SHOULD MEDICARE HMO BENEFITS BE STANDARDIZED?

Peter D. Fox, Rani Snyder,
Geraldine Dallek, and Thomas Rice

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TABLE OF CONTENTS

Executive Summary v

Introduction 1

Medigap Reform: What Is It, Has It Succeeded, and Is It Applicable to HMOs? 2
- Background of the Medigap Reform Legislation. 2
- Impact of the Medigap Reforms 3
- Differences Between HMO and Medigap Coverage 4

How Confusing Are Medicare HMO Benefits? 5

The Standardization Debate 8
- Arguments for Standardizing Benefits. 8
- Arguments Against Standardizing Benefits 9

Alternatives to Full Standardization of Benefits 11

Discussion and Recommendations 12

Appendix A Participants at the Medicare HMO Standardization Meeting Held on November 13, 1998 15

Appendix B Benefits Comparison for Los Angeles 17

Appendix C Benefits Comparison for Chicago 27

Appendix D Discrepancies Between Marketing Materials and Medicare Compare for Three Health Plans in Los Angeles 35

EXECUTIVE SUMMARY

Some 6 million Medicare beneficiaries are enrolled in health maintenance organizations (HMOs), which have wide latitude in designing their benefit packages. In contrast, the only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. This paper addresses whether Medicare HMO benefits should also be standardized.

Differences Between HMO and Medigap Coverage

In seeking to apply the experience of the 1990 Medigap reform legislation to HMOs, one must be aware of several key differences:

- The Medicare HMO market is less mature than the Medigap market, which has a history that dates back to the implementation of Medicare in 1966.

- HMO benefit and premium levels exhibit greater geographic variation than Medigap policies, reflecting differences in county-based Medicare payment levels to HMOs.

- Consumers select Medigap policies based mostly on premiums, benefits, and service from the carrier, whereas enrolling in an HMO also entails accepting the health plan's delivery system. Plans differ in their network composition, medical necessity determination processes, ease of access to specialists, drug formulary composition, and quality assurance mechanisms, none of which lend themselves to standardization.

- Benefits in an HMO change frequently in response to changes in local market conditions and federal policy (including Medicare payment levels), and standardization may complicate responding to these changes.

How Confusing Are Medicare HMO Benefits?

In examining the marketing materials disseminated by six large HMOs in Los Angeles County, California, and Cook County, Illinois (Chicago), plan benefits, as described, were found to be very confusing. Three sources of potential confusion are analyzed. The first concerns plans' use of different wording to describe the same benefit. The second results from the failure of some plans to list all the benefits that are offered. Both of these issues can be addressed by standardizing the format and wording of the information provided to beneficiaries rather than standardizing the actual benefits. The third source of confusion lies in the benefits themselves; prescription drugs were found to be particularly confusing.

Pros and Cons of Standardizing Benefits

Standardizing Medicare HMO benefits would not only make plan comparisons easier for consumers, it would potentially encourage competition on cost and quality. Without standardization, plans' benefit packages could become even more confusing if, as seems likely, the availability of point-of-service offerings increases.

The major argument against standardization is that it would reduce both consumer choice and the ability of HMOs to innovate in designing their benefits. In addition, standardization would also shift the process of benefit package design from the marketplace to the political arena.

Alternatives to Full Standardization of Benefits

If the Medigap model were followed, the federal government would designate a set of standardized HMO benefit packages that would be the only ones that could be offered. Less far-reaching reform options include:

- Standardizing the format and wording of benefit descriptions in marketing materials.
- Standardizing within certain categories of benefits, such as copayments for Medicare-covered services, prescription drugs, and dental, vision, and hearing benefits.
- Establishing a minimum benefit package while allowing HMOs to market more comprehensive benefits. The minimum benefit package could include prescription drugs in order to prevent health plans from dropping drug coverage for enrollees who may not be healthy enough to qualify for a Medigap plan that covers drugs.
- Adopting a "core-plus-rider" approach, in which a minimum level of supplemental benefits is established, with a series of standardized riders that can be purchased individually.

Discussion

The authors' view is that standardizing the format and wording of benefits in plan marketing materials would significantly improve comparability. Although some level of standardization of the benefits themselves would also be appropriate, steps would have to be taken to avoid stifling plans' creativity in designing benefit packages. For the near future, the authors recommend that only a limited number of benefit package features be standardized. For example, health plans could be required to allow physicians the discretion to prescribe up to a 90-day supply of drugs; to state any benefit limits on an annual basis (rather than, say, a quarterly basis); and to use a standardized method of calculating when these limits have been reached.

An incremental approach permits an assessment of standardization efforts before undertaking further expansion. In this way, the unintended consequences that may be inherent in complete and immediate standardization of benefits can hopefully be avoided.

SHOULD MEDICARE HMO BENEFITS BE STANDARDIZED?

INTRODUCTION

Some 6 million Medicare beneficiaries are enrolled under capitated arrangements in HMOs. In March 1998, 72 percent of these enrollees had a choice of more than one HMO, and 39 percent had access to five or more.[1] The differences in premiums charged and benefits and health care delivery systems offered by these plans is creating difficulty for beneficiaries who are trying to make an informed choice. Currently, HMOs have wide latitude in benefit package design as long as Medicare benefits are included.

With Medigap policies—private insurance that pays benefits beyond those included in the standard Medicare program—the situation is different. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) required that, effective July 31, 1992, the only Medigap policies which could be sold were the 10 standardized packages designed by the National Association of Insurance Commissioners (NAIC).[2] In addition, some large employers who offer employees a choice of multiple plans have specified the benefit packages for the health plans with which they contract in order to promote comparability.

In addressing whether Medicare HMO benefits should similarly be standardized, this paper draws on comparisons of benefit packages offered by health plans in Los Angeles and Chicago and interviews with key government officials, health plan representatives, large employers, and consumer groups. It was informed by a one-day meeting in November 1998, funded by the Robert Wood Johnson Foundation, of persons who are particularly knowledgeable about HMO and benefits standardization issues. That meeting was jointly convened under the auspices of *Health Affairs* and George Washington University's Health Insurance Reform Project, which is also funded by the Foundation. Participants included health plan representatives, the federal government, state regulators, consumer groups, and the academic community. (See Appendix A for a listing of meeting participants.)

The report that follows will review the experience of Medigap standardization and discuss the relevance of that experience for HMOs; analyze selected benefit offerings for Los Angeles and Chicago health plans; present the advantages and disadvantages of standardization; and discuss alternatives to the OBRA '90 approach to Medigap standardization.

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[1] Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, Washington, D.C., July 1998.

[2] Exceptions were made for three states—Massachusetts, Minnesota, and Wisconsin—that had standardized Medigap offerings prior to 1990. In addition, carriers could continue to offer old (nonstandardized) policies to persons already covered prior to the implementation of OBRA '90. Also, the Balanced Budget Act of 1997 allowed insurers to offer selected plans with a high deductible—$1,500 in 1998 and 1999, with adjustments to be made in subsequent years for rises in the consumer price index. Finally, standardization does not apply to retiree benefits, that is, employer-provided benefits that supplement Medicare.

MEDIGAP REFORM: WHAT IS IT, HAS IT SUCCEEDED, AND IS IT APPLICABLE TO HMOs?

Background of the Medigap Reform Legislation

OBRA '90 dramatically changed the rules regarding the sale of Medigap policies. The cornerstone of the Medigap reform provisions was the requirement that benefits be standardized in order to lessen confusion among consumers caused by the disparate benefit packages that were then being sold. Other provisions included:

- increasing the minimum loss ratio—the ratio of benefit payments to premiums—for individual policies from 60 to 65 percent;[3]

- limiting agent commissions for the first year of coverage to reduce the incentive to "churn," that is, to switch beneficiaries' coverage in order to earn additional commissions;

- instituting severe penalties for agents and insurers who knowingly sell duplicate coverage;

- requiring that insurers hold a six-month open enrollment period when beneficiaries age 65 or older first enroll in Part B of the Medicare program; and

- limiting preexisting condition exclusions to the first six months of coverage.[4]

During the deliberations leading to the enactment of the 1990 Medigap reforms, no consideration was given to standardizing the benefit offerings of HMOs. HMO and Medigap regulations also differ with regard to open enrollment, preexisting condition exclusions, and premium-setting practices. In each case, HMOs are more tightly regulated than Medigap plans. With regard to open enrollment, Medigap carriers are allowed to medically screen and may deny coverage, except during the six-month open enrollment period and under other limited circumstances set forth in the Balanced Budget Act of 1997 (BBA '97), such as being enrolled in an HMO that terminates its Medicare contract. HMOs, in contrast, are never allowed to reject an applicant because of his or her health status.[5] Also, HMOs are never allowed to exclude coverage of preexisting conditions, whereas Medigap policies may do so for up to six months if the

[3] The minimum loss ratio for group policies remained at 75 percent.

[4] A second preexisting condition period may not be imposed if a person switches plans or carriers. However, after the six-month open enrollment period, carriers can, with limited exceptions, refuse coverage. Also, the BBA '97 precludes application of preexisting exclusions during the open enrollment window for individuals who have been covered continuously during the six months prior to first obtaining Medigap coverage.

[5] By law, HMOs are not allowed to enroll individuals who have end-stage renal disease at the time of application. Also, prior to the enactment of the Balanced Budget Act of 1997, beneficiaries already in hospice could not enroll in HMOs; as a result of the act, beneficiaries in hospice may now enroll in HMOs.

applicant lacked private health insurance during the prior six months. Finally, with regard to premium-setting practices, HMOs must "community rate"—charge the same premium to all enrollees. Medigap carriers, on the other hand, are allowed to relate premiums to the enrollee's age.

Impact of the Medigap Reforms

A four-year study of the OBRA '90 reforms has found that consumer understanding of benefits, as reported by consumer representatives and state health insurance regulators, has been significantly enhanced.[6] This finding has been confirmed by more recent interviewing as well. In addition, consumer complaints to insurance commissioners' offices have declined markedly since implementation of the reforms.[7] In Florida, for example, the number of Medicare-related complaints fell from 812 in 1990 to 178 in 1994. In Wisconsin, which standardized Medigap benefits in 1989, complaints declined from 819 in that year to 250 in 1997.[8]

Another measure of the reforms' impact is national loss ratio data, which all states report to the National Association of Insurance Commissioners (NAIC). If standardization enhances price competition—an objective of the 1990 legislation—one would expect that a higher proportion of the premium dollar would be paid in benefits rather than retained for administration and profit. Consumers benefit from higher loss ratios, whereas health plans strive to keep them low to bolster profitability.

Though ambiguous, the national loss ratio data support, if only minimally, the hypothesis that standardization results in higher loss ratios (Exhibit 1). In the four years preceding the introduction of standardization (1988–91), loss ratios nationally averaged 81.6 percent; the average loss ratio for 1994–96 was 83.2 percent. To be sure, this difference is small. However, the proportion retained for administration and profit decreased fairly substantially from 18.4 percent to 16.8 percent—a decline of 8.7 percent.[9]

Exhibit 1
Loss Ratios: Individual and Group Medigap Policies

	Loss Ratio

[6] See P. D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* 20 (Spring 1995):31–47; L. A. McCormack, P. D. Fox, T. Rice and M. L. Graham, "Medigap Reform Legislation of 1990: Have the Objectives Been Met?," *Health Care Financing Review* 18 (Fall 1996):157–74; and T. Rice, M. L. Graham, and P. D. Fox, "The Impact of Policy Standardization on the Medigap Market," *Inquiry* 34 (Summer 1997):106–16.

[7] See McCormack et al. Other provisions, such as ones designed to combat churning and sale of duplicate coverage, have undoubtedly contributed to the decline in complaints. Nevertheless, standardization was in all likelihood the major factor.

[8] Conversation with Guenther Ruch, Director, Market Regulation Bureau, Office of the Commissioner of Insurance, State of Wisconsin.

[9] The loss ratio for 1992 is ignored because it was a transitional year in which states were required to implement the federally defined standardization requirements. Disregarding 1993 seems reasonable as well: it was an atypical year in that Medigap carriers faced greater risk from having to set premiums for benefit packages that they had not previously offered.

Year	(Percent)
1988	84.0%
1989	77.7
1990	81.2
1991	83.4
Average 1988–91	*81.6*
1992	79.7
1993	75.9
1994	81.3
1995	85.6
1996	82.5
Average 1994–96	*83.2*

Source: National Association of Insurance Commissioners.

Nevertheless, these data should be interpreted with caution, as health insurance pricing is generally thought to be subject to underwriting cycles of several years' duration. In addition, many carriers that previously did not vary premiums by age, or based them on the enrollee's age at the time of enrollment (the "issue age"), switched to basing them on "attained age," or the enrollee's age at any given time. With issue age policies, carriers expect to make money on younger enrollees and incur losses on older ones, a loss against which they may feel a need to keep a reserve. However, the need for reserves to protect against losses for this specific reason is obviated when plans shift from issue to attained age.

Also, some people argue that HMOs have benefited from more favorable than expected risk selection and/or more rapid enrollment, leaving the Medigap pool with the sicker, more expensive enrollees. If true, loss ratios would have risen temporarily in a manner unrelated to whether or not standardization has enhanced price competition. This argument, however, is unpersuasive: insurers would have to consistently underestimate any effect of beneficiaries' switching from Medigap to HMO coverage.

Finally, the increase in the minimum loss ratio for individual policies could have had an impact. However, it would have been a small one, since most policies were significantly above the minimum.

Differences Between HMO and Medigap Coverage

Applying the experience of the 1990 Medigap reforms to HMOs can be problematic. First, the Medicare HMO market may be less mature than the Medigap market, which has a history that dates back to the implementation of Medicare in 1966. Second, HMO benefit and premium levels exhibit greater geographic variation than Medigap policies, reflecting differences in county-based Medicare payment levels for HMOs.[10] For example, in some market areas HMOs

[10] The Balanced Budget Act of 1997 made several changes to the way in which HMOs are paid, including blending county and national rates in order to reduce payment variations.

offer generous drug coverage as part of basic benefits, while in others they do not. This wider variation exists because HMOs with capitation contracts are financially liable for all Medicare benefits, not just the supplementary portion, as is the case with Medigap coverage.

Third, consumers select Medigap policies mainly on the basis of premiums, benefits, and the services, whereas enrolling in an HMO also entails accepting the health plan's delivery system. HMO plans differ in their network composition, processes for determining medical necessity, ease of access to specialist care, drug formulary composition, and quality assurance mechanisms—none of which easily lend themselves to standardization.

Fourth, HMO benefits change frequently in response to changes in local market conditions and federal policy, including Medicare payment levels. Some argue that standardization would hinder responses to these changes, particularly when most benefits would not normally be changed in small increments. For example, a plan would be loath to change its coverage for skilled nursing facility benefits beyond those covered by Medicare from 50 to 48 days a year. On the other hand, premium levels could be adjusted in small increments, provided a premium is charged.[11]

HOW CONFUSING ARE MEDICARE HMO BENEFITS?

To answer this question, the study examined plans in two counties with high Medicare HMO market penetration: Los Angeles County, California, and Cook County, Illinois (Chicago). Since the only health plans available to beneficiaries are those that serve the area in which they reside, plan benefits were compared only within each market. The three plans with the highest market penetration within each county were identified through the Health Care Financing Administration (HCFA) web page, and their marketing packages were obtained from the health plans. In comparing benefits, every attempt was made to be accurate; however, for this study, reflecting the information that consumers actually have when choosing plans was the most important consideration. Thus, when the details of a plan's benefits were unclear—which was true in several instances—no attempt was made to verify the information with the health plan.

Three sources of potential confusion exist. The first occurs when health plans employ different wording to describe the same benefit; for example, a benefit covered without a cost-sharing requirement might be described by one plan as being "covered in full" and by another as having "no charge." Exhibit 2 illustrates some of the differences identified for the three Los Angeles plans. The second source of confusion lies in the failure of some plans to list all the benefits offered, particularly Medicare benefits that plans are required to cover. An enrollee who is not aware that a benefit exists may not request it. The marketing materials for Kaiser

[11] Approximately 70 percent of HMOs do not charge a premium for basic coverage. However, the lower payment levels and increased regulatory burden in the BBA '97 are likely to lead to increased premiums.

Permanente in Los Angeles, for instance, do not specify that pap smears or colorectal cancer screening are covered. They also state that chiropractic services are excluded and make no mention of covering manual manipulation of the spine. United HealthCare of Illinois also fails to mention that it covers physical therapy, occupational therapy, second opinions, and preventive services such as mammography and influenza vaccinations.

Exhibit 2
Examples of Wording Differences Among HMOs in Los Angeles

"Zero premiums" may mean:
- No premiums (Kaiser Permamente)
- Members must continue to make monthly Part B premiums (CareAmerica)
- Low or no monthly premiums (PacifiCare)

Hospital care that is paid in full is described as:
- Covered in full for an unlimited number of days (PacifiCare)
- Covered in full for an unlimited number of days as long as the stay is medically necessary according to Medicare guidelines (CareAmerica)
- No charge (Kaiser Permamente)

For prescription drug formularies:
- Kaiser Permamente is explicit that there is a formulary.
- PacifiCare mentions that there is a formulary but does not explain what it is.
- CareAmerica makes no mention of a formulary.

Inpatient mental health benefits are:
- Same as Medicare's (CareAmerica)
- Fully covered for 190 days, including partial hospitalization and psychiatric programs (PacifiCare)

The third source of confusion lies in the benefits themselves. Not only are there numerous differences among plans' individual benefits, but multiple combinations of features are offered. Appendixes B and C compare the benefits provided by the three largest plans in Los Angeles and Chicago. In preparing them, the wording from the health plans' marketing materials was changed to make the benefit descriptions as consistent as possible with each other in order to illustrate true differences in benefits rather than differences in wording. The objective in so doing was to determine whether standardizing the presentations eliminated most of the confusion. Confusion arises not only from differences among health plans in the individual benefits they offer but also from the large number of combinations of features from which beneficiaries must choose.

The greatest difficulty consumers face is in comparing benefits that Medicare does not cover, such as prescription drugs, dental care, hearing tests and aids, and vision care. In Los Angeles, for example, PacifiCare's prescription drug benefits are unlimited; Kaiser has an annual limit of $2,000; and CareAmerica has no limit on generics but imposes a limit on brand-name drugs of $900 *per quarter*.

Copayments may also vary depending on whether a drug is brand-name or generic, if it is obtained through mail order, and what the maximum supply is that can be prescribed without generating a new copayment. To illustrate the latter, the maximum supply allowed per fill for drugs dispensed through a retail pharmacy among the six HMOs studied is 30, 31, 90, or 100 days. Two HMOs did not state limits on drugs obtained through a retail pharmacy, although they undoubtedly impose them. Five of the plans allow a 90-day supply for mail-order drugs (Kaiser's limit is 100 days); however, the two plans that did not state a maximum for drugs dispensed through a pharmacy do subject the 90-day supply to a double copayment.

Copayments and upper limits also vary for a variety of Medicare-covered services. For example, PacifiCare charges $20 for in-area emergency services, Kaiser charges $3, and CareAmerica charges the lesser of $25 or 20 percent of charges. PacifiCare and CareAmerica waive the copayment if the beneficiary is admitted to the hospital; Kaiser apparently does not do so, although the marketing materials are unclear.

Except for CareAmerica in Los Angeles, which offers vision coverage, none of the six plans examined offer significant point-of-service benefits, which pay for services rendered by non-network providers. However, such benefits are offered by plans in other markets and are a growing phenomenon. Plans differ in their deductibles, coinsurance, and limits on these benefits, which typically range from $2,000 to $50,000 per year. Some plans cover only services that are provided outside the service area (often referred to as a "travel benefit"); since urgent out-of-area services are always covered, confusion is likely regarding the scope of this benefit. In addition, some plans limit the nature of services that are offered—for example, by not covering certain hospital services or occupational or speech therapy—and some require pre-certification for services delivered by non-network providers.

For the Los Angeles health plans, the information contained in the marketing materials was also compared with the Medicare Compare web site, which lets beneficiaries compare plans' benefit packages. Significant discrepancies were discovered:[12]

- PacifiCare's marketing materials state that only one benefit plan is offered—a fact confirmed by calling the health plan—but Medicare Compare reports that two plans are offered. Also, inconsistencies exist in the descriptions of the cost-sharing and benefit limit structure for prescription drugs, preventive dental services, and chiropractic care.

- CareAmerica's marketing materials list only one available benefit plan, while Medicare Compare reports, erroneously, that four plans are offered that differ in premium and

[12] Some of the wording in the Medicare Compare web site was also vague, which could to some extent reflect the newness of the service. To ameliorate the problem, HCFA plans in the future to base the Medicare Compare tables on the benefit and rate filings that HMOs are required to submit annually.

number of chiropractic visits allowed per year. For physical exams, CareAmerica specifies a $3 copayment, whereas Medicare Compare states only that enrollees are covered for one physical exam per year—thus implying that no copayment is charged, since copayments *are* specified for other benefit categories.

(See Appendix D for a more extensive list for the three Los Angeles health plans included in this study.)

THE STANDARDIZATION DEBATE

Arguments for Standardizing Benefits

The major argument in favor of standardizing HMO benefits is that doing so would make it easier for consumers to compare plans. As with Medigap, standardization would reduce consumer choice because there would be fewer benefit package on the market. This choice becomes less meaningful, however, if the choices are confusing. Standardization also has the potential to enhance price competition. In addition, several respondents felt that the greater comparability of benefits achieved through standardization would allow prospective enrollees to focus on delivery system differences and would also enhance competition based on quality. Finally, some interviewees felt that the HMO Medicare market was mature enough to withstand standardizing at least some of the benefits, such as prescription drugs, but not long-term care. However, they also saw the need for a defined process to reassess the standardized benefit packages every few years in light of changed market conditions.

Many of the consumer representatives interviewed for this study believe that ensuring some standard level of prescription drug coverage is particularly important, even it entails higher premiums. They argue that: (1) managing care is difficult if prescription drugs are not covered; (2) where health plans drop coverage of drugs, enrollees may not have the opportunity to revert to a Medigap policy that does; and (3) covering prescription drugs as part of basic benefits reduces the potential for the HMO to gain from favorable risk selection.

Some consumer representatives felt that HMOs are allowed to market benefits that may be accurately portrayed but are in fact illusory. For example, the extent to which the price of "discounted" dental services is below the amount charged is generally not stated in brochures. Furthermore, dentists who agree to the discounts may do so only as a loss-leader to undiscounted services. These interviewees questioned whether such a benefit constituted anything more than meaningless product differentiation.

The advent of point-of-service, if it is in fact a trend, will make comparison of benefits even more complicated. Developing standardized packages for these benefits could prove particularly challenging.

Arguments Against Standardizing Benefits

One argument against standardizing HMO benefit packages for Medicare beneficiaries is that choosing a health care delivery system—which selecting an HMO entails—is more important than the choosing the benefit package itself. Medigap policies, by contrast, differ mainly in their benefits, price, and carrier-provided service. By this argument, standardizing benefits solves at most a minor problem.

Another argument against standardization is that it would reduce the ability of HMOs to innovate in designing their benefit packages. Although this was also a principal objection to standardizing Medigap policies, the level of HMO experimentation in designing benefits for the Medicare population is greater than in the years preceding the OBRA '90 reforms. Furthermore, this period of creative ferment is likely to continue for several years as HMOs respond to the far-reaching changes in the BBA '97 and the implementing regulations.

An example of health plan innovation that might be hindered by standardization concerns copayment levels. Traditionally, health plans have had set copayment levels for physician visits, differing only according to whether the provider was a primary care physician (PCP) or a specialist to whom the patient was referred. Some health plans, however, while requiring beneficiaries to visit doctors only within the network, charge lower copayments for specialist visits when the patient has first obtained a referral from his or her PCP. This hybrid of a PCP gatekeeper model and an open-access model could be attractive to many consumers. Indeed, choosing the type of health care delivery system, which selecting an HMO entails, may in general be more important than choosing the benefit package itself. Standardizing benefits, as some contend, solves at most a minor problem.

Health plans may also have less flexibility to react to changes in the Medicare program itself. The fee-for-service Medicare program undergoes changes regularly in terms of benefits as well as coverage and reimbursement rules. Although these changes are in theory reflected in HMO payment levels and thus would require few adjustments, HMOs may not consider the payment change to have been accurately calculated. Medigap policies also have to adjust to changes in Medicare, but the effects are more dramatic for HMOs, which are at risk for all benefits—not just the supplemental portion.

Another argument against standardization is that it may reduce the ability of plans to respond to geographic variation in benefit levels, which to a substantial degree mirror variations in the county-based monthly capitation amounts that plans receive from Medicare. The level of benefits in a standardized package might be acceptable to consumers in some markets but not in others. On the other hand, the 10 standardized Medigap packages do vary in the level of benefits they provide. The least comprehensive package, Plan A, covers mostly Medicare

coinsurance and not, for example, the Part A or Part B deductibles or prescription drugs. The most comprehensive one, Plan J, pays deductibles, offers limited prescription drug coverage, and covers SNF coinsurance, foreign travel, and selected preventive and in-home benefits not paid for by Medicare. Average premiums for Plan J are more than three times those of Plan A.[13] HMOs, however, need not offