Queens, & Richmond Counties, New York	High-Risk Enrollees
9	Health Net Smart*Choice*	Bronx, Queens, & Richmond Counties, New York	Disenrollees
10	Fee-for-Service and Non-Sub-Zero M+C Plans	Bronx, Queens, & Richmond Counties, New York	Non-enrollees

[λ] Telephone interviews were conducted in place of a focus group due to recruiting difficulties encountered with the high-risk enrollees.

Beneficiary Lists

Names, plan enrollment information, date of birth, risk (PIP-DCG) factor, and contact details for Medicare beneficiaries were gathered using combined April 2003 data from CMS's Monthly Membership Data and Enrollment Database (EDB) files sent to BearingPoint by CMS upon completing a data use agreement. Variables used included enrollee name, address, race/ethnicity, gender, Medicaid eligibility, age, and M+CO/health plan affiliation. Using this data, the project team created beneficiary lists to meet the minimum desired characteristics related to health plan participation status.

Because the CMS databases did not include telephone numbers, the research facilities used telephone directory assistance to recruit participants based upon the supplied name and address information. Subsequent to the initiation of this research phase, BearingPoint obtained additional CMS data with telephone numbers for a portion of the beneficiaries in the sample. Participants in Groups 6, 7, and 8 were recruited using the new telephone number data.

Interview Protocol and Moderator

A focus group moderator's interview guide was designed to capture information about how the sub-zero premium plans' features affected beneficiary plan selection; how beneficiaries have used the plans' covered benefits; and how their experience to date has affected out-of-pocket costs and plan satisfaction. Several versions of the moderator guide were drafted to capture differences in the target audiences.[50] A professional moderator with experience in health care and elder populations was retained to facilitate each focus group using the CMS-approved moderator guides.

Participant Profile

A total of 66 Medicare beneficiaries participated in the focus groups and telephone interviews in New York City and Florida. Across all groups, 31 participants were female and 35 were male, ranging in age from 36 to at least 85 years. Some participants chose not to respond to screening inquiries regarding income; however, of focus group participants who reported income, household income figures ranged from below $1,500 per month to over $3,050 per month for single persons, and from below $1,500 per month to above $3,725 per month for married persons. Education levels ranged from less than a high school diploma to completion of post-graduate education.

Due to the difficulty encountered in recruiting from among a relatively small sample, demographic profiles of the focus group participants were not evenly distributed across all groups. For example, three focus groups had no racial/ethnic minority group representation, although racial/ethnic minority group beneficiaries comprised 30 percent of total focus groups participants. A schematic of selected demographic data collected by the research facilities as reported by the focus group participants, are presented as Appendix G to this report.

Focus groups included five types of Medicare beneficiaries enrolled in sub-zero premium plans: active enrollees, passive enrollees, high risk enrollees, low income enrollees, and dual (Medicaid/Medicare) eligible enrollees. Other types of beneficiaries included those who had disenrolled from a sub-zero premium plan and those who were enrolled in a non-sub-zero premium M+C plan or the Original Medicare FFS plan. Table 4.2 summarizes focus group characteristics.

[50]For copies of the moderator guides, contact Vic McVicker at vmcvicker@cms.hhs.gov or at Centers for Medicare & Medicaid Services, C3-20-17, 7500 Security Boulevard, Baltimore, MD, 21244-1850.

Table 4.2 Summary of Respondent Characteristics

Enrollee Type		Beneficiary Subgroup		Gender		Age		Race/Ethnicity		Education	
Active Enrollees	32	High Risk	16	Female	31	<65	8	AA	16	SHS	3
Passive Enrollees	15	Low Income	7	Male	35	65-69	28	Asian	0	HS	25
Non-Enrollees	14	Dual Eligible	5			70-74	11	Cauc	46	SC	21
Disenrollees	5					75-79	9	Hisp	4	CG/PG	17
						80+	10				

Key to Abbreviations
Race/Ethnicity: AA = African American; Cauc =Caucasian; Hisp = Hispanic
Education Levels: SHS = Some High School; HS = High School; SC = Some College; CG = College Graduate; PG = Post Graduate

Active Sub-Zero Enrollees

"Active" enrollees are Medicare beneficiaries who chose to enroll in a sub-zero premium plan following the plan's announcement of its offering of the Part B premium reduction benefit. All focus group participants enrolled in the CarePlus CareFree Plan in Florida are active enrollees.[51] In other words, they learned about the CareFree benefits and elected to enroll in the plan versus enrolling in another plan in the market. In New York, only a minority of focus group participants were active enrollees.

Passive Sub-Zero Enrollees

The majority of sub-zero premium plan enrollees interviewed in New York were "passive" enrollees. Health Net elected to transfer its entire existing membership into its Smart*Choice* product effective January 1, 2003. During Fall 2002, the M+CO sent the required change announcement letter, at which time enrollees could opt to do nothing and remain enrolled in Health Net and receive the new Part B premium reduction benefit, or they could take action to disenroll from the plan.

High Risk Sub-Zero Enrollees

The project team designated certain individuals as "high-risk," according to the relative risk factor noted in the Monthly Membership Data file, to denote beneficiaries who are more likely to require and access health care services. The Principal Inpatient Diagnostic Cost Group (PIP-DCG) Model adjusts M+C payments using demographics and diagnoses associated with inpatient hospital stays occurring in the year prior to payment.[52] Application of the model includes calculation of a relative risk factor using previous inpatient diagnoses, age, gender,

[51] Prior to joining CarePlus CareFree, 1.4 percent (13 of 938) of the June 2003 members had been members of another CarePlus plan.
[52] Ellis, R.P., Pope, G.C., Iezzoni, L.I, et al. Diagnosis-Based Risk Adjustment for Medicare Capitation Payments. Health Care Financing Review. 17(3):101-128, Spring 1996.

originally-disabled criteria, and Medicaid eligibility to modify the appropriate county payment rate according to the characteristics of the individual M+C enrollee.[53] CMS provided the average risk factor for counties in which the sub-zero premium plans are offered. Enrollees with risk factors greater than the county average were assigned to the high-risk recruitment list.

Low-Income and Dual Eligible Sub-Zero Enrollees

Individuals with self-reported monthly incomes of less than $1,850 for individuals or less than $2,525 for married persons were designated "low income beneficiaries."[54] Participants were screened to include married and single (including widowed or divorced persons) with earnings of two and one-half times the national poverty rate.

Sub-zero enrollees were identified as dual eligibles according to a "third-party assignment" designation in CMS records. For these enrollees, the State pays the Part B premium under a Medicaid benefit and, therefore, would receive the premium reduction benefit offered by the sub-zero premium plans.

Sub-Zero Disenrollees

Sub-zero disenrollees are Medicare beneficiaries who disenrolled from a sub-zero premium plan since January 2003.

Non-Enrollees

Medicare beneficiaries enrolled in non-sub-zero M+C health plans or in Original Medicare fee-for-service were designated non-sub-zero enrollees.

Sub-Zero Premium Plan Descriptions

Focus groups were conducted with members of the two sub-zero premium plans with the largest membership. At the time of the focus group planning and scheduling, enrollment was as shown in Table 4.3.

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[53] Medicare+Choice Rates -- 45 Day Notice, Changes in Methodology Since 1999 Rates: Risk Adjustment. Retrieved from www.cms.hhs.gov/healthplans/rates/2000/45day-03.asp_. 9/4/03.

[54] Low-income was determined to be 250 percent of the Federal Poverty Guidelines (FPG) for 2003 to capture "poor" and "near poor" beneficiaries. Monthly income amount for a family unit of size one is $1,850 based on an annual income of $22,450, which is equal to 2.5 times the annual FPG of $8,980 (rounded). Monthly income for a family unit of size two is $2,525 based on an annual income of $30,300, which is equal to 2.5 times the annual FPG of $12,120.

Table 4.3 Sub-Zero Premium Plan Enrollment, May 2003				
M+CO	**Plan Name**	**Contract No. & Plan ID**	**County**	**May Enrollment**
CarePlus Health Plans	CareFree	H1019-004	Broward	**1,035**
CarePlus Health Plans	CareFree	H1019-005	Dade	**315**
Well Care	Advantage	H1032-026	Hillsborough	**0**
Well Care	Advantage	H1032-027	Dade	**5**
Vista Healthplan	Medicare Value Advantage	H1076-010	Dade	**24**
Vista Healthplan	Medicare Value Advantage	H1076-012	Broward	**1**
Health Net of New York	Smart*Choice*	H3366-001	Bronx	**1,307**
Health Net of New York	Smart*Choice*	H3366-007	Queens	**678**
Health Net of New York	Smart*Choice*	H3366-008	Richmond	**3,222**
United Healthcare of New York	Give Back	H3379-006	Bronx, Kings, New York, Queens, Richmond,	**13**
Total Enrollment				**6,600**

CarePlus CareFree

CarePlus offers its sub-zero premium plan, CareFree, in Broward and Dade Counties in Florida and offers a full reduction of the Part B premium of $58.70. The CarePlus plan, a non-sub-zero premium plan, is also offered in these same counties. Within each county, the two plans are nearly identical, differing only in premium amounts and levels of outpatient prescription drug coverage. The CareFree Plan in both counties offers very limited drug benefits, with no coverage for brand name or non-formulary generic drugs and a maximum monthly drug benefit of $25. By contrast, the CarePlus plan offers coverage of formulary and non-formulary brand name drugs and a much higher drug benefit limit.[55]

The two sub-zero premium plans offered in Dade County are more generous than their counterparts in Broward County, mainly with respect to inpatient hospital care co-pays, outpatient facility co-pays, specialist visit co-pays, and outpatient prescription coverage. This difference between the two counties is consistent with findings for the other M+CO benefit packages in these markets. However, in both counties, the CareFree Plan benefit package compares favorably with those of other M+COs in the market, with the only clear disadvantage being their very limited coverage of outpatient prescription drugs. Relative to the other plans, the dental, vision, and hearing benefits offered by the CareFree Plans are quite generous.

[55] In Dade County, the CarePlus plan has a semi-annual benefit limit of $750 on brand name drugs and no limit on generic drugs. In Broward County, this plan has a semi-annual limit of $500 for generic drugs and $300 for brand name drugs. This benefit information is from the plans' Summary of Benefits document dated 10/25/02.

Health Net SmartChoice

Health Net offers the Smart*Choice* plan in Bronx, Queens, and Richmond Counties in New York. Across these counties, the plan attributes under consideration are identical and a Part B premium reduction of $20 per month is offered. In comparison with other M+C plans offered in these counties, Smart*Choice* requires comparatively mid-range co-pays for inpatient hospital care and specialist visits and no co-pays for skilled nursing facility care[56] or routine physical exams. Along with approximately two-thirds of the M+C plans in these counties, the Smart*Choice* plans provide some outpatient drug coverage, although it is limited to formulary generics. Smart*Choice* plans offer limited coverage of hearing aids, but do not cover dental services.

Findings

Key findings from the focus groups and key informant interviews are described below and are organized according to the following four topics: beneficiary awareness and understanding of the Medicare program; beneficiary awareness of sub-zero premium plans and reasons for enrollment; enrollee experience with sub-zero premium plans; and future enrollment expectations and beneficiary recommendations for CMS. Unless specifically noted, findings are reflective of research across all focus group participants.

Understanding of the Medicare Program

While Medicare and M+COs communicate in various ways with beneficiaries, there is no recognized central information resource.

Medicare beneficiaries receive Medicare-related information through mail correspondence from CMS, or simply from "Medicare," the Medicare website, individual health plan booklets and mailings, "word-of-mouth" from family and friends, phone calls from sales people, and newspaper advertisements. They reported receiving large amounts of junk mail, but noted they read "anything with 'Medicare' on it." Luncheons and information seminars sponsored by M+COs were also common sources for Medicare information.

When beneficiaries need help deciding which Medicare coverage is right for them, they are likely to call the number for Medicare (1-800 Medicare) listed in their *Medicare & You* Guide or area M+COs to request literature or a visit from a sales representative. "Word-of-mouth" recommendations were noted as valuable and participants said they would discuss health care options with their children, doctors, or peers. One respondent noted,

"I could probably call AARP...to see what [they] might suggest or [I could] just talk with people my own age. See what coverage they have and see if they're happy with it...practically everyone I know is searching like me...there doesn't seem to be any central source that we can contact to

[56] Assumes 100-day benefit period.

get information on this. No place where you can go if you want to change your plan. I don't know of anything like that."

This sense of not knowing exactly where to go for assistance was expressed by many of the interviewees.

Some respondents use the Medicare website or the "booklet that Medicare sends each year" for assistance. A majority was aware of the annual *Medicare & You* Handbook and uses the publication to review changes and information regarding their health care. In addition, the M+COs' Summary of Benefits booklets were useful. One respondent in Florida commented, "their booklet is very helpful because it explains well, it gives you every category, it compares their CareFree and CarePlus together so you can just go down through the book." Other beneficiaries seemed unfamiliar with CMS and its annual publications.

The member identification card from an M+C health plan has several telephone numbers to call for assistance and was frequently mentioned as a starting point for more information. Some said they would visit the health plan's member services office to get answers to their questions or review the member handbook provided by the plan. A number of respondents, including some in the low-income and high-risk groups, indicated they were not sure how to change their health plan enrollment.

While some beneficiaries found common media sources effective advertising for health plan changes, others preferred more interactive methods.

Several beneficiaries reported they felt it is the responsibility of Medicare to make significant efforts to inform them when aspects of their health plan change. One respondent noted that she typically reads the *Medicare & You* Handbook carefully each year to ensure that she is aware of benefit changes in her plan. Other respondents stated that they typically reviewed the Handbook only when they had a question regarding benefits available to them.

Medicare beneficiaries relayed that common media sources such as television, newspaper, and billboard advertisements are effective methods to advertise changes in plan features. Others thought that a telephone call from a Medicare representative would also be an effective way to provide important information. Enrollees stated that they would like to hear about changes to their benefit plan through an informational meeting so that they could "sit and talk with someone who represents the company." If this were not possible, they would prefer to read about changes in literature received by mail.

In response to the resonating theme in the dual eligible group that plan features and changes are not adequately explained to special-needs beneficiaries, one participant suggested,

"we're people that need special treatment and [we have] special conditions for special needs...I'm a person like everyone here [in the dual eligible focus group] who has special needs

and conditions that are not going to change in the foreseeable future...I know the insurance company knows what I go to the doctor for because they are paying the bill.... [They] should be able to contact me or send the information to tell me if there's going to be specific detrimental changes to what I need and what treatments I seek on a regular basis...."

This person, and several agreed, that people with special needs should receive additional attention to ensure they understand the impact that certain changes have on their individual situations. Several dual eligible beneficiaries were unaware that they qualified for Medicaid until they were informed by the State. In this case, the beneficiaries were informed of their change in status and were grateful to hear the news.

Respondents rely on counsel from personal contacts, as well as Medicare and M+COs, when considering changing health plans.

When asked how they would go about changing coverage if necessary, most respondents indicated that they would first seek the recommendation of a doctor, family member, or friend. Others indicated that if they needed information to compare the various plans, they would call Medicare directly, search the Medicare website, call prospective HMOs directly, or, in the case of some with employer-sponsored coverage, call the employer's personnel office. Emphasizing the importance of her prescription drug benefit package, one dual eligible respondent noted that she would inquire with her pharmacist should the need arise for her to investigate changing her Medicare coverage.

Beneficiaries see more active communication and improvement of the Medicare image as a way to increase understanding of different program features and changes.

Respondents who had disenrolled from a sub-zero premium plan were especially familiar with the Medicare program and health insurance. A respondent in this group mentioned access to a "health care coordinator" at a local senior center, and deferred to his advice concerning matters of health insurance selection. Non-enrollees suggested that the best way for Medicare to effectively distribute important information is to do so by mail and on Medicare letterhead, and not to assume that the health plans will distribute the necessary information. Respondents indicated that this method is a better way to achieve accountability and objectivity when making important health care decisions. One respondent elaborated when he said, "Spend more time [working] on your image, and develop an image that's perceived as being honest to the public so that if they declare something, and it has their stamp on it, then I can believe it."

Provider choice is a deciding factor in many beneficiaries' health plan selection process.

Access to a broader pool of primary care physicians and specialists was a significant consideration when choosing a health plan, as reported by Medicare beneficiaries in both focus groups of non-enrollees in the New York City and Miami areas. Many beneficiaries, especially the low-income and high-risk beneficiaries, appeared to be more frustrated with the quality of

their health care than participants in other focus groups. Feedback captured from these groups included frustration with the perceived narrowing choice of health plans, rushed medical visits, and loss of physician choice. One participant said, "[Doctors] have all developed the 'HMO mentality'...where it's like the Burger King mentality is that the doctors are always looking to cut the cost because they're told all the time, 'Cut the cost. Cut the cost.' Kill the patient but cut the cost, you know?" Respondents in these groups viewed HMOs with caution when considering financial savings in health care costs, viewed plans as possibly predatory, and, overall, felt helpless in their ability to effectively dictate the course of their health care coverage.

In an age of mistrust and skepticism of HMOs, beneficiaries expressed significant trust and faith in their physicians.

Respondents expressed varying levels of awareness of Medicare features, such as the premium reduction feature and differences between Part A and Part B. Non-enrollees seemed particularly less informed regarding health plan options for Part B coverage. Several respondents' seemingly blind trust in their doctor's opinions regarding health care coverage could be one potential reason why respondents lacked the initiative to educate themselves on Medicare products. One respondent summed up this point when she said, "I'm so happy with my own doctor that I've had for 40 years, I love that guy, so I don't look. Wherever he sends me I go blindly, because he's one of the last honest ones, totally honest."

One beneficiary in fee-for-service Original Medicare was advised against joining any kind of HMO. He relayed the story by saying, "A lot of people told me, 'listen, if you can afford it, keep paying what you're paying. Don't go on any HMO because they don't treat you right.' When [I went] into the hospital...the doctor told me, 'stay away [from HMOs] if you can.'" Additionally, non-enrollees overwhelmingly associated problems perceived with the Medicare system with their distrust of their local M+COs. They cited problems depicted by the media as reasons not to participate in a managed care plan. One respondent lamented,

"The only thing I don't like about Medicare and Medicaid [is that] it is too politically influenced, and whenever they start to say why it's losing money... they do nothing about it... You're talking about billions of dollars, and they treat it like nothing. The Medicare system is too politically controlled, and they have to do something about the fraud. That's where the problem is, and nobody wants to acknowledge that."

Awareness and Reasons for Enrollment in Sub-Zero Premium Plans

Active enrollees learned about their sub-zero premium plan through health plan marketing efforts such as telemarketing, mailers, and newspaper advertisements.

The majority of beneficiaries learned about their sub-zero premium plan through a plan-sponsored source such as a written letter, advertisement, or telephone call. Often this initial notice was followed by a visit from a sales representative, or an informational seminar or luncheon. A handful of beneficiaries learned about their plan through friends or neighbors.

There was a general consensus, especially among the low-income group, that both the plan and the premium reduction benefit were not explained very well. This point was highlighted when one participant noted, "I was surprised after I enrolled and I was told I was going to get this money back; I was shocked, but it was the best plan anyway." Additionally, there was confusion among some Florida focus group participants regarding the name of their health plan. Respondents identified their plan according to their level of prescription drug coverage.

Only one participant, who was among the high-risk beneficiaries, cited that the plan had been "very well explained" by the sales representative who visited his home and oriented him to the plan. Some recalled reading about the new premium reduction feature in the *Medicare & You* Handbook, but also did not find it easily understandable. Participants noted that they preferred to hear, rather than to read, about new information. Informational seminars or telephone calls were noted as good ways to learn details about their health plans.

