M+C ALTERNATIVE PAYMENT DEMONSTRATION EVALUATION: FINAL REPORT

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1.1 Introduction

With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, since the enactment of BBA, the number of plans and percentage of beneficiaries enrolled have steadily declined until the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the M+C payment systems could address the declining number of M+C plans, specifically in areas where only one Medicare+Choice organization (M+CO) was serving the area. In particular various risk sharing arrangements and potential higher base payments could be used to encourage M+COs to remain in the M+C program.

The Centers for Medicare & Medicaid Service (CMS) implemented the M+C Alternative Payment demonstration, specifically in areas where only one M+CO was serving the area. Seven demonstration sites (10 separate contracts or M+COs) were approved; six of the sites started in January 2002 and a seventh site (Wisconsin) in June 2002. The demonstration was initially scheduled to last 2 years (2002 and 2003) but was extended an additional year for 2004. The demonstration sites included:

- a Preferred Provider Organization (PPO) serving the Philadelphia area (Independence Blue Cross),
- an agreement with Wheeling Pittsburgh Steel Company (WPSC), United Steelworkers Union and three M+COs to provide M+C programs to WPSC retirees only in Ohio and West Virginia,
- a Private Fee for Service (PFFS) plan (Humana) serving DuPage county, Illinois, and
- four HMOs (five M+COs) serving counties in Colorado, Kentucky, Michigan, Ohio and Wisconsin (Anthem, PacifiCare of Colorado, United HealthCare of Wisconsin and M-Care).

Under the demonstration, CMS negotiated with the sites the following alternative payment approaches (see Table 2.1 for the details):

- Four sites were paid the higher of the standard M+C rate or a specified percentage of the average fee-for-service payment in each of the counties, which resulted in higher payments to three sites for 2002.
- Six sites entered into a variety of risk sharing arrangements with specified corridors around targeted medical expenses.
- One site entered into a reinsurance arrangement.

CMS contracted with BearingPoint to conduct a limited evaluation of the M+C alternative payment demonstration. The quantitative part of the study evaluated plan benefits and cost sharing, the demographic profiles and health experiences of demonstration plan enrollees, persons enrolled in similar non-demonstration M+C plans, and beneficiaries enrolled in original Medicare fee-for-service (FFS) located in the same market area. The qualitative part of the study conducted interviews of key informants in M+COs involved in the demonstration sites.

1.2 Data and Methods

The following CMS databases were used in the analysis.

- Group Health Plan Master (GHPM) File;
- Plan Benefit Package (PBP) File;
- Denominator 5 Percent Sample File;
- Principal Inpatient Diagnosis Categories (PIP-DCG) and Hierarchical Condition Category (HCC) Data Files ; and
- MMC-CAHPS Survey Data

Comparison M+C plans were selected that were as similar as possible to demonstration plans across numerous characteristics. Several types of quantitative analyses were conducted. First, pre-demonstration, cross-sectional comparisons were made between Medicare beneficiaries enrolled in plans participating in the demonstration and those enrolled in non-participating comparison plans. This was useful for determining if participating plans differed markedly from non-participating plans in terms of plan features, enrollee characteristics, health experiences, and market characteristics. Comparisons of characteristics of demonstration plan enrollees with those of comparable Medicare fee-for-service enrollees were also made. Similar cross-sectional analyses were performed for Year 1 and Year 2.

In addition to cross-sectional analyses for the Base Year, Year 1 and Year 2, time-series and difference-in-difference analyses were performed. Difference-in-difference analyses compared the year-to-year changes for demonstration participants with the year-to-year changes for comparison plans.

1.3 Findings

1.3.1 Demonstration Enrollment

Most of the enrollees in these pre-demonstration plans continued to be enrolled in the new alternative payment demonstration plans in Year 1. Because the majority of these plans retained their benefit structure, the beneficiaries were automatically “rolled over” to the demonstration plans. There were two exceptions. The two DuPage County, Illinois plans in demonstration site #2 merged and switched to a private fee-for-service (PFFS) plan with the start of the demonstration in 2002 and enrollment dropped by about 75%. In demonstration site #6, the

demonstration plans were created as new employer-only plans for Medicare retirees of the Wheeling-Pittsburgh Steel Corporation (WPSC). In the Base Year, approximately 1,574 of 4,735 of the WPSC Medicare retirees were enrolled in the pre-demonstration plans. The remaining WPSC retires were in Medicare fee-for-service prior to the demonstration.

Enrollment in the demonstration and comparison plans declined in the first year of the demonstration. The decrease in enrollment for demonstration plans from the Base Year to Year 1 was less than that for comparison plans, both in terms of absolute numbers and percentages. In the second year of the demonstration enrollment in M+C plans declined further, but after adjusting for the withdrawal of M-Care from the demonstration in Year 2, the demonstration enrollment increased a small amount in Year 2.

1.3.2 Health Status

Risk scores reflect the relative health status of beneficiaries. The risk score for a particular beneficiary was developed for the Base Year and Year 1 from that individual's demographics and inpatient hospital diagnoses (PIP-DCG risk model) in the previous year while for Year 2, it was developed from the individual's demographics, and the diagnoses from hospital inpatient and outpatient and physician services (HCC risk model) in the previous year. The average risk score of demonstration participants was lower than those of their comparison plan counterparts in the Base Year and Year 1, signaling that demonstration participants were healthier than their counterparts in comparison plans. However, at the site level, for two of the demonstration sites the average risk score of demonstration enrollees was higher than the comparison plan enrollees. In year 2, using the HCC risk model, the average risk score of demonstration participants was higher than the comparison plan counterparts, and for three of the demonstration plans the average risk scores were higher than the sample of FFS beneficiaries located in the same market areas.

1.3.3 Demonstration Plan Benefits

An area of continuing policy interest is the availability of prescription drug coverage in Medicare. M+C organizations typically do offer some level of coverage. Demonstration plan benefits and costs were very different across plans for a given year and across years for a given plan. This made it impractical to calculate benefit coverage and cost statistics by which plans might be quantitatively compared on an equalized basis for a given year and through time. The approach taken was to analyze the data and provide observations at the individual demonstration plan-year level and then to draw overall conclusions that capture the common elements found at the plan-year level.

In Year 1, demonstration plans tended to retain generic drug coverage, albeit with higher basic premiums or under an optional supplemental package with its own additional premium. There was a tendency to drop coverage of brand name and/or non-formulary drugs or to require a higher premium or copay to retain brand name/non-formulary coverage. Copays for PCP visits changed little if at all in Year 1 compared with the Base Year. There was a slightly greater

tendency for specialist visit copays to rise in Year 1. Demonstration M+COs that offered multiple plan choices in the Base Year reduced the plan choices to one in Year 1, in some cases with optional supplemental packages being made available. Drug benefits in Year 2 were generally the same as in Year 1, with slightly higher copays, on average. Premiums tended to rise from the Base Year to Year 1 and again from Year 1 to Year 2.

Vision exams were covered by all plans. Hearing exams were covered in nearly all cases. Dental exams were covered by only one plan under the higher of two premium options. These patterns of coverage for vision, hearing, and dental exams persisted in the following two years of the demonstration.

1.3.4 Demonstration Plan Interviews

The following are the results obtained from interviews of key personnel at each organization regarding MCO's reasons for participating in the demonstration, expectations, and experiences during the first year of the demonstration:

- The MCOs' participation in the demonstration allowed them to continue to provide M+C services to beneficiaries by sharing with CMS the burden of risk.

- The MCOs' ability to continue offering their plans meant they could take advantage of opportunities in the insurance market that would have otherwise been lost. The opportunities included provisions for an affordable, high-quality product, zero premiums, and premiums for additional benefits. In most if not all instances, they were the last M+C plan available in the area.

- The transparency of the demonstration plans compared with their non-demonstration counterparts allowed beneficiaries to continue to receive benefits without the realization the plan had transitioned into the demonstration.

- Participation in the demonstration meant that MCOs were able to extend their coverage to include more providers, and improvements in benefits allowed them to remain competitive in the insurance market. Most organizations agreed that the demonstration was expected to have more of a positive than a negative impact on beneficiary satisfaction; however, this expectation was not supported by the MMC-CAHPS data on enrollees' satisfaction with plans and providers.

- Organizations expressed satisfaction with their ability to mitigate risk and to allow HMO/PPO plans to continue providing services to existing beneficiaries and new enrollees. However, one MCO dropped out of the demonstration because the plan continued to lose money in 2002.

- To date, overall satisfaction by MCOs in the demonstration was high, and organizations voiced interest in the demonstration being extended for a longer term. Most MCOs could

not provide specifics on profits/gains, citing as a reason that the year run-out had just been completed and numbers were not tallied at the time of the interview. MCOs remained optimistic that the demonstration would provide the necessary means to stabilize many of the problematic plans. All MCOs hoped that CMS would consider extending the demonstration for a longer period of time if not making the risk-sharing arrangement permanent.

1.4 Conclusions

The M+C Alternative Payment Demonstration was successful in encouraging the participating M+COs to continue to serve Medicare beneficiaries. Most of the demonstration plans were on the verge of being dropped before the opportunity to participate in the demonstration. Only one of the seven demonstration sites (M-Care) terminated its participation during the original 2 years of the demonstration. Anthem and United Healthcare of Wisconsin decided not to accept the offer to participate in the demonstration for an additional year in 2004 but have continued to offer M+C plans in the demonstration counties. Humana, Pacificare, Independence and the Wheeling-Pittsburg sites were extended to December 31, 2004. At the present time, Humana, Pacificare and Independence sites are participating in the Medicare Advantage program and the Wheeling-Pittsburg site is participating in an employer-only demonstration. The demonstration also allowed Humana to test operating a PFFS plan with CMS sharing the risk. As a result, in January 2003, Humana started offering Medicare PFFS plans in five states and today, is operating in five additional states.

The risk sharing results were mixed for the first year of the demonstration. Two sites experienced savings and paid half of the savings to CMS while two sites experienced losses and received funds from CMS. At the time of this report was written, a reconciliation analysis for the other three sites have not been finalized for the first year of the demonstration.

2. Introduction

2.1 Background

With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled have steadily declined until the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the current M+C payment systems could address the declining number of M+C plans, specifically in areas where only one M+CO was serving the area. In particular various risk sharing arrangements and potential higher base payments could be used to encourage M+COs to remain in the M+C program.

Six new demonstration sites were effective on January 1, 2002. This included one PPO (Independence Blue Cross in the Philadelphia, PA area), one PFFS (Humana in DuPage County, IL), and one employer-only site sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh demonstration site sponsored by United Healthcare of Wisconsin was added (see Table 2.1). The risk sharing arrangements were based on variants of either a risk corridor model or a reinsurance model. In addition, many of the demonstration plans were paid the higher of the standard M+C rate or a specified percentage of the average fee-for-service payment in each of the counties. The transition was transparent to most of the affected beneficiaries, who continued to face the same benefits and cost sharing.

CMS contracted with BearingPoint to conduct an evaluation of the alternative payment demonstration. This report has several objectives:

- To select similar "comparison" plans not involved in the demonstration in the year prior to the start of the demonstration (Base Year).
- To compare demonstration plans with the same comparison plans in Year 1 and Year 2 of the demonstration.
- To compare the year-to-year changes for demonstration plans with those for comparison plans.
- To present the results from the Qualitative Data Collection effort obtained from interviews of key informants in M+COs involved in the demonstration sites.

The quantitative part of the study evaluated plan benefits and cost sharing, the demographic profiles and health experiences of demonstration plan enrollees, persons enrolled in similar non-demonstration M+C plans, and beneficiaries enrolled in original Medicare fee-for-service (FFS) located in the same market area. Differences were calculated and tested for statistical significance.

2.2 Legislative Authority

The Centers for Medicare & Medicaid Services (CMS) was permitted to conduct the demonstration pursuant to Section 402 of the Social Security Amendment of 1967, which authorizes demonstrations and allows CMS to waive requirements in Title XVIII that relate to reimbursement or payment.

2.3 Selection Process

CMS met with associations and various organizations regarding its interest in testing alternative payment methodologies and receiving innovative demonstration proposals from M+COs. Interested M+COs initially submitted brief concept papers and, after further discussion with the M+COs, CMS solicited more specific proposals. A panel of senior technical experts and management staff from the CMS Center for Beneficiary Choices and Office of Research, Development, and Information reviewed the proposals. The panels considered the following factors: budget neutrality, the impact on beneficiaries, innovations in payment methodology, feasibility of implementing the proposal by January 1, 2002, and contribution to the demonstration goal of preserving and expanding participation and enrollment in the M+C program. Based on the review and comments of the individual panelists, CMS recommended awarding six demonstration sites, later expanded to a seventh demonstration site.

The selected plans include a variety of delivery models including closed panel health maintenance organizations (HMOs), a preferred provider organization (PPOs), and a private fee for service model plan (PFFS). In addition to a variety of risk sharing arrangements, one proposal involves the implementation of a reinsurance pool.

2.4 Evaluation

This report compares demonstration plans with similar plans not involved in the demonstration. It also compares the demographic profiles and health experiences of demonstration plan enrollees, persons enrolled in similar non-demonstration M+C plans, and beneficiaries enrolled in original Medicare fee-for-service located in the same market area.

Table 2.1. Overview of M+C Alternative Payment Demonstration

Dem site #	Company and Plan Name	States and Counties	Type of Risk Sharing	Brief Description	Risk Sharing
1	Anthem—Anthem Senior Advantage	Ohio: Trumbull (sole) Ohio: Preble (non sole) Kentucky: Boone (non sole)	Reinsurance	Plan paid base M+C rate for county. CMS will set aside in a reinsurance pool, for each demo enrollee, the difference between the standardized FFS rate and the base M+C rate in the county.	For enrollees in Trumbull County for whom annual expenses exceed $75,000 during the year, M+CO will be paid from the pool 80% of the excess. If pool runs out of funds, M+CO absorbs the loss. If funds are left over, they are to be used to fund losses in other counties.
2	Employers Health Insurance Company—Humana Gold (A PFFS plan)	Illinois: DuPage	Targeted medical expense	Plan paid base county M+C rate. The targeted medical expense is the difference between plan revenue (CMS payments + beneficiary premiums) minus administrative fee.	If actual medical claims costs are within +/– 2% of targeted medical expense, M+CO is at full risk. If costs are more than 2% different than target, CMS and plan share equally in the gains or losses. No limit on amount of gains/losses that will be considered for risk sharing.
3	Independence BC—Personal Choice 65 PPO	Pennsylvania: Bucks, Chester, Delaware, Montgomery, Philadelphia	Targeted medical expense	In counties where plan is not the sole PPO, plan will be paid the base M+C rate. In counties where plan is sole PPO, will be paid greater of base M+C rate and	If actual costs are within +/– 2% of targeted medical expense, plan and CMS share gain/loss equally. If costs are more than 2% different than

Dem site #	Company and Plan Name	States and Counties	Type of Risk Sharing	Brief Description	Risk Sharing
				98.5% of standardized FFS. Targeted medical expense is difference between revenue to plan (CMS payments + bene premiums) minus administrative fee minus cost of non-Medicare covered prescription drugs.	target, gains/losses are shared 80% CMS/20% plan.
4	PacifiCare—Secure Horizons	Colorado: Pueblo	Targeted medical expense	Participation is subject to plan being sole remaining M+C plan in county. Base payment is 95% of standardized FFS. Targeted medical expense is 90% of plan revenue (CMS payments + bene premiums), assuming administrative expenses are 10%.	M+CO at full risk for gains and losses within +/– 2% of targeted medical expense. If costs are more than 2% different than target, CMS and plan share equally in the gains or losses. No limit on amount of gains/losses that will be considered for risk sharing.
5	M-CARE	Michigan: Livingston, Washtenaw	Targeted medical expense	Participation is subject to plan being sole remaining M+C plan in county. Plan paid greater of standard M+C rate or 95% of standardized FFS payment. Targeted medical expense is the difference between —plan revenue (CMS payments + bene premiums) minus administrative fee.	If actual expenses are greater or less than targeted expense, plan and CMS share equally in the gains/losses. No limit on amount of gains/losses that will be considered for risk sharing.

Dem site #	Company and Plan Name	States and Counties	Type of Risk Sharing	Brief Description	Risk Sharing
6	Carelink Health Plans and Health Plan of the Upper Ohio Valley Note: All enrollees are retirees of Wheeling-Pittsburgh Steel Corporation ("Corporation")	West Virginia: Brooke, Hancock, Marshall, Ohio Ohio: Belmont, Guernsey, Harrison, Jefferson	Targeted medical expense	CMS pays plan greater of either 95% of standardized FFS amount or standard M+C rate for all plan enrollees. Corporation pays $59 per member per month premium to plan for each Medicare-eligible retiree and Medicare-eligible dependent covered under Corporation's retiree benefit plan. Corporation also pays $28 pmpm to plan for administrative expenses. Targeted medical expense is total revenue to the plan from CMS and Corporation minus $28 pmpm administrative fee.	If actual medical claim costs differ from targeted amount, CMS, plan, and Corporation share the difference as follows: 0-2.5%: Plan—up to 10% of adm. fee; Corporation (50%) and CMS (50%) of remainder 2.51-7.5%: Corporation (25%) and CMS (75%) 7.51-25%: Corporation (10%) and CMS (90%) > 25%: CMS (100%)
7	United Healthcare of Wisconsin	Milwaukee, Ozaukee, Washington, Waukesha	Targeted medical expense	Payment is at the usual M+C payment amount. A medical expense target for total medical expenses will be set at 90% of total plan revenue (CMS revenue not including funds withdrawn from Benefit Stabilization Fund, plus member premium)	If actual costs are within +/– 2% of targeted medical expense, plan and CMS share gain/loss equally. If costs are more than 2% different than target, gains/losses are shared 75% CMS/25% plan.

The period of analysis encompasses the Base Year (CY2001), Year 1 (CY2002), and Year 2 (CY2003) except for demonstration site #7 that began 5 months later---Base Year (June 1, 2001 through May 31, 2002). Statistical results are presented and discussed for each year separately, year-to-year changes for demonstration plans and comparison plans, as well as differences in the year-to-year changes for demonstration plans and comparison plans.

2.5 M+C Plans Involved in the Demonstration

Table 2.2 presents selected characteristics of demonstration plans in the Base Year.[1,2]

Table 2.2. Demonstration Plans: Selected Characteristics, Base Year

DEMO site #	COUNTY	ST	H # 2001	ID # 2001	PREM $	COPAY $	BENES	PEN %	TYPE	TAX
1	Boone	KY	1849	1	0	5	1151	12.4	HMO	PRO
				2	29	5				
	Preble	OH	3655	7	0	5	424	6.6	HMO	NON
				8	29	5				
	Trumbull	OH	3655	1	0	5	7541	19.0	HMO	NON
				2	29	5				
2	DuPage	IL	1406	14	69	10	7759	7.8	HMO	NON
				15	19	15				
3	Bucks	PA	3963	1	114	10	2276	2.7	PPO	NON
	Chester			1	114	10	1286	2.4		
	Delaware			1	114	10	2983	3.2		
	Montgomery			1	114	10	5078	3.9		
	Philadelphia			1	114	10	5516	2.3		
4	Pueblo	CO	0609	1	99	15	5837	22.3	HMO	PRO
5	Livingston	MI	2353	1	0	10	907	6.7	HMO	NON
				4	47	7				
	Washtenaw	MI	2353	1	0	10	3213	10.0	HMO	NON
				4	47	7				
6	Belmont	OH	3673	4	38	10	690	4.8	HMO	PRO
	Jefferson			4	38	10	1264	7.7		
	Brooke	WV	5149	1	38	10	600	13.5	HMO	PRO
	Hancock			1	38	10	1560	20.0		
	Ohio			1	38	10	366	3.5		
	Belmont	OH	5151	1	39	10	2255	15.7	HMO	NON
	Guernsey			1	39	10	32	0.4		
	Jefferson			1	39	10	361	2.2		
	Belmont			2	49	5	2255	15.7		

[1] The "Benes" and "Pen" rows are the same for the same County/H# combination. As reporting is not done at the "ID #" level, the 1151, for example, reported for Demo #1 in Boone County represents the total number of demonstration enrollees for both ID #1 and ID #2.

[2] For demonstration #7 (United Healthcare of Wisconsin) that began five months later and is out of phase with the others, the Base Year is June 1, 2001 through May 31, 2002.

Table 2.2. Demonstration Plans: Selected Characteristics, Base Year

DEMO site #	COUNTY	ST	H # 2001	ID # 2001	PREM $	COPAY $	BENES	PEN %	TYPE	TAX
	Guernsey			2	49	5	32	0.4		
	Harrison	OH	5151	2	49	5	164	4.9	HMO	NON
	Jefferson			2	49	5	361	2.2		
	Marshall	WV	5151	1	39	10	864	14.3	HMO	NON
	Ohio			1	39	10	1809	17.0		
	Brooke			1	39	10	166	3.7		
	Hancock			1	39	10	41	0.5		
	Marshall			2	49	5	864	14.3		
	Ohio			2	49	5	1809	17.0		
	Brooke			2	49	5	166	3.7		
	Hancock			2	49	5	41	0.5		
7	Milwaukee	WI	5253	4	55	20	8094	5.7	HMO	PRO
	Ozaukee			4	55	20	1058	8.9		
	Washington			4	55	20	1758	11.4		
	Waukesha			4	55	20	4797	9.5		

Source: BearingPoint analysis of PBP Data for 2001 and 2002.
Notes: The two plans in demonstration #2 merged and converted to private fee-for-service in 2002. PREM is monthly plan premium; COPAY is beneficiary copayment for a visit to a primary care provider; BENES is number of demonstration enrollees in a particular H # and county; PEN is the market penetration percentage of a particular H # and county; HMO is health maintenance organization; PFFS is private fee-for-service; PPO is preferred provider organization; NON is non-profit; PRO is for-profit.

The demonstration sites are numbered 1 through 7 where the order has no significance. The typical situation of multiple plans within a given demonstration site means that the M+CO and CMS agreed that plans in several counties—or variations in plan characteristics within a given county—or would be included in a given demonstration site.

The plans in Table 2.2 are those that preceded the commencement of the demonstrations. All of the pre-demonstration sites were health maintenance organizations (HMOs) except for demonstration #3 that was a PPO.

Most of the enrollees in these pre-demonstration plans continued to be enrolled in the new alternative payment demonstration plans in Year 1. The majority of these plans retained their structure as M+C plans and retained nearly all of their pre-demonstration enrollees. There were two exceptions. The two DuPage County, Illinois plans in demonstration site #2 merged and switched to private fee-for-service (PFFS) with the start of the demonstration in 2002 and enrollment dropped by about 75%. In demonstration site #6, the demonstration plans were

created as new employer-only plans for Medicare retirees of the Wheeling-Pittsburgh Steel Corporation (WPSC). In the Base Year, approximately 1,574 of 4,735 of the WPSC Medicare retirees were enrolled in the pre-demonstration plans. The remaining WPSC retirees were in fee-for-service prior to the demonstration.

3. Data and Methods

Several databases were employed in the evaluation of the demonstrations. When files were linked for analysis, such variables as the plan H number, plan identification (ID) number, or beneficiary health insurance claim (HIC) number were used to merge the different files.

3.1 Data Sources

3.1.1 Group Health Plan Master File

The GHPM contains information on beneficiaries enrolled in M+C organizations, including their HIC number (patient identifier), dates of enrollment and disenrollment, reason for Medicare entitlement, Medicaid indicator, current residence, and demographic characteristics. The unit of observation is the Medicare beneficiary.

3.1.2 Plan Benefit Package File

The PBP file contains detailed information on plan benefits, such as premiums, copayments for visits to doctors, whether the plan covers certain services that Medicare does not (e.g., prescription drugs, preventive care, dental care, eye care, and hearing aids), number of enrollees, Medicare's monthly payment, type of plan, tax status of plan, and years of experience with Medicare. In addition, such information as the plan's state and county, H number, and plan type are included. The PBP file encompasses a calendar year. The unit of observation is every unique set of benefits and cost-sharing amounts for a given plan H number (identifies a particular Medicare-health plan contract), ID number (identifies a particular set of benefits and beneficiary cost-sharing associated with a given H number), and county.

