POLICY BRIEF

PRIVATE, INDIVIDUAL DRUG COVERAGE IN THE CURRENT MEDICARE MARKET

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PRIVATE, INDIVIDUAL DRUG COVERAGE IN THE CURRENT MEDICARE MARKET

Reliance on the private market to offer drug coverage to Medicare beneficiaries is a hallmark of the two congressional bills now in conference. When evaluating these bills, it is useful to consider issues related to Medigap and Medicare+Choice—two current private, individual drug coverage plans for Medicare beneficiaries. Lessons gleaned from these examples suggest that individual market initiatives addressing drug coverage will need to find ways to achieve better participation (of plans and beneficiaries) than currently exist in the Medigap and Medicare+Choice markets. Financial subsidy levels, regulations concerning access, and geographic variation also will need to be addressed in new private, nongroup initiatives on Medicare drug coverage.

This brief uses the 2003 House and Senate bills to provide concrete examples of likely private market approaches. With respect to some issues, these two drug benefit proposals include measures that ameliorate identified problems with Medigap and the Medicare+Choice program. In other cases, the proposals ignore lessons learned from these programs.

The Medigap Market: An Unpopular Source for Drug Coverage

Medigap insurance offers a set of 10 standardized health insurance plans (labeled A through J) designed specifically to supplement the traditional Medicare fee-for-service program. All 10 Medigap plans, for instance, cover Medicare's hospital deductible; just three plans cover prescription drugs—Plans H, I, and J. Medigap policies are sold by private insurers and marketed primarily to individual beneficiaries. Although the benefits of each of the 10 plans are standardized, the prices are not. Consequently, premiums vary substantially among beneficiaries based on factors such as age, health, and geographic area.[1]

The three Medigap policies that cover prescription drugs all have limits on the coverage they provide. All three plans have a $250 annual deductible for drugs and a 50 percent coinsurance rate. Plans H and I cap the amount paid for an individual's drugs at $1,250 per year. To receive this maximum benefit, a beneficiary must have purchased at least $2,750 in prescription drugs and spent at least $1,500 out-of-pocket. Plan J has a higher payment cap—$3,000 per year—at which point a beneficiary must have purchased

[1] Grandfathered plans (available prior to 1992) and variations in some states also exist, but are not considered here. The number of beneficiaries with pre-standard Medigap coverage is decreasing steadily.

$6,250 in prescription drugs and spent $3,250 out-of-pocket in order to reach the maximum benefit.

Medigap policies that cover prescription drugs are not popular. Indeed, only 6 percent to 8 percent of all standard Medigap policies currently owned by Medicare beneficiaries cover prescription drugs.[2] Two issues discussed below—high prices and access—offer some explanation for the low enrollment rates.

Medigap premium cost issues. In addition to being extremely expensive—averaging $3,065 per year for Plan J for persons age 65 in 2000[3]—Medigap policies are simply a bad deal financially. That is, even those who can afford drug coverage through Medigap do not purchase it, because to them it costs more than it is worth. Determining the cost of drug coverage through Medigap requires some simple calculations because Medigap has no drug-only plans; all three of the plans that cover prescription drugs include additional benefits. To calculate the portion of the premium associated with only the drug coverage, we compare two Medigap plans that differ primarily in whether they include that coverage. Therefore, the premium difference between the two plans is the consumers' cost to upgrade to a policy with drug coverage (assuming that the value of all other benefits remains the same).

Plan G and Plan I may be used to make this cost comparison, because the two plans differ almost entirely with respect to the presence of prescription drug coverage in Plan I.[4] Text Box 1 presents three calculations showing the cost of the added drug coverage in Plan I. These examples reveal that in some areas of the country, insurers effectively charge more for drug coverage than the maximum possible benefit, and certainly more than the expected actuarial value. For example, in Miami, annual premiums for Plan G for a 65-year-old man, range from $1,766 to $3,585; premiums for Plan I range from $3,090 to $5,870. By subtracting Plan G premiums from Plan I premiums, we conclude that Medicare consumers are facing a range of $1,324 to $2,285

[2] See Deborah Chollet and Anna Cook, *The Cost of Medigap Prescription Drug Coverage* (Washington, D.C.: Mathematica Policy Research, Inc., August 2001). See also U.S. General Accounting Office, *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs* (Washington, D.C.: GAO, July 2001).

[3] Deborah Chollet and Anna Cook, *The Cost of Medigap Prescription Drug Coverage* (Washington, D.C.: Mathematica Policy Research, Inc., August 2001).

[4] Although both Plan G and Plan I cover Part B charges that exceed Medicare reimbursement, Plan G (the non-drug plan) covers 80 percent of these charges, while Plan I (the drug plan) covers them in full. Medicare limits to 15 percent the amount providers and suppliers may bill a patient in excess of the Medicare-approved amount. For example, if the Medicare-approved amount is $100 for a given procedure, a physician may charge a maximum of $115. A beneficiary with Plan G would be liable for a maximum of $3. Further, few doctors charge these additional amounts.

for prescription drug coverage in Plan I.[5] Yet the maximum amount Plan I will pay for drugs is $1,250—less than the differential in premium costs for all plans in the range, including the lowest-cost plan. Clearly, purchasing Plan I rather than Plan G is unwise in Miami. In addition to the premium costs, beneficiaries estimating their expected drug costs often may find that their added deductible and cost-sharing expenses make upgrading to Plan I more expensive than staying with Plan G and paying for all their drugs out-of-pocket. Similar results would apply for Plans H and J.

Premium cost issues in drug plan proposals. The current standardized Medigap market has proven to be an unlikely mechanism for offering reasonably priced drug coverage in the future. It is difficult, however, to determine what the "right" price for private, drug-only coverage should be, because enrollees' drug needs can vary significantly across private insurers. That is, plans with sicker beneficiaries need to charge higher premiums. Any drug benefit passed by Congress will need to address ways to keep premiums affordable, likely through generous subsidies, while also minimizing plans' ability to avoid high-cost beneficiaries.[6] Without careful controls, the market will likely mimic Medigap with very high costs associated with the more comprehensive options.

Both the House and Senate drug bills prohibit attained-age premium rating, currently permitted in many state Medigap markets. This practice allows insurers to increase premiums as the policyholders age, causing considerable financial hardships for older beneficiaries who tend also to have lower incomes, on average. Instead, both bills require community rating, which means that all beneficiaries in the same plan generally pay the same premium. Community rating would protect older beneficiaries (who disproportionately have health problems) from paying exorbitantly high premiums. It can, however, contribute to another dilemma by discouraging younger and healthier individuals from enrolling, thus exacerbating risk selection. To address this potential problem, considerable subsidies would be needed to increase participation among people who expect below-average drug expenses. These subsidies would lower individuals' premiums and thus make drug coverage more attractive to those who do not anticipate high annual drug costs. When healthier people purchase drug coverage, average per person costs decline. Even more important, costs grow more slowly over time.

Medigap access issues. The steep premium prices discussed above prohibit many individuals from purchasing drug coverage through Medigap. This is particularly true for

[5] Premiums were obtained from Weiss Ratings, Inc., a company that provides insurance industry analysis.

[6] Further discussion of risk-selection issues in drug coverage can be found in Cristina Boccuti and Marilyn Moon, *Adverse Selection in Private, Stand-Alone Drug Plans and Techniques to Reduce It* (New York: The Commonwealth Fund, October 2003).

people who have health problems and live in states without community-rating requirements. In addition to steep prices, lack of guaranteed-issue regulations in most states also may contribute to the low enrollment rates in Medigap's prescription drug plans, particularly among people with disabilities. Medigap insurers in most states can deny a drug coverage policy to Medicare beneficiaries based on health status, unless they are applying during their initial Medicare enrollment period[7] or have other special circumstances. Further, Medigap insurers in most states are *never* required to offer disabled beneficiaries under age 65 a drug coverage policy.

Access issues in drug plan proposals. The 2003 House and Senate drug bills require plans to accept all eligible Medicare applicants, but allow plans to impose financial penalties on beneficiaries who delay enrollment past their initial enrollment period. The House bill permits plans to vary the premium penalty for individual applicants based on health status and other demographic characteristics. This underwriting practice (used by many Medigap insurers) may result in plans charging extremely high premiums to some late enrollees, particularly those with health problems, effectively eliminating their access to drug coverage. Consequently, those who initially decline coverage may face the same affordability and access problems currently affecting most Medigap markets. This is especially true in the House bill because it does not establish limits on the penalties that plans may impose. The Senate bill contains more oversight on penalties, requiring that they be standardized across all enrollees based on a specified penalty amount per year for delayed enrollment. This procedure is similar to the current method for determining delayed Medicare Part B enrollment penalties, which has worked relatively well.

Medicare+Choice: A Program with Declining Participation

Through the Medicare+Choice program, the federal government subsidizes private managed care plans to offer coverage to Medicare beneficiaries. Medicare+Choice plans are allowed to charge premiums (over and above beneficiaries' Part B premiums) if they provide additional benefits, such as prescription drug coverage. Those premiums cannot vary by age or other beneficiary characteristics. In some parts of the country, particularly urban areas, beneficiaries have joined Medicare+Choice plans to take advantage of these supplemental benefits. However, the last four years have seen a sharp decline in the number of plans and enrollees participating in the program because of dissatisfaction on the part of all parties involved: private health plans, providers, and beneficiaries.[8] From

[7] A beneficiary's initial enrollment period is a seven-month window of time, usually beginning three months before turning age 65.

[8] Brian Biles, Geraldine Dallek, and Andrew Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future* (New York: The Commonwealth Fund, September 2002).

1999 to 2003, more than 2.4 million beneficiaries were affected by the withdrawal of Medicare+Choice plans.[9]

Many other beneficiaries may have opted not to join a Medicare+Choice plan because of the negative publicity surrounding these withdrawals. In the future, beneficiaries may be reluctant to accept private options for drug coverage (through managed care and/or private insurance plans) without guarantees that plans will not disrupt their medical care by withdrawing from the market, abruptly altering formularies, or instituting steep premium increases. Primary care physician turnover rates in Medicare+Choice plans also have been high in many geographic areas.[10] These concerns are especially important for the chronically ill and for low-income beneficiaries, a problem discussed further in Cristina Boccuti, Marilyn Moon, and Krista Dowling, *Chronic Conditions and Disabilities: Trends and Issues for Private Drug Plans* (New York: The Commonwealth Fund, October 2003).

Medicare+Choice plan benefits also have decreased, with fewer HMOs offering prescription drug coverage, or offering it subject to strict caps on the amount of benefits available.[11] For example, in a recent study, Achman and Gold found that among Medicare+Choice plans offering drug coverage in their 2003 standard benefit package, 60 percent limited that coverage to generic medications only.[12] This finding marks a steep trend in reducing brand-name drug coverage; in 2001, only 19 percent of Medicare+ Choice plans with drug coverage in their basic benefit package had limited coverage to generics. Furthermore, this study found that plans that *do* cover both brand-name and generic drugs have tightened the annual limits on that drug coverage—25 percent of these plans cap drug coverage at $500 or less.

Whether justified or not, Medicare's limit on payment increases to Medicare+ Choice plans is blamed for the pullouts of private health plans from the Medicare+Choice program and reductions in drug coverage. This is a complicated issue. Although plans were being overpaid to provide Medicare-covered services, they devoted most of the

[9] Marsha Gold, Lori Achman, and James Verdier, *The Medicare Preferred Provider Organization Demonstration: Overview of Design, Characteristics, and Outstanding Issues of Interest* (Washington, D.C.: AARP Public Policy Institute, Publication #2003-07, June 2003).

[10] Geraldine Dallek, Brian Biles, and Lauren Hersch Nicholas, *Lessons from Medicare+Choice for Medicare Reform* (New York: The Commonwealth Fund, June 2003).

[11] Medicare Payment Advisory Commission, *Report to Congress: Assessing Medicare Benefits* (Washington, D.C.: MedPAC, June 2002).

[12] Lori Achman and Marsha Gold, *Medicare+Choice Plans Continue to Shift More Costs to Enrollees* (New York: The Commonwealth Fund, April 2003).

excess to additional services, especially prescription drugs.[13] Then, just when drug costs began to rise rapidly, the Balanced Budget Act of 1997 was passed and payment increases to plans—linked to Medicare spending on fee-for-service beneficiaries—were only about 2 percent. Thus, the complaints from plans of insufficient payments may reflect their difficulty covering *non*-Medicare benefits, such as prescription drugs.

Participation issues in drug plan proposals. The lesson for the proposed prescription drug coverage legislation is that private plans are willing to pull out of participation if they find themselves in an unprofitable situation. They may also change the terms of coverage. Under these circumstances, a Medicare fallback option—discussed in more detail below—could be particularly important to beneficiaries. Policymakers also need to consider measures that could be put in place if private plans become too costly. Also, without the requirement of a standard set of benefits, plans may manipulate benefit packages where possible to lower costs and attract the healthiest applicants.[14] The House and Senate bills establish a "standard" benefit package, but both allow plans to vary its actual structure. Indeed, the House bill does not specifically require plans to offer the standard benefit.

Geographic Variation in Access to and Affordability of Coverage

Because spending on prescription drugs varies widely across the United States,[15] Medicare+Choice and Medigap both face issues of geographic variation. For example, in the Medicare+Choice program, plan availability and the comprehensiveness of benefit packages vary considerably across the country. Able to select their service areas by county, Medicare+Choice plans have been less willing to enter rural areas. Indeed, in 2003, only 13 percent of beneficiaries living in rural areas had access to a Medicare+ Choice managed care plan, compared with 72 percent in urban areas.[16] Moreover, only half of all Medicare beneficiaries have access to at least one Medicare+Choice managed care plan with drug coverage.[17] In areas where Medicare's payments to plans are considered low, drug benefits may only be offered with large premiums. Therefore,

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[13] U.S. General Accounting Office, *Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings* (Washington, D.C.: GAO, September 2000).

[14] A further discussion of risk-selection issues can be found in Cristina Boccuti and Marilyn Moon, *Adverse Selection in Private, Stand-Alone Drug Plans and Techniques to Reduce It* (New York: The Commonwealth Fund, October 2003).

[15] Fred Teitelbaum et al., *Express Scripts 2000 Drug Trend Report* (St. Louis: Express Scripts, June 2001); Department of Health and Human Services, *Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices* (Washington, D.C.: DHHS, April 2000).

[16] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2003).

[17] Carlos Zarabozo, Presentation at "Health Insurance for the Elderly: Issues in Measurement," sponsored by Agency for Healthcare Research and Quality, April 29, 2003.

beneficiaries' access to drug coverage through managed care plans depends heavily on where they live.

The federal government has tried to entice managed care plans to enter rural markets by increasing subsidies to Medicare+Choice plans, but drug benefits have declined and fewer beneficiaries are enrolling in these plans each year. Moreover, recent findings from the preferred provider organization (PPO) demonstration project show that although PPOs generally receive higher subsidies than Medicare+Choice plans and also incur less risk, most PPOs (80%) have not entered rural markets. Further, only 16 percent of PPOs offer generic and brand-name drug coverage, 24 percent offer no drug coverage, and 60 percent offer generic-only drug coverage.[18]

Medigap plans also are subject to geographic variation in premium prices and availability. A 2001 report by the General Accounting Office (GAO) found that although most Medigap insurers offer plans without drug benefits, comparatively few offer the three standardized plans that include prescription drug coverage (Plans H, I, and J).[19] For example, in New York, only a single insurer offers Plan J and in Delaware, *no* insurer offers any of these plans. Additionally, Medigap plans charge vastly different premium amounts based on geographic area, at both the county and state levels. Referring back to Text Box 1, Plan I premiums for a 65-year-old man in Miami range from $3,090 to $5,870; in Sioux City, they range from $1,467 to $4,587.[20]

Ultimately, a beneficiary without employer-sponsored retiree health benefits, who is seeking drug coverage from a Medigap policy or an HMO, quickly discovers that although the specific problems associated with each may differ, the end result—limited access to drug coverage—is the same for both. That is, although Medigap prescription drug policies are offered in most U.S. counties, the premiums are unaffordable for many beneficiaries, particularly the very old. Meanwhile, Medicare+Choice plans, with somewhat lower premiums, generally are unavailable to rural beneficiaries, offer declining drug benefits, and are plagued with market instability.[21]

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[18] Leslie Greenwald, Lee Mobley, Greg Pope, Shula Bernard, Nathan West, Philip Salib, John Kautter, Mark Bruhn, Victor McVicker, Ronald Deacon, and Debbie Van Hoven, "Medicare Preferred Provider Organization (PPO) Demonstration: Early Findings from the Demonstration Sites," Poster presentation at AcademyHealth Annual Research Meeting, Nashville, Tenn., June 2003.

[19] U.S. General Accounting Office, *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs* (Washington, D.C.: GAO, July 2001).

[20] Some of the premium price variation may be attributable to differences in rating methods (e.g., issue-age, attained-age, and community-rating) sometimes regulated by the state.

[21] Geraldine Dallek, Brian Biles, and Lauren Hersch Nicholas, *Lessons from Medicare+Choice for Medicare Reform* (New York: The Commonwealth Fund, June 2003).

Geographic variation issues in proposed drug plans. The 2003 House and Senate prescription drug bills attempt to address geographic differences in the willingness of plans to participate by permitting Medicare to take on more of the risk in areas where plans resist entering the market. In contrast to the House bill, however, the Senate bill guarantees drug coverage in all parts of the country by offering a Medicare-sponsored fallback plan in areas with fewer than two private plans. The stability of this option in the Senate bill could be further improved by allowing fallback plans to remain in the area for several years.

The design of premium subsidies is likely to raise geographic equity concerns with respect to both the House and Senate bills. Although the Congressional Budget Office (CBO) currently estimates that, *on average*, beneficiaries will face $35 premiums for basic coverage in stand-alone drug plans under both bills, *actual* premiums and benefits would likely vary considerably by geographic area.

The Senate bill adjusts the national average premium subsidies to drug plans by geographic differences in input prices and possibly utilization differences. With these adjusters, the dollar amount discrepancies could become quite visible and thus quite contentious, as currently seen in the Medicare+Choice program. Additionally, beneficiaries in rural areas may find themselves in less-generous drug plans than their urban counterparts because rural plans would receive lower federal subsidies. Accordingly, rural beneficiaries could face higher premiums, more restrictive formularies, and higher cost-sharing than urban beneficiaries.

The reverse likely would be the case if Medicare's payments to plans per beneficiary were, instead, the same across the country, as is proposed for drug plans in the House bill. Under this scenario, beneficiaries in urban areas likely would be offered leaner benefit packages than those in rural areas.

Conclusions

It is safe to assume that a Medicare drug benefit offered through the private market would contain some of the features found in Medigap and Medicare+Choice plans—the current options for Medicare beneficiaries to obtain individual drug coverage (where available). Future drug plan premiums need to be more affordable than current Medigap options and plans need to be more stable and generally more accessible to rural beneficiaries than current Medicare+Choice options. Fallback provisions are likely to be a key element for ensuring access. Also, with broader reliance on private plans for prescription drug coverage, the equity issues raised by geographic variations will need to be addressed. To

achieve these goals, generous plan subsidies and consumer access regulations will be required to support private market initiatives.

Text Box 1

Consumer Cost for Medigap
Prescription Drug Coverage for Males at Age 65, 2003

Plan G and Plan I differ almost entirely with respect to the presence or absence of prescription drug coverage.* Thus, a comparison of premiums for these plans reveals the costs a 65-year-old man faces if he wants to upgrade Plan G to add drug coverage. Plan I has a maximum payout of $1,250 for drugs.

Miami, Florida

Plan I	$3,090 – 5,870	(premium range)
Plan G	– $1,766 – 3,585	(premium range)
	$1,324 – 2,285	(drug portion of Plan I)

Sacramento, California

Plan I	$1,334 – 5,659	(premium range
Plan G	– $1,125 – 2,083	(premium range)
	$ 209 – 3,576	(drug portion of Plan I)

Sioux City, Iowa

Plan I	$1,467 – 4,587	(premium range)
Plan G	– $ 819 – 1,886	(premium range)
	$ 648 – 2,701	(drug portion of Plan I)

* Although both Plan G and Plan I cover Part B charges that exceed Medicare reimbursement, Plan G (the non-drug plan) covers 80 percent of these charges, while Plan I (the drug plan) covers them in full. Medicare limits to 15 percent the amount providers and suppliers may bill a patient in excess of the Medicare-approved amount.

Source: Premiums obtained from Weiss Ratings, Inc.
http://www.weissratings.com/News/Ins_Medigap