Passive enrollees were more likely not to know about the premium reduction feature of their health plan and were more likely to learn about changes to their plan benefits during a service encounter.

Several passive enrollees in New York noted that they had learned about the sub-zero premium plan in a letter from the health plan that described the changes to the plan benefit package. Those who had disenrolled from the sub-zero premium plan were more likely to remember receiving the letter regarding the changes, although several currently enrolled members remembered receiving the letter. However, in many cases, passive enrollees only discovered the changes to their health plan benefits during a service encounter (e.g., when filling a prescription). Although a few sub-zero premium plan active enrollees were also unaware of the premium reduction feature, passive enrollees were more likely to be unaware of this benefit.

Non-enrollees were unaware of the sub-zero premium health plans and the premium reduction feature.

Non-enrollees were unfamiliar with the sub-zero premium plans. After being informed of the plan's features, these focus group participants could generally be characterized as skeptics regarding the viability of the sub-zero premium health plans. These respondents expressed their belief that the plans had been designed as "gimmicks" used to allure seniors toward enrollment. A few respondents supported their view with examples of now-defunct M+COs that had offered features to solicit membership that were ultimately financially unsustainable for the organization. Other skeptics suggested that the sub-zero plans would be forced to discontinue the premium reduction enticement when the high cost of such a feature becomes evident.

Cost is a major reason for joining an M+CO and the premium reduction feature is a welcome benefit for beneficiaries in Florida; however, the new benefit was not the primary motivator for enrollment into a sub-zero premium plan for most enrollees.

Even though most actively enrolled sub-zero premium plan members stated that the premium reduction feature was explained well, the feature did not motivate the majority of participants to *initially* consider the plan. Sub-zero premium plan members in Florida were very aware of the premium reduction benefit and seemed to view sub-zero plans as "interim" health plans for healthy aged until serious health concerns develop. For these members, for whom the premium reduction is $58.70 per month or approximately $705 per year, the savings is an incentive to stay enrolled with the plan. In one case, a participant reported that upon learning about the premium reduction, he was willing to give up his doctor. Another stated that the savings was the "paramount" reason for staying with the sub-zero premium plan. This is a very different case than in New York where most enrollees had not actively selected the health plan and the reduction is $20 per month, or $120 per year.

Medicare beneficiaries who select M+COs suggest that their decision to participate in a managed care plan is at least in part due to income pressures. In general, Medicare beneficiaries report being influenced to participate in specific health plans at least partially by *perceptions* of lower out-of-pocket costs. Low-income enrollees were likely to cite limited incomes, in addition to a variety of other reasons, for enrolling in their sub-zero premium plan. Several had switched from Original Medicare FFS for financial reasons. Although the sub-zero premium plan had poor prescription drug coverage, participants rationalized that the benefits, including the prescription drug benefit, were greater than what is offered in Original Medicare.

Among high-risk members, respondents noted a general satisfaction with their level of understanding of the benefits available to them in their health plan. However, multiple respondents highlighted their dissatisfaction with the current provider referral system. They also demonstrated more difficulty articulating their benefit coverage and the reasons why they joined the M+C plan initially. This finding was consistent across active and passive high-risk enrollees.

New York sub-zero premium plan enrollees were more likely to have been introduced to their health plan by their physician than Florida enrollees. Physician network participation was the primary determinant for enrollment in both states.

The majority of New York enrollees had initially joined an M+CO at the recommendation of their doctor. This level of trust was indicated for several reasons, including not fully understanding the plan benefits, wanting to stay with a trusted doctor, and apathy toward all health plans that seem to have equal benefits. One participant noted, "My doctor told me [about the health plan]. I was with U.S. Healthcare and he just said, 'I like Smart Choice better.' I said, 'Fine with me. It doesn't make any difference; I don't like any of them...' He didn't give me no explanation...I said, 'if you like it, you work with it and you say it's good, fine.'"

Participants cited that their physician's participation in a health plan's network was a major incentive to either join or to remain in the plan. In the event their doctor no longer participated with the health plan, participants explained that they would be motivated to seek a different plan in which their doctor did participate. While some Medicare beneficiaries select their source of health care services at least partially based upon perceptions of lower out-of-pocket costs, the primary influence for type of health plan organization (i.e., fee-for-service, preferred provider organization, or health maintenance organization), as reported by the majority of participants across all focus groups, appears to be the perception of physician choice.

Many sub-zero premium plan enrollees identified additional sources for receiving prescription drugs.

Respondents appeared to be sensitive to the costs and benefits of their plan enrollment, even in cases in which they indicated that they were not aware of the premium reduction prior to enrollment. While some respondents indicated that they had experienced a small savings in the plan, they were likely to be enrolled in other programs that provided prescription drug coverage. For instance, several focus group participants from Florida received benefits through the Veterans Administration, including prescription drug coverage. Respondents admitted that their secondary health coverage was necessary, thereby making it financially possible to take advantage of their sub-zero plan's other features at no great financial burden. In New York, several beneficiaries mentioned EPIC, an income-based State program that assists with prescription drug costs. A number of beneficiaries from Florida also claimed to be very satisfied with ordering prescriptions from Canada at "fantastic" prices.

Following explanation of the sub-zero premium plan, non-enrollees had questions about the legitimacy and viability of the premium reduction feature. Few expressed interest in leaving their current plan to enroll in a sub-zero premium plan.

Although non-enrollees were curious to know more details about sub-zero premium plans, Original Medicare FFS participants in particular seemed resistant to considering M+COs of any type for their health care coverage. Following explanation of the sub-zero premium feature, non-enrollees in New York City indicated that the premium reduction of $20 per month offered by Health Net was not a sufficient incentive to join the plan and consequently lose some of the benefits of their current plan. One respondent indicated that he would be willing to consider the sub-zero premium plan, but he would have to perform a cost-benefit analysis between it and his current plan.

There was also significant confusion regarding the source and reason for the premium reduction. One respondent questioned the motive for having the premium reduction feature. She commented, "Something that I don't understand [about] that twenty dollars [is] even though it's going to be added to my social security payment, I want to know exactly where that twenty dollars is [coming from]...somebody else is [paying] it and I just don't trust it."

When asked why participants did not enroll in an M+CO, FFS beneficiaries cited common complaints against the HMO system such as the lack of freedom to visit a specialist with fewer restrictions and not having to switch doctors because a trusted doctor does not participate in a given plan. In addition, some noted their ability to afford the additional costs of the Original Medicare plan as what kept them in the FFS system.

Managed care enrollees in non-sub-zero premium M+C plans provided three general responses regarding their satisfaction with their health plan choice and their reason to remain where they are:

1) Some respondents were fully satisfied with their plan and the financial contributions required to maintain their current health plan;

2) Other respondents were generally pleased with the benefits provided by their current health plan, but were not entirely pleased with the costs associated with the plan and were therefore open to better options, should they become available; and

3) The remaining respondents were not satisfied with their out-of-pocket costs for their current health plan, but were willing to remain enrolled because they were completely satisfied with the level of care they received from their doctors.

Experience with Sub-Zero Premium Plans

Sub-zero premium plan enrollees were generally satisfied with certain features of their health plan, but for many the premium reduction feature alone did not compensate for the decrease in benefits.

When asked to rank their satisfaction with their sub-zero premium plan, the majority of enrollees reported that they were satisfied or very satisfied with their sub-zero plan, even though some indicated they could benefit from understanding more about their health coverage. One person explained that she was "very satisfied" because she is content with the services and information provided by the plan. Satisfaction was also correlated with the frequency with which a respondent used the plan's features. Greater satisfaction with sub-zero premium plans was noted in cases where the respondent described him or herself as "healthy" and consequently did not use the plan as frequently.

Respondents reported ambivalent feelings regarding their membership in the sub-zero premium plan. Most indicated that the premium reduction was a perk of the plan, but not a reason to stay enrolled. "It doesn't affect my life one way or the other," one participant said. There was a general consensus to stay enrolled as long as their doctors remained with the plan, but to disenroll if the plan at some point no longer covered their doctors' services. They also expressed that when one's doctor leaves the plan, that is a "red flag" indicator that there is a problem. "It's very important that your doctors are happy with the plan and you're happy with the doctor," one respondent commented.

Although recipients of the premium reduction benefit noted multiple ways of spending the additional money, prescription drug expenses was mentioned most frequently.

Respondents varied by group when asked how they use, or intend to use, the money from the premium reduction benefit. Many indicated specific designations for the use of the funds that they will, in theory, save by joining a sub-zero premium plan such as paying bills, going to better restaurants, or daily expenditures. Several respondents emphasized that the additional funds were allocated directly to their monthly prescription drug costs. In New York, enrollees believed that the twenty dollars was insignificant and had not given it much consideration. During a discussion of the premium reduction benefit, one New York respondent questioned, "What are you covered for and by saving that twenty dollars, because they glorified it when they deducted it. They do glorify it, 'oh, you're going to get twenty dollars back,' but to be honest with you, I don't really know if I get my twenty dollars back. What am I losing?" Another respondent added to this sentiment, suggesting, "Twenty dollars in the long haul is minuscule.... Think of the long haul. Don't think about the short term." Twenty dollars in New York was compared to one dollar elsewhere.

Sub-zero premium plan enrollees generally noted an increase in out-of-pocket health care expenses, especially for prescription drug costs.

All sub-zero premium plan participants recognized that they would need to pay more for prescription drugs should they need them. The majority of active enrollees did not indicate that they were paying more in out-of-pocket expenses when compared to their previous plan. They understood that it would cost more to stay with Original Medicare and, as one respondent put it, "we have to expect to put up with some things that are not entirely to our liking; it's a choice that we make." One "high-risk" enrollee in Florida determined it would be cost-effective to join the plan and simply pay out-of-pocket to visit his non-participating cardiologist. He cited, however, that he was aware that this might not be feasible for most people, yet he would continue to do so as long as he could financially manage the extra expenses.

For those who had not yet required services such as hospital care or prescription medicines, it was difficult for them to determine if they paid more out-of-pocket or if they would pay more than they would in another plan. Passive enrollees were more likely to note that they had paid more out-of-pocket under the new benefit structure than in the old structure. Most notably, they said costs had increased for medications for diabetes and asthma, as well as for hospital and physician visits. Many in this group also highlighted that they used their savings to cover prescription drug costs.

Disenrollees were willing to incur greater out-of-pocket costs in exchange for perceived greater flexibility in a health plan.

Some disenrollees were adamant that accessing benefits in the sub-zero premium plan had cost, or would cost, them more money than the health plan they had recently joined. Others noted that

although they would incur greater expenses with their new non-sub-zero premium health plan, the extra cost was worth the improved access to doctors and decreased difficulty in obtaining referrals. One respondent noted that the reason he left his sub-zero premium plan was a result of the ongoing elimination of benefits he experience during his enrollment period. He commented,

"PHS [former Health Net name] was good to the point until they started cutting back and...and you couldn't talk to people without hearing bad remarks at what they did now or that they took this away. The cut back on this and the book [of benefits] is getting smaller... Whether they're falling on hard times, they didn't tell us. We want to know the truth. I'll tell you the truth. They never advised us about the cutbacks."

Although both sub-zero premium plan enrollees and non-enrollees complained of a lack of, or minimal coverage of, some types of benefits, most said they had joined an M+CO because it was a less expensive option than Original Medicare.

The majority of respondents joined an M+CO for cost reasons. Supplemental insurance costs have increased, making M+COs a more affordable option than Original Medicare. Less paperwork was also cited as a reason for joining an M+CO. In general, people noted that they had originally enrolled in their current health plan because they were attracted to certain aspects of the benefit package, typically the low co-pays or, in the case of M+C non-sub-zero enrollees, a sufficient prescription drug package. Participants in Florida favorably noted the plan's low $50 emergency room co-payment, vision, and dental benefits. However, passive enrollees expressed disapproval of the gradual elimination of important plan features such as the lack of or minimal dental, vision, and prescription drug coverage.

Future Enrollment Expectations and Beneficiary Recommendations for CMS

Beneficiaries frequently noted that the sub-zero premium plan is a good option for those without significant health care needs, particularly prescription drug needs, and for those with a low-income.

Some respondents indicated that the sub-zero premium plan is a viable option for health coverage when one's current health status is relatively positive and requires few medications, particularly brand-name medications, or services that would not be covered by the health plan. Respondents indicated they would reconsider enrollment if the plan benefit package or their health status changed significantly. They also seemed to consider the sub-zero premium plan a good interim option while one is in relatively good health. Should their health status worsen, they would quickly enroll in a different health plan with more coverage. Interestingly, the premium reduction approach was referred to as "profit-sharing" approach with people in good health who are not costing the company money.

Several current enrollees said they would recommend the plan to others around the country, and in particular, to people on a limited budget or living on a "fixed income." Some participants suggested that the sub-zero premium plans would also be appropriate for beneficiaries new to

Medicare and without previous experience or connection to a Medicare provider network. This group would not yet have an established network and may be more willing to adapt to a health plan's physician network.

Beneficiaries are prepared to disenroll should further benefit reductions occur, but, in general, they dislike change and would prefer to remain with their existing health plan.

Many respondents indicated that the premium reduction was an attractive feature, but if benefits were further reduced, they would be prompted to leave the plan. One respondent cited that having his health issues addressed in a timely manner and accessing a specialist relatively hassle-free was more important than receiving the premium reduction. One active enrollee in the high-risk group in Florida had decided that she was going to disenroll from the health plan because she had learned when reading her member handbook that she had minimal prescription drug coverage.

There was a general consensus that beneficiaries are motivated to respond to benefit changes by pursuing other health plan options and looking for the plan that provides the most benefits at the least amount of cost. While discussing how to decide in which plan to enroll, one respondent in the low-income group observed, "Okay, well, that's what this is, shopping for HMOs. And wherever you get the best service is where you'll stay." Another respondent agreed when he said, "But you know what? If Medicare had medicine coverage, I'd go to Medicare."

Although many respondents believed they were paying more out-of-pocket now than when they were enrolled in their previous plan, there was a sense that better alternatives were not available. When asked whether they would consider joining another plan, one respondent in the dual eligible group answered, "No, I figure they're all the same now." Some low-income respondents indicated that they would consider leaving their health plan, particularly if coverage of certain important benefits, such as dental, visions, or prescriptions, were reduced or other changes were made that would increase out-of-pocket costs. In addition, if benefits in the Original Medicare plan were increased, beneficiaries would consider disenrolling from the health plan and enrolling in Original Medicare. Another respondent shared her frustration when she said, "you get settled in with one company, and then they change [the benefits] and then I'm forced to leave."

Many respondents repeatedly noted that they would be more satisfied with their participation in the sub-zero premium plan if a more comprehensive prescription drug package were included. However, when asked if they had considered switching plans in search of a better drug package, one respondent summed up the group's concern regarding switching health plans when she noted, "We have received notices from other plans, but we're not sure who to switch to. We need to find a plan that includes drugs, but we risk having the option taken away from us later." Yet another respondent commented, "I've gotten enough information on plans in general. I don't like change. So if I can afford this plan, then I'll stay with the plan. Right now, I'm very satisfied. Better to stick with what you have than what you don't know."

Some Medicare beneficiaries expressed feelings of skepticism about the long-term viability of sub-zero premium plans. They expressed difficulty comprehending how the health plan could remain financially stable with the premium reduction benefit. This uncertainty is a result of their observations of frequent closings and mergers of health plans and health systems around the country. In general, respondents expressed a desire for assurance that the health insurance plan is founded and secure. One participant noted, "I always hear rumors that the HMOs periodically one day have the insurance and the next day they're out of business...I want to make sure that I am getting a stable company." Additionally, many beneficiaries believed that there is a potential for future changes in their plan's compensation to physicians that may "force" their physicians from the plan's network, as had been observed in several HMOs.

Beneficiary recommendations to CMS include applying the premium reduction savings to improving Medicare and requiring M+COs to expand their provider networks.

Enrollees and disenrollees alike suggested eliminating the premium reduction feature and instead, improving plan benefits. One respondent suggested another way to use the additional funds, "[To make the plan better the insurance company should] take the money, send a lobby to Washington, and get the drug companies to reduce American drug costs." Another respondent added, "if you combine the twenty dollars from all the participants and then you could enhance the program then go forward with something that would help the people, otherwise, [the benefit] is worthless." Respondents generally agreed that features that would make M+COs more desirable include a better prescription drug benefit and an element of the plan that addresses long-term care. Other benefits important for Medicare to offer include more comprehensive dental and vision benefits.

High-risk beneficiaries suggested requiring health plans to include all Medicare-approved physicians in their network. Several respondents advocated for an open network to include all physicians and dentists. They also suggested that beneficiaries should be able to evaluate their physicians and provide feedback to the health plan to "let [others] know what you think of the doctor they've selected to be in their program."

Appendix A: CMS Guidance on Medicare Part B Premium Reduction Plans

Based on a review of the CMS web site in March 2003, guidance to health plans appears to be minimal. When provided, it is of a fairly technical nature (e.g., how to complete the ACR worksheet or Plan Benefit Package database). Search terms included "606," "premium reduction" and "premium rebate." Results are listed below, according to publication date.

1) *Health Care Financing Review* Article

Winter 2001

http://cms.hhs.gov/review/01winter/feldman.pdf

2) How to Transmit and Support Your ACR for Contract Year 2003

Issued early 2002

http://cms.hhs.gov/healthplans/acr/transmitsupport03acr.pdf

The document states, "Worksheet E, Part I (Adjusted Community Rate) has undergone minor changes for 2003, including the addition of a new line (line 11) to display amounts to fund Part B premium reductions for enrollees. The amount displayed on line 11 will be withheld from the monthly payments by CMS to an M+CO."

3) PBP 2003 USER INSTRUCTIONS

http://cms.hhs.gov/healthplans/acr/03pbpuserinstr.pdf

Page 6 states, "Beginning in CY 2003, M+COs will be able to use their adjusted excess to reduce the Medicare Part B premium for beneficiaries. When offering this benefit, a plan cannot reduce its payment by more than 125 percent of the Medicare Part B premium. As a result, the PBP system must validate the 'indicate your MCO plan payment reduction amount, per member' field to ensure that the number entered is not greater than 125 percent of the Medicare Part B premium. Since the Medicare Part B premium for 2003 will not be released until the fall of 2002, the PBP (and ACR) will use an estimated 2003 Medicare Part B premium amount. In order to calculate the Part B premium reduction amount, the PBP system must multiply the number entered in the 'indicate your MCO plan payment reduction amount, per member' field by 80 percent. The resulting number is the Part B premium reduction amount for each member in that particular plan (rounded to the nearest multiple of 10 cents). This rounded number will then be used to populate the corresponding SB sentence describing the Part B premium reduction benefit."

4) Federal Register

Proposed Rule

October 25, 2002

http://cms.hhs.gov/providerupdate/regs/cms4041p.pdf

See description on Page 65673 (Item #2). See the first bullet on Page 65679; this suggests that premium reduction must be disclosed to enrollees. See the fourth and eighth bullets on the same page. The latter describes fundamental aspects of the benefit.

5) Health Plan Letter, December 17, 2002

http://cms.hhs.gov/healthplans/letters/03memo41_1.pdf

In a brief mention, the document states: "We would also like to remind you of some other issues . . . 2003 is the first year of the BIPA 606 Part B premium reduction."

6) Medicare Managed Care Systems Information Web Page

Last Modified January 29, 2003

http://cms.hhs.gov/healthplans/systems/

Lists "Benefits Improvement Protection Act 606(BIPA606)" as a topic but provides no additional information.

Appendix B: County-Level Analysis of M+C Plan Offerings

The county-level analysis that follows is intended to provide context for later evaluation of beneficiaries' selection of a sub-zero premium plan. Equally as important, this information provides a context in which to analyze an M+CO's decision to offer the premium reduction benefit. These analyses will be conducted in a subsequent task.

For each of the eight counties under study, an overview of the type and number of plans available to beneficiaries is provided and attempts to characterize each market's available benefit packages; in New York, however, this characterization is limited to premium amounts, coverage for preventive care services, and additional benefits, due to the variation in the size of co-payments and coinsurances for basic services.

Plan comparisons are restricted to a set number of plan attributes selected for inclusion due to their known influence in the beneficiary plan selection process based on published research concerning beneficiary health plan choice. Furthermore, except where noted, these comparisons include all M+C plans available in a given county, as indicated by Medicare Health Plan Compare, and do not distinguish plans available to all beneficiaries from those limited or marketed to special populations such as nursing home residents or Medicare/Medicaid dually-eligible beneficiaries. Lastly, non-benefit information that may figure into beneficiaries' decision-making processes, such as data about quality of care and services, was not considered.

New York Counties

Within the five New York counties under study, two M+COs offer sub-zero premium plans: United Healthcare of New York, Inc. and Health Net of New York (Table B.1). The former offers its sub-zero premium plan, the Medicare Complete (Plan 4) or Medicare Give Back Plan, in all five counties, whereas Health Net offers a Smart*Choice* sub-zero premium plan only in Bronx, Queens, and Richmond Counties. While each county's Health Net sub-zero premium plan has a unique plan identification number, these three plans are identical with respect to the plan attributes under consideration.

Table B.1 Availability of Sub-Zero Premium Plans, by County

Bronx	Kings	New York	Queens	Richmond
▪ Medicare Complete (Plan 4) ▪ Smart*Choice* for Bronx County	▪ Medicare Complete (Plan 4)	▪ Medicare Complete (Plan 4)	▪ Medicare Complete (Plan 4) ▪ Smart*Choice* for Queens County	▪ Medicare Complete (Plan 4) ▪ Smart*Choice* for Richmond County

Although available M+COs and plans differ across counties, our analysis reveals that the same generalizations apply across markets with respect to how the sub-zero premium products compare with each other and with the other plans in the given market. For the sake of space, this

information will not be repeated for each county, but will be presented after the county-specific information.

Bronx County

Bronx County Medicare beneficiaries can currently choose from one of 22 M+C plans offered by 11 M+COs (Table B.2).[57] Of these 22 plans, five are PPOs, one is an HMO-POS plan, and 16 are HMOs. Both Health Net and United Healthcare offer their sub-zero premium product in this county.

Table B.2 Operating M+COs, Number and Type of Plans Available in Bronx County

Medicare+Choice Organization	Plan Type	Plans Offered	Sub-Zero Premium Plans Offered
Aetna, Inc.	HMO	2	0
Empire HealthCare HMO, Inc.	HMO	1	0
GHI Medicare Choice PPO	PPO	2	0
Health Net of NY	HMO	1	1
HealthFirst 65 Plus	HMO	4	0
HealthFirst PPO	PPO	2	0
HIP Health Plan of Greater New York	HMO	2	0
Oxford Health Plans (NY), Inc.	HMO, HMO-POS	3 (2 HMOs, 1 HMO-POS)	0
United Healthcare Insurance Company of NY, Inc.	PPO	1	0
United Healthcare of New York, Inc.	HMO	3	1
Well Care Choice of New York	HMO	1	0

Listed below are characterizations of the 22 plans currently offered in this county:

- Twelve of the 16 HMO plans charge no additional premium for providing enhanced benefits. Two HMO plans require an additional premium of $25 and $65 per month. The remaining two HMO plans offer a partial reduction of the Part B monthly premium.
- Nineteen of the 22 plans (85 percent) provide 100 percent coverage for preventive care services.[58]

[57] According to Medicare Health Plan Compare, two additional HIP Health Plan of Greater New York plans, H3314 and H3315, operate in this county. Both are cost HMOs and are closed to new members. No information on these plans' benefit packages is available on the Medicare website.

[58] References to preventive care services throughout this report should be understood to include bone mass measurement, colorectal screening exams, immunizations, mammograms, pap smears and pelvic exams, and prostate cancer screening exams. Primary Care Physician (PCP) visits and routine physical exams are separate categories.

- For primary care physician visits, most plans require a co-pay of $10 or less. There is a wider range of co-pays for specialist visits.
- Thirteen plans (59 percent) offer at least partial coverage for dental services.
- Nineteen plans (86 percent) offer at least partial coverage for vision services beyond Original Medicare's provision.[59]
- Seventeen plans (77 percent) offer some outpatient drug coverage; eight plans (36 percent) offer at least partial coverage of brand name drugs.
- Eight plans (36 percent) provide some coverage for hearing aids.

Kings County

In Kings County, there are currently 26 M+C plans available to Medicare beneficiaries, offered by 13 M+COs (Table B.3).[60] These plans include one social HMO, five PPOs, one HMO-POS, and 19 HMOs, including United Healthcare of New York's sub-zero premium product.

Table B.3 Operating M+COs, Number and Type of Plans Available in Kings Country

Medicare+Choice Organization	Plan Type	Plans Offered	Sub-Zero Premium Plans Offered
Aetna, Inc.	HMO	2	0
AmeriChoice of New York, Inc.	HMO	1	0
Elderplan, Inc.	Social HMO	1	0
Empire HealthCare HMO, Inc.	HMO	1	0
GHI Medicare Choice PPO	PPO	2	0
Health Net of NY	HMO	1	0
HealthFirst 65 Plus	HMO	4	0
HealthFirst PPO	PPO	2	0
HIP Health Plan of Greater New York	HMO	2	0
Oxford Health Plans (NY), Inc.	HMO, HMO-POS	4 (3 HMOs, 1 HMO-POS)	0
United Healthcare Insurance Company of NY, Inc.	PPO	1	0
United Healthcare of New York, Inc.	HMO	4	1
Well Care Choice	HMO	1	0

[59] See Footnote 33.
[60] Plan H3314-999 also operates in this county, but it is excluded from the analysis. See Footnote 34.

The following generalizations can be made about the 26 plans available in this market:

- Nineteen of the plans (73 percent), including two of the PPOs, charge no additional premium to the monthly Part B premium. One of the remaining seven plans offers a partial reduction in the monthly Part B premium.
- Twenty-three plans (88 percent) offer 100 percent coverage for preventive care services.
- For primary care physician visits, most plans require a co-pay of $10 or less. There is a wider range of co-pays for specialist visits.
- Seventeen plans (65 percent) offer outpatient prescription drug coverage, with 11 (42 percent) covering brand name drugs.
- Twenty-three plans (88 percent) offer some coverage for vision services beyond the Original Medicare provision.
- Seventeen plans (65 percent) offer some coverage for hearing aids.
- Sixteen plans (62 percent) offer some coverage for dental services.

New York County

Medicare beneficiaries living in New York County have 24 M+C plans available to them (Table B.4).[61] Of these plans, five are PPOs, one is an HMO-POS plan, and 18 are HMOs, including United Healthcare of New York's Medicare Give Back Plan.

Table B.4 Operating M+COs, Number and Type of Plans Available in New York County

Medicare+Choice Organization	Plan Type	Plans Offered	Sub-Zero Premium Plans Offered
Aetna, Inc.	HMO	2	0
Elderplan, Inc.	Social HMO	1	0
Empire HealthCare HMO, Inc.	HMO	1	0
GHI Medicare Choice PPO	PPO	2	0
HealthFirst 65 Plus	HMO	4	0
HealthFirst PPO	PPO	2	0
HIP Health Plan of Greater New York	HMO	2	0
Oxford Health Plans (NY), Inc.	HMO, HMO-POS	4 (3 HMOs, 1 HMO-POS)	0
United Healthcare Insurance Company of NY, Inc.	PPO	1	0
United Healthcare of New York, Inc.	HMO	4	1
Well Care Choice	HMO	1	0

[61] Plans H3314-999 and H3315-999 also operate in this county. See Footnote 34.

The following generalizations can be made about the 24 plans available in this market:

- Seventeen plans (71 percent) charge no additional premium to the monthly Part B premium.
- Most of the plans require a co-pay of $10 or less for primary care physician visits. There is a wider range of co-pays for specialist visits.
- Twenty-one plans (88 percent) offer 100 percent coverage for preventive care.
- Fifteen plans (63 percent) offer some outpatient prescription drug coverage, and 10 plans (42 percent) provide some coverage of brand name drugs.
- Fifteen plans (63 percent) offer some coverage for dental services.
- Fifteen plans (63 percent) offer some coverage of hearing aids.
- Twenty-one plans (88 percent) offer some coverage of vision services beyond Original Medicare's provision.

Queens County

Medicare beneficiaries residing in Queens County have 26 M+C plans available to them (Table B.5).[62] Offered by 13 M+COs, these plans include one social HMO, one HMO-POS, five PPOs, and 19 HMOs, including United Healthcare of New York and Health Net's sub-zero premium products.

[62] Plans H3314-999 and H3315-999 also operate in this county. See Footnote 34.

Table B.5 Operating M+COs, Number and Type of Plans Available in Queens County			
Medicare+Choice Organization	**Plan Type**	**Plans Offered**	**Sub-Zero Premium Plans Offered**
Aetna, Inc.	HMO	2	0
AmeriChoice Of New York, Inc.	HMO	1	0
Elderplan, Inc.	Social HMO	1	0
Empire HealthCare HMO, Inc.	HMO	1	0
GHI Medicare Choice PPO	PPO	2	0
Health Net of New York, Inc.	HMO	1	1
HealthFirst 65 Plus	HMO	4	0
HealthFirst PPO	PPO	2	0
HIP Health Plan of Greater New York	HMO	2	0
Oxford Health Plans (NY), Inc.	HMO, HMO-POS	4 (3 HMOs, 1 HMO-POS)	0
United Healthcare Insurance Company of NY, Inc.	PPO	1	0
United Healthcare of New York, Inc.	HMO	4	1
Well Care Choice	HMO	1	0

The following statements are offered as characterizations of the 26 plans in this market:

- Seventeen plans (65 percent) charge no additional premium to the monthly Part B premium. One of the remaining nine plans offers a partial reduction of the Part B premium.
- Most of the plans require a co-pay of $10 or less for primary care physician visits. There is a wider range of co-pays for specialist visits.
- Twenty-three plans (88 percent) offer 100 percent coverage for preventive care.
- Seventeen plans (65 percent) offer some outpatient prescription drug coverage, and nine plans (35 percent) offer some coverage of brand name drugs.
- Twenty-three plans (88 percent) offer some coverage for vision services.
- Sixteen plans (62 percent) offer some coverage of dental services.
- Seventeen plans (65 percent) offer some coverage of hearing aids.

Richmond County

In Richmond County, there are 23 M+C plans available to the Medicare population (Table B.6).[63] Of these plans, one is a social HMO, one is an HMO-POS, five are PPOs, and 16 are HMOs. Both sub-zero premium plans are available in this county.

Table B.6 Operating M+COs, Number and Type of Plans Available in Richmond County

Medicare+Choice Organization	Plan Type	Plans Offered	Sub-zero Premium Plans Offered
Aetna, Inc.	HMO	2	0
Elderplan, Inc.	Social HMO	1	0
Empire HealthCare HMO, Inc.	HMO	1	0
GHI Medicare Choice PPO	PPO	2	0
Health Net of New York, Inc.	HMO	1	1
HealthFirst 65 Plus	HMO	4	0
HealthFirst PPO	PPO	2	0
HIP Health Plan of Greater New York	HMO	2	0
Oxford Health Plans (NY), Inc.	HMO, HMO-POS	4 (3 HMOs, 1 HMO-POS)	0
United Healthcare Insurance Company of NY, Inc.	PPO	1	0
United Healthcare of New York, Inc.	HMO	3	1

The following statements can be made regarding the 23 plans available in this market:

- Fifteen plans (65 percent) charge no additional premium to the monthly Part B premium. Two of the remaining eight plans offer a partial reduction of the Part B premium.
- Most of the plans require a co-pay of $10 or less for primary care physician visits. There is a wider range of co-pays for specialist visits.
- Twenty plans (87 percent) offer 100 percent coverage for preventive care.
- Fifteen plans (65 percent) offer some outpatient prescription drug coverage, and nine plans (39 percent) provide some coverage of brand name drugs
- Twenty plans (87 percent) offer some coverage for vision services.
- Fourteen plans (61 percent) offer some coverage for dental services.
- Fifteen plans (65 percent) provide some coverage for hearing aids.

[63] Plans H3314-999 and H3315-999 also operate in this county. See Footnote 34.

Sub-Zero Premium Plans Offered in the New York Counties

Similar findings about how United Healthcare's sub-zero premium plan compares with Health Net's sub-zero premium plans, and how these plans compare with other health plans offered in their markets, apply across the five counties. First, compared with other plans in these markets, including Health Net's Smart*Choice* plans, United Healthcare's Medicare Give Back Plan requires higher co-pays and offers less generous benefits than its competitors. For instance, it has much higher co-pays for inpatient hospital stays and Skilled Nursing Facility (SNF) care, the highest co-pays for specialist visits, and the second highest co-pays for routine physical exams.[64] In contrast to the majority of other plans in the five New York counties, this plan also offers no coverage of any type for outpatient prescription drugs, dental services, or hearing aids, and co-pays for vision and hearing exams are comparatively high.

By contrast, Health Net's Smart*Choice* plans require comparatively mid-range co-pays for inpatient hospital care and specialist visits and no co-pay for SNF care or routine physical exams.[65] They provide some outpatient drug coverage, though this is limited to formulary generics. Smart*Choice* plans offer some coverage of hearing aids, but do not cover dental services. The table below provides some context for evaluating the sub-zero premium plans' benefit packages with those of their competitors.

Table B.7 Percent of M+C Plans Offering Additional Benefits, by County

	Bronx	Kings	New York	Queens	Richmond
Generic drugs	77%	65%	63%	65%	65%
Brand name drugs	36%	42%	42%	35%	39%
Dental services	59%	62%	63%	62%	61%
Vision services[μ]	86%	88%	88%	88%	87%
Hearing aids	36%	65%	63%	65%	65%

[μ] BearingPoint used the online Medicare Health Plan Compare, available at www.medicare.gov, to determine which plans qualify as offering "Coverage for Vision Services." It appears that coverage here is understood to mean at least partial coverage of a vision service or material that is not covered at all by Medicare. Thus, a plan offering some coverage of a routine eye exam would qualify, but a plan that requires enrollees to pay 100% of non-Medicare-covered services or materials—even if it covers some portion of beneficiaries' share of the cost of a Medicare-covered vision service—would not.

Despite having higher co-pays and less generous benefits, United Healthcare's Medicare Give Back Plan offers a greater reduction in the Part B premium at $30 than the Smart*Choice* plans at $20 per month. Moreover, it caps members' out-of-pocket expenses at $4,800 (for certain

[64] For example, most of the plans cap enrollees' out-of-pocket contribution toward the cost of an inpatient hospital stay (up to 90 days) at $750 or less. The Medicare Give Back Plan requires a co-pay of $265 per day for days 1-19, and $0 per day for days 20-90.
[65] Assumes 100-day benefit period.

services), while the Smart*Choice* plans offer no such cap. Finally, the Medicare Give Back Plan, along with United Healthcare's other plans offered in these counties, are the only HMO plans that do not require members to obtain a referral to visit network specialists.

Florida Counties

In Florida, three M+COs offer sub-zero premium products: CarePlus Health Plans, Inc., Vista Healthplan, Inc., and Well Care Choice. CarePlus Health Plans and Vista Healthplan offer their sub-zero premium products, the CareFree Plan and the Medicare VALUE Advantage plan, respectively, in Dade and Broward Counties. Well Care Choice offers its Well Care Advantage plan in Dade and Hillsborough Counties (Table B.8).

Table B.8 Availability of Sub-Zero Premium Plans, by County

Dade	Broward	Hillsborough
▪ CareFree Plan ▪ Medicare VALUE Advantage plan ▪ Advantage plan	▪ CareFree Plan ▪ Medicare VALUE Advantage plan	▪ Advantage plan

Dade County

Beneficiaries residing in Dade County can choose from among 21 M+C plans, three of which offer the Part B premium reduction (Table B.9). All plans but one are HMOs, with the exception being a Provider Sponsored Organization (PSO).

Table B.9 Operating M+COs, Number and Type of Plans Available in Dade County

Medicare+Choice Organization	Plan Type	Plans Offered	Sub-Zero Premium Plans Offered
AvMed Medicare Plan	HMO	1	0
CarePlus Health Plans, Inc.	HMO	2	1
Health Options, Inc./BCBSFL	HMO	1	0
Humana Medical Plan, Inc.	HMO	3	0
Neighborhood Health Partnership, Inc.	HMO	4	0
United Healthcare of Florida, Inc.	HMO	2	0
Vista Healthplan of South Florida, Inc.	HMO	1	0
Vista Healthplan, Inc. (H1027)	HMO	1	0
Vista Healthplan, Inc. (H1076)	HMO	3	1
Well Care Choice	HMO	2	1
PSO Health Plan	PSO	1	0

Compared with the other two Florida counties under study, Dade offers people with Medicare the greatest number of M+C plans to choose from, as well as the most generous benefit packages. Below is a list of some of the characteristics of the county's 21 M+C plans:

- Excluding the sub-zero premium plans, all of the plans (100 percent) charge no premium in addition to the monthly Part B premium.
- All three sub-zero premium plans offer a full reduction of the Part B premium.
- Excluding the sub-zero premium plans, only three of the remaining 18 plans (17 percent) require a co-pay for inpatient hospital care.[66]
- Most of the plans (76 percent) do not require a co-pay for SNF care.[67]
- None of the plans require a co-pay for primary care physician visits. Most plans (67 percent) do not require a co-pay for specialist visits.
- All but one of the plans (95 percent) offer 100 percent coverage for preventive care services.
- Seventeen plans (81 percent), including all three sub-zero premium plans, offer some outpatient prescription drug coverage. Fifteen plans (71 percent) offer some coverage of brand name drugs, including Well Care Choice's Advantage plan.
- Nine plans (43 percent) offer some coverage for dental services.
- Ten plans (48 percent) offer some coverage of hearing aids.
- Nineteen plans (91 percent) offer some coverage for vision services beyond what Original Medicare provides.

For Medicare beneficiaries residing in Dade County, the opportunity to receive a partial or full reduction of their Part B premium is accompanied by a greater financial risk in terms of out-of-pocket costs. Unlike most plans available in Dade, both Vista Healthplan and Well Care Choice's sub-zero premium plans require co-pays for inpatient hospital care, SNF care, specialist visits, and outpatient surgery.[68] CarePlus Health Plan's CareFree Plan appears to be an exception—it requires no co-pay for the basic services reviewed. The only noticeable financial disadvantage to enrolling in this plan is its very limited outpatient drug benefit, namely coverage of formulary generic drugs only and a $25 monthly benefit limit. While the other two sub-zero premium products require co-pays for basic services, they offer more generous outpatient drug coverage than does the CareFree Plan. The table below compares the outpatient prescription drug coverage offered by the three sub-zero premium plans in this market.

[66] According to CMS's Medicare Health Plan Compare, CarePlus Health Plans' products have a $0 co-pay for days 1-90, whereas the other plans have no co-pay for plan-approved inpatient hospital care. For these latter plans, no limit on days is mentioned.
[67] All plans define their benefit period as 100 days.
[68] Additional benefit information can be found on the Medicare Health Plan Compare website available at www.medicare.gov.

Table B.10 Comparison of Sub-Zero Premium Plan Drug Coverage			
	CarePlus Health Plans, Inc.	Vista Healthplan, Inc.	Well Care Choice[v]
	CareFree	Medicare VALUE Advantage	Advantage
Formulary	$0 co-pay generic (30-day supply), $25 monthly benefit limit	$10 co-pay generic (30-day supply), $30 co-pay generic mail order (90-day supply), no individual benefit limit on generics	$5 co-pay generic (30-day supply), $15 co-pay brand (30-day supply), no individual limit on generics, $100 monthly benefit limit on all brand drugs
Non-Formulary	No benefit	No benefit	$5 co-pay generic (30-day supply), $30 co-pay brand (30-day supply), no individual limit on generics, $100 monthly limit on all brand drugs
[v] Information on Well Care Choice's outpatient prescription drug coverage was obtained from marketing materials received from Well Care Choice.			

Broward County

In Broward County, nine M+COs offer a total of 13 M+C plans (Table B.11). Two of the plans are PPOs and two are HMOs that offer the sub-zero premium benefit.

Table B.11 Operating M+COs: Number and Type of Plans Available in Broward County			
Medicare+Choice Organization	Plan Type	Plans Offered	Sub-Zero Premium Plans Offered
AvMed Medicare Plan	HMO	1	0
CarePlus Health Plans, Inc.	HMO	2	1
Health Options, Inc./BCBSFL	HMO	1	0
Humana Medical Plan, Inc.	HMO	2	0
Neighborhood Health Partnership, Inc.	HMO	1	0
Vista Healthplan of South Florida, Inc.	HMO	1	0
Vista Healthplan, Inc.	HMO	3	1
EncorEncore	PPO	1	0
United Healthcare Insurance Company, Inc.	PPO	1	0

The plans available in Broward are less generous than their counterparts in Dade, but more generous than those in Hillsborough. Characteristics of the 13 M+C plans in Broward County include the following:

- One HMO and two PPOs charge monthly premium amounts of $45, $105 and $155 in addition to the Part B premium. Two HMO plans reduce the full Part B premium. The

remaining plans (62 percent) charge no additional premium to the monthly Part B premium.

- Six of the plans (46 percent) cap enrollees' annual out-of-pocket expenses, with this cap ranging from $1,800 to $4,000.
- With the exception of Vista Healthplan's sub-zero premium product, all of the plans (92 percent) require a co-pay that would amount to, or is capped at, $1,800 or less per 90-day inpatient hospital stay.
- Twelve plans (92 percent) require a co-pay of $10 or less for PCP visits. Co-pays for specialist visits range from $0 to $40.[69]
- Twelve plans (92 percent) require no co-pay for preventive care services.
- Ten of the 13 (77 percent) plans offer outpatient prescription drug coverage. Seven plans, including the two sub-zero premium plans, (54 percent) cover formulary generics only.
- Only four plans (31 percent) offer dental coverage.
- Only three plans (23 percent) offer coverage of hearing aids.
- Eleven plans (85 percent) offer vision services beyond what Original Medicare covers.

The county's two sub-zero premium plans differ from one another considerably. The CareFree Plan compares very favorably with the other plans in this market, with the only clear disadvantage being its very limited coverage of outpatient prescription drugs. This plan requires no co-pay for SNF care and caps its enrollees' out-of-pocket costs for inpatient hospital care at $250 per stay. No co-pay is required for PCP visits, while specialist visits require a $10 co-pay. Relative to the other plans, the dental, vision and hearing coverage offered by the CareFree Plan is very generous. By contrast, Vista Healthplan's Medicare VALUE Advantage benefit package is not nearly as generous, though it does cap enrollees' out-of-pocket expenses (for certain services) at $4,000 per year. Relative to the other plans in this market, this product requires much higher co-pays for inpatient hospital care, specialist visits, and outpatient surgery. Like the CareFree Plan, this plan's drug benefit is limited, covering only formulary generics and capping its monthly benefit at $50. Unlike that plan, the Medicare VALUE Advantage plan does not cover dental services or non-Medicare covered hearing services.

Hillsborough County

Four M+COs offer five different M+C plans to Medicare beneficiaries residing in Hillsborough County (Table B.12). Four of these plans are HMO plans, including one sub-zero premium plan, and one is a PPO plan.

[69] According to the Medicare website, AvMed's Medicare Preferred plan charges between $0 and $100 per Specialist visit.

Table B.12 Operating M+COs, Number and Type of Plans Available in Hillsborough County			
Medicare+Choice Organization	**Plan Type**	**Plans Offered**	**Sub-Zero Premium Plans Offered**
Humana Medical Plan, Inc.	HMO	1	0
United Healthcare Insurance Company, Inc.	PPO	1	0
United Healthcare of Florida, Inc.	HMO	1	0
Well Care Choice	HMO	2	1

Compared with their counterparts in Dade and Broward Counties, Medicare beneficiaries residing in Hillsborough County have the fewest and least generous M+C options available to them. Below is a list of some of the characteristics of this county's plans:

- Three of the plans (60 percent) cap enrollees' yearly out -of-pocket expenses, though their respective limits are very different. United Healthcare Insurance Company's PPO plan caps these expenses at $1,800, while United Healthcare of Florida's Medicare Complete plan has a cap of $4,800 and Well Care Choice's sub-zero premium plan has a maximum limit of $5,000.
- Preventive care services are 100 percent covered by all of the plans.
- Required co-pays for SNF care range from $50 per day to $150 per day.
- Four plans (80 percent) have a co-pay of $10 or less for primary care physician visits. Co-pays for specialist visits range from $25 to $35.
- Three plans (60 percent) offer some coverage of generics.
- Four of the plans (80 percent) offer some coverage of dental care.
- Three of the plans (60 percent) offer some coverage of hearing services.
- All of the plans offer some vision coverage beyond what Original Medicare provides.

Well Care Choice's Advantage plan offers a partial reduction of the Part B monthly premium but requires higher co-pays for inpatient hospital care, SNF care and specialist visits than do the other plans, excluding United Healthcare of Florida's Medicare Complete plan. The Advantage plan does not offer any coverage of outpatient prescription drugs, but does offer relatively generous coverage of vision and hearing services.

Appendix C: Introductory Letters

<DATE>
<FIRST NAME> <LAST NAME>
<TITLE>
<ORGANIZATION>
<STREET ADDRESS>
<CITY>, <STATE> <ZIPCODE>

Dear <SALUTATION> <LAST NAME>:

On behalf of the Centers for Medicare & Medicaid Services (CMS), we are pleased to announce an important study of the new Medicare Part B premium reduction benefit. As you likely know, Section 606 of the Benefits Improvement and Protection Act of 2000 permits Medicare + Choice Organizations (M+COs) to offer a reduction of the Medicare Part B premium as an additional member benefit effective January 1, 2003.

CMS has contracted with BearingPoint, a Virginia-based consulting firm, to conduct an evaluation that examines how Medicare beneficiaries and health plans have responded to the new Medicare Part B premium reduction option and the initial impacts on beneficiary benefits and access to care. One aim of the evaluation is to learn why beneficiaries have enrolled in these new M+C products, which types of beneficiaries have enrolled, and what their initial experiences have been. Another objective is to better understand the reasons why some M+COs decided to offer products with this new benefit, whether they targeted the benefit to certain types of beneficiaries, whether they have altered other health plan benefits, and their experiences to date.

The evaluation will take place from March to August 2003 and cover the two market areas where the Medicare Part B premium reduction benefit is currently offered, Florida and New York. Research activities will include: 1) a review of background and marketing materials related to the new M+C products; 2) telephone interviews with health plan and State Health Insurance Assistance Program (SHIP) representatives; and 3) focus group discussions with Medicare beneficiaries.

CMS is extremely interested in your <DECISION/DECISION NOT> to offer a product with the new Medicare Part B premium reduction benefit. Therefore, *we are asking that your organization participate in the telephone interviews for this study.* If you agree to participate, the project team will request telephone interviews (approximately one hour per interview) with key

individuals in your organization who are involved in developing or providing new Medicare products. Potential interviewees include yourself, the Directors of Finance, Government Affairs/Medicare Product Line, Marketing/Outreach, Member Services, and others who you think could provide valuable information. Telephone interviews will take place individually or in small groups. All questions during the interviews will be open-ended and relatively informal, *requiring no prior preparation on your part.* Furthermore, all information will be held strictly confidential and no individual health plan information will be reported or released outside of the project team or CMS.

Within the next week, a representative from BearingPoint will be contacting you to solicit your participation in the study and arrange telephone interviews. Meanwhile, if you would like additional information regarding the interviews, please contact Dennis McIntyre at Bearing Point at 703-747-6642 or by email at dbmcintyre@bearingpoint.net. If you have any questions or concerns about this study in general, please do not hesitate to contact the CMS Project Officer, Vic McVicker, by phone at 410-786-6681 or by e-mail at vmcvicker@cms.hhs.gov.

CMS thanks you in advance for your support of this research. Your organization's experiences are invaluable to improving program operations and we look forward to learning about them as the study proceeds.

Sincerely,

Stuart Gutterman
Office Director of Office of Research, Development, & Information (ORDI)
Centers for Medicare & Medicaid Services

Jean Lemasurier
Group Director
Health Plan Benefits Group
Centers for Medicare & Medicaid Services

<DATE>

<FIRST NAME> <LAST NAME>
<TITLE>
<ORGANIZATION>
<STREET ADDRESS>
<CITY>, <STATE> <ZIPCODE>

Dear <SALUTATION> <LAST NAME>:

On behalf of the Centers for Medicare & Medicaid Services (CMS, we are pleased to announce an important study of the new Medicare Part B premium reduction benefit. As you likely know, Section 606 of the Benefits Improvement and Protection Act of 2000 permits Medicare + Choice Organizations (M+COs) to offer a reduction of the Medicare Part B premium as an additional member benefit effective January 1, 2003.

CMS has contracted with BearingPoint, a Virginia-based consulting firm, to conduct an evaluation that examines how Medicare beneficiaries and health plans have responded to the new Medicare Part B premium reduction option and the initial impacts on beneficiary benefits and access to care. One aim of the evaluation is to learn why beneficiaries have enrolled in these new M+C products, which types of beneficiaries have enrolled, and what their initial experiences have been. Another objective is to better understand the reasons why some M+COs decided to offer products with this new benefit, whether they targeted the benefit to certain types of beneficiaries, whether they have altered other health plan benefits, and their experiences to date.

The evaluation will take place from March to August 2003 and cover the two market areas where the Medicare Part B premium reduction benefit is currently offered, Florida and New York. Research activities will include: 1) a review of background and marketing materials related to the new M+C products: 2) telephone interviews with health plan and State Health Insurance Assistance Program (SHIP) representatives; and 3) focus group discussions with Medicare beneficiaries.

CMS is extremely interested in the SHIPs' experiences related to the new Medicare Part B premium reduction benefit. Therefore, *we are asking that your organization participate in the telephone interviews for this study.* If you agree to participate, the project team will request telephone interviews with yourself and the local SHIP director for <COUNTY/AREA NAME>. Each interview will last approximately one hour. All questions during the interviews will be open-ended and relatively informal, *requiring no prior preparation on your part.*

Within the next week, a representative from BearingPoint will be contacting you to solicit your participation in the study and arrange the telephone interviews. Meanwhile, if you would like additional information regarding the interviews, please contact Dennis McIntyre at BearingPoint

at 703-747-6642 or by email at dbmcintyre@bearingpoint.net. If you have any questions or concerns about this study in general, please do not hesitate to contact the CMS Project Officer, Vic McVicker, by phone at 410-786-6681 or by e-mail at vmcvicker@cms.hhs.gov.

CMS thanks you in advance for your support of this research. Your organization's experiences are invaluable to improving program operations and we look forward to learning about them as the study proceeds.

Sincerely,

Stuart Gutterman
Office Director of Office of Research, Development, & Information (ORDI)
Centers for Medicare & Medicaid Services

Jean Lemasurier
Group Director
Health Plan Benefits Group
Centers for Medicare & Medicaid Services

Appendix D: Interviewees and Corresponding Organizations

Organization Name	Key Representatives Interviewed
Participating Plans	
Florida- CarePlus Health Plans, Inc., CareFree Plan	Chief Compliance Officer, Director of Member Services, Director of Enrollment, Sales Manager Staff
Florida- Vista Health Plan, Inc., Medicare VALUE Advantage	Chief Compliance Officer, Vice President of M+C Marketing, Vice President of Product Development, Evidence of Coverage Development Associate
Florida- Well Care Choice, Advantage Plan	Vice President of Marketing, Vice President of Corporate Development, Manager of Regulatory Affairs and Compliance, Business Analysis Associate
New York- Health Net, Smart*Choice*	Director of Sales and Marketing, Sales Manager, and Sales Representative
New York- United Health Care of New York, Inc., Give Back Plan	Manager of Medicare United Health Care-Ovations, Vice President of Sales and Marketing for United Health Care, Inc. (national office), Vice President of Marketing United Health Care of New York, Inc.
Non-Participating Plans	
Florida- Neighborhood Health Partnership, Inc.	Vice President of Government Programs and Customer Relations
United Health Care of Florida, Inc.	Director of Underwriting, United Health Care, Inc.
New York- Aetna, Inc.	Chief Compliance Officer; Director of Government Programs, Program Manager
New York- Empire HealthCare HMO, Inc.	Vice President of M+C plans
Advocacy and Government Organizations	
Health Insurance Information & Counseling Assistance Program (HIICAP)	Program Director contacted. Project team referred to Founder and Director of Medicare Rights Center
Serving Health Information Needs For Elderly (SHINE)	State Research Specialist, Government Analyst, Information Specialist for SHINE
Medicare Care Rights Center (MRC)	Founder and Director
Florida & New York State Medicaid Offices	Executive Director(s); Medical Health Care Program Analyst

Appendix E: Florida Medicare BIPA 606 Focus Groups

Group	#1	#2	#3	#4
Location	Broward County Florida	Broward County Florida	Dade County Florida	Dade County Florida
Medicare Part B Status	CareFree Plan Member	Care Free Plan Member	Not enrolled in CareFree Plan (i.e., FFS or other MCO insurance enrollees)	CareFree Plan Member
Insurance Type	CarePlus	CarePlus	Random Mix of Insurance Types	CarePlus
Risk Adjustment	High Risk	Neutral	Neutral	Neutral
Race/Ethnicity	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix
Spanish-bilingual	Representative Mix	Representative Mix	Representative Mix	Representative Mix
Gender	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix
Months enrolled in current health plan	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix
Beneficiary Type	Medicare only	Medicare/ Medicaid Dual Eligibles	Medicare only	Medicare Only

Research Facilities:

Florida in Focus (Broward County)
Galleria Professional Building
915 Middle River Drive, No. 109
Fort Lauderdale, FL 33304
Telephone: 954 566 5729
Facsimile: 954 566 6819
www.floridainfocus.com
Contact: Doris Wagman

Ask Miami (Dade County)
2121 Ponce DeLeon Boulevard
Coral Gables, FL 33134
Telephone: 305 448 7769
Facsimile: 305 448 6825
www.askmiami.com
Contact: Adrian Ladner

Notes	
Months enrolled in current health plan	Indicates that participants in this focus group will have a diverse distribution of experience with CarePlus CareFree with respect to length of time enrolled in the plan
Random Mix	Inclusion of demographically appropriate participants without numerical target
Risk adjustment	Determined by Risk Adjuster A score
Neutral	Participant recruitment is neutral to this characteristic
Equivalent Mix	Equal distributions of participants with respect to gender, income, and other insurance demographic information
Representative Mix	Recruitment of participants is with respect to local racial/ethnic demographic representation
Medicare/ Medicaid Dual Eligibles	Indicates that participants in this focus group will be eligible for both Medicare and Medicaid

Appendix F: New York City Medicare BIPA 606 Focus Groups

Group	#5	#6	#7	#8	#9	#10
Location	New York City	New York City	New York City	New York City	New York City	New York City
Medicare Part B Status	Rollover/ Passive Smart*Choice* Plan Members	New/Active (Nonrollover) Smart*Choice* Plan Members	Smart*Choice* Plan Members	Smart*Choice* Plan Members	Disenrolled from Smart*Choice*	Not-enrolled in Smart*Choice* Plan (FFS, other MCO enrollees)
Insurance Type	Health Net	Health Net	Health Net	Health Net	Health Net	Random Mix
Risk Adjustment	Neutral	Neutral	Neutral	High Risk	Neutral	Neutral
Race/Ethnicity	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix
Spanish-bilingual	Representative Mix	Representative Mix	Representative Mix	Representative Mix	Representative Mix	Representative Mix
Gender	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix
Months enrolled in current health plan	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix	Equivalent Mix
Beneficiary Type	Medicare only	Medicare Only	Medicare/ Medicaid Dual Eligibles	Medicare Only	Medicare Only	Medicare Only

Research Facilities:

The Focus Room *(Groups 5 and 10)*
693 5th Avenue, 13th Floor
New York, NY 10022
Telephone: 212 935 6820
Facsimile: 212 935 6825
www.focusroom.com
Contact: Jodi Lechner

Recruiting Resources Unlimited
(Groups 6,7,8,and individual interviews)
350 Court Street
Brooklyn, NY 11231
Telephone: 718 222 5600
Facsimile: 718 222 5689
www.recruitingresourcesllc.com

Notes

Months enrolled in current plan	Indicates that participants in this focus group will have a diverse distribution of experience with Health Net Smart*Choice* membership with respect to length of time enrolled in the plan.
Random Mix	Inclusion of demographically appropriate participants without a specific numerical target.
Risk Adjustment	Determined by "Risk Adjuster A" score from database.
Neutral	Participant recruitment is neutral to this characteristic.
Equivalent Mix	Equal distributions of participants with respect to gender, income, and other insurance demographic information.
Representative Mix	Recruitment of participants is with respect to local racial/ethnic demographic representation.
Medicare/Medicaid Dual Eligibles	Indicates that participants in this focus group will be eligible for both Medicare and Medicaid.

Appendix G: Selected New York and Florida Participant Demographics

Location	Female	Male	Married	Single°	Non-Caucasian	Caucasian	Income				Bilingual (Spanish)	Total
							Income < $2000/month		Income ≥ $2000/month			
							Single	Married	Single	Married		
Bronx, Queens, Richmond Counties, New York	18	16	19	15	8	26	15	3	1	15	N/A	34
Broward County, Florida	7	8	10	5	2	13	5	2	0	8	2	15
Dade County, Florida	6	11	9	8	10	7	6	2	1	8	N/A	17
Total	31	35	38	28	20	46	26	7	2	31	2	66
Broward and Dade Counties, FL												
Group 1: High Risk Enrollees	2	6	7	1	2	6	1	2	0	5	2	8
Group 2: Low Income Enrollees	5	2	3	4	0	7	4	0	0	3	N/A	7
Group 3: Non-Sub-Zero Enrollees	2	5	3	4	4	3	2	1	0	4	N/A	7
Group 4: Sub-Zero Enrollees	4	6	6	4	6	4	4	1	1	4	N/A	10
Total	13	19	19	13	12	20	11	4	1	16	2	32
Bronx, Queens, Richmond Counties, NY												
Group 5: Passive Enrollees	2	0	0	2	1	1	2	0	0	0	0	2
Group 6: Active Enrollees	4	3	6	1	1	6	1	2	0	4	N/A	7
Group 7: Dual Eligible Enrollees	3	2	1	4	5	0	4	0	0	1	N/A	5
Group 8: Sub-Zero High Risk Enrollees	5	3	4	4	0	8	4	1	0	3	N/A	8
Group 9: Sub-Zero Disenrollees	2	3	5	0	1	4	0	0	0	5	N/A	5
Group 10: Non-Sub-Zero Enrollees	2	5	3	4	0	7	4	0	1	2	0	7
Total	18	16	19	15	8	26	15	3	1	15	N/A	34

° "Single" includes persons who are widowed or divorced.