3.1.3 Denominator 5 Percent Sample File

The Denominator file is a beneficiary level file with HIC number as the key value. It includes original and current reasons for Medicare entitlement, Part A and Part B enrollment dates, ESRD indicators, current residence, demographic data, managed care indicators, and Medicaid indicator. Only beneficiaries participating in the original FFS Medicare program were extracted from this file. They are used for comparison with the M+C enrollees in the demonstration plans to evaluate the differences between the two Medicare programs for individuals who are otherwise similar.

3.1.4 PIP-DCG and HCC Data Files

A portion of capitation payments to Medicare health plans are risk adjusted for beneficiary health status using the PIP-DCG model for the base year and year 1 and the HCC model for year 2. These risk scores provide a measure of the health status, or expected costliness, of each Medicare enrollee. Additionally, included in these data files are the risk scores for fee-for-service beneficiaries.

3.1.5 MMC-CAHPS Data

Since 1997, the CAHPS (Consumer Assessment of Health Plans Study®) surveys have been administered to a sample of persons enrolled in Medicare managed care (MMC) under the Medicare+Choice (M+C) program. The MMC-CAHPS surveys solicit information on the enrollee's ratings of their plans and providers, their health status, health conditions, and utilization of health services, and demographic information. The survey design includes persons from every plan participating in M+C in a given year.[3] The unit of observation is the M+C enrollee. The unique contribution of the MMC-CAHPS data to this study is the ratings of plans and providers. The data on demograhpics and health experiences supplement those from other sources.

The MMC-CAHPS data used in this study are:

- Age (five categories)
- Gender
- Educational attainment (five categories)
- Hispanic ethnicity (two categories)
- Race (white, black, Asian, Native Hawaiian/other Pacific Islander, and American Indian/Alaska Native)
- Current health status (very good/excellent, good, and fair/poor)
- Health conditions (two categories)
- Health utilization (doctor's office visit, inpatient hospitaliztion and six other categories)
- Rating of health plan (0-10 scale)
- Rating of providers (0-10 scale)

3.2 Analysis File Construction

3.2.1 Enrollee Characteristics and Inpatient Utilization

Analysis file construction required summarizing information from the various data sources up to two levels—the plan level and the beneficiary level. For certain attributes, such as enrollee demographic characteristics, these were relatively straightforward aggregations. For other information, more extensive data processing was required. For example, to determine risk scores for beneficiaries enrolled in a demonstration plan, we first identified beneficiaries enrolled in the specific plans from the GHPM file, creating a "finder file." We provided this finder file to Fu Associates who generated a cross-reference file to identify beneficiaries changing HIC values between the first two years of data (our Base Year is CY 2001 which requires data from two

[3] Up to 600 participants from a plan were selected for the MMC-CAHPS survey sample; in plans that had fewer than 600 enrollees, all enrollees were selected for the sample. The plan—or contract—may encompass multiple counties. Therefore, the number of MMC-CAHPS survey respondents will be less than 600 in multiple-county plans. In some of the plans involved in this study, the number of MMC-CAHPS survey respondents is substantially under 600—fewer than 20 in a few cases.

"payment years" of encounter data, one for the period 7/1/2000-6/30/2001 and one for the period 7/1/2001-6/30/2002). A similar procedure was used for Year 2. Fu Associates then extracted all inpatient encounter records for the HIC values (including original and cross-referenced values of HIC) from our finder file. Encounter records that fell outside the Base Year (based on admission and discharge dates) or outside the time period during which the beneficiary was enrolled in the target plan were filtered out of the merged file.

Next, all remaining valid encounter data were rolled up to the beneficiary level, and merged with the demographic data extracted from the GHPM file. The same procedure was used with MMC-CAHPS files that contained patient satisfaction and health information. Identifying the counties relevant for comparison and then selecting a sample of FFS beneficiaries from the Denominator file preceded construction of the FFS cohort. HIC numbers were used to match with data from the Inpatient Encounter file.

The plan-level file was keyed by the five-character plan H number (e.g., "H1234"). Cohorts in the fee-for-service sample were assigned a dummy plan ID number (e.g., "FFS"). The beneficiary-level file was keyed by HIC number. The two levels of files, then, had both plan ID numbers in common. For example, the GHPM file contained up to six M+C plan IDs per person with the corresponding enrollment period, which provided the ability to map plan-level data to a beneficiary.

Data from the beneficiary-level files (e.g., MMC-CAHPS, GHPM, Denominator file, Inpatient Encounter Data) were matched by HIC number for a given year's data. We used the GHPM file to build a finder file to identify beneficiaries in specific M+C plans and used that file to extract records from the Inpatient Encounter Data, as mentioned above. As the Inpatient Encounter Data file also includes the plan H number, we checked for data anomalies. As a small percentage of HICs change across time because of death, marriage, etc., when tracking beneficiaries longitudinally, a cross-reference of HICs was performed.

3.2.2 MMC-CAHPS

All of the MMC-CAHPS survey respondents for a given demonstration plan or comparison plan in the county of interest were used. The demonstration number and the demonstration status (i.e., demo plan = 1; comparison plan = 2) were added. This constituted the analysis file for the MMC-CAHPS data. Because the MMC-CAHPS surveys are random samples, the respondents associated with a particular plans were generally different from year to year.

3.3 Methodological Approach

3.3.1 Cross-sectional Comparisons

Quantitative analyses were conducted using the analysis files discussed above. Pre-demonstration, cross-sectional comparisons were made between plans participating in the demonstration and non-participating plans that were selected for comparison. A similar process was used for making Year 1 and Year 2 comparisons. This was useful for determining if

participating plans differed markedly from non-participating plans in terms of plan features, enrollee characteristics, health experiences, and market characteristics.

These analyses consisted primarily of comparisons between demonstration participants and various comparison groups. The PBP file of M+C plans and their characteristics was analyzed with the aim of finding the non-demonstration plan that best matched the characteristics of a given pre-demonstration plan. The types of characteristics considered were:

- Geographic proximity
- Plan type
- Beneficiary cost sharing
- Supplemental benefits
- Plan enrollment
- M+C market penetration level
- Years of experience as a Medicare managed care plan

Table 3.1 presents the comparison plans that were selected and their associated pre-demonstration plans. As a rule, comparison plans and pre-demonstration plan are in close geographic proximity, are of the same plan type, and have roughly comparable enrollments, market shares, benefits, and cost-sharing structures.

Table 3.1. Demonstration Plans and Plans Selected For Comparison, Base Year

Demo #	Demo Status	Plan Name	State	County	H # 2001	ID # 2001
1	Demo	Anthem	KY	Boone	1849	1,2
	Comparison	Anthem	KY	Campbell	1849	1
1	Demo	Anthem	OH	Preble	3655	7,8
	Comparison	Anthem	OH	Shelby	3655	7
1	Demo	Anthem	OH	Trumbull	3655	1,2
	Comparison	Anthem	OH	Mahoning	3655	1
2	Demo	Humana	IL	DuPage	1406	14,15
	Comparison	Sterling	LA	East Baton Rouge	5006	1
3	Demo	Independence BC	PA	Bucks	3963	1
	Comparison	Aetna	PA	Delaware	3931	4
3	Demo	Independence BC	PA	Chester	3963	1
	Comparison	Aetna	PA	Chester	3931	4
3	Demo	Independence BC	PA	Delaware	3963	1
	Comparison	Aetna	PA	Delaware	3931	4
3	Demo	Independence BC	PA	Montgomery	3963	1
	Comparison	Aetna	PA	Delaware	3931	4
3	Demo	Independence BC	PA	Philadelphia	3963	1
	Comparison	Aetna	PA	Philadelphia	3931	19
4	Demo	PacifiCare	CO	Pueblo	0609	1
	Comparison	PacifiCare	CO	El Paso	0609	2
5	Demo	M-CARE	MI	Livingston	2353	1,4
	Comparison	Health Alliance	MI	Oakland	2312	4
5	Demo	M-CARE	MI	Washtenaw	2353	1,4
	Comparison	Health Alliance	MI	Oakland	2312	4
6	Demo	HealthAmerica of PA	OH	Belmont, Jefferson	3673	4
	Comparison	United Healthcare	OH	Clark	3659	2
6	Demo	CareLink	WV	Brooke, Hancock, Ohio	5149	1
	Comparison	United Healthcare	OH	Clark	3659	2
6	Demo	Health Plan of Upper Ohio Valley	OH WV	Belmont, Jefferson Marshall, Ohio	5151	1,2
	Comparison	Health Plan of Upper Ohio Valley	OH	Monroe	5151	2
6	Demo	Health Plan of Upper Ohio Valley	OH WV	Guernsey, Harrison Brooke, Hancock	5151	1,2
	Comparison	Health Plan of Upper Ohio Valley	WV	Wetzel	5151	2
7	Demo	United Healthcare of Wisconsin	WI	Milwaukee	5253	4
	Comparison	Humana Health Plan	IL	Cook	1406	13
7	Demo	United Healthcare of Wisconsin	WI	Ozaukee, Washington,	5253	4
	Comparison	Humana Health Plan	IL	Kendall	1406	15
7	Demo	United Healthcare of Wisconsin	WI	Waukesha	5253	4
	Comparison	Humana Health Plan	IL	Kane	1406	15

Comparisons of characteristics of demonstration plan enrollees with those of comparable Medicare fee-for-service enrollees were also made.[4] The fee-for-service cohort was constructed by first identifying the counties relevant for comparison. The relevant counties comprised the county in which the demonstration and comparison plans operate (although we investigated doing this, due to the complexities of neighboring plans serving neighboring counties, we did not use contiguous counties). These areas were labeled "FFS Market Areas." Next, FFS beneficiaries in those counties were extracted from the Five Percent Standard Analytic Denominator file.

Several types of cross–sectional comparisons were made using the PIP-DCG and HCC data files and MMC-CAHPS Analysis files. Beneficiaries enrolled in demonstration M+C plans were compared with those enrolled in comparison M+C plans. Beneficiaries were compared on the basis of demographic characteristics (e.g., age, gender, educational attainment, race and Hispanic ethnicity), current health status, health conditions, health care utilization, and ratings of plans and providers.

Percentage distributions were calculated for categorical variables, such as age. Means were calculated for continuous variables, such as risk score. Hypothesis tests were performed, comparing results for demonstration participants with those for comparison plan participants and—in the case of demographic data—between demonstration participants and fee-for-service beneficiaries in the relevant market areas. A five-percent level of significance was chosen for hypothesis tests regarding differences.

3.3.2 Time Series Comparisons

Quantitative comparisons were made for Base Year, Year 1, and Year 2 results for demonstration plans and their enrollees, comparison plans and their enrollees, and, as appropriate, Medicare FFS beneficiaries. The variables of interest were the same ones mentioned in the previous section.

The change from the Base Year to Year 1 and from Year 1 to Year 2 were calculated for demonstration plans and their enrollees. The change was tested for statistical significance at the five-percent level. These steps were repeated for comparison plans and, as the case may be, for FFS beneficiaries.

3.3.3 Difference-in-Difference Comparisons

Difference-in-difference (DID) comparisons consist of tracking how baseline cross-sectional differences in demonstration and comparison plans and enrollees change over time. Changes in plan enrollment and costs might not necessarily be due solely to the demonstration, but rather due to general factors impacting all M+C plans.

[4] A complication arose when some non-demonstration plans that existed in 2001 withdrew from M+C in 2002. In selecting comparison plans, it was necessary to restrict choices to non-demonstration plans that existed in both 2001 and 2002. A complete discussion of comparison plan selection is contained in a separate report (Barents 2002).

The calculated Base Year-to-Year 1 change for demonstration plans was compared with that for comparison plans. The difference was tested for statistical significance at the five-percent level. The same was done for differences between Year 1 and Year 2.

Appendixes A, B, C and D contain tables that present detailed demonstration-level descriptive statistics pertinent to this analysis.

3.3.4 Enrollee Pre-Demonstration Status

A "backward-looking" statistical analysis was done to determine the Base Year status of persons who were enrolled in a demonstration plan in Year 1. Such individuals were in one of the following four categories in the year prior to the start of the demonstration:

- The pre-demonstration version of the demonstration plan with the same M+C organization;
- A different plan in the same county;
- Fee-for-service Medicare; or
- Not in Medicare.

The first category requires some further description. The contracts for demonstration plans were, for the most part, identical to the Base Year contracts. The main exception was the alternative payment arrangement between the MCO and CMS for the demonstration contract. All other aspects were the same: eligibility, coverage, benefits, cost sharing and so on. The only exceptions were the Humana M+CO that converted an HMO plan to a PFFS plan and the WPSC site that created new employer-only plans.

The GHPM file was used to identify and tabulate the number of beneficiaries in the four status categories for each demonstration plan. The GHPM includes one record per beneficiary ever enrolled in Medicare Managed Care with each record containing information regarding the six most recent managed care enrollment episodes including plan ID and enrollment dates. In addition, each record on the GHPM file indicates a beneficiary's Medicare enrollment date. Thus, it was possible to identify those not in Medicare during the base year as those with a Medicare enrollment date of 1/1/2002 or later. Persons in FFS Medicare in the base year were identified as those with a Medicare enrollment date earlier than 1/1/2002 and who were not enrolled in a managed care plan during 2001.

4. Quantitative Research Findings

This section summarizes the results that are presented in detail in Appendixes A, B, C and D. Patterns of comparison that comprise all demonstration sites are identified. Individual cases might differ from these general patterns. The relevant populations are persons enrolled in one of the demonstration plans, or its selected comparison plan, or fee-for-service (FFS) beneficiaries in the relevant market area.

4.1 Plan and Enrollee Characteristics and Health Status

This section presents a summary of results on plan benefits and characteristics, selected enrollee demographics, and risk scores. Statistics on averages across all seven demonstration sites are presented for the Base Year, Year 1, and Year 2.

4.1.1 Demonstration Plan Benefits

Demonstration plan benefits and costs were very different across plans for a given year and across years for a given plan. This heterogeneity made it impossible to calculate benefit coverage and cost statistics by which plans might be quantitatively compared on an equalized basis for a given year and through time. The approach taken in this study was to analyze the data and state verbal observations at the demonstration individual plan-year level and then to draw overall conclusions that capture the common elements found at the plan-year level.

Summary information for the individual demonstration plans is presented in Tables A1-A11 in Appendix A. Following are conclusions based on analysis of this information.

Base Year

Most of the demonstration plans offered some type of drug coverage in the Base Year. Vision exams were covered by all plans. Hearing exams were covered in nearly all cases. Dental exams were covered by only one plan under the higher of two premium options. These patterns of coverage for vision, hearing, and dental exams persisted in the following two years of the demonstrations. Some organizations offered two plan choices that differed by monthly premium amount, visit copays, and coverage of certain benefits.

Year 1

In Year 1 of the demonstrations, plans tended to retain generic drug coverage, albeit with higher basic premiums or under an optional supplemental package with its own additional premium. There was a tendency to drop coverage of brand name and/or non-formulary drugs or to require a higher premium or copay to retain brand name/non-formulary coverage.

Copays for PCP visits changed little if at all in Year 1 compared with the Base Year. There was a slightly greater tendency for specialist visit copays to rise in Year 1.

M+COs that offered multiple plan choices in the Base Year reduced the plan choices to one in Year 1, in some instances with optional supplemental packages being made available.

Year 2

Drug benefits in Year 2 were generally the same as in Year 1, with slightly higher copays, on average. Premiums tended to rise from the Base Year to Year 1 and again from Year 1 to Year 2. It is not possible to precisely compare the changes, however, because of many other changes in costs and coverages. Drug coverage is one of the most important features that M+C plans provide that original Medicare fee-for-service does not. One way of comparing benefit packages is by way of the minimum premium required for drug coverage. Table 4.1 does that for generic drugs.

Table 4.1. Generic Drug Benefits and Premiums

Demo	County	Base Year Premium (BY)	Year 1 Premium (Y1)	Year 2 Premium (Y2)	BY-Y1	Y1-Y2
1	Boone, Preble	$0	$29	$40	$29	$11
1	Trumbull	$0	$0	$25	$0	$25
2	DuPage	$65	$89	$89	$24	$0
3	Bucks, et al.	$114	$135	$179	$21	$44
4	Pueblo	$99	$105	$110	$6	$5
5	Livingston, Washtenaw	$0	$55	na	$55	Na
6	Belmont et al.	N	N	N	Na	Na
7	Milwaukee et al.	N	N	N	Na	Na

Source: BearingPoint tabulations of Plan Benefit Package (PBP) and Adjusted Community Rate Proposal (ACPR) data for 2001, 2002 and 2003.

Note: Dollar amount is the minimum monthly premium required to obtain generic drug coverage.

N = No drug benefit

Na = not applicable

In the Base Year, the minimum premium for generic drug coverage ranged from $0 to $114 for the five out of seven demonstrations that offered such coverage. In the first year of the demonstrations, the cost of obtaining generic drug coverage increased $0-55, with a median in the $21-24 range. In the second demonstration year, the minimum premium increased further by $0-44, with a median of $11. It appears that the more dramatic increases took place in the transition from the Base Year to Year 1. However, the experience of a given plan may have departed from this trend. Tabulations not presented here for brand name drugs indicated similar overall trends.

4.1.2 Plan Characteristics

This and the following section summarize the information by demonstration number presented in Appendix Tables B1 to B7, C1 to C7, and D1 to D7.

Table 4.2a below presents summary statistics on plan characteristics for the Base Year and the two demonstration years. It is important to note that the relatively high enrollment in site# 3 compared to the other sites may have a strong influence on the averages. Table 4.2b shows the year-to-year changes in plan and enrollee characteristics and health status. Table 4.2c shows how the year-to-year changes for comparison plans and FFS enrollees compare with those for demonstration plans. It expresses more directly some of the differences shown in previous tables and tests for significance of those differences.

Table 4.2a. Plan and Enrollee Characteristics, Three Years

Variable	Base Year			Year 1			Year 2		
	Demo	Comp	FFS	Demo	Comp	FFS	Demo	Comp	FFS
Plan Characteristics									
Enrollees (from GHPM file)	56,860	106,371	34,583	50,230	86,005	36,589	47,302	78,606	37,542
	10.01	10.37	--	8.44	8.70	--	7.39	7.43	--
Enrollee characteristics									
Age									
64 or younger (%)	11.0	10.9	17.4[a]	6.3	8.3[a]	17.6[a]	6.2	8.1[a]	18.1[a]
65-79 (%)	71.9	69.4[a]	58.1[a]	74.3	69.9[a]	57.8[a]	74.3	68.4[a]	57.0[a]
80 or older (%)	17.1	19.8[a]	24.4[a]	19.4	21.8[a]	24.6[a]	19.5	23.4[a]	24.8[a]
Gender (% male)	42.7	41.2[a]	40.3[a]	42.6	40.6[a]	40.6[a]	42.6	40.6[a]	40.9[a]
Medicaid (%)	2.3	4.1[a]	14.3[a]	2.2	4.4[a]	14.0[a]	2.1	5.7[a]	13.7[a]
Health Status									
Risk score (mean)	0.89	0.93[a]	1.03[a]	0.88	0.94[a]	1.03[a]	1.01	0.97[a]	1.14[a]

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Masterfile (GHPM), Five-Percent Sample Denominator file, and Inpatient Encounter Files for 2001, 2002, and 2003.
Note: Averages are weighted by enrollment in M+C plans or number of fee-for-service beneficiaries.
[a] $p < .05$ for difference from Demo for a given year.

Enrollment in demonstration plans was less in the aggregate than it was for comparison plans in each year. The number of FFS beneficiaries is based on a five-percent sample and therefore is not directly comparable to demonstration plan enrollment in the relevant counties.

Enrollment in the demonstration and comparison plans declined significantly in the first year of the demonstration. The decrease in enrollment for demonstration plans from the Base Year to Year 1 was less than that for comparison plans, both in terms of absolute numbers and percentages. In the second year of the demonstration, enrollment in demonstration plans declined further, but not to as great an extent as in the first year. Demonstration plans experienced smaller absolute and percentage decreases than comparison plans did in the second year as well.

Table 4.2b. Plan and Enrollee Characteristics, Year-to-Year Differences

Variable	Base Year to Year 1 Difference			Year 1 to Year 2 Difference		
	Demo	Comp	FFS	Demo	Comp	FFS
Plan Characteristics						
Enrollees (from GHPM file)	-6,630	-20,366	2,006	-2,928	-7,399	953
Market penetration (%)	-1.6	-1.7	--	-1.1	-1.3	--
Enrollee characteristics						
Age						
64 or younger (%)	-4.7[a]	-2.6[a]	0.2	-0.1	-0.2	0.5
65-79 (%)	2.4[a]	0.5[a]	-0.4	0.0	-1.5[a]	-0.7[a]
80 or older (%)	2.3[a]	2.0[a]	0.2	0.2	1.6[a]	0.2
Gender (% male)	-0.1	-0.6[a]	0.3	0.0	-0.1	0.3
Medicaid (%)	-0.2	0.4[a]	-0.3	-0.1	1.2[a]	-0.2
Health Status						
Risk score (mean)	-0.010[a]	0.011[a]	-0.007	0.129 [a]	0.033[a]	0.110[a]

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Masterfile (GHPM), Five-Percent Sample Denominator file, and Inpatient Encounter Files for 2001, 2002, and 2003.
Note: Averages are weighted by enrollment in M+C plans or number of fee-for-service beneficiaries.
[a] $p < .05$

The downward enrollment trend might have occurred for several reasons. Some of the individuals enrolled in the Base Year might have not qualified for the demonstration; for example, one of the demonstrations was employer-only, which disqualified many enrollees in the pre-demonstration plan from participating in the demonstration. There was a secular downward trend in enrollment in M+C plans in general during this period, as evidenced by the drop in comparison plan enrollment.

In each year the market penetration rates for demonstration and comparison plans were virtually identical. The market penetration rate was lower in Year 1 than in the Base Year for both demonstration and comparison plans, and lower still in Year 2. While both demonstration and comparison plans had small year-to-year decreases in market penetration, the changes were relatively minor.

4.1.3 Enrollee Characteristics

The age distribution of persons enrolled in demonstration M+C plans shown in Table 4.2a was slightly younger than that for those enrolled in comparison plans. In FFS Medicare, however, the percentage of persons under 65 (“disabled”) and 80 or older tended to substantially exceed those for demonstration plans.

Table 4.2c. Plan and Enrollee Characteristics, Differences in Year-to-Year Differences

Variable	Base Year to Year 1 Diff.-in-Diff. (vs. Demo)		Year 1 to Year 2 Diff.-in-Diff. (vs. Demo)	
	Comp	FFS	Comp	FFS
Plan Characteristics				
Enrollees (from GHPM file)	-13,736	8,636	-4,471	3,881
Market penetration (%)	-0.1	--	-0.2	--
Enrollee characteristics				
Age				
64 or younger (%)	2.1[a]	4.9[a]	-0.1	0.7[a]
65-79 (%)	-1.9[a]	-2.8[a]	-1.5[a]	-0.7
80 or older (%)	-0.2	-2.1[a]	1.4[a]	0.0
Gender (% male)	-0.5	0.4	-0.1	0.3
Medicaid (%)	0.5[a]	-0.1	1.3[a]	-0.1
Health Status				
Risk score (mean)	0.021[a]	0.003	-0.096[a]	-0.019

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Masterfile (GHPM), Five-Percent Sample Denominator file, and Inpatient Encounter Files for 2001, 2002, and 2003.
Note: Averages are weighted by enrollment in M+C plans or number of fee-for-service beneficiaries.
[a] $p < .05$

From the Base Year to Year 1, there was a shift in the age distribution of both demonstration and comparison enrollees toward older persons. This shift occurred for all demonstrations, but was more pronounced for two of them. In demonstration #2, the two Base Year HMO plans merged and converted to private fee-for-service. Approximately 75 percent of enrollees disenrolled. The share of enrollees 80 years and older increased from a quarter to a third, which drove the average age up more for this demonstration than for most of the others. It appears in demonstration #6, younger, non-union worker enrollees did not qualify for the demonstration plan. Therefore, the demonstration comprised only older retirees, which accounted for a greater than expected increase in the average age of enrollees in demonstration #6.

From Year 1 to Year 2, changes in the age distributions were miniscule for demonstration enrollees. This was as anticipated because the structure of the demonstrations was essentially unchanged from one year to the next. Similarly, there were only minor changes in the age distributions for comparison plans and FFS beneficiaries in the respective markets.

Demonstration enrollees were more likely to be male than were comparison plan enrollees. The difference was minor—1.5 percentage points in the Base Year. This is in concert with the age findings, because men tend to not live as long as women. FFS enrollees had a slightly smaller percentage of males than comparison plans did in the Base Year.

Demonstration enrollees were only about one-half as likely to have been enrolled in Medicaid as comparison enrollees were. This was primarily due to the comparison plans located in New Orleans and Chicago for demonstration sites #2 and #7, respectively, which have a much higher

Medicaid population than the demonstration sites. But both demonstration and comparison plans had Medicaid enrollment percentages far less than those for FFS beneficiaries.

Year-to-year changes in gender and Medicaid status were generally small—albeit statistically significant—among the three comparison groups. Among demonstration enrollees in particular, the changes from Year 1 to Year 2 tended to be less than those from the Base Year to Year 1.

4.1.4 Health Status

Risk scores in Table 4.2a reflect the relative health status of beneficiaries. The risk score for a particular beneficiary was developed for the Base Year and Year 1 from that individual's demographics and inpatient hospital diagnoses (PIP-DCG risk model) in the previous year while for Year 2 it is developed from the individual's demographics, and the diagnoses from hospital inpatient and outpatient and physician services (HCC risk model) in the previous year. The average risk score of demonstration participants was lower than those of their comparison plan counterparts in the Base Year and Year 1, signaling that demonstration participants were healthier than their counterparts in comparison plans. Risk scores of FFS beneficiaries were much higher than those of both demonstration and comparison plan enrollees in both years.

Nevertheless, an anomaly is the higher average risk score in Year 2 for demonstration plans than for comparison plans, a reversal of the relationship in the previous two years. One explanation was the change in the risk adjuster model used. Also a closer examination of the appendix tables indicates that the principal anomalies were in demonstration sites #3 and #6. In both instances, the risk scores for the demonstration plans increased a great deal in Year 2 as compared to the increase in the respectively comparison plans and FFS beneficiaries. Moreover, the relatively high enrollment in the demonstration #3 plans meant that figures for that demonstration site exerted a strong influence on the averages for all demonstrations shown in Table 4.2a. Additionally, for three of the demonstration sites (sites #2, 4, and 6) the average risk scores were much higher than the sample of FFS beneficiaries located in the same market areas.

4.2 Education, Race/Ethnicity, Health and Ratings of Plans and Providers

This section summarizes the results from tabulations of MMC-CAHPS data that are presented in detail for each demonstration in Appendixes B, C and D. Patterns of comparison are presented based on averages across all demonstration sites. Individual cases may differ from these overall patterns.

Tables 4.3a, 4.3b, and 4.3c present highlights of results for both demonstration and comparison plan enrollee education, race/ethnicity, health condition and utilization, and ratings of health plans and providers.

4.2.1 Educational Attainment, Race and Ethnicity

As shown in Table 4.3a, demonstration participants tended to have fewer years of schooling than comparison plan enrollees did in both the Base Year and Year 1. The opposite was the case, however, in Year 2. Unlike the enrollee characteristics and risk score results presented in the previous section, the MMC-CAHPS data come from random sample surveys in which the

respondents are generally different individuals from year to year. Therefore, it is not so surprising to observe these education findings differing from one year to the next for a given plan. Similar conclusions would apply to other MMC-CAHPS variables discussed below.

Demonstration participants were more likely to be white and less likely to be black than was the case for comparison plan enrollees. The share of enrollees for other racial categories combined averaged less than two percent. Year-to-year changes in race and ethnicity were very small and generally not statistically significant. One exception was a large shift from white to black in Year 2 among comparison plans, which was primarily due to the comparison plans for demonstration #6 in Cook, Kendall, and Kane Counties in Illinois. The overall percentages of demonstration and comparison plan enrollees of Hispanic/Latino ethnicity were quite similar in three to seven percent range for all years.[5]

4.2.2 Health Status, Health Conditions, and Health Care Utilization

The results for self-reported health status were very similar between demonstration and comparison plans in the Base Year and Year 1. In Year 2, a statistically significant difference appeared in which demonstration enrollees reported better health than their comparison plan counterparts did. Demonstration participants were less likely than their comparison plan counterparts to report having a physical or mental condition lasting at least three months in the Base Year; the difference disappeared in Year 1 and Year 2. Differences in the likelihood of seeing a doctor two or more times in 12 months for a health condition were minor between types of plans and all years.

[5] However, one demonstration (#4 PacifiCare) had 30 percent of demonstration participants of Hispanic/Latino ethnicity.

Table 4.3a. Demographics, Health Utilization, and Enrollee Satisfaction, Three Years

Variable	Base Year		Year 1		Year 2	
	Demo	Comp	Demo	Comp	Demo	Comp
Sample Size	3,418	2,688	5,311	2,946	4,623	2,012
Enrollee Characteristics (% distribution)						
Education						
8th grade or less	10.8	11.7	11.8	11.2	9.3	13.5[a]
Some high school	18.2	19.4	19.1	18.8	16.0	21.8[a]
High school graduate or GED	46.3	38.0[a]	42.1	38.3[a]	41.4	37.7[a]
HS grad or less	75.3	69.1[a]	73.0	68.4[a]	66.7	73.1[a]
Some college/2 yr degree	14.8	17.5[a]	15.4	18.7[a]	17.0	16.4
4-year college degree or more	9.9	13.3[a]	11.6	12.9	16.3	10.6[a]
At least some college	24.7	30.9[a]	27.0	31.6[a]	33.3	26.9[a]
Hispanic or Latino origin or descent						
Hispanic or Latino	2.7	3.3	4.1	3.8	4.2	6.7[a]
Not Hispanic or Latino	97.3	96.7	95.9	96.2	95.8	93.3[a]
Race						
White, non-Hispanic	96.1	87.4[a]	95.7	87.0[a]	94.0	73.9[a]
Black/African-American, non-Hispanic	3.1	11.4[a]	3.3	11.6[a]	5.1	24.1[a]
Asian, non-Hispanic	0.4	0.9[a]	0.7	1.0	0.5	1.4[a]
Native Hawaiian/ or PI, non-Hispanic						
AI/AN, non-Hispanic	0.4	0.2	0.4	0.4	0.4	0.6
Other	0.8	1.2	1.0	1.4	0.9	2.1[a]
Health Experience						
Current Health Status (% distribution)						
Very good or excellent	30.3	31.2	29.0	29.1	34.1	27.3[a]
Good	39.1	39.8	38.7	38.4	37.2	37.6
Fair or poor	30.5	29.0	32.3	32.6	28.7	35.0[a]
Health Conditions (% with condition)						
Physical/mental condition 3+ months	63.3	65.8[a]	67.8	68.4	62.7	62.1
Seen doctor 2+ times	78.8	80.0	78.1	78.3	80.3	80.9
Health Utilization (% utilizing)						
Doctor's office or clinic visit	78.0	78.3	77.5	77.0	79.1	75.8[a]
Specialist visit	57.0	59.8[a]	58.6	57.5	64.0	57.7[a]
Prescription medicine use	90.0	90.9	91.5	90.2	90.5	89.5
Emergency room	17.3	16.7	19.4	17.5[a]	18.1	19.1
Inpatient hospitalization	21.6	19.1[a]	21.2	19.0[a]	21.5	19.5
Needed special medical equipment	11.8	13.1	14.0	13.6	13.2	14.9
Needed special therapy	10.0	11.8[a]	11.8	10.5	11.5	10.9
Home health care	4.2	4.2	5.1	5.5	5.5	7.3[a]
Plan and Provider Ratings						
Rating of Medicare health plan (% dist.)						
0-7	22.8	27.4[a]	26.1	28.7[a]	38.6	39.3
8	16.1	20.5[a]	18.3	19.0	18.9	18.9
9	19.4	17.4[a]	18.3	17.7	14.5	13.5
10	41.7	34.7[a]	37.3	34.6[a]	28.0	28.2
Rating of providers (% dist.)						
0-7	11.4	13.2	13.2	15.6[a]	12.4	15.9[a]
8	16.2	17.8	17.4	17.5	18.0	18.1
9	20.6	20.5	20.3	19.2	19.3	18.0
10	51.8	48.4[a]	49.2	47.7	50.3	48.0

Source: BearingPoint tabulations of MMC-CAHPS data for 2001, 2002 and 2003.
[a] $p < .05$ for difference from Demo.

Table 4.3b. Demographics, Health Utilization, and Enrollee Satisfaction, Year-to-Year Differences

Variable	Base Year to Year 1 Difference		Year 1 to Year 2 Difference	
	Demo	Comp	Demo	Comp
Sample Size	1,893	258	-688	-934
Enrollee Characteristics (% distribution)				
Education				
8th grade or less	0.9	-0.5	-2.5[a]	2.3
Some high school	0.9	-0.6	-3.1[a]	3.0[a]
High school graduate or GED	-4.1[a]	0.3	-0.7	-0.6
HS grad or less	-2.3[a]	-0.8	-6.3[a]	4.7[a]
Some college/2 yr degree	0.6	1.2	1.5	-2.3
4-year college degree or more	1.8[a]	-0.4	4.7[a]	-2.4[a]
At least some college	2.3[a]	0.8	6.3[a]	-4.7[a]
Hispanic or Latino origin or descent				
Hispanic or Latino	1.5[a]	0.5	0.0	2.8[a]
Not Hispanic or Latino	-1.5[a]	-0.5	0.0	-2.8[a]
Race				
White, non-Hispanic	-0.5	-0.4	-1.7[a]	-13.2[a]
Black/African-American, non-Hispanic	0.2	0.2	1.8[a]	12.5[a]
Asian, non-Hispanic	0.3	0.1	-0.1	0.4
Native Hawaiian/ or PI, non-Hispanic	0.0	-0.1	0.0	0.1
AI/AN, non-Hispanic	0.0	0.2[a]	0.0	0.2
Other	0.3	0.2	-0.1	0.7
Health Experience				
Current Health Status (% distribution)				
Very good or excellent	-1.3	-2.1	5.0[a]	-1.7
Good	-0.4	-1.4	-1.5	-0.7
Fair or poor	1.7	3.5[a]	-3.6[a]	2.5
Health Conditions (% with condition)				
Physical/mental condition 3+ months	4.5[a]	2.6	-5.0[a]	-6.3[a]
Seen doctor 2+ times	-0.7	-1.7	2.2	2.6
Health Utilization (% utilizing)				
Doctor's office or clinic visit	-0.5	-1.3	1.5	-1.1
Specialist visit	1.6	-2.3	5.4[a]	0.2
Prescription medicine use	1.5	-0.7	-1.1	-0.7
Emergency room	2.2[a]	0.8	-1.3	1.6
Inpatient hospitalization	-0.4	-0.2	0.3	0.6
Needed special medical equipment	2.3[a]	0.4	-0.9	1.4
Needed special therapy	1.8[a]	-1.3	-0.3	0.4
Home health care	0.9[a]	1.3[a]	0.4	1.8[a]
Plan and Provider Ratings (% dist.)				
Rating of Medicare health plan				
0-7	3.3[a]	1.4	12.5[a]	10.6[a]
8	2.1[a]	-1.6	0.7	0.0
9	-1.1	0.3	-3.8[a]	-4.2[a]
10	-4.3[a]	-0.1	-9.4[a]	-6.4[a]
Rating of providers				
0-7	1.8[a]	2.4[a]	-0.8	0.3
8	1.2	-0.3	0.6	0.6
9	-0.4	-1.3	-1.0	-1.2
10	-2.6[a]	-0.8	1.1	0.3

Source: BearingPoint tabulations of MMC-CAHPS data for 2001, 2002 and 2003.
[a] $p < .05$ for difference between years.

Table 4.3c. Demographics, Health Utilization, and Enrollee Satisfaction, Year-to-Year Differences

Variable	Base Year to Year 1 Diff.-in-Diff. (vs. Demo)	Year 1 to Year 2 Diff.-in-Diff. (vs. Demo)
Sample Size	-1,635	-246
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	-1.5	4.8[a]
Some high school	-1.5	6.1[a]
High school graduate or GED	4.5[a]	0.1
HS grad or less	1.6	11.0[a]
Some college/2 yr degree	0.6	-3.9[a]
4-year college degree or more	-2.1	-7.1[a]
At least some college	-1.6	-11.0[a]
Hispanic or Latino origin or descent		
Hispanic or Latino	-0.9	2.8[a]
Not Hispanic or Latino	0.9	-2.8[a]
Race		
White, non-Hispanic	0.1	-11.5[a]
Black/African-American, non-Hispanic	0.0	10.7[a]
Asian, non-Hispanic	-0.2	0.5
Native Hawaiian/ or PI, non-Hispanic	-0.1	0.1
AI/AN , non-Hispanic	0.2	0.2
Other	0.0	0.9
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	-0.8	-6.8[a]
Good	-1.0	0.7
Fair or poor	1.8	6.0[a]
Health Conditions (% with condition)		
Physical/mental condition 3+ months	-1.9	-1.3
Seen doctor 2+ times	-1.0	0.4
Health Utilization (% utilizing)		
Doctor's office or clinic visit	-0.9	-2.6
Specialist visit	-3.9[a]	-5.2 [a]
Prescription medicine use	-2.2	0.4
Emergency room	-1.4	2.9
Inpatient hospitalization	0.3	0.2
Needed special medical equipment	-1.9	2.3
Needed special therapy	-3.1	0.7
Home health care	0.4	1.4
Plan and Provider Ratings (% dist.)		
Rating of Medicare health plan		
0-7	-2.0	-1.9
8	-3.7[a]	-0.7
9	1.5	-0.4
10	4.2[a]	3.0
Rating of providers		
0-7	0.6	1.1
8	-1.5	0.0
9	-1.0	-0.2
10	1.9	-0.8

Source: BearingPoint tabulations of MMC-CAHPS data for 2001, 2002 and 2003.
[a] $p < .05$

For the health care utilization trends we focus on the Base Year and Year 2. In the Base Year, there were essentially no differences in doctor's office and specialist visits between demonstration and comparison enrollees. In Year 2, demonstration participants were more likely to have undertaken both types of visits than comparison plan enrollees. Some small differences in utilization of a few health care services were found. A higher propensity for inpatient hospitalization among demonstration participants in the Base Year disappeared in Year 2. Conversely, a lesser propensity for home health care among demonstration participants that developed in Year 2 was not present in previous years. For other key health utilization variables—such as emergency room and prescription drug use—there were essentially no differences at any point in time between demonstrations and comparison plans. Prescription drug use was around 90 percent of the sampled enrollees for both types of plans for all years, so there was not much room for an increase.

The diverse health utilization experiences for enrollees in demonstration plans and those in comparison plans are difficult to generalize and attribute to the special risk-sharing features of demonstration M+C plans.

4.2.3 Ratings of Health Plans and Providers

Demonstration participants gave higher ratings to both health plans and providers than comparison plan enrollees did in the Base Year, but these differences did not persist. Ratings of providers fell slightly from the Base Year to Year 1 for both demonstration and comparison plan enrollees but were essentially unchanged in Year 2. In the case of ratings of health plans, however, the shift toward lower ratings was more pronounced and statistically significant among demonstration enrollees; in Year 2 there was no difference between demonstration and comparison plan enrollees.

4.3 Year-to-Year Changes In Status Among Demonstration Enrollees

4.3.1 Status of Demonstration Plan Enrollees in Base Year

Table 4.4 summarizes the Base Year status of persons enrolled in a demonstration plan in Year 1.

Table 4.4 Status of Demonstration Plan Enrollees in Base Year

Demo #	County	State	H # Year 1**	Status in Base Year* (percent)			
				Pre-Demo Plan	Different Plan, Same County	FFS	New Medicare Enrollee
1	Boone	KY	1803	95.7	0.7	2.5	1.1
1	Preble	OH	3610	95.4	0.5	2.7	1.4
1	Trumbull	OH	3610	89.6	0.4	8.8	1.1
2	DuPage	IL	1407	90.4	0.1	9.4	0.1
3	Bucks	PA	3909	67.9	17.8	10.2	4.1
3	Chester	PA	3909	77.5	6.9	10.7	4.9
3	Delaware	PA	3909	82.7	5.6	8.5	3.2
3	Montgomery	PA	3909	73.9	14.1	9.4	2.6
3	Philadelphia	PA	3909	88.2	2.5	6.7	2.6
4	Pueblo	CO	0619	98.4	0.2	0.7	0.7
5	Livingston	MI	2317	99.8	0.0	0.0	0.2
5	Washtenaw	MI	2317	99.2	0.0	0.5	0.3
6	Belmont	OH	3911	69.5	1.0	26.9	2.7
6	Jefferson	OH	3911	28.5	0.8	69.3	1.4
6	Brooke	WV	5104	33.9	0.5	63.4	2.1
6	Hancock	WV	5104	27.1	0.0	64.6	8.3
6	Ohio	WV	5104	78.6	1.9	17.8	1.6
6	Belmont	OH	5105	41.7	6.0	50.1	2.2
6	Guernsey	OH	5105	50.0	0.0	50.0	0.0
6	Jefferson	OH	5105	13.1	6.7	78.7	1.5
6	Brooke	WV	5105	22.2	3.0	73.7	1.0
6	Hancock	WV	5105	7.7	0.0	92.3	0.0
6	Marshall	WV	5105	48.6	0.8	49.8	0.8
6	Ohio	WV	5105	39.9	3.6	56.0	0.5

Some general observations can be made:

- For demonstrations #1 through #5, a substantial majority (approximately 90 percent) of enrollees came from the pre-demonstration plan. No more than five percent were new Medicare enrollees. In demonstration #3, 9 to 27 percent came from either FFS Medicare or were in a different M+C plan in the same county.

- Demonstration #6 involved retirees in employer-sponsored plans, many of whom had been covered under FFS Medicare prior to the commencement of the demonstration.

4.3.2 Enrollment Transitions for Demonstration Sites

Table 4.5 summarizes the transitions into and out of demonstration sites after the Base Year. The term "pre-demonstration" plan refers to the Base Year pool from which Year 1 demonstration plan enrollees were drawn. The benefits and cost sharing to the beneficiaries should have been the same in both cases and therefore they would have been indifferent between plans and perhaps not even knowledgeable about the existence of these parallel plans.

Approximately two-thirds of persons enrolled in a pre-demonstration site in the Base Year remained enrolled in a demonstration site in Year 1. A separate analysis not reported here shows that the majority of those who disenrolled between years went into FFS Medicare. The remainder of the dropouts either moved, stayed in the non-demonstration plan, switched to a different plan. The two demonstrations with high dropout figures were:

- Demonstration #2. This plan switched from an HMO to a PFFS plan for the demonstration. Over three-quarters of pre-demonstration enrollees did not enroll in the demonstration.[6] An unreported analysis shows that about 92 percent of the dropouts went into FFS in Year 1, three percent moved, three percent stayed in the non-demonstration plan during Year 1, one percent switched to a different plan.

Table 4.5. Total Enrollment and Transitions in Enrollment for Demonstration Sites by Year

Demo Number	Base Year Enrollees	Year 1 New Enrollees	Year 1 Disenrollees	Year 1 Enrollees	Year 2 New Enrollees	Year 2 Disenrollees	Year 2 Enrollees
1	8,971	1,299	1,030	9,240	473	1,237	8,476
2	6,893	120	5,327	1,686	126	262	1,550
3	16,935	6,913	1,547	22,301	3,953	3,914	22,340
4	5,502	152	1,190	4,464	124	642	3,946
5	3,957	192	717	3,432	0	3,432	0
6	9,909	2,580	8,119	4,370	319	344	4,345
7	4,693	1,169	1,125	4,737	2,399	491	6,645
All Demos	56,860	12,392	19,055	50,230	7,394	10,322	47,302

Source: BearingPoint and Social & Scientific Systems tabulations of Group Health Plan Master (GHPM) file, and Five-Percent Denominator Files for 2001, 2002 and 2003.
Note: Enrollment was as of December 31 except for the base year of site #7 which was May 31.

- Demonstration #6. This demonstration involved union members receiving health care coverage through their former employer. In excess of 8,000 (more than 80 percent) of pre-demonstration enrollees did not enroll in the demonstration and this site alone accounted for about 42 percent of total disenrollment.[7] Many non-union members

[6] This demonstration site required beneficiaries to actively enroll in the demonstration, in contrast to most of the other demonstration sites in which beneficiaries were automatically "rolled over" in the demonstration plan.
[7] ibid

enrolled in the pre-demonstration plan and were not eligible for the demonstration. A separate analysis showed that about 53 percent of dropouts stayed in the non-demonstration plan during Year 1, 15 percent went into FFS in Year 1, one percent moved, and 33 percent switched to a different plan.

Overall, disenrollment was partially offset by new enrollment in Year 1. New enrollment was less than disenrollment for four of the seven sites. Demonstration #3 accounted for about half of new enrollment, but the reasons for this are unclear.

Transitions both out of and into demonstration sites were of lower magnitudes in Year 2. For the majority of sites, disenrollment exceeded new enrollment or the two flows essentially balanced out. Demonstration #7 was the outlier, with nearly 2000 more new enrollees than disenrollees. Demonstration #5 withdrew from the demonstration program effective with Year 2.

5. Qualitative Data Collection

5.1 Introduction

Qualitative data on the seven participating organizations were obtained through telephone interviews with key individuals of the plans. The interviews were structured to acquire information on the MCOs' reasons for participation, expectations of the demonstration, and experiences to date. Prior to conducting the interviews, BearingPoint sent an introductory letter to each of the participating demonstration organizations (see Appendix D for a sample of this letter). Interviews were scheduled and conducted by BearingPoint staff. During the course of the interview process, the questionnaire instrument was revised to accommodate the variation in responses (see Appendices E and F for the original and revised questionnaire instruments).

The body of this section consists of a synthesis of the responses of demonstration representatives organized around three main areas of inquiry: reasons for choosing to participate in the demonstration, expectations prior to the commencement of the demonstration, and experiences with the demonstration since it began.

5.2 Reasons for Participation

The seven organizations participating in the demonstration already had existing plans in their respective regions, however, the increase in costs associated with the maintenance of their Medicare+Choice plans made continuation of several plans not feasible. The MCOs' participation in the demonstration allowed them to continue to provide Medicare+Choice services to beneficiaries. By allowing MCOs and employer groups to share the burden of risk with CMS, the entities now had the opportunity to remain in the target area and continue providing services to beneficiaries, build their beneficiary base, and extend their network to include a larger number of hospitals and providers.

Due to the Balanced Budget Act of 1997 (section 1853), which restricted the increase in capitation rates paid to Medicare+Choice organizations, along with an overall decrease in beneficiary enrollment over the years, the costs of maintaining the M+C plan exceeded the payments received from CMS and beneficiaries. To prevent such losses, the MCOs had no choice but to increase premiums to the beneficiaries, which would hurt the already diminishing enrollment rate. To minimize losses, MCOs would have ultimately been forced to pull out of the target area completely. The demonstration allowed the MCOs to maintain a presence in these areas because of the risk-sharing partnership between CMS and the MCO and the increase in the base payments. As one organization pointed out, "our objective [by participating in the demonstration] was to remain in the market and continue to be a health care option for beneficiaries."

The organizations' ability to continue offering their plans meant that the MCOs could take advantage of opportunities in the market that would have otherwise been lost. The opportunities included provisions for an affordable, high-quality product, zero premiums, and premiums for additional benefits. An MCO cited, "we were able to continue offering our product to consumers,

a product that is well accepted by the community." Another organization further strengthened this argument by noting that, "we were the last M+C plan available in the area and the ability to continue to provide plans with a competitive price, selection, and value was key." Therefore, the demonstration opened up new market possibilities to organizations, allowing them to remain competitive by revitalizing their plans (adding benefits, providers, etc.) and making them more appealing to potential enrollees in the targeted areas.

5.3 Expectations of the Demonstration

One significant advantage of the demonstration to the MCOs was the ability for them to maintain the established M+C plans in the demonstration areas. The transparency of the demonstration plans compared with their non-demonstration counterparts allowed beneficiaries to continue to receive benefits without the realization that the plan had transitioned into the demonstration. In a market where plan longevity is taken into account by potential enrollees, the ability for an MCO to continue to offer services to beneficiaries is paramount to a plan's credibility.

The opportunity for the MCOs to remain a competitive entity in the healthcare market is vital for the growth of health services in the area. An MCO in the demonstration continues to maintain that, "If we had withdrawn from the counties in question, I have no doubt that we would not have been able to reapply for service to them at a later date." The market for HMOs/PPOs in the affected areas is largely determined by the ability of these plans to be an alternative to original Medicare FFS in the area. As another plan suggests, "the demonstration is a win-win situation for us and the provider, not to mention that plan members don't have to worry about going back to fee-for-service." By allowing the plans to continue providing services to the demonstration areas, increased options were made available to beneficiaries.

For one MCO the opportunity to contract with more providers and hospitals in the demonstration county was not possible, which limited the appeal of the plan to new enrollees. The MCO used the demonstration as an opportunity to expand its network by converting to a PFFS plan. By entering into the demonstration, this organization hoped to expand on its network by converting to a PFFS plan with the additional benefit of sharing the risk with CMS.

The demonstration's risk sharing agreements enabled plans to continue supplying benefits to enrollees without expectation of significant investment losses. Most organizations agreed that the demonstration was expected to have more of a positive than a negative impact on beneficiary satisfaction. As a spokesperson from one of the demonstration MCOs commented, "We were looking to determine whether the community would welcome new choices and the M+C Alternative Payment Demonstration gave us a chance to test the waters with less risk of loss." By investing more into the plan and opportunities afforded by the plan, new enrollees would be able to realize lower premiums while still receiving better plan benefits with coverage including more providers.

The demonstration was expected to not only allow beneficiaries to receive upgraded benefits within a particular plan but also to afford beneficiaries an opportunity to enroll in plans that would normally be unobtainable through the employer group. An example of the increased

benefit opportunity was provided by a representative from a plan, who stated, "these people [beneficiary base] generally are not very wealthy and the [demonstration gave us the] ability to provide an HMO to these members who would normally not have access to an HMO plan."

5.4 Experiences to Date

Overall, the participating organizations expressed satisfaction with their ability to mitigate risk and to allow them to continue providing services to existing beneficiaries and new enrollees. However, in September 2002, M-Care, which offered a plan in Livingston and Washtenaw counties in Michigan, notified CMS that it would terminate its participation in the demonstration effective January 1, 2003. M-Care continued to lose money in 2002 and decided to not only drop out of the demonstration but also drop its other plans in the M+C program. The MCO declined the opportunity for an interview despite numerous attempts by BearingPoint.

The majority of the organizations noted that the most beneficial outcome of participating in the demonstration was the opportunity to continue providing services to beneficiaries. While not numerically measured, beneficiary plan satisfaction remained high and the opportunity for the plans to continue offering services in the affected areas was judged by some as more important than the overall monetary gains from staying in those areas.

It was largely agreed that CMS's implementation of the demonstration was responsible for the transparency of the program. One organization which was particularly impressed with the implementation of the demonstration stated, "We had a very short turnaround time to start new offerings . . . and CMS was very helpful in coming up with workable solutions to any problems we experienced." By working with the MCOs to iron out inconsistencies and quickly initiating the demonstration, the critical plans could be saved in short order, which translated in a seamless transition from non-demonstration plan to demonstration plan.

One organization presented some possible improvements that could be made to the demonstration, most of which were administrative in nature: "Reporting requirements could be simplified to include total premiums and total costs only. This would still capture the information needed by CMS while reducing the current administrative burden of break out costs in the same categories as the ACR with supporting schedules." The organization also suggested the termination of the Audit Requirement, as it was "onerous and unclear." A final suggestion made by this particular demonstration MCO was to incorporate "risk sharing across all beneficiaries, including ESRD."

To date, overall satisfaction in the demonstration was high, and organizations voiced interest in the demonstration being extended for a longer term. However, the MCOs could not provide specifics to support profits/gains as the final reconciliation had not been finalized. A demonstration MCO noted that its first year netted a "break-even" point in revenues, in which "CMS lost some and we gained some." However, MCOs remained optimistic that the demonstration would provide the necessary means to stabilize many of the plans. One such advocate of the demonstration noted a more favorable financial result than they had previously expected and hoped (along with the other MCOs involved in the demonstration) that CMS would

consider extending the demonstration for a longer period of time, with possible hopes of a permanent arrangement between CMS and MCOs.

6. Reconciliation Analysis

As introduced in the beginning of this report, the Centers for Medicare & Medicaid Service (CMS) implemented the M+C Alternative Payment demonstration to address the declining participation by Medicare managed care organizations (MCOs). As described earlier, one of the demonstration sites is based on a reinsurance model, where CMS is contributing to a funding pool for each demonstration enrollee an amount equal to the difference in the M+C payment rate and a fee-for-service payment rate that has been standardized to be comparable to the M+C payment rate. Payments in the other six sites are based on variants of a "risk corridor" model.

Table 6.1 identifies these sites and summarizes their essential risk-sharing features. In addition, Table 6.1 summarizes the reconciliation amounts for each site for Year 1 of the demonstration. The reconciliation process resolves all claims, adjustments, capitation and premium amount, and other financial transactions between the MCO and CMS for the first year of the demonstration. For the demonstration sites utilizing a risk corridor model, costs that fall within the corridor (e.g., plus/minus two percent of the targeted medical expense) are absorbed by the MCO. Costs that fall outside of the corridor are shared by both the MCO and CMS. In addition, savings are also shared by both CMS and the MCO. As such, the reconciliation process determines for each demonstration site whether the MCO will pay CMS or whether CMS will pay the MCO, and what amount of payment, if any, will be. For the demonstration using a reinsurance model, Anthem, the MCO will be paid from the pool 80% of the excess for all beneficiaries living in Trumbull County for whom annual expenses exceed $75,000 during the year. If the pool runs out of funds, the MCO absorbs the loss. If funds are left over, they are to be used to fund losses in other counties.

After the first year of the demonstration, two sites, Humana and PacifiCare, experienced savings. These sites paid CMS half of the savings amount; Humana paid CMS $209,463 and PacifiCare paid CMS $1,472,652. Two plans, Independence Blue Cross and Anthem, experienced losses and received funds from CMS. As of the end of January 2004, CMS was slated to pay Independence Blue Cross $2,012,342. This amount, however, excludes projected claims that had not yet been paid. As such, it is likely that CMS will owe Independence Blue Cross additional funds once the final claims have been paid. The preliminary amount owed M-CARE is $2,783,585. However, CMS has not paid M-CARE because the plan has not submitted an audited report. Finally, CMS paid Anthem $813,870. It is likely that CMS will owe Anthem another $80,000, bringing the total to approximately $893,870.

At the time this report was written, a reconciliation analysis for Year 2 of the demonstrations had not been completed.

Table 6.1. Overview of M+C Alternative Payment Demonstration Sites' Risk Reconciliation, 2002

Company and Plan Name	Type of Risk Sharing	Risk Sharing*	Savings/Losses	Reconciliation
Anthem—Anthem Senior Advantage	Reinsurance	For losses in Turnbull county the MCO will be paid from a pool; if the pool runs out of funds, the MCO absorbs the loss. If funds are left over, they are to be used to fund losses in other counties.	Losses	CMS paid Anthem approximately $813,870 (CMS will most likely owe Anthem another $80,000, bringing the total to approximately $893,870)
Employers Health Insurance Company—Humana Gold (A PFFS plan)	Targeted medical expense	If actual medical claims costs are within +/– 2% of targeted medical expense, M+CO is at full risk. If costs are more than 2% different than target, CMS and plan share equally in the gains or losses.	Savings	Humana paid CMS $209,463
Independence BC—Personal Choice 65 PPO	Targeted medical expense	If actual costs are within +/– 2% of targeted medical expense, plan and CMS share gain/loss equally. If costs are more than 2% different than target, gain/loss shared 80% CMS and 20% plan.	Losses	CMS paid Independence $2,012,342 (CMS will owe Independence additional funds once final claims have been paid)
PacifiCare—Secure Horizons	Targeted medical expense	MCO at full risk for gains and losses within +/– 2% of targeted medical expense. If costs are more than 2% different than target, CMS and plan share equally in the gains or losses.	Savings	PacifiCare paid CMS $1,472,652
M-CARE	Targeted medical expense	If actual expenses are greater or less than targeted expense, plan and CMS share equally in the gains/losses.	Losses	CMS owes M-CARE $2,783,585 (this amount is preliminary; M-CARE's reconciliation paperwork had not been audited at the time of this report)
United Healthcare of Wisconsin	Targeted medical expenses	If actual costs are within +/– 2% of targeted medical expense, plan and CMS share gain/loss equally. If costs are more than 2% different than target, gain/loss shared 75% CMS and 25% plan.	MCO has not yet sent reconciliation to CMS	MCO has not yet sent reconciliation to CMS

Table 6.1. Overview of M+C Alternative Payment Demonstration Sites' Risk Reconciliation, 2002

Company and Plan Name	Type of Risk Sharing	Risk Sharing*	Savings/Losses	Reconciliation
Coventry Health Care—Carelink Health Plans Note: All enrollees in this demo are retirees of Wheeling-Pittsburgh Steel Corporation ("Corporation")	Targeted medical expense	If actual medical claim costs differ from targeted amount, CMS, plan, and Corporation share the difference.	Reconciliation not due to CMS for another year (expect it to be break-even)	Reconciliation not due to CMS for another year (expect it to be break-even)

For a more detailed description of the risk sharing features, see Table 2.1

7. References

Barents Group of KPMG Consulting. 2002. *M+C Alternative Payment Demonstration Evaluation: Selection of Non-Demo Plans That Are Comparable To Demo Plans*. Report submitted to the Centers for Medicare & Medicaid Services, Contract No. 500-95-0057, TO #6, (November 22).

Mathematica Policy Research, Inc. 2003. *Medicare+Choice and Medicare Beneficiaries Monthly Tracking Report for May, 2003.*

8. Appendix A: Highlights of Demonstration Plan Benefits and Costs, 2001-2003

Table A.1. Demonstration #1 (Boone County), Plan Benefits and Costs, 2001-2003

Benefit	2001		2002	2003		
	H1849-001 Standard 100	H1849-002 Premier 200	H1803-001 Plan 003	H1803-004 Basic 2	H1803-002 Standard 2	H1803-003 Premier 2
Premium ($)	0	29	0	0	40	80
Copay for PCP visit ($)	5	5	5	25	20	10
Copay for Specialist visit ($)	20	20	20	35	30	20
Drug coverage	Y	Y	N	N	Y	Y
Additional Premium ($)	0	0	N	N	0	0
Generic copay ($)	12[c]	12[c]	N	N	15[e]	15[e]
Brand copay ($)	35[a]	35[a]	N	N	N	N
Dental	N	Y	N	N	N	N
Vision	Y	Y	Y	Y	Y	Y
Hearing	N	Y	Y	Y	Y	Y
Optional Supplemental Package 1						
Additional Premium ($)			29		40	40
Generic copay ($)			15[c]		15[c]	15[c]
Brand copay ($)			N		40[f]	40[f]
Optional Supplemental Package 2						
Additional Premium ($)			59			
Generic copay ($)			15[c]			
Brand copay ($)			35[e]			

Y = Benefit covered

N = No benefit

[a]$75 limit every three months for Formulary Brand

[b]$175 limit every three months for Formulary Brand

[c]No annual limit on generic drugs

[d]$100 limit every three months on generic drugs

[e]$500 annual limit on Formulary Brand

[f]$125 limit every three months for Formulary Brand

Note: Prescription drug coverage based on a 30-day supply for drugs purchased in person, and a 90-day supply for mail ordered drugs.

Observations:

Base Year: Two plans were offered. Both had drug coverage. The higher premium plan offered dental and hearing that the lower-premium one did not offer.

Year 1: Two plans were consolidated into one with beginning of demonstration

Year 1: Zero-premium drug coverage was eliminated. Drug coverage was only available with payment of additional premium and higher copays for generics.

Year 1: Dental coverage was eliminated. Vision and hearing coverage were retained.

Year 2: Basic benefit coverage choices were expanded to three plans.

Year 2: Visit copays were higher than in Year 1 for comparable benefits. Higher premium went with lower copays.

Year 2: Paying a higher premium bought coverage for generic drugs as well as lower doctor and specialist visit copays.

Year 2: Brand drug coverage could be obtained through Optional Supplemental packages.

Base Year to Year 2: Minimum premium to get generic coverage went from $0 in Base Year to $29 in Year 1 to $40 in Year 2.

Base Year to Year 2: Minimum premium to get brand coverage went from $0 in Base Year to $59 in Year 1 to $80 in Year 2.

Table A.2. Demonstration #1 (Preble County), Plan Benefits and Costs, 2001-2003

Benefit	2001		2002	2003		
	H3655-007 Standard 700	H3655-008 Premier 800	H3610-002 Plan 003	H3610-008 Basic 2	H3610-005 Standard 2	H3610-006 Premier 2
Premium ($)	0	29	0	0	40	80
Copay for PCP visit ($)	5	5	5	25	20	10
Copay for Specialist visit ($)	20	20	20	35	30	20
Drug coverage	Y	Y	N	N	Y	Y
Additional Premium ($)	0	0	N	N	0	0
Generic copay ($)	12[d]	12[c]	N	N	15[e]	15[e]
Brand copay ($)	N	35[a]	N	N	N	N
Dental	N	Y	N	N	N	N
Vision	Y	Y	Y	Y	Y	Y
Hearing	Y	Y	Y	Y	Y	Y
Optional Supplemental Package 1						
Additional Premium ($)			29		40	40
Generic copay ($)			15[c]		15[c]	15[c]
Brand copay ($)			N		40[f]	40[f]
Optional Supplemental Package 2						
Additional Premium ($)			59			
Generic copay ($)			15[c]			
Brand copay ($)			35[e]			

Y = Benefit covered

N = No benefit

[a]$75 limit every three months for Formulary Brand

[b]$175 limit every three months for Formulary Brand

[c]No annual limit on generic drugs

[d]$100 limit every three months on generic drugs

[e]$500 annual limit on Formulary Brand

[f]$125 limit every three months for Formulary Brand

Note: Prescription drug coverage based on a 30-day supply.

Observations:

Base Year: Coverage same as for Boone Co., except no brand drug coverage under Standard Plan, but hearing covered under Standard Plan.

Year 1: Costs and coverages same as for Boone Co.

Year 2: Costs and coverages same as for Boone Co.

Base Year to Year 2: Minimum premium to get generic coverage went from $0 in Base Year to $29 in Year 1 to $40 in Year 2.

Base Year to Year 2: Minimum premium to get brand coverage went from $29 in Base Year to $59 in Year 1 to $80 in Year 2.

Table A.3. Demonstration #1 (Trumbull County), Plan Benefits and Costs, 2001-2003

Benefit	2001		2002	2003		
	H3655-007 Standard 700	H3655-008 Premier 800	H3610-002 Plan 003	H3610-008 Basic 2	H3610-005 Standard 2	H3610-006 Premier 2
Premium ($)	0	29	0	0	40	80
Copay for PCP visit ($)	5	5	5	25	20	10
Copay for Specialist visit ($)	20	20	20	35	30	20
Drug coverage	Y	Y	N	N	Y	Y
Additional Premium ($)	0	0	N	N	0	0
Generic copay ($)	12[d]	12[c]	N	N	15[e]	15[e]
Brand copay ($)	N	35[a]	N	N	N	N
Dental	N	Y	N	N	N	N
Vision	Y	Y	Y	Y	Y	Y
Hearing	Y	Y	Y	Y	Y	Y
Optional Supplemental Package 1						
Additional Premium ($)			29		40	40
Generic copay ($)			15[c]		15[c]	15[c]
Brand copay ($)			N		40[f]	40[f]
Optional Supplemental Package 2						
Additional Premium ($)			59			
Generic copay ($)			15[c]			
Brand copay ($)			35[e]			

Y = Benefit covered
N = No benefit
[a]$75 limit every three months for Formulary Brand
[b]$175 limit every three months for Formulary Brand
[c]No annual limit on generic drugs
[d]$100 limit every three months on generic drugs
[e]$500 annual limit on Formulary Brand
[f]$125 limit every three months for Formulary Brand
Note: Prescription drug coverage based on a 30-day supply.

Observations:
Base Year: Coverage same as for Boone Co., except no brand drug coverage under Standard Plan, but hearing covered under Standard Plan.
Year 1: Costs and coverages same as for Boone Co.
Year 2: Costs and coverages same as for Boone Co.
Base Year to Year 2: Minimum premium to get generic coverage went from $0 in Base Year to $29 in Year 1 to $40 in Year 2.
Base Year to Year 2: Minimum premium to get brand coverage went from $29 in Base Year to $59 in Year 1 to $80 in Year 2.

Table A.4. Demonstration #2, Plan Benefits and Costs, 2001-2003

Benefit	2001		2002		2003
	H1406-014 Human Gold Plus Value	HI406-015 Human Gold Plus Standard	H1407-001 Humana Gold Choice (11/08/01)	H1407-001 Humana Gold Choice (8/13/02)	H1407-001 Humana Gold Choice
Premium ($)	65	19	89	89	89
Copay for PCP visit ($)	10	15	10	10	15
Copay for Specialist visit ($)	10	15	20	20	25
Drug coverage	Y	N	N	Y	Y
Additional Premium ($)	0	N	N	0	0
Formulary Generic copay ($)	10	N	N	5[b]	10[c]
Formulary Brand copay ($)	20[a]	N	N	5[b]	10[c]
Non-Formulary Generic copay ($)	35	N	N	5[b]	10[c]
Non-Formulary Brand copay ($)	35[a]	N	N	5[b]	10[c]
Dental	N	N	N	N	N
Vision	Y	Y	Y	Y	Y
Hearing	N	N	Y	Y	Y

Y = Benefit covered

N = No benefit

[a] $100 limit every three months for combined Formulary Brand and Non-Formulary Brand prescription drugs.

[b] $5 limit (not copay) on both Generic and Brand drugs

[c] $10 limit (not copay) on both Generic and Brand drugs

Note: Prescription drug coverage based on a 30-day supply.

Observations:

Base Year: Two plans were offered. The one with the higher premium provided drug coverage and lower visit copays; the lower premium plan did provide drug coverage and had higher visit copays.

Year 1: Only one plan was offered. Premium was higher than either Base Year plan.

Year 1: Visit copays increased slightly. Hearing coverage was added.

Year 1: No drug coverage was provided initially. In mid-year, drug coverage was added for no additional premium.

Year 2: Coverages and costs essentially same as for Year 1. $5 increase in visit and drug copays.

Base Year to Year 2: Minimum premium to get generic coverage went from $65 in Base Year to $89 in Year 1 and Year 2.

Base Year to Year 2: Minimum premium to get brand coverage went from $65 in Base Year to $89 in Year 1 and Year 2.

Base Year to Year 2: Drug copays (when coverage was provided) decreased.

Base Year to Year 2: Hearing coverage was added but dental and vision coverage was unchanged.

Table A.5. Demonstration #3, Plan Benefits and Costs, 2001-2003

Benefit	2001		2002	2003	
	H3963-001 Personal Choice 65 Medicare Standard (10/12/00)	H3963-001 Personal Choice 65 Medicare Standard (01/29/01)	H3909-001 Personal Choice 65	H3909-001 Personal Choice 65 Standard	H3909-801 (employer-only) Personal Choice 65 Group Only
Premium ($)	120	114	135	179	142
Copay for PCP visit ($)	10	10	10	10	
Copay for Specialist visit ($)	25	25	25	25	
Drug coverage	Y	Y	Y	Y	
Additional Premium ($)	0	0	0	0	
Generic copay ($)	10[a]	10[a]	10[a]	15[a]	
Brand copay ($)	N	N	N	N	
Dental	N	N	N	N	
Vision	Y	Y	Y	Y	
Hearing	Y	Y	Y	Y	
Optional Supplemental Package 1					
Additional Premium ($)	35	35	35	35	
Generic copay ($)	10[a]	10[a]	10[a]	15[a]	
Formulary Brand copay ($)	15[b]	15[b]	15[b]	20[b]	
Non-Formulary Brand copay ($)	15[b]	15[b]	25[b]	30[b]	

Y = Benefit covered

N = No benefit

[a]No annual limit for generic drugs

[b]$500 annual limit on brand drugs

Note: Prescription drug coverage based on a 30 day supply. Blank cell indicates no information available.

Observations:

Base Year: One plan was offered.

Base Year: In mid-year, premium was reduced $6; other costs and coverages remained the same.

Base Year: Coverage of generic drugs was provided at no additional premium and $10 copay. Brand coverage with $35 premium was available with Optional Supplemental package

Base Year: Vision and hearing covered but not dental. This did not change in future periods.

Year 1: Premium increased $21. Other benefits and costs unchanged from Base Year, except Non-Formulary Brand copay increased $10.

Year 2: Premium increased $44. All drug copay increased $5. No other changes from Year 1.

Year 2: An employer-only plan was added. But no details are available other than premium.

Base Year to Year 2: Minimum premium to get generic coverage went from $114 in Base Year to $135 in Year 1 to $179 in Year 2.

Base Year to Year 2: Minimum premium to get brand coverage went from $149 in Base Year to $170 in Year 1 to $214 in Year 2.

Table A.6. Demonstration #4, Plan Benefits and Costs, 2001-2003

Benefit	2001 H0609-001 Basic Plan	2002 H0619-001 Standard Plan Correction (02/22/02)	2003 H0619-001 Standard Plan
Premium ($)	99	105	110
Copay for PCP visit ($)	15	15	15
Copay for Specialist visit ($)	15	40	40
Drug coverage	Y	Y	Y
Additional Premium ($)	0	0	0
Formulary Generic copay ($)	11[a]	11[a]	15[a]
Formulary Brand copay ($)	30	N	N
Non-Formulary Generic copay ($)	60	N	N
Non-Formulary Brand copay ($)	60	N	N
Dental	N	N	N
Vision	Y	Y	Y
Hearing	Y	Y	Y
Optional Supplemental Package 1			
Additional Premium ($)	13.25	14	14.50
Dental	Y	Y	Y

Y = Benefit covered
N = No benefit
[a]No individual limit on Formulary generic

Observations:
Base Year: $99 premium.
Base Year: Generic and brand name drugs covered for no additional premium.
Base Year: No dental under basic plan, but coverage could be purchased with additional premium under Optional package.
Year 1: Premium increased $6.
Year 1: Zero premium for generic drug coverage retained, but brand name drug coverage dropped.
Year 1: Additional premium for dental coverage increased nominally.
Year 1: PCP visit copay unchanged, but specialist visit copay increased $25.
Year 2: Premium increased $5.
Year 2: Visit copays were the same as for Year 1.
Year 2: Zero additional premium for generic coverage retained; $4 increase in generic copay.
Year 2: Additional premium for dental coverage increased nominally.
Base Year to Year 2: Minimum premium to get generic drug coverage went from $99 in Base Year to $105 in Year 1 to $110 in Year 2.
Base Year to Year 2: Minimum premium to get brand name drug coverage went from $99 in Base Year to no coverage in Year 1 and Year 2.

Table A.7. Demonstration #5, Plan Benefits and Costs, 2001-2003

	2001	2001	2002	2003*
Benefit	**H2353-001**	**H2353-004**	**H2317-001**	
Premium ($)	0	47	55	
Copay for PCP visit ($)	10	7	10	
Copay for Specialist visit ($)	10	7	10	
Drug coverage	Y	Y	Y	
Additional Premium ($)	0	0	na	
Generic copay ($)	7	7	na	
Brand copay ($)	35	35	na	
Dental	N	Y	N	
Vision	Y	Y	Y	
Hearing	Y	Y	Y	

Y = Benefit covered

N = No benefit

na = information not available

* M-Care did not participate in the demonstration for 2003.

Note: Prescription drug coverage based on a 30 day supply for drugs purchased in person, and a 90 day supply for mail ordered drugs.

Observations:

Base Year: Two plans were offered, both with drug coverage. The higher-premium plan offered dental exam coverage.

Year 1: Two plans were consolidated into one with beginning of demonstration

Year 1: Zero-premium drug coverage was eliminated in Year 1. Drugs were covered with $55 basic monthly premium.

Year 1: Dental coverage was eliminated. Vision and hearing coverage were retained.

Base Year to Year 1: Minimum premium to get generic coverage went from $0 in Base Year to $55 in Year 1.

Base Year to Year 1: Minimum premium to get brand coverage went from $0 in Base Year to $55 in Year 1.

Table A.8. Demonstration #6 (Belmont and Jefferson Counties), Plan Benefits and Costs, 2001-2003

Benefit	2001 H3673-004 Health Assurance Advantra	2002 H3911-801 (employer only)	2003 H3911-801 (employer only)
Premium ($)	38	78	78
Copay for PCP visit ($)	10	10	10
Copay for Specialist visit ($)	10	20	20
Drug coverage	N	N	N
Additional Premium ($)	N	N	N
Generic copay ($)	N	N	N
Brand copay ($)	N	N	N
Dental	N	N	N
Vision	Y[a]	N	N
Hearing	Y[a]	N	N

Y = Benefit covered
N = No benefit
[a]$10 copay for vision and hearing exams

Source: ACRP Reports for 2001 and 2003
Note: 2002 assumed to be same as for 2003

Observations:
Base Year: Former employees of the Wheeling-Pittsburgh Steel Corporation were enrolled in the pre-demonstration plan, along with many Medicare beneficiaries.
Base Year: No drug coverage available.
Base Year: Vision and hearing exams covered, but not dental exams.
Year 1: The demonstration plan was "employer only," covering only the Wheeling-Pittsburgh Steel Corporation former employees
Year 1: Premium increased by $40. Specialist visit copays increased by $10.
Year 1: Still no drug coverage. Vision and hearing coverage dropped.
Year 2: Same coverages and costs as in Year 1.
Base Year to Year 2: No drug coverage was available at any time for any cost.

Table A.9. Demonstration #6 (Brooke, Hancock and Ohio Counties), Plan Benefits and Costs, 2001-2003

	2001	2002	2003
Benefit	**H5149-001 Carelink Advantra**	**H5104-801 (employer-only)**	**H5104-801 (employer-only)**
Premium ($)	38	78	78
Copay for PCP visit ($)	10	10	10
Copay for Specialist visit ($)	10	20	20
Drug coverage	N	N	N
Additional Premium ($)	N	N	N
Generic copay ($)	N	N	N
Brand copay ($)	N	N	N
Dental	N	N	N
Vision	Y[a]	N	N
Hearing	Y[a]	N	N

Y = Benefit covered
N = No benefit
[a]$10 copay for vision and hearing exams

Source: ACRP Reports for 2001 and 2003
Note: 2002 assumed to be same as for 2003

Observations:
Base Year: Former employees of the Wheeling-Pittsburgh Steel Corporation were enrolled in the pre-demonstration plan, along with many Medicare beneficiaries.
Base Year: No drug coverage available.
Base Year: Vision and hearing exams covered, but not dental exams.
Year 1: The demonstration plan was "employer only," covering only the Wheeling-Pittsburgh Steel Corporation former employees
Year 1: Premium increased by $40. Specialist visit copays increased by $10.
Year 1: Still no drug coverage. Vision and hearing coverage dropped.
Year 2: Same coverages and costs as in Year 1.
Base Year to Year 2: No drug coverage was available at any time for any cost.

Table A.10. Demonstration #6 (Eight Counties in OH and WV), Plan Benefits and Costs, 2001-2003

Benefit	2001		2002	2003
	H5151-001 Health Plan of the Upper Ohio Valley Standard Option	H5151-002 Health Plan of the Upper Ohio Valley High Option	H5105-001	H5105-001
Premium ($)	39	49	69	
Copay for PCP visit ($)	10	5	15	
Copay for Specialist visit ($)	10	5	15	
Drug coverage	N	N		
Additional Premium ($)	N	N		
Generic copay ($)	N	N		
Brand copay ($)	N	N		
Dental	N	N		
Vision	Y[a]	Y[b]		
Hearing	Y[a]	Y[b]		

Y = Benefit covered
N = No benefit
[a]$10 copay for vision and hearing exams

Source: ACRP Reports for 2001; PBP data for 2002

Observations:
Base Year: Former employees of the Wheeling-Pittsburgh Steel Corporation were enrolled in the pre-demonstration plan, along with many Medicare beneficiaries.
Base Year: Two plans available. One had a lower premium but higher visit copays.
Base Year: No drug coverage available in either plan.
Base Year: Vision and hearing exams covered, but not dental exams.
Year 1: The demonstration plan was "employer only," covering only the Wheeling-Pittsburgh Steel Corporation former employees
Year 1: Only one plan offered.
Year 1: Premium increased by $10-20 over Base Year. Visit copays increased by $5-10.
Year 1: No other information on coverages or costs available.
Year 2: No information available.
Base Year to Year 2: No drug coverage in Base Year. No information available for other years.

Table A.11. Demonstration #7, Plan Benefits and Costs, 2001-2003

Benefit	2001	2002	2003	
	H5253-004 Medicare Complete Version 4 (12/06/01)	H5253-004 Medicare Complete Version 5 Mid-Year Enhancement (05/15/02)	H5253-004 Medicare Complete (11/18/02)	H5253-006 Medicare Complete Premium (11/18/02)
Premium ($)	55	30	0	65
Copay for PCP visit ($)	20	20	20	15
Copay for Specialist visit ($)	20	20	20	15
Drug coverage	N	N	N	N
Additional Premium ($)	N	N	N	N
Generic copay ($)	N	N	N	N
Brand copay ($)	N	N	N	N
Dental	N	N	N	N
Vision	Y[a]	Y[a]	Y[a]	Y[b]
Hearing	Y[a]	Y[a]	Y[a]	Y[b]

Y = Benefit covered

N = No benefit

[a]$20 for vision and hearing exams

[b]$15 for vision and hearing exams

Source: ACRP Reports for 2001-2003

Observations:

Base year: No drug coverage available. Vision and hearing exams covered, but not dental exams.

Year 1: Premium reduced $25. No other changes in other costs or coverages from Base Year.

Year 2: Choices expanded to two plans. The zero premium plan had the same costs and coverages as the Year 1 plan did. The $65 premium plans $5 lower visit copays, but otherwise was the same as the zero premium plan.

Base Year to Year 2: No coverage of drugs was available at any time for any plan.

9. Appendix B: Detailed Statistical Results for 2001 (Base Year)

9.1 Plan and Enrollee Characteristics and Health Status, 2001

Table B.1. Demonstration #1, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**1**		
Plan Name	**Anthem**	**Anthem**	--
County	Boone (KY), Trumbull, Preble (OH)	Campbell (KY), Shelby, Mahoning (OH)	Boone (KY), Trumbull, Preble (OH)
Plan Characteristics			
Type	HMO	HMO	--
Tax status	Non	Non	--
Enrollees (from GHPM file)	8,971	10,377	2,134
Market penetration (%)	17.6	15.5	--
Enrollee characteristics			
Age			
64 or younger (%)	11.4	11.4	19.7*
65-79 (%)	72.3	70.7*	61.2*
80 or older (%)	16.3	18.0*	19.2*
Gender (% male)	43.0	41.8	42.0
Medicaid (%)	6.0	5.5	11.4*
Health Status			
Risk score (mean)	0.93	0.94	0.99*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.2. Demonstration #2, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**2**		
Plan Name	**Humana**	**Sterling**	--
County	DuPage, Il	East Baton Rouge, LA	DuPage, Il
Plan Characteristics			
Type	PFFS	PFFS	--
Tax status	PRO	PRO	--
Enrollees (from GHPM file)	6,893	39	3,874
Market penetration (%)	7.8	n.a.	--
Enrollee characteristics			
Age			
64 or younger (%)	8.0	46.2*	12.5*
65-79 (%)	69.2	41.0*	62.9*
80 or older (%)	22.8	12.8	24.5*
Gender (% male)	41.6	28.2	40.8
Medicaid (%)	2.0	10.3	5.0*
Health Status			
Risk score (mean)	0.94	0.82	0.98

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.3. Demonstration #3, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**3**		
Plan Name	**Independence Blue Cross**	**Aetna**	**--**
County	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia	PA: Chester, Delaware, Philadelphia	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia
Plan Characteristics			
Type	PPO	HMO	--
Tax status	NON	PRO	--
Enrollees (from GHPM file)	16,935	28,389	15,045
Market penetration (%)	3.5	7.9	--
Enrollee characteristics			
Age			
64 or younger (%)	13.5	7.9*	18.3*
65-79 (%)	72.0	73.8*	54.6*
80 or older (%)	14.5	18.3*	27.1*
Gender (% male)	41.7	42.3	38.8
Medicaid (%)	0.8	1.9*	18.2*
Health Status			
Risk score (mean)	0.81	0.93*	1.08*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.4. Demonstration #4, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**4**		
Plan Name	**PacifiCare**	**PacifiCare**	**--**
County	Pueblo, CO	El Paso, CO	Pueblo, CO
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO	PRO	--
Enrollees (from GHPM file)	5,502	9,628	860
Market penetration (%)	22.3	19.7	
Enrollee characteristics			
Age			
64 or younger (%)	8.5	9.3	25.5*
65-79 (%)	69.4	70.9*	53.6*
80 or older (%)	22.1	19.8*	20.9
Gender (% male)	44.4	40.7*	43.0
Medicaid (%)	2.5	2.1	24.7*
Health Status			
Risk score (mean)	0.96	0.90*	1.03*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.5. Demonstration #5, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**5**		
Plan Name	**M-CARE**	**Health Alliance**	**--**
County	Livingston, Washtenaw, MI	Oakland, MI	Livingston, Washtenaw, MI
Plan Characteristics			
Type	HMO	HMO	--
Tax status	NON	NON	--
Enrollees (from GHPM file)	3,957	4,304	1,815
Market penetration (%)	9.2	3.1	--
Enrollee characteristics			
Age			
64 or younger (%)	10.7	11.5	18.9*
65-79 (%)	73.4	73.3	58.8*
80 or older (%)	15.8	15.2	22.3*
Gender (% male)	43.0	44.6	43.4
Medicaid (%)	2.1	2.6	9.8*
Health Status			
Risk score (mean)	0.86	0.88	0.98

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.6. Demonstration #6, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**6**		
Plan Name	**HealthAmerica of Pennsylvania, CareLink, Health Plan of the Upper Ohio Valley**	**United Healthcare, Health Plan of the Upper Ohio Valley**	**--**
County	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall	OH: Clark, Monroe; WV: Wetzel	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO,NON	PRO,NON	--
Enrollees (from GHPM file)	9,909	2,327	2,419
Market penetration (%)	13.2	8.4	--
Enrollee characteristics			
Age			
64 or younger (%)	11.2	14.7*	18.1*
65-79 (%)	73.3	70.0*	61.4*
80 or older (%)	15.5	15.3	20.5*
Gender (% male)	43.6	45.2	41.4*
Medicaid (%)	2.5	6.4*	13.6*
Health Status			
Risk score (mean)	0.92	0.95*	1.04*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*p < .05 for difference from Demonstration Plan.

Table B.7. Demonstration #7, Plan and Enrollee Characteristics and Health Status, 2001

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**7**		
Plan Name	**United Healthcare of Wisconsin**	**Humana**	**--**
County	Milwaukee, Ozaukee, Washington, Waukesha (WI)	Cook, Kendall, Kane (IL)	Milwaukee, Ozaukee, Washington, Waukesha (WI)
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO	NON	--
Enrollees (from GHPM file)	4,693	51,307	8,436
Market penetration (%)	7.7	9.8	--
Enrollee characteristics			
Age			
64 or younger (%)	8.7	12.5*	16.1*
65-79 (%)	73.0	66.0*	60.9*
80 or older (%)	18.2	21.5*	23.0*
Gender (% male)	43.0	40.2*	41.1*
Medicaid (%)	0.9	5.4*	12.2*
Health Status			
Risk score (mean)	0.88	0.93*	0.99*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
*$p < .05$ for difference from Demonstration Plan.

9.2 Education, Race/Ethnicity, Health Conditions, & Ratings of Plans & Providers, 2001

Table B.8. Demonstration #1, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**1**	
Plan Name	**Anthem**	**Anthem**
County	Boone (KY), Trumbull, Preble (OH)	Campbell (KY), Shelby, Mahoning (OH)
Sample Size	299	422
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	13.7	13.8
Some high school	27.1	26.1
High school graduate or GED	47.5	37.9*
Some college/2 yr degree	8.5	15.1*
4-year college degree or more	3.2	7.0*
Hispanic or Latino origin or descent		
Hispanic or Latino	1.9	1.9
Not Hispanic or Latino	98.1	98.1
Race		
White, non-Hispanic	95.8	94.1
Black/African-American, non-Hispanic	3.9	5.9
Asian, non-Hispanic	0.0	0.0
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.4	0.0
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	21.7	28.7*
Good	40.0	42.8
Fair or poor	38.3	28.5
Health Conditions (%)		
Physical/mental condition 3+ months	64.9	61.7
Seen doctor 2+ times	83.8	86.6
Health Utilization (%)		
Doctor's office or clinic visit	82.6	80.3
Specialist visit	57.9	54.0
Prescription medicine use	91.5	92.8
Emergency room	26.1	18.7*
Inpatient hospitalization	20.1	21.6
Needed special medical equipment	11.3	10.5
Needed special therapy	11.0	10.4
Home health care	4.6	3.0
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	26.8	18.6*
8	15.6	20.4
9	17.5	18.3
10	40.1	42.7
Rating of providers (0-10)		
0-7	13.4	9.5
8	16.9	15.1
9	17.3	17.4
10	52.4	58.0

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.9. Demonstration #2, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**2**	
Plan Name	**Humana**	**Sterling**
County	DuPage, Il	East Baton Rouge, LA
Sample Size	310	na
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	9.2	na
Some high school	16.8	na
High school graduate or GED	35.6	na
Some college/2 yr degree	21.5	na
4-year college degree or more	16.8	na
Hispanic or Latino origin or descent		
Hispanic or Latino	2.4	na
Not Hispanic or Latino	97.6	na
Race		
White, non-Hispanic	96.3	na
Black/African-American, non-Hispanic	1.0	na
Asian, non-Hispanic	2.3	na
Native Hawaiian/ or PI, non-Hispanic	0.0	na
AI/AN , non-Hispanic	0.3	na
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	37.0	na
Good	38.0	na
Fair or poor	24.9	na
Health Conditions (%)		
Physical/mental condition 3+ months	62.5	na
Seen doctor 2+ times	71.6	na
Health Utilization (%)		
Doctor's office or clinic visit	78.4	na
Specialist visit	56.5	na
Prescription medicine use	88.2	na
Emergency room	16.8	na
Inpatient hospitalization	16.1	na
Needed special medical equipment	10.7	na
Needed special therapy	8.1	na
Home health care	3.4	na
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	40.2	na
8	18.6	na
9	15.5	na
10	25.7	na
Rating of providers (0-10)		
0-7	25.1	na
8	20.3	na
9	19.9	na
10	34.6	na

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
Na = not available.

Table B.10. Demonstration #3, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**3**	
Plan Name	**Independence Blue Cross**	**Aetna**
County	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia	PA: Chester, Delaware, Philadelphia
Sample Size	464	1007
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	6.5	8.8
Some high school	11.8	17.3*
High school graduate or GED	38.1	42.0
Some college/2 yr degree	17.6	15.8
4-year college degree or more	26.1	16.0*
Hispanic or Latino origin or descent		
Hispanic or Latino	0.7	0.7
Not Hispanic or Latino	99.3	99.3
Race		
White, non-Hispanic	91.8	91.4
Black/African-American, non-Hispanic	7.3	8.1
Asian, non-Hispanic	0.9	0.3
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.0	0.1
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	34.2	35.3
Good	40.8	39.9
Fair or poor	24.9	24.8
Health Conditions (%)		
Physical/mental condition 3+ months	69.8	67.6
Seen doctor 2+ times	83.5	80.2
Health Utilization (%)		
Doctor's office or clinic visit	86.0	81.9*
Specialist visit	76.9	70.3*
Prescription medicine use	90.6	91.3
Emergency room	18.8	18.3
Inpatient hospitalization	19.5	20.3
Needed special medical equipment	10.6	13.5
Needed special therapy	14.9	12.7
Home health care	4.1	3.6
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	22.2	26.2
8	19.3	21.7
9	19.7	18.9
10	38.8	33.2*
Rating of providers (0-10)		
0-7	9.1	9.8
8	17.7	18.6
9	24.9	22.4
10	48.3	49.3

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.11. Demonstration #4, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**4**	
Plan Name	**PacifiCare**	**PacifiCare**
County	Pueblo, CO	El Paso, CO
Sample Size	169	325
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	21.1	8.0*
Some high school	23.5	13.8*
High school graduate or GED	30.1	38.1
Some college/2 yr degree	21.1	24.4
4-year college degree or more	4.2	15.7*
Hispanic or Latino origin or descent		
Hispanic or Latino	32.7	5.7*
Not Hispanic or Latino	67.3	94.3*
Race		
White, non-Hispanic	96.1	94.8
Black/African-American, non-Hispanic	2.6	2.9
Asian, non-Hispanic	0.0	1.6*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.3
AI/AN , non-Hispanic	1.3	0.3
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	23.3	30.5
Good	37.4	37.7
Fair or poor	39.3	31.8
Health Conditions (%)		
Physical/mental condition 3+ months	61.0	69.6
Seen doctor 2+ times	80.0	70.8
Health Utilization (%)		
Doctor's office or clinic visit	78.7	77.5
Specialist visit	54.4	53.5
Prescription medicine use	90.0	88.2
Emergency room	21.3	16.3
Inpatient hospitalization	22.4	15.3
Needed special medical equipment	15.0	16.3
Needed special therapy	7.6	6.4
Home health care	7.5	2.5*
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	29.7	34.2
8	16.5	21.3
9	19.6	18.8
10	34.2	25.7
Rating of providers (0-10)		
0-7	19.8	18.3
8	14.7	20.0
9	14.7	24.2*
10	50.9	37.5*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.12. Demonstration #5, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**5**	
Plan Name	**M-CARE**	**Health Alliance**
County	Livingston, Washtenaw, MI	Oakland, MI
Sample Size	87	187
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	6.0	7.7
Some high school	12.0	14.8
High school graduate or GED	28.9	30.2
Some college/2 yr degree	27.7	25.8
4-year college degree or more	25.3	21.4
Hispanic or Latino origin or descent		
Hispanic or Latino	1.3	0.6
Not Hispanic or Latino	98.7	99.4
Race		
White, non-Hispanic	90.4	87.6
Black/African-American, non-Hispanic	8.4	8.1
Asian, non-Hispanic	0.0	3.8*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	1.2	0.5
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	43.0	31.5
Good	36.0	39.8
Fair or poor	20.9	28.7
Health Conditions (%)		
Physical/mental condition 3+ months	74.1	66.3
Seen doctor 2+ times	72.6	75.0
Health Utilization (%)		
Doctor's office or clinic visit	75.9	77.0
Specialist visit	59.8	63.6
Prescription medicine use	93.7	90.6
Emergency room	20.7	21.9
Inpatient hospitalization	14.9	18.8
Needed special medical equipment	15.7	8.5
Needed special therapy	15.9	13.1
Home health care	1.2	2.3
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	10.8	19.4
8	13.3	21.7
9	20.5	18.3
10	55.4	40.6*
Rating of providers (0-10)		
0-7	4.8	11.1
8	14.5	17.0
9	19.4	18.5
10	61.3	53.3

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.13. Demonstration #6, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**6**	
Plan Name	**HealthAmerica of Pennsylvania, CareLink, Health Plan of the Upper Ohio Valley**	**United Healthcare, Health Plan of the Upper Ohio Valley**
County	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall	OH: Clark, Monroe; WV: Wetzel
Sample Size	1555	81
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	9.9	11.3
Some high school	19.0	31.3*
High school graduate or GED	54.7	38.8*
Some college/2 yr degree	11.0	16.3
4-year college degree or more	5.4	2.5
Hispanic or Latino origin or descent		
Hispanic or Latino	0.6	1.4
Not Hispanic or Latino	99.4	98.6
Race		
White, non-Hispanic	98.1	94.8
Black/African-American, non-Hispanic	1.4	5.2
Asian, non-Hispanic	0.1	0.0
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN, non-Hispanic	0.4	0.0*
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	27.7	22.8
Good	38.8	34.2
Fair or poor	33.4	43.0
Health Conditions (%)		
Physical/mental condition 3+ months	62.9	68.8
Seen doctor 2+ times	79.3	86.8
Health Utilization (%)		
Doctor's office or clinic visit	78.8	76.5
Specialist visit	58.2	58.0
Prescription medicine use	90.5	94.4
Emergency room	19.5	14.8
Inpatient hospitalization	24.3	20.0
Needed special medical equipment	11.5	16.9
Needed special therapy	9.2	18.2*
Home health care	4.2	2.6
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	18.2	33.3*
8	14.5	19.8
9	19.2	17.3
10	48.1	29.6*
Rating of providers (0-10)		
0-7	8.6	16.4
8	13.8	23.0
9	19.5	19.7
10	58.1	41.0*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
*$p < .05$ for difference from Demonstration Plan.

Table B.14. Demonstration #7, Health Utilization, Plan and Provider Ratings, 2001

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**7**	
Plan Name	**United Healthcare of Wisconsin**	**Humana**
County	Milwaukee, Ozaukee, Washington, Waukesha (WI)	Cook, Kendall, Kane (IL)
Sample Size	534	666
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	14.3	17.9
Some high school	16.3	21.0*
High school graduate or GED	42.4	34.0*
Some college/2 yr degree	19.2	16.1
4-year college degree or more	7.8	11.1
Hispanic or Latino origin or descent		
Hispanic or Latino	1.3	8.1*
Not Hispanic or Latino	98.7	91.9*
Race		
White, non-Hispanic	95.3	72.2*
Black/African-American, non-Hispanic	4.3	26.2*
Asian, non-Hispanic	0.0	1.3*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.2
AI/AN, non-Hispanic	0.4	0.2
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	35.6	27.5*
Good	39.6	39.5
Fair or poor	24.8	33.0*
Health Conditions (%)		
Physical/mental condition 3+ months	57.5	63.4*
Seen doctor 2+ times	74.6	81.1*
Health Utilization (%)		
Doctor's office or clinic visit	71.7	77.3*
Specialist visit	51.1	58.6*
Prescription medicine use	87.2	90.2
Emergency room	18.0	23.0*
Inpatient hospitalization	20.3	17.6
Needed special medical equipment	12.6	13.5
Needed special therapy	8.4	12.8*
Home health care	3.9	7.4*
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	24.1	32.7*
8	17.4	18.2
9	23.1	13.4*
10	35.4	35.7
Rating of providers (0-10)		
0-7	11.1	19.0*
8	20.3	16.9
9	24.4	18.4*
10	44.2	45.7

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2001.
*$p < .05$ for difference from Demonstration Plan.

9.3 Summary Statistics on Demonstrations, 2001

Table B.15. Summary Statistics on Enrollee Age, Gender, and Medicaid Status, 2001

Demo No. Plan Name	Group	64 or Under %	65-79 %	80 or Older %	Male %	Medicaid %	Risk Score	N
1	Demo	11.4	72.3	16.3	43.0	6.0	0.93	8,971
Anthem	Comparison	11.4	70.7*	18.0*	41.8	5.5	0.94	10,377
	FFS	19.7*	61.2*	19.2*	42.0	11.4*	0.99*	2,134
2	Demo	8.0	69.2	22.8	41.6	2.0	0.94	6,893
Humana	Comparison	46.2*	41.0*	12.8	28.2	10.3	0.82	39
	FFS	12.5*	62.9*	24.5*	40.8	5.0*	0.98	3,874
3	Demo	13.5	72.0	14.5	41.7	0.8	0.81	16,935
Independence BC	Comparison	7.9*	73.8*	18.3*	42.3	1.9*	0.93*	28,389
	FFS	18.3*	54.6*	27.1*	38.8	18.2*	1.08*	15,045
4	Demo	8.5	69.4	22.1	44.4	2.5	0.96	5,502
PacifiCare	Comparison	9.3	70.9*	19.8*	40.7*	2.1	0.90*	9,628
	FFS	25.5*	53.6*	20.9	43.0	24.7*	1.03*	860
5	Demo	10.7	73.4	15.8	43.0	2.1	0.86	3,957
M-Care	Comparison	11.5	73.3	15.2	44.6	2.6	0.88	4,304
	FFS	18.9*	58.8*	22.3*	43.4	9.8*	0.98	1,815
6	Demo	11.2	73.3	15.5	43.6	2.5	0.92	9,909
Wheeling-Pittsburgh Steel Corporation	Comparison	14.7*	70.0*	15.3	45.2	6.4*	0.95*	2,327
	FFS	18.1*	61.4*	20.5*	41.4*	13.6*	1.04*	2,419
7	Demo	8.7	73.0	18.2	43.0	0.9	0.88	4,693
United Healthcare of WI	Comparison	12.5*	66.0*	21.5*	40.2*	5.4*	0.93*	51,307
	FFS	16.1*	60.9*	23.0*	41.1*	12.2*	0.99*	8,436
	Demo	11.0	71.9	17.1	42.7	2.3	0.89	56,860
All Demonstrations	Comparison	10.9	69.4*	19.8*	41.2*	4.1*	0.93*	106,371
	FFS	17.4*	58.1*	24.4*	40.3*	14.3*	1.03*	34,583

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2001.
Notes: Demo = Persons enrolled in a demonstration plan; Comparison = Persons enrolled in a comparison plan; FFS = Persons enrolled in fee-for-service Medicare; N = Number of enrollees from GHPM file. FFS Market Area figures are from Five-Percent Sample Denominator File.
*$p < .05$ for difference from Demonstration Plan.

Table B.16. Summary Statistics on Educational Attainment, Race, and Ethnicity, 2001

Demo No. Plan Name	Group	<=HS %	Coll+ %	Hisp. %	White %	Black %	Other %	N
1	Demo	88.4	11.6	1.9	95.8	3.9	0.4	299
Anthem	Comparison	77.9	22.1	1.9	94.1	5.9	0.0	422
	Difference	-10.5*	10.5*	0.0	-1.7	2.0	-0.4	
2	Demo	61.7	38.3	2.4	96.3	1.0	2.7	310
Humana	Comparison	na	na	na	na	na	na	na
	Difference	na	na	na	na	na	na	
3	Demo	56.3	43.7	0.7	91.8	7.3	0.9	464
Independence BC	Comparison	68.1	31.9	0.7	91.4	8.1	0.4	1007
	Difference	11.8*	-11.8*	0.0	-0.4	0.8	-0.5	
4	Demo	74.7	25.3	32.7	96.1	2.6	1.3	169
PacifiCare	Comparison	59.9	40.1	5.7	94.8	2.9	2.3	325
	Difference	-14.8*	14.8*	-27.0*	-1.3	0.3	1.0	
5	Demo	47.0	53.0	1.3	90.4	8.4	1.2	87
M-CARE	Comparison	52.7	47.3	0.6	87.6	8.1	4.3	187
	Difference	5.8	-5.8	-0.7	-2.8	-0.3	3.1	
6	Demo	83.6	16.4	0.6	98.1	1.4	0.5	1555
Wheeling-Pittsburgh Steel Corporation	Comparison	81.3	18.8	1.4	94.8	5.2	0.0	81
	Difference	-2.4	2.4	0.8	-3.3	3.8	-0.5*	
7	Demo	72.9	27.1	1.3	95.3	4.3	0.4	534
United Healthcare of WI	Comparison	72.8	27.2	8.1	72.2	26.2	1.6	666
	Difference	-0.1	0.1	6.8*	-23.1*	21.9*	1.2	
All Demonstrations	Demo	75.3	24.7	2.7	96.1	3.1	0.8	3418
	Comparison	69.1	30.9	3.3	87.4	11.4	1.2	2688
	Difference	-6.2*	6.2*	0.6	-8.7*	8.3*	0.4	

Source: BearingPoint tabulations of MMC-CAHPS data for 2001.
Notes: <=HS = Persons with a high school diploma or less; Coll+ = Persons with at least some college; Hisp. = Person with Hispanic/Latino ethnicity; Other = Other race; na = not available. N = Number of observations.
* $p < .05$.

Table B.17. Summary Statistics on Health Condition and Utilization, 2001

Demo No. Plan Name	Group	VG/E	F/P	PHYS-MEN	DOC	SPEC	Rx	ER	HOSP	HH
1	Demo	21.7	38.3	64.9	81.4	56.1	91.5	21.4	20.1	4.6
Anthem	Comparison	28.7	28.5	61.7	79.1	51.7	92.8	15.9	21.6	3.0
	Difference	7.0*	-9.8	-3.3	-2.3	-4.4	1.3	-5.4	1.5	-1.6
2	Demo	37.0	24.9	62.5	77.4	53.1	88.2	14.9	16.1	3.4
Humana	Comparison	na	na	na	na	na	na	na	na	na
	Difference	na	na	na	na	na	na	na	na	na
3	Demo	34.2	24.9	69.8	85.3	75.6	90.6	15.5	19.5	4.1
Independence BC	Comparison	35.3	24.8	67.6	80.7	69.0	91.3	15.2	20.3	3.6
	Difference	1.1	-0.2	-2.2	-4.6*	-6.7*	0.7	-0.3	0.8	-0.5
4	Demo	23.3	39.3	61.0	77.5	51.3	90.0	19.9	22.4	7.5
PacifiCare	Comparison	30.5	31.8	69.6	76.5	51.6	88.2	14.7	15.3	2.5
	Difference	7.2	-7.5	8.6	-1.0	0.3	-1.8	-5.1	-7.1	-5.0
5	Demo	43.0	20.9	74.1	74.7	58.3	93.7	17.9	14.9	1.2
M-CARE	Comparison	31.5	28.7	66.3	76.0	61.1	90.6	20.7	18.8	2.3
	Difference	-11.5	7.8	-7.8	1.3	2.8	-3.1	2.8	3.8	1.0
6	Demo	27.7	33.4	62.9	78.1	55.9	90.5	17.6	24.3	4.2
Wheeling-Pittsburgh Steel Corporation	Comparison	22.8	43.0	68.8	75.3	55.8	94.4	11.5	20.0	2.6
	Difference	-5.0	9.6	5.9	-2.7	0.0	4.0	-6.1	-4.3	-1.6
7	Demo	35.6	24.8	57.5	70.6	48.4	87.2	15.9	20.3	3.9
United Healthcare WI	Comparison	27.5	33.0	63.4	76.0	55.0	90.2	19.8	17.6	7.4
	Difference	-8.0*	8.2*	5.9*	5.4*	6.6*	2.9	3.9	-2.7	3.5*
All Demonstrations	Demo	30.3	30.5	63.3	78.0	57.0	90.0	17.3	21.6	4.2
	Comparison	31.2	29.0	65.8	78.3	59.8	90.9	16.7	19.1	4.2
	Difference	0.8	-1.5	2.5*	0.3	2.8*	0.9	-0.6	-2.5*	0.0

Source: BearingPoint tabulations of MMC-CAHPS data for 2001.
Notes: VG/E = Very Good/Excellent health status; F/P = Fair/Poor health status; PHYS-MEN = Physical or mental condition lasting at least 3 months; DOC = Doctor's office visit in last 6 months; SPEC = Specialist visit in last 6 months; Rx = Took prescription medicine in last 3 months for a health condition; ER = Emergency room visit in last 6 months; HOSP = Inpatient hospitalization in last 12 months; HH = Home health visit in last 6 months; na =not available.
* $p < .05$.

Table B.18. Summary Statistics on Health Plan and Providers Ratings, 2001

Demo No. Plan Name	Group	Plan 0-7	Plan 8	Plan 9	Plan 10	Prov 0-7	Prov 8	Prov 9	Prov 10
1	Demo	26.8	15.6	17.5	40.1	13.4	16.9	17.3	52.4
Anthem	Comparison	18.6	20.4	18.3	42.7	9.5	15.1	17.4	58.0
	Difference	-8.2*	4.8	0.8	2.6	-4.0	-1.7	0.0	5.7
2	Demo	40.2	18.6	15.5	25.7	25.1	20.3	19.9	34.6
Humana	Comparison	na	na	na	na	na	na	na	na
	Difference	na	na	na	na	na	na	na	na
3	Demo	22.2	19.3	19.7	38.8	9.1	17.7	24.9	48.3
Independence BC	Comparison	26.2	21.7	18.9	33.2	9.8	18.6	22.4	49.3
	Difference	4.0	2.4	-0.8	-5.6*	0.6	0.9	-2.6	1.0
4	Demo	29.7	16.5	19.6	34.2	19.8	14.7	14.7	50.9
PacifiCare	Comparison	34.2	21.3	18.8	25.7	18.3	20.0	24.2	37.5
	Difference	4.4	4.9	-0.8	-8.5*	-1.5	5.3	9.5*	-13.4*
5	Demo	10.8	13.3	20.5	55.4	4.8	14.5	19.4	61.3
M-CARE	Comparison	19.4	21.7	18.3	40.6	11.1	17.0	18.5	53.3
	Difference	8.6	8.4	-2.1	-14.9*	6.3	2.5	-0.8	-8.0
6	Demo	18.2	14.5	19.2	48.1	8.6	13.8	19.5	58.1
Wheeling-Pittsburgh Steel Corporation	Comparison	33.3	19.8	17.3	29.6	16.4	23.0	19.7	41.0
	Difference	15.1*	5.3	-1.9	-18.5*	7.8	9.2	0.1	-17.1*
7	Demo	24.1	17.4	23.1	35.4	11.1	20.3	24.4	44.2
United Healthcare of WI	Comparison	32.7	18.2	13.4	35.7	19.0	16.9	18.4	45.7
	Difference	8.6*	0.8	-9.7*	0.3	7.9*	-3.4	-6.1*	1.6
All Demonstrations	Demo	22.8	16.1	19.4	41.7	11.4	16.2	20.6	51.8
	Comparison	27.4	20.5	17.4	34.7	13.2	17.8	20.5	48.4
	Difference	4.6*	4.4*	-2.1*	-7.0*	1.8	1.6	-0.1	-3.4*

Source: BearingPoint tabulations of MMC-CAHPS data for 2001.
Notes: “Plan” refers to ratings of health plan; “Prov” refers to ratings of providers. Ratings are on a 0-10 scale in which a higher number represents a better rating; na = not available.
* $p < .05$.

10. Appendix C: Detailed Statistical Results for 2002 (Year 1)

10.1 Plan and Enrollee Characteristics and Health Status, 2002

Table C.1. Demonstration #1, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**1**		
Plan Name	**Anthem**	**Anthem**	--
County	Boone (KY), Trumbull, Preble (OH)	Campbell (KY), Shelby, Mahoning (OH)	Boone (KY), Trumbull, Preble (OH)
Plan Characteristics			
Type	HMO	HMO	--
Tax status	Non	Non	--
Enrollees (from GHPM file)	9,240	11,767	2,158
Market penetration (%)	18.0	17.9	--
Enrollee characteristics			
Age			
64 or younger (%)	7.6	7.3	19.1*
65-79 (%)	73.1	71.6*	60.8*
80 or older (%)	19.2	21.1*	20.1
Gender (% male)	42.7	41.7	41.6
Medicaid (%)	6.5	5.7*	12.0*
Health Status			
Risk score (mean)	0.97	0.95	1.00

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.2. Demonstration #2, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**2**		
Plan Name	**Humana**	**Sterling**	--
County	DuPage, Il	East Baton Rouge, LA	DuPage, Il
Plan Characteristics			
Type	HMO	HMO	--
Tax status	NON	NON	--
Enrollees (from GHPM file)	1,686	843	4,281
Market penetration (%)	1.8	1.8	--
Enrollee characteristics			
Age			
64 or younger (%)	12.0	7.8*	12.7
65-79 (%)	53.8	66.9*	63.5*
80 or older (%)	34.2	25.3*	23.8*
Gender (% male)	39.1	35.5	40.6
Medicaid (%)	2.4	3.7	5.1*
Health Status			
Risk score (mean)	1.03	0.99	0.96*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.3. Demonstration #3, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**3**		
Plan Name	**Independence Blue Cross**	**Aetna**	**--**
County	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia	PA: Chester, Delaware, Philadelphia	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia
Plan Characteristics			
Type	PPO	HMO	--
Tax status	NON	PRO	--
Enrollees (from GHPM file)	22,301	19,951	15,645
Market penetration (%)	4.0	5.7	--
Enrollee characteristics			
Age			
64 or younger (%)	5.8	4.8*	19.0*
65-79 (%)	77.9	74.0*	53.8*
80 or older (%)	16.3	21.1*	27.2*
Gender (% male)	42.1	41.0*	39.9*
Medicaid (%)	0.7	2.3*	17.7*
Health Status			
Risk score (mean)	0.79	0.97*	1.07*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.4. Demonstration #4, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**4**		
Plan Name	**PacifiCare**	**PacifiCare**	**--**
County	Pueblo, CO	El Paso, CO	Pueblo, CO
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO	PRO	--
Enrollees (from GHPM file)	4,464	8,785	912
Market penetration (%)	17.4	16.1	
Enrollee characteristics			
Age			
64 or younger (%)	6.1	7.7*	25.1*
65-79 (%)	68.5	69.7	54.3*
80 or older (%)	25.4	22.5*	20.6*
Gender (% male)	44.4	40.1*	44.0
Medicaid (%)	2.5	2.3	24.5*
Health Status			
Risk score (mean)	0.99	0.94*	0.99

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.5. Demonstration #5, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**5**		
Plan Name	**M-CARE**	**Health Alliance**	**--**
County	Livingston, Washtenaw, MI	Oakland, MI	Livingston, Washtenaw, MI
Plan Characteristics			
Type	HMO	HMO	--
Tax status	NON	NON	--
Enrollees (from GHPM file)	3,342	2,940	1,922
Market penetration (%)	8.0	1.9	--
Enrollee characteristics			
Age			
64 or younger (%)	5.6	6.2	18.7*
65-79 (%)	76.2	75.9	59.2*
80 or older (%)	18.2	18.0	22.1*
Gender (% male)	42.0	44.3	42.5
Medicaid (%)	1.5	2.7*	10.5*
Health Status			
Risk score (mean)	0.90	0.91	0.96

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.6. Demonstration #6, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**6**		
Plan Name	**HealthAmerica of Pennsylvania, CareLink, Health Plan of the Upper Ohio Valley**	**United Healthcare, Health Plan of the Upper Ohio Valley**	**--**
County	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall	OH: Clark, Monroe; WV: Wetzel	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO, NON	PRO, NON	--
Enrollees (from GHPM file)	4,370	2,176	2,370
Market penetration (%)	5.9	7.6	--
Enrollee characteristics			
Age			
64 or younger (%)	4.5	13.3*	19.8*
65-79 (%)	72.8	70.0*	59.5*
80 or older (%)	22.7	16.7*	20.8
Gender (% male)	46.6	44.5	41.4*
Medicaid (%)	1.3	6.8*	15.4*
Health Status			
Risk score (mean)	0.91	0.97*	1.05*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*p < .05 for difference from Demonstration Plan.

Table C.7. Demonstration #7, Plan and Enrollee Characteristics and Health Status, 2002

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**7**		
Plan Name	**United Healthcare of Wisconsin**	**Humana**	**--**
County	Milwaukee, Ozaukee, Washington, Waukesha (WI)	Cook, Kendall, Kane (IL)	Milwaukee, Ozaukee, Washington, Waukesha (WI)
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO	NON	--
Enrollees (from GHPM file)	4,737	543	9,301
Market penetration (%)	2.2	7.7	--
Enrollee characteristics			
Age			
64 or younger (%)	6.1	10.3*	15.5*
65-79 (%)	74.5	66.9*	60.8*
80 or older (%)	19.5	22.7*	23.7*
Gender (% male)	41.4	39.9*	40.7*
Medicaid (%)	1.5	5.6*	11.5*
Health Status			
Risk score (mean)	0.89	0.92*	0.99*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
*$p < .05$ for difference from Demonstration Plan.

10.2 Education, Race/Ethnicity, Health Conditions, & Ratings of Plans & Providers, 2002

Table C.8. Demonstration #1, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**1**	
Plan Name	**Anthem**	**Anthem**
County	Boone (KY), Trumbull, Preble (OH)	Campbell (KY), Shelby, Mahoning (OH)
Sample Size	983	496
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	14.5	10.5*
Some high school	26.1	26.6
High school graduate or GED	43.4	41.0
Some college/2 yr degree	11.8	15.5
4-year college degree or more	4.2	6.5
Hispanic or Latino origin or descent		
Hispanic or Latino	0.8	2.0
Not Hispanic or Latino	99.2	98.0
Race		
White, non-Hispanic	97.4	93.1*
Black/African-American, non-Hispanic	2.0	6.3*
Asian, non-Hispanic	0.1	0.2
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.5	0.4
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	25.1	26.1
Good	37.5	37.8
Fair or poor	37.5	36.1
Health Conditions (%)		
Physical/mental condition 3+ months	69.5	68.9
Seen doctor 2+ times	80.7	81.7
Health Utilization (%)		
Doctor's office or clinic visit	79.7	80.4
Specialist visit	57.9	59.9
Prescription medicine use	91.1	91.2
Emergency room	23.4	20.2
Inpatient hospitalization	23.6	18.9*
Needed special medical equipment	12.2	16.0
Needed special therapy	10.3	9.8
Home health care	4.5	6.1
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	25.2	20.5
8	18.4	18.0
9	17.6	17.8
10	38.7	43.7
Rating of providers (0-10)		
0-7	12.5	11.2
8	20.3	13.5*
9	20.7	16.9
10	46.4	58.3*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002. *$p < .05$ for difference from Demonstration Plan.

Table C.9. Demonstration #2, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**2**	
Plan Name	**Humana**	**Sterling**
County	DuPage, Il	East Baton Rouge, LA
Sample Size	433	147
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	12.0	19.3
Some high school	19.9	14.3
High school graduate or GED	35.6	35.7
Some college/2 yr degree	21.1	17.1
4-year college degree or more	11.3	13.6
Hispanic or Latino origin or descent		
Hispanic or Latino	3.8	3.6
Not Hispanic or Latino	96.2	96.4
Race		
White, non-Hispanic	95.9	85.0*
Black/African-American, non-Hispanic	1.0	15.0*
Asian, non-Hispanic	2.9	0.0*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.2	0.0
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	32.4	26.4
Good	35.6	35.4
Fair or poor	32.0	38.2
Health Conditions (%)		
Physical/mental condition 3+ months	63.6	68.5
Seen doctor 2+ times	74.8	83.3
Health Utilization (%)		
Doctor's office or clinic visit	72.3	82.3*
Specialist visit	52.0	70.7*
Prescription medicine use	87.3	96.9*
Emergency room	23.8	19.0
Inpatient hospitalization	20.8	23.3
Needed special medical equipment	14.3	13.2
Needed special therapy	11.4	9.8
Home health care	6.8	4.9
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	38.7	19.1*
8	19.2	14.2
9	15.0	18.4
10	27.2	48.2*
Rating of providers (0-10)		
0-7	17.1	4.3*
8	24.6	20.7
9	19.5	16.4
10	38.9	58.6*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.10. Demonstration #3, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**3**	
Plan Name	**Independence Blue Cross**	**Aetna**
County	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia	PA: Chester, Delaware, Philadelphia
Sample Size	927	498
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	4.5	7.9*
Some high school	11.6	21.7*
High school graduate or GED	38.4	39.0
Some college/2 yr degree	17.5	16.3
4-year college degree or more	28.0	15.1*
Hispanic or Latino origin or descent		
Hispanic or Latino	0.8	0.7
Not Hispanic or Latino	99.2	99.3
Race		
White, non-Hispanic	94.4	85.6*
Black/African-American, non-Hispanic	4.8	14.2*
Asian, non-Hispanic	0.7	0.0*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.1	0.2
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	38.2	29.7*
Good	38.9	46.5*
Fair or poor	22.9	23.8
Health Conditions (%)		
Physical/mental condition 3+ months	70.1	68.4
Seen doctor 2+ times	82.5	81.7
Health Utilization (%)		
Doctor's office or clinic visit	84.8	78.9*
Specialist visit	75.0	67.5*
Prescription medicine use	91.5	91.4
Emergency room	19.8	18.9
Inpatient hospitalization	19.1	19.0
Needed special medical equipment	12.9	13.6
Needed special therapy	15.0	11.7
Home health care	5.8	5.3
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	24.9	24.6
8	22.7	20.2
9	19.8	20.6
10	32.6	34.6
Rating of providers (0-10)		
0-7	10.9	11.5
8	16.6	16.3
9	21.7	22.7
10	50.7	49.6

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.11. Demonstration #4, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**4**	
Plan Name	**PacifiCare**	**PacifiCare**
County	Pueblo, CO	El Paso, CO
Sample Size	479	512
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	20.3	7.4*
Some high school	20.3	12.3*
High school graduate or GED	36.7	37.7
Some college/2 yr degree	17.3	27.3*
4-year college degree or more	5.4	15.4*
Hispanic or Latino origin or descent		
Hispanic or Latino	29.9	5.8*
Not Hispanic or Latino	70.1	94.2*
Race		
White, non-Hispanic	96.0	94.9
Black/African-American, non-Hispanic	1.2	2.5
Asian, non-Hispanic	0.2	1.8*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.2
AI/AN , non-Hispanic	2.6	0.6
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	19.7	29.3*
Good	38.0	38.5
Fair or poor	42.3	32.3*
Health Conditions (%)		
Physical/mental condition 3+ months	66.0	72.2*
Seen doctor 2+ times	76.2	75.4
Health Utilization (%)		
Doctor's office or clinic visit	74.9	79.7
Specialist visit	55.3	57.4
Prescription medicine use	93.8	90.1
Emergency room	22.5	17.6
Inpatient hospitalization	20.5	17.7
Needed special medical equipment	20.5	14.5*
Needed special therapy	7.4	8.7
Home health care	6.9	4.7
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	33.9	36.6
8	15.2	20.9*
9	15.2	19.3
10	35.7	23.2*
Rating of providers (0-10)		
0-7	16.5	20.5
8	17.3	20.0
9	16.2	20.3
10	50.0	39.2*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.12. Demonstration #5, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**5**	
Plan Name	**M-CARE**	**Health Alliance**
County	Livingston, Washtenaw, MI	Oakland, MI
Sample Size	523	244
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	6.2	4.8
Some high school	10.2	12.6
High school graduate or GED	29.1	32.5
Some college/2 yr degree	24.3	23.8
4-year college degree or more	30.1	26.4
Hispanic or Latino origin or descent		
Hispanic or Latino	1.2	1.7
Not Hispanic or Latino	98.8	98.3
Race		
White, non-Hispanic	93.2	90.9
Black/African-American, non-Hispanic	5.2	6.5
Asian, non-Hispanic	1.4	2.2
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.2	0.4
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	36.5	36.0
Good	37.5	35.1
Fair or poor	26.1	28.9
Health Conditions (%)		
Physical/mental condition 3+ months	69.8	70.9
Seen doctor 2+ times	72.8	66.5
Health Utilization (%)		
Doctor's office or clinic visit	78.6	80.3
Specialist visit	63.1	60.7
Prescription medicine use	87.7	88.2
Emergency room	21.2	24.6
Inpatient hospitalization	20.5	14.7*
Needed special medical equipment	16.5	8.4*
Needed special therapy	17.3	9.8*
Home health care	7.4	2.5*
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	25.9	27.1
8	15.8	17.4
9	23.7	18.6
10	34.6	36.9
Rating of providers (0-10)		
0-7	12.7	15.9
8	18.7	22.2
9	27.3	19.0*
10	41.3	42.9

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.13. Demonstration #6, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**6**	
Plan Name	**HealthAmerica of Pennsylvania, CareLink, Health Plan of the Upper Ohio Valley**	**United Healthcare, Health Plan of the Upper Ohio Valley**
County	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall	OH: Clark, Monroe; WV: Wetzel
Sample Size	1474	101
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	13.4	14.4
Some high school	22.5	25.8
High school graduate or GED	52.1	41.2*
Some college/2 yr degree	9.5	12.4
4-year college degree or more	2.6	6.2
Hispanic or Latino origin or descent		
Hispanic or Latino	1.1	2.2
Not Hispanic or Latino	98.9	97.8
Race		
White, non-Hispanic	97.6	91.6*
Black/African-American, non-Hispanic	2.3	8.4*
Asian, non-Hispanic	0.1	0.0
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.1	0.0
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	22.3	23.0
Good	41.6	36.0
Fair or poor	36.1	41.0
Health Conditions (%)		
Physical/mental condition 3+ months	70.0	72.9
Seen doctor 2+ times	78.9	80.3
Health Utilization (%)		
Doctor's office or clinic visit	79.7	80.2
Specialist visit	61.1	54.5
Prescription medicine use	94.4	89.3
Emergency room	22.5	15.8
Inpatient hospitalization	23.4	17.8
Needed special medical equipment	13.6	12.4
Needed special therapy	10.9	7.3
Home health care	4.2	2.1
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	21.5	27.6
8	16.3	22.4
9	18.4	16.3
10	43.8	33.7*
Rating of providers (0-10)		
0-7	13.4	13.2
8	13.6	11.8
9	18.5	18.4
10	54.5	56.6

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002.
*$p < .05$ for difference from Demonstration Plan.

Table C.14. Demonstration #7, Health Utilization, Plan and Provider Ratings, 2002

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**7**	
Plan Name	**United Healthcare of Wisconsin**	**Humana**
County	Milwaukee, Ozaukee, Washington, Waukesha (WI)	Cook, Kendall, Kane (IL)
Sample Size	492	948
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	12.2	15.4
Some high school	16.2	18.3
High school graduate or GED	41.6	38.5
Some college/2 yr degree	20.5	16.6
4-year college degree or more	9.5	11.1
Hispanic or Latino origin or descent		
Hispanic or Latino	4.0	6.2
Not Hispanic or Latino	96.0	93.8
Race		
White, non-Hispanic	91.0	79.1*
Black/African-American, non-Hispanic	7.9	19.1*
Asian, non-Hispanic	1.1	1.5
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.0	0.3
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	37.7	29.5*
Good	37.0	35.9
Fair or poor	25.3	34.7*
Health Conditions (%)		
Physical/mental condition 3+ months	56.6	65.0*
Seen doctor 2+ times	70.8	78.5*
Health Utilization (%)		
Doctor's office or clinic visit	70.3	74.5
Specialist visit	48.0	55.4*
Prescription medicine use	88.6	88.6
Emergency room	15.2	23.1*
Inpatient hospitalization	15.0	20.1*
Needed special medical equipment	12.1	13.3
Needed special therapy	10.1	11.8
Home health care	2.3	7.1*
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	29.0	32.9
8	20.8	18.5
9	15.3	15.0
10	34.9	33.6
Rating of providers (0-10)		
0-7	12.9	19.9*
8	17.5	17.8
9	18.5	18.5
10	51.1	43.9*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2002.
*$p < .05$ for difference from Demonstration Plan.

10.3 Summary Statistics on Demonstrations, 2002

Table C.15. Summary Statistics on Enrollee Age, Gender, and Medicaid Status, 2002

Demo No. Plan Name	Group	64 or Under %	65-79 %	80 or Older %	Male %	Medicaid %	Risk Score	N
1	Demo	7.6	73.1	19.2	42.7	6.5	0.97	9,240
Anthem	Comparison	7.3	71.6*	21.1*	41.7	5.7*	0.95	11,676
	FFS	19.1*	60.8*	20.1	41.6	12.0*	1.00	2,158
2	Demo	12.0	53.8	34.2	39.1	2.4	1.03	1,686
Humana	Comparison	7.8*	66.9*	25.3*	35.5	3.7	0.99	843
	FFS	12.7	63.5*	23.8*	40.6	5.1*	0.96*	4,281
3	Demo	5.8	77.9	16.3	42.1	0.7	0.79	22,301
Independence BC	Comparison	4.8*	74.0*	21.1*	41.0*	2.3*	0.97*	19,951
	FFS	19.0*	53.8*	27.2*	39.9*	17.7*	1.07*	15,645
4	Demo	6.1	68.5	25.4	44.4	2.5	0.99	4,464
PacifiCare	Comparison	7.7*	69.7	22.5*	40.1*	2.3	0.94*	8,785
	FFS	25.1*	54.3*	20.6*	44.0	24.5*	0.99	912
5	Demo	5.6	76.2	18.2	42.0	1.5	0.90	3,432
M-Care	Comparison	6.2	75.9	18.0	44.3	2.7*	0.91	2,940
	FFS	18.7*	59.2*	22.1*	42.5	10.5*	0.96*	1,922
6	Demo	4.5	72.8	22.7	46.6	1.3	0.91	4,370
Wheeling-Pittsburgh Steel Corporation	Comparison	13.3*	70.0*	16.7*	44.5	6.8*	0.97*	2,176
	FFS	19.8*	59.5*	20.8	41.4*	15.4*	1.05*	2,370
7	Demo	6.1	74.5	19.5	41.4	1.5	0.89	4,737
United Healthcare of WI	Comparison	10.3*	66.9*	22.7*	39.9*	5.6*	0.92*	39,543
	FFS	15.5*	60.8*	23.7*	40.7	11.5*	0.99*	9,301
	Demo	6.3	74.3	19.4	42.6	2.2	0.88	50,230
All Demonstrations	Comparison	8.3*	69.9*	21.8*	40.6*	4.4*	0.94*	86,005
	FFS	17.6*	57.8*	24.6*	40.6*	14.0*	1.03*	36,589

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2002.
Notes: Demo = Persons enrolled in a demonstration plan; Comparison = Persons enrolled in a comparison plan; FFS = Persons enrolled in fee-for-service Medicare; N = Number of enrollees from GHPM file. FFS Market Area figures are from Five-Percent Sample Denominator File.
*$p < .05$ for difference from Demonstration Plan.

Table C.16. Summary Statistics on Educational Attainment, Race, and Ethnicity, 2002

Demo No. Plan Name	Group	<=HS	Coll+	Hisp.	White	Black	Other	N
1	Demo	84.0	16.0	0.8	97.4	2.0	0.6	983
Anthem	Comparison	78.0	22.0	2.0	93.1	6.3	0.6	496
	Difference	-6.0*	6.0*	1.2	-4.2*	4.2*	0.0	
2	Demo	67.6	32.4	3.8	95.9	1.0	3.2	433
Humana	Comparison	69.3	30.7	3.6	85.0	15.0	0.0	147
	Difference	1.7	-1.7	-0.2	-10.9*	14.0*	-3.2*	
3	Demo	54.6	45.4	0.8	94.4	4.8	0.8	927
Independence BC	Comparison	68.6	31.4	0.7	85.6	14.2	0.2	498
	Difference	14.0*	-14.0*	-0.1	-8.7*	9.3*	-0.6*	
4	Demo	77.3	22.7	29.9	96.0	1.2	2.8	479
PacifiCare	Comparison	57.4	42.6	5.8	94.9	2.5	2.7	512
	Difference	-19.9*	19.9*	-24.0*	-1.2	1.3	-0.1	
5	Demo	45.6	54.4	1.2	93.2	5.2	1.6	523
M-CARE	Comparison	49.8	50.2	1.7	90.9	6.5	2.6	244
	Difference	4.2	-4.2	0.5	-2.3	1.3	1.0	
6	Demo	87.9	12.1	1.1	97.6	2.3	0.1	1474
Wheeling-Pittsburgh Steel Corporation	Comparison	81.4	18.6	2.2	91.6	8.4	0.0	101
	Difference	-6.4	6.4	1.0	-6.0*	6.2*	-0.1	
7	Demo	70.0	30.0	4.0	91.0	7.9	1.1	492
United Healthcare of WI	Comparison	72.3	27.7	6.2	79.1	19.1	1.8	948
	Difference	2.2	-2.2	2.2	-11.9*	11.2*	0.7	
All Demonstrations	Demo	73.0	27.0	4.1	95.7	3.3	1.0	5311
	Comparison	68.4	31.6	3.8	87.0	11.6	1.4	2946
	Difference	-4.6*	4.6*	-0.3	-8.6*	8.3*	0.3	

Source: BearingPoint tabulations of MMC-CAHPS data for 2002.
Notes: <=HS = Persons with a high school diploma or less; Coll+ = Persons with at least some college; Hisp. = Person with Hispanic/Latino ethnicity; Other = Other race; na = not available. N = Number of observations.
* $p < .05$.

Table C.17. Summary Statistics on Health Condition and Utilization, 2002

Demo No. Plan Name	Group	VG/E	F/P	PHYS-MEN	DOC	SPEC	Rx	ER	HOSP	HH
1	Demo	25.1	37.5	69.5	78.6	55.7	91.1	21.6	23.6	4
Anthem	Comparison	26.1	36.1	68.9	79.3	57.7	91.2	16.3	18.9	6.1
	Difference	1.1	-1.4	-0.6	0.8	2.0	0.2	-5.3*	-4.7*	1.7
2	Demo	32.4	32.0	63.6	70.2	48.3	87.3	19.5	20.8	7
Humana	Comparison	26.4	38.2	68.5	81.9	69.7	96.9	18.5	23.3	4.9
	Difference	-6.1	6.2	4.9	11.7*	21.5*	9.6*	-1.0	2.5	-2.0
3	Demo	38.2	22.9	70.1	84.1	74.0	91.5	17.9	19.1	6
Independence BC	Comparison	29.7	23.8	68.4	77.7	65.6	91.4	14.8	19.0	5.3
	Difference	-8.5*	0.9	-1.7	-6.4*	-8.4*	-0.1	-3.1	-0.1	-0.6
4	Demo	19.7	42.3	66.0	73.9	52.4	93.8	20.2	20.5	7
PacifiCare	Comparison	29.3	32.3	72.2	78.7	54.8	90.1	14.9	17.7	4.7
	Difference	9.5*	-10.0*	6.1*	4.8	2.3	-3.7	-5.3*	-2.8	-2.2
5	Demo	36.5	26.1	69.8	77.9	61.4	87.7	18.9	20.5	7
M-CARE	Comparison	36.0	28.9	70.9	79.3	59.1	88.2	21.4	14.7	2.5
	Difference	-0.5	2.8	1.1	1.4	-2.3	0.5	2.5	-5.8*	-4.9*
6	Demo	22.3	36.1	70.0	78.8	59.2	94.4	20.8	23.4	4
Wheeling-Pittsburgh Steel Corporation	Comparison	23.0	41.0	72.9	79.4	52.6	89.3	15.0	17.8	2.1
	Difference	0.7	4.9	2.9	0.6	-6.6	-5.0	-5.8	-5.6	-2.1
7	Demo	37.7	25.3	56.6	68.9	44.6	88.6	13.8	15.0	2
United Healthcare WI	Comparison	29.5	34.7	65.0	72.7	52.8	88.6	20.0	20.1	7.1
	Difference	-8.2*	9.4*	8.4*	3.8	8.2*	0.0	6.1*	5.1*	4.8*
All Demonstrations	Demo	29.0	32.3	67.8	77.5	58.6	91.5	19.4	21.2	5
	Comparison	29.1	32.6	68.4	77.0	57.5	90.2	17.5	19.0	5.5
	Difference	0.1	0.3	0.7	-0.6	-1.1	-1.3	-2.0*	-2.2*	0.4

Source: BearingPoint tabulations of MMC-CAHPS data for 2002.
Notes: VG/E = Very Good/Excellent; F/P = Fair/Poor; PHYS-MEN = Physical or mental condition lasting at least 3 months; DOC = Doctor's office visit; SPEC = Specialist visit; Rx = Took prescription medicine; ER = Emergency room visit; HOSP = Inpatient hospitalization; HH = Home health visit; na =not available.
* $p < .05$.

Table C.18. Summary Statistics on Health Plan and Providers Ratings, 2002

Demo No. Plan Name	Group	Plan 0-7	Plan 8	Plan 9	Plan 10	Prov 0-7	Prov 8	Prov 9	Prov 10
1	Demo	25.2	18.4	17.6	38.7	12.5	20.3	20.7	46.4
Anthem	Comparison	20.5	18.0	17.8	43.7	11.2	13.5	16.9	58.3
	Difference	-4.7	-0.4	0.1	5.0	-1.3	-6.8*	-3.8	11.9*
2	Demo	38.7	19.2	15.0	27.2	17.1	24.6	19.5	38.9
Humana	Comparison	19.1	14.2	18.4	48.2	4.3	20.7	16.4	58.6
	Difference	-19.5*	-5.0	3.5	21.0*	-12.8*	-3.9	-3.1	19.7*
3	Demo	24.9	22.7	19.8	32.6	10.9	16.6	21.7	50.7
Independence BC	Comparison	24.6	20.2	20.6	34.6	11.5	16.3	22.7	49.6
	Difference	-0.3	-2.5	0.8	2.0	0.5	-0.3	0.9	-1.1
4	Demo	33.9	15.2	15.2	35.7	16.5	17.3	16.2	50.0
PacifiCare	Comparison	36.6	20.9	19.3	23.2	20.5	20.0	20.3	39.2
	Difference	2.7	5.7*	4.1	-12.4*	4.0	2.7	4.1	-10.8*
5	Demo	25.9	15.8	23.7	34.6	12.7	18.7	27.3	41.3
M-CARE	Comparison	27.1	17.4	18.6	36.9	15.9	22.2	19.0	42.9
	Difference	1.2	1.6	-5.0	2.2	3.2	3.5	-8.3*	1.6
6	Demo	21.5	16.3	18.4	43.8	13.4	13.6	18.5	54.5
Wheeling-Pittsburgh Steel Corporation	Comparison	27.6	22.4	16.3	33.7	13.2	11.8	18.4	56.6
	Difference	6.0	6.2	-2.1	-10.1*	-0.3	-1.7	-0.1	2.0
7	Demo	29.0	20.8	15.3	34.9	12.9	17.5	18.5	51.1
United Healthcare of WI	Comparison	32.9	18.5	15.0	33.6	19.9	17.8	18.5	43.9
	Difference	3.9	-2.3	-0.3	-1.3	6.9*	0.2	0.0	-7.2*
All Demonstrations	Demo	26.1	18.3	18.3	37.3	13.2	17.4	20.3	49.2
	Comparison	28.7	19.0	17.7	34.6	15.6	17.5	19.2	47.7
	Difference	2.7*	0.7	-0.6	-2.8*	2.4*	0.1	-1.1	-1.5

Source: BearingPoint tabulations of MMC-CAHPS data for 2002.
Notes: “Plan” refers to ratings of health plan; “Prov” refers to ratings of providers. Ratings are on a 0-10 scale in which a higher number represents a better rating; na = not available.
* $p < .05$.

11. Appendix D: Detailed Statistical Results for 2003 (Year 2)

11.1 Plan and Enrollee Characteristics and Health Status, 2003

Table D.1. Demonstration #1, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**1**		
Plan Name	**Anthem**	**Anthem**	**--**
County	Boone (KY), Trumbull, Preble (OH)	Campbell (KY), Shelby, Mahoning (OH)	Boone (KY), Trumbull, Preble (OH)
Plan Characteristics			
Type	HMO	HMO	--
Tax status	NON	NON	--
Enrollees (from GHPM file)	8,476	10,956	2,225
Market penetration (%)	16.5	16.6	
Enrollee characteristics			
Age			
64 or younger (%)	6.9	6.9	20.3*
65-79 (%)	72.6	70.2*	59.3*
80 or older (%)	20.5	22.9*	20.4
Gender (% male)	42.1	41.5	41.8
Medicaid (%)	5.5	4.8*	11.3*
Health Status			
Risk score (mean)	1.03	1.03	1.14*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*$p < .05$ for difference from Demonstration plan.

Table D.2. Demonstration #2, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**2**		
Plan Name	**Humana**	**Sterling**	--
County	DuPage, Il	East Baton Rouge, LA	DuPage, Il
Plan Characteristics			
Type	HMO	HMO	--
Tax status	NON	NON	--
Enrollees (from GHPM file)	1,550	669	4,299
Market penetration (%)	1.6	1.4	--
Enrollee characteristics			
Age			
64 or younger (%)	12.8	6.7*	12.5
65-79 (%)	51.0	64.4*	63.1*
80 or older (%)	36.1	28.8*	24.4*
Gender (% male)	38.8	37.5	40.9
Medicaid (%)	2.8	4.0	5.5*
Health Status			
Risk score (mean)	1.11	1.15	1.02*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*$p < .05$ for difference from Demonstration Plan.

Table D.3. Demonstration #3, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**3**		
Plan Name	**Independence Blue Cross**	**Aetna**	**--**
County	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia	PA: Chester, Delaware, Philadelphia	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia
Plan Characteristics			
Type	PPO	HMO	--
Tax status	NON	PRO	--
Enrollees (from GHPM file)	22,340	18,094	15,824
Market penetration (%)	4.2	5.1	--
Enrollee characteristics			
Age			
64 or younger (%)	5.8	5.5	19.7*
65-79 (%)	78.6	72.5*	53.3*
80 or older (%)	15.5	22.0*	27.0*
Gender (% male)	42.3	40.8*	40.2*
Medicaid (%)	0.6	2.5*	17.3*
Health Status			
Risk score (mean)	0.98	0.98*	1.22*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*$p < .05$ for difference from Demonstration Plan.

Table D.4. Demonstration #4, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**4**		
Plan Name	**PacifiCare**	**PacifiCare**	**--**
County	Pueblo, CO	El Paso, CO	Pueblo, CO
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO	PRO	--
Enrollees (from GHPM file)	3,946	7,596	944
Market penetration (%)	14.9	13.3	
Enrollee characteristics			
Age			
64 or younger (%)	5.1	7.6*	25.4*
65-79 (%)	67.2	67.8	55.2*
80 or older (%)	27.6	24.6*	19.4*
Gender (% male)	43.3	40.5*	44.7
Medicaid (%)	2.9	3.3	22.7*
Health Status			
Risk score (mean)	1.12	1.06*	1.02*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*$p < .05$ for difference from Demonstration Plan.

Table D.5. Demonstration #5, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**5**		
Plan Name	**M-CARE**	**Health Alliance**	**--**
County	Livingston, Washtenaw, MI	Oakland, MI	Livingston, Washtenaw, MI
Plan Characteristics			
Type	HMO	HMO	--
Tax status	NON	NON	--
Enrollees (from GHPM file)	--	2,577	2,199
Market penetration (%)	--	--	--
Enrollee characteristics			
Age			
64 or younger (%)	--	5.2*	18.8*
65-79 (%)	--	74.5*	59.1*
80 or older (%)	--	20.3*	22.1*
Gender (% male)	--	44.3*	42.1*
Medicaid (%)	--	2.7*	10.9*
Health Status			
Risk score (mean)	--	1.00*	1.05*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*$p < .05$ for difference from Demonstration Plan.

Table D.6. Demonstration #6, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**6**		
Plan Name	**HealthAmerica of Pennsylvania, CareLink, Health Plan of the Upper Ohio Valley**	**United Healthcare, Health Plan of the Upper Ohio Valley**	**--**
County	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall	OH: Clark, Monroe; WV: Wetzel	OH: Belmont, Jefferson, Guernsey, WV: Brooke, Hancock, Ohio, Marshall
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO, NON	PRO, NON	--
Enrollees (from GHPM file)	4,345	2,133	2,353
Market penetration (%)	8.0	7.2	--
Enrollee characteristics			
Age			
64 or younger (%)	4.9	12.9*	20.5*
65-79 (%)	70.4	69.5	58.9*
80 or older (%)	24.7	17.6*	20.6*
Gender (% male)	46.2	44.0	41.9*
Medicaid (%)	1.3	6.3*	15.9*
Health Status			
Risk score (mean)	1.20	1.15	1.15

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*p < .05 for difference from Demonstration Plan.

Table D.7. Demonstration #7, Plan and Enrollee Characteristics and Health Status, 2003

Characteristic	Demonstration	Comparison	FFS Market Area
Demonstration Number	**7**		
Plan Name	**United Healthcare of Wisconsin**	**Humana**	**--**
County	Milwaukee, Ozaukee, Washington, Waukesha (WI)	Cook, Kendall, Kane (IL)	Milwaukee, Ozaukee, Washington, Waukesha (WI)
Plan Characteristics			
Type	HMO	HMO	--
Tax status	PRO	NON	--
Enrollees (from GHPM file)	6,645	36,581	9,698
Market penetration (%)	2.6	5.3	--
Enrollee characteristics			
Age			
64 or younger (%)	6.2	9.9*	16.1*
65-79 (%)	75.1	65.6*	59.2*
80 or older (%)	18.7	24.5*	24.7*
Gender (% male)	42.5	39.8*	41.0
Medicaid (%)	2.7	8.2*	11.4*
Health Status			
Risk score (mean)	0.84	0.88*	1.08*

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Plan Benefit Package File, Plan Benefit Package File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
*$p < .05$ for difference from Demonstration Plan.

11.2 Education, Race/Ethnicity, Health Conditions, and Ratings of Plans and Providers, 2003

Table D.8. Demonstration #1, Health Utilization, Plan and Provider Ratings, 2003

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**1**	
Plan Name	**Anthem**	**Anthem**
County	Boone (KY), Trumbull, Preble (OH)	Campbell (KY), Shelby, Mahoning (OH)
Sample Size	942	464
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	10.2	10.0
Some high school	24.8	22.5
High school graduate or GED	48.7	47.1
Some college/2 yr degree	11.3	15.3
4-year college degree or more	4.9	5.2
Hispanic or Latino origin or descent		
Hispanic or Latino	1.5	1.4
Not Hispanic or Latino	98.5	98.6
Race		
White, non-Hispanic	97.0	93.7*
Black/African-American, non-Hispanic	3.0	5.8*
Asian, non-Hispanic	0.0	0.0
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.1	0.5
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	29.2	25.2
Good	38.1	40.8
Fair or poor	32.7	34.0
Health Conditions (%)		
Physical/mental condition 3+ months	58.0	58.3
Seen doctor 2+ times	79.8	75.5
Health Utilization (%)		
Doctor's office or clinic visit	77.1	79.7
Specialist visit	58.8	57.6
Prescription medicine use	90.7	90.8
Emergency room	17.6	20.1
Inpatient hospitalization	22.1	19.4
Needed special medical equipment	13.6	13.5
Needed special therapy	10.2	10.2
Home health care	4.4	7.7*
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	44.5	46.6
8	16.8	16.3
9	11.5	11.3
10	27.2	25.8
Rating of providers (0-10)		
0-7	17.3	14.0
8	17.5	13.7
9	14.5	16.5
10	50.7	55.9

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2003. *$p < .05$ for difference from Demonstration Plan.

Table D.9. Demonstration #2, Health Utilization, Plan and Provider Ratings, 2003

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**2**	
Plan Name	**Humana**	**Sterling**
County	DuPage, IL	East Baton Rouge, LA
Sample Size	441	131
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	16.9	27.2*
Some high school	16.7	14.9
High school graduate or GED	38.2	33.9
Some college/2 yr degree	16.5	12.7
4-year college degree or more	11.8	11.4
Hispanic or Latino origin or descent		
Hispanic or Latino	6.1	0.8*
Not Hispanic or Latino	93.9	99.2*
Race		
White, non-Hispanic	94.6	76.6*
Black/African-American, non-Hispanic	1.4	22.5*
Asian, non-Hispanic	3.6	0.0*
Native Hawaiian/ or PI, non-Hispanic	0.2	0.0
AI/AN , non-Hispanic	0.2	0.9
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	29.2	28.5
Good	39.5	29.9*
Fair or poor	31.3	41.6*
Health Conditions (%)		
Physical/mental condition 3+ months	60.8	68.8
Seen doctor 2+ times	75.7	77.0
Health Utilization (%)		
Doctor's office or clinic visit	75.6	84.5*
Specialist visit	52.3	68.1*
Prescription medicine use	85.6	93.1*
Emergency room	19.5	20.7
Inpatient hospitalization	21.3	28.2
Needed special medical equipment	16.2	11.9
Needed special therapy	10.9	11.6
Home health care	5.9	7.3
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	43.2	32.3*
8	18.8	24.9
9	12.7	12.9
10	25.2	29.9
Rating of providers (0-10)		
0-7	21.2	13.4
8	20.3	14.4
9	19.0	18.7
10	39.5	53.5*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2003. *$p < .05$ for difference from Demonstration Plan.

Table D.10. Demonstration #3, Health Utilization, Plan and Provider Ratings, 2003

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**3**	
Plan Name	**Independence Blue Cross**	**Aetna**
County	PA: Bucks, Chester, Delaware, Montgomery, Philadelphia	PA: Chester, Delaware, Philadelphia
Sample Size	866	443
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	5.2	6.9
Some high school	10.1	20.4*
High school graduate or GED	36.8	40.8
Some college/2 yr degree	20.3	15.4*
4-year college degree or more	27.6	16.4*
Hispanic or Latino origin or descent		
Hispanic or Latino	1.0	2.2
Not Hispanic or Latino	99.0	97.8
Race		
White, non-Hispanic	92.7	86.0*
Black/African-American, non-Hispanic	6.4	13.5*
Asian, non-Hispanic	0.7	0.5
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.3	0.0
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	40.2	29.8*
Good	36.3	41.2
Fair or poor	23.5	29.0*
Health Conditions (%)		
Physical/mental condition 3+ months	65.5	66.7
Seen doctor 2+ times	82.7	85.1
Health Utilization (%)		
Doctor's office or clinic visit	83.0	81.7
Specialist visit	73.6	72.6
Prescription medicine use	90.9	89.5
Emergency room	16.9	17.8
Inpatient hospitalization	21.9	21.5
Needed special medical equipment	11.9	15.6
Needed special therapy	13.2	9.8
Home health care	5.9	6.6
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	38.7	42.5
8	19.8	17.8*
9	15.5	14.0
10	26.0	25.7
Rating of providers (0-10)		
0-7	9.7	12.1
8	18.3	15.0
9	22.0	20.3
10	50.1	52.5

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2003. *$p < .05$ for difference from Demonstration Plan.

Table D.11. Demonstration #4, Health Utilization, Plan and Provider Ratings, 2003

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**4**	
Plan Name	**PacifiCare**	**PacifiCare**
County	Pueblo, CO	El Paso, CO
Sample Size	476	449
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	17.7	7.1*
Some high school	19.7	13.0*
High school graduate or GED	41.1	34.4*
Some college/2 yr degree	17.1	28.7*
4-year college degree or more	4.4	16.8*
Hispanic or Latino origin or descent		
Hispanic or Latino	30.5	8.8*
Not Hispanic or Latino	69.5	91.2*
Race		
White, non-Hispanic	95.9	95.6
Black/African-American, non-Hispanic	2.1	1.9
Asian, non-Hispanic	0.0	1.9*
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	2.0	0.7
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	23.7	32.1*
Good	35.5	36.6
Fair or poor	40.8	31.3*
Health Conditions (%)		
Physical/mental condition 3+ months	64.7	66.4
Seen doctor 2+ times	79.1	76.4
Health Utilization (%)		
Doctor's office or clinic visit	77.0	74.2
Specialist visit	52.6	56.1
Prescription medicine use	92.9	84.7*
Emergency room	17.5	20.5
Inpatient hospitalization	19.4	20.9
Needed special medical equipment	16.9	19.0
Needed special therapy	8.5	12.2
Home health care	8.0	5.5
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	35.2	43.2*
8	19.5	17.9
9	14.5	13.1
10	30.9	25.8
Rating of providers (0-10)		
0-7	10.7	19.9*
8	17.3	17.4
9	13.1	16.8
10	59.0	45.9*

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2003. *$p < .05$ for difference from Demonstration Plan.

Table D.12. Demonstration #6, Health Utilization, Plan and Provider Ratings, 2003

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**6**	
Plan Name	**HealthAmerica, CareLink, Health Plan of the Upper Ohio Valley**	**United Healthcare, Health Plan of the Upper Ohio Valley**
County	OH: Belmont, Jefferson, Guernsey WV: Brooke, Hancock, Ohio, Marshall	OH: Clark, Monroe WV: Wetzel
Sample Size	1400	106
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	12.6	12.7
Some high school	21.0	29.3
High school graduate or GED	54.7	40.7*
Some college/2 yr degree	9.7	14.6
4-year college degree or more	2.1	2.7
Hispanic or Latino origin or descent		
Hispanic or Latino	0.6	0.0*
Not Hispanic or Latino	99.4	100.0*
Race		
White, non-Hispanic	97.8	90.8*
Black/African-American, non-Hispanic	2.0	8.0*
Asian, non-Hispanic	0.0	0.0
Native Hawaiian/ or PI, non-Hispanic	0.0	0.0
AI/AN , non-Hispanic	0.3	1.2
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	22.0	22.5
Good	39.9	37.7
Fair or poor	38.1	39.8
Health Conditions (%)		
Physical/mental condition 3+ months	64.9	69.5
Seen doctor 2+ times	80.6	88.2
Health Utilization (%)		
Doctor's office or clinic visit	77.4	88.3*
Specialist visit	58.9	66.8
Prescription medicine use	92.4	93.8
Emergency room	21.8	21.4
Inpatient hospitalization	23.6	19.3
Needed special medical equipment	13.8	11.7
Needed special therapy	10.4	8.0
Home health care	5.4	2.9
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	33.9	37.1
8	20.4	19.3
9	14.2	18.1
10	31.4	25.5
Rating of providers (0-10)		
0-7	12.7	15.9
8	18.7	13.4
9	18.8	25.2
10	49.8	45.5

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2003. *$p < .05$ for difference from Demonstration Plan.

Table D.13. Demonstration #7, Health Utilization, Plan and Provider Ratings, 2003

Characteristic	Demonstration Plan	Comparison Plan
Demonstration Number	**7**	
Plan Name	**United Healthcare of Wisconsin**	**Humana**
County	WI: Milwaukee, Ozaukee, Washington, Waukesha	IL: Cook, Kendall, Kane
Sample Size	498	419
Enrollee Characteristics (% distribution)		
Education		
8th grade or less	13.4	19.2*
Some high school	18.1	24.0*
High school graduate or GED	37.7	33.9
Some college/2 yr degree	19.3	14.7
4-year college degree or more	11.5	8.2
Hispanic or Latino origin or descent		
Hispanic or Latino	2.5	10.9*
Not Hispanic or Latino	97.5	89.1*
Race		
White, non-Hispanic	88.5	54.5*
Black/African-American, non-Hispanic	10.2	42.0*
Asian, non-Hispanic	0.8	2.4
Native Hawaiian/ or PI, non-Hispanic	0.0	0.2
AI/AN , non-Hispanic	0.5	0.8
Health Experience		
Current Health Status (% distribution)		
Very good or excellent	37.4	25.9*
Good	38.2	35.1
Fair or poor	24.4	39.0*
Health Conditions (%)		
Physical/mental condition 3+ months	55.6	59.3
Seen doctor 2+ times	70.0	80.7*
Health Utilization (%)		
Doctor's office or clinic visit	68.3	71.0
Specialist visit	47.2	49.4
Prescription medicine use	84.5	90.0
Emergency room	21.4	18.9
Inpatient hospitalization	18.3	18.0
Needed special medical equipment	13.0	14.4
Needed special therapy	10.0	11.6
Home health care	3.7	8.3*
Plan and Provider Ratings		
Rating of Medicare health plan (0-10)		
0-7	32.9	34.7
8	16.9	20.5
9	16.4	13.7
10	33.8	31.0
Rating of providers (0-10)		
0-7	15.2	18.1
8	16.6	22.2
9	21.7	16.8
10	46.6	42.9

Source: BearingPoint tabulation of MMC-CAHPS survey data for 2003. *$p < .05$ for difference from Demonstration Plan.

11.3 Summary Statistics on Demonstrations, 2003

Table D.14. Summary Statistics on Enrollee Age, Gender, and Medicaid Status, 2003

Demo No. Plan Name	Group	64 or Under %	65-79 %	80 or Older %	Male %	Medicaid %	Risk Score	N
1	Demo	6.9	72.6	20.5	42.1	5.5	1.03	8,476
Anthem	Comparison	6.9	70.2*	22.9*	41.5	4.8*	1.03	10,956
	FFS	20.3*	59.3*	20.4	41.8	11.3*	1.14*	2,225
2	Demo	12.8	51.0	36.1	38.8	2.8	1.11	1,550
Humana	Comparison	6.7*	64.4*	28.8*	37.5	4.0	1.15	669
	FFS	12.5	63.1*	24.4*	40.9	5.5*	1.02*	4,299
3	Demo	5.8	78.6	15.5	42.3	0.6	0.98	22,340
Independence BC	Comparison	5.5	72.5*	22.0*	40.8*	2.5*	1.06*	18,094
	FFS	19.7*	53.3*	27.0*	40.2*	17.3*	1.22*	15,824
4	Demo	5.1	67.2	27.6	43.3	2.9	1.12	3,946
PacifiCare	Comparison	7.6*	67.8	24.6*	40.5*	3.3	1.06*	7,596
	FFS	25.4*	55.2*	19.4*	44.7	22.7*	1.02*	944
5	Demo	0.0	0.0	0.0	0.0	0.0	0.00	0
M-Care	Comparison	5.2*	74.5*	20.3*	44.3*	2.7*	1.00*	2,577
	FFS	18.8*	59.1*	22.1*	42.1*	10.9*	1.05*	2,199
6	Demo	4.9	70.4	24.7	46.2	1.3	1.20	4,345
Wheeling-Pittsburgh Steel Corporation	Comparison	12.9*	69.5	17.6*	44.0	6.3*	1.15	2,133
	FFS	20.5*	58.9*	20.6*	41.9*	15.9*	1.15*	2,353
7	Demo	6.2	75.1	18.7	42.5	2.7	0.84	6,645
United Healthcare of WI	Comparison	9.9*	65.6*	24.5*	39.8*	8.2*	0.88*	36,581
	FFS	16.1*	59.2*	24.7*	41.0	11.4*	1.08*	9,698
	Demo	6.2	74.3	19.5	42.6	2.1	1.01	47,302
All Demonstrations	Comparison	8.1*	68.4*	23.4*	40.6*	5.7*	0.97*	78,606
	FFS	18.1*	57.0*	24.8*	40.9*	13.7*	1.14*	37,542

Source: BearingPoint and Social & Scientific Systems tabulations of the Group Health Plan Master (GHPM) File, Five-Percent Sample Denominator File, and Inpatient Encounter File for 2003.
Notes: Demo = Persons enrolled in a demonstration plan; Comparison = Persons enrolled in a comparison plan; FFS = Persons enrolled in fee-for-service Medicare; N = Number of enrollees from GHPM file. FFS Market Area figures are from Five-Percent Sample Denominator File.
*$p < .05$ for difference from Demonstration Plan.

Table D.15. Summary Statistics on Educational Attainment, Race, and Ethnicity, 2003

Demo No. Plan Name	Group	<=HS	Coll+	Hisp.	White	Black	Other	N
1	Demo	83.8	16.2	1.5	97.0	3.0	0.1	942
Anthem	Comparison	79.6	20.4	1.4	93.7	5.8	0.5	464
	Difference	-4.2	4.2	-0.2	-3.3*	2.8*	0.4	-478
2	Demo	71.7	28.3	6.1	94.6	1.4	4.0	441
Humana	Comparison	75.9	24.1	0.8	76.6	22.5	0.9	131
	Difference	4.2	-4.2	-5.4*	-18.0*	21.2*	-3.1	-310
3	Demo	52.1	47.9	1.0	92.7	6.4	1.0	866
Independence BC	Comparison	68.2	31.8	2.2	86.0	13.5	0.5	443
	Difference	16.1*	-16.1*	1.2	-6.6*	7.1*	-0.5	-423
4	Demo	78.5	21.5	30.5	95.9	2.1	2.0	476
PacifiCare	Comparison	54.5	45.5	8.8	95.6	1.9	2.5	449
	Difference	-24.0*	24.0*	-21.6*	-0.3	-0.3	0.5	-27
5	Demo	na	na	na	na	na	na	na
M-CARE	Comparison	na	na	na	na	na	na	na
	Difference	na	na	na	na	na	na	na
6	Demo	88.2	11.8	0.6	97.8	2.0	0.3	1400
Wheeling-Pittsburgh Steel Corporation	Comparison	82.7	17.3	0.0	90.8	8.0	1.2	106
	Difference	-5.5	5.5	-0.6*	-7.0*	6.0*	0.9	-1294
7	Demo	69.2	30.8	2.5	88.5	10.2	1.3	498
United Healthcare of WI	Comparison	77.1	22.9	10.9	54.5	42.0	3.4	419
	Difference	7.9*	-7.9*	8.4*	-34.0*	31.8*	2.1*	-79
All Demonstrations	Demo	66.7	33.3	4.2	94.0	5.1	0.9	4623
	Comparison	73.1	26.9	6.7	73.9	24.1	2.1	2012
	Difference	6.4*	-6.4*	2.5*	-20.1*	19.0*	1.2*	-2611

Source: BearingPoint tabulations of MMC-CAHPS data for 2003.
Notes: <=HS = Persons with a high school diploma or less; Coll+ = Persons with at least some college; Hisp. = Person with Hispanic/Latino ethnicity; Other = Other race; na = not available. N = Number of observations.
na – not available
* $p < .05$.

Table D.16. Summary Statistics on Health Condition and Utilization, 2003

Demo No. Plan Name	Group	VG/E %	F/P %	PHYS-MEN %	DOC %	SPEC %	Rx %	ER %	HOSP %	HH %
1	Demo	29.2	32.7	58.0	77.1	58.8	90.7	17.6	22.1	4.4
Anthem	Comparison	25.2	34.0	58.3	79.7	57.6	90.8	20.1	19.4	7.7
	Difference	-4.0	1.4	0.3	2.6	-1.2	0.1	2.5	-2.7	3.2*
2	Demo	29.2	31.3	60.8	75.6	52.3	85.6	19.5	21.3	5.9
Humana	Comparison	28.5	41.6	68.8	84.5	68.1	93.1	20.7	28.2	7.3
	Difference	-0.7	10.3*	8.0	8.9*	15.8*	7.5*	1.2	6.9	1.4
3	Demo	40.2	23.5	65.5	83.0	73.6	90.9	16.9	19.1	5.9
Independence BC	Comparison	29.8	29.0	66.7	81.7	72.6	89.5	17.8	21.5	6.6
	Difference	-10.4*	5.5*	1.2	-1.4	-1.0	-1.4	0.9	2.4	0.7
4	Demo	23.7	23.5	65.5	83.0	73.6	90.9	16.9	21.9	5.9
PacifiCare	Comparison	29.8	29.0	66.7	81.7	72.6	89.5	17.8	21.5	6.6
	Difference	6.1*	5.5*	1.2	-1.4	-1.0	-1.4*	0.9	-0.4	0.7
5	Demo	na	na	na	na	na	na	na	na	na
M-CARE	Comparison	na	na	na	na	na	na	na	na	na
	Difference	na	na	na	na	na	na	na	na	na
6	Demo	22.0	23.5	65.5	83.0	73.6	90.9	16.9	21.9	5.9
Wheeling-Pittsburgh Steel Corporation	Comparison	29.8	29.0	66.7	81.7	72.6	89.5	17.8	21.5	6.6
	Difference	7.8	5.5	1.2	-1.4*	-1.0	-1.4	0.9	-0.4	0.7
7	Demo	37.4	24.4	55.6	68.3	47.2	84.5	21.4	18.3	3.7
United Healthcare WI	Comparison	25.9	39.0	59.3	71.0	49.4	90.0	18.9	18.0	8.3
	Difference	-11.5*	14.6*	3.6	2.7	2.2	5.5	-2.5	-0.4	4.6*
All Demonstrations	Demo	34.1	28.7	62.7	79.1	64.0	90.5	90.5	18.1	21.5
	Comparison	27.3	35.0	62.1	75.8	57.7	89.5	89.5	19.1	19.5
	Difference	-6.7*	6.3*	-0.6	-3.2*	-6.2*	-0.9	-0.9	1.0	-2.0*

Source: BearingPoint tabulations of MMC-CAHPS data for 2003.

Notes: VG/E = Very Good/Excellent health status; F/P = Fair/Poor health status; PHYS-MEN = Physical or mental condition lasting at least 3 months; DOC = Doctor's office visit in last 6 months; SPEC = Specialist visit in last 6 months; Rx = Took prescription medicine in last 3 months for a health condition; ER = Emergency room visit in last 6 months; HOSP = Inpatient hospitalization in last 12 months; HH = Home health visit in last 6 months; na =not available.
* $p < .05$

Table D.17. Summary Statistics on Health Plan and Providers Ratings, 2003

Demo No. Plan Name	Group	Plan 0-7	Plan 8	Plan 9	Plan 10	Prov 0-7	Prov 8	Prov 9	Prov 10
1	Demo	44.5	16.8	11.5	27.2	17.3	17.5	14.5	50.7
Anthem	Comparison	46.6	16.3	11.3	25.8	14.0	13.7	16.5	55.9
	Difference	2.1	-0.5	-0.1	-1.4	-3.3	-3.9	2.0	5.2
2	Demo	43.2	18.8	12.7	25.2	21.2	20.3	19.0	39.5
Humana	Comparison	32.3	24.9	12.9	29.9	13.4	14.4	18.7	53.5
	Difference	-10.9*	6.0	0.2	4.7	-7.8	-5.9	-0.3	14.1*
3	Demo	38.7	19.8	15.5	26.0	9.7	18.3	22.0	50.1
Independence BC	Comparison	42.5	17.8	14.0	25.7	12.1	15.0	20.3	52.5
	Difference	3.9	-2.0*	-1.5	-0.4	2.4	-3.2	-1.7	2.5
4	Demo	35.2	19.5	14.5	30.9	10.7	17.3	13.1	59.0
PacifiCare	Comparison	43.2	17.9	13.1	25.8	19.9	17.4	16.8	25.8
	Difference	8.0*	-1.6	-1.3	-5.1	9.2*	0.2	3.7	-33.2*
5	Demo	na	na	na	na	na	na	na	na
M-CARE	Comparison	na	na	na	na	na	na	na	na
	Difference	na	na	na	na	na	na	na	na
6	Demo	33.9	20.4	14.2	31.4	12.7	18.7	18.8	49.8
Wheeling-Pittsburgh Steel Corporation	Comparison	37.1	19.3	18.1	25.5	15.9	13.4	25.2	45.5
	Difference	3.2	-1.1	3.9	-6.0	3.2	-5.3	6.4	-4.3
7	Demo	32.9	16.9	16.4	33.8	15.2	16.6	21.7	46.6
United Healthcare of WI	Comparison	34.7	20.5	13.7	31.0	18.1	22.2	16.8	42.9
	Difference	1.8	3.7	-2.7	-2.8	3.0	5.6	-4.9	-3.7
All Demonstrations	Demo	38.6	18.9	14.5	28.0	12.4	18.0	19.3	50.3
	Comparison	39.3	18.9	13.5	28.2	15.9	18.1	18.0	48.0
	Difference	0.7	0.0	-1.0	0.2	3.5*	0.1	-1.3	-2.3

Source: BearingPoint tabulations of MMC-CAHPS data for 2003.
Notes: "Plan" refers to ratings of health plan; "Prov" refers to ratings of providers. Ratings are on a 0-10 scale in which a higher number represents a better rating; na = not available.
* $p < .05$.

12. Appendix E: Introductory Letter (Sample)

Date

Name of contact person
Title
Organization
Address 1
Address 2
Address 3

Re: Qualitative Interviews for M+C Alternative Payment Demonstration

Dear Name:

On behalf of the Centers for Medicare & Medicaid Services (CMS), KPMG Consulting is requesting your time to answer some questions in a telephone interview to assess the benefits of the M+C Alternative Payment Demonstration, in which your organization is currently participating. The interview guide is comprised of questions evaluating reasons for participation, expectations of the demonstration, and experiences to date, and should take no more than 30 minutes of your time. A representative from KPMG Consulting will be contacting you shortly to schedule a time that is convenient for you.

We appreciate your cooperation in this endeavor and we look forward to your comments. If you have any questions, please contact James Moser of KPMG Consulting at 703-747-6962.

Sincerely,

Kenneth R. Cahill
Managing Director

cc: CMS Demonstration Project Officer
CMS Plan Manager
CMS Regional Office Contact
Victor G. McVicker, CMS

13. Appendix E: Questionnaire Instrument (Original)

Original Key Informant Interview Guide

1. Reasons for Participation
    a. **What is the reason that your organization proposed an alternative payment arrangement?**

    b. **Which one—the prospect of higher payment, or risk sharing—was more important in your decision and why?**

    c. **Did your plan consider other payment approaches, and if so, what factors led to the decision to move forward with this particular payment approach? What would you plan to do if the demonstration were not available?**

    d. **What were the market conditions for the benefits you were addressing at the time your organization was considering participating in the demonstration? What opportunity in the insurance market did your organization attempt to take advantage of by participating in the demonstration (i.e., price, access, quality, choice, diversity of offerings, number and desirability of benefits, consistency)? What degree of importance was assigned to these factors?**

    e. **Prior to your organization's commitment to participate in the alternative payment project, did you conduct any research on other payment alternatives? Do you have any written reports on this research that you could share with us?**

    f. **What changes have been made to your plan operations to participate in this demonstration?**

2. Expectations of Demonstration
    a. **How do you expect this alternative payment initiative to affect the local insurance market? What possible benefits does your organization hope to realize upon participating in the demonstration?**

    b. **Which groups/demographics do you hope to address with your organization's participation in this initiative? What impacts on beneficiaries enrolled in the demonstration do you expect as a result of your plan's participation in the demonstration?**

    c. **To what degree do you expect enrollees' access to care to be affected by your organization's participation in the demonstration? How do you expect these changes will affect the enrollees' satisfaction with the plan in general, and specific dimensions of care?**

d. **Would you provide some of the advantages the demonstration plan has over your non-demonstration plan? Disadvantages? With these issues in mind, could you propose some ways of improving on the demonstration?**

e. **What is the applicability of the demonstration plan to other plans/sites?**

f. **Do you believe the alternative arrangement should be permanent?**

g. **What does your organization plan to do after the conclusion of the demonstration on 12/31/03?**

h. **Was the demonstration plan offered to employer groups? Are they risk-sharing with respect to employer groups? How did risk-sharing affect benefit plan design and pricing for employer groups as compared with individuals?**

3. Experiences to Date

Since the demonstration began on [date], please share what your organization's experiences have been regarding:

a. **The overall financial experience and how it is related to the alternative payments under the demonstration.**

b. **The demographic groups you had hoped to address.**

c. **Impacts on beneficiaries' access to care.**

d. **Impacts on beneficiaries' satisfaction with your plan.**

e. **Advantages to your organization of participation in the demonstration.**

f. **Disadvantages to your organization of participation in the demonstration.**

g. **Applicability of the demonstration to other plans/sites.**

4. Do you have any written materials you could share with us?

14. Appendix F: Questionnaire Instrument (Revised)

Revised Key Informant Interview Guide

1. Reasons for Participation

a. Please briefly describe your organization's alternative payment arrangement under this demonstration.

b. Why did you propose an alternative payment arrangement?

c. Which one—the prospect of higher payment, or risk sharing—was more important in your decision and why?

d. Did you consider other payment approaches?

1). [If Yes:] Why did you go forward with this particular payment approach?

a). Did you conduct any research on other payment alternatives?

i. [If Yes:] Do you have any written reports on this research that you could share with us?

ii. [If No: Skip to e]

2). [If No: Skip to e]

e. What would you have done if the demonstration were not available?

f. From a business perspective, what opportunity in the insurance market did you attempt to take advantage of by participating in the demonstration (for example: price, access, quality, choice, diversity of benefits)?

g. What changes to your plan operations did you make to participate in this demonstration?

2. Expectations of Demonstration

a. How did you expect this alternative payment initiative to affect the local insurance market?

b. What benefits did your organization hope to realize by participating in the demonstration?

c. Which demographic groups did you hope to address with your organization's initiative?

d. What impacts on the beneficiaries in your demonstration plan did you expect (for example, access, satisfaction, out of pocket costs)?

e. What are some of the advantages the demonstration plan has over your non-demonstration plan? Disadvantages?

f. With these issues in mind, what are some ways of improving on the demonstration?

g. What is the applicability of the demonstration plan to other plans/sites?

h. Do you believe the alternative arrangement should be permanent?

i. What does your organization plan to do after the conclusion of the demonstration?

j. Was the demonstration plan offered to employer groups?

1). [If Yes:] Is the plan risk-sharing with respect to employer groups?

a). [If Yes:] How did risk-sharing affect benefit plan design and pricing for employer groups as compared with individuals?

b). [If No, go to 3]

2). [If No, go to 3]

3. Experiences to Date

Since the demonstration began, what has been your organization's experiences regarding:

a. Your overall financial experience and how it is related to the alternative payments demonstration?

b. The demographic groups you had hoped to address?

c. Impacts on beneficiaries' access to care?

d. Impacts on beneficiaries' satisfaction with your plan?

e. Advantages to your organization of participation in the demonstration?

f. Disadvantages to your organization of participation in the demonstration?

g. Applicability of the demonstration to other plans/sites?

4. Do you have any written materials you could share with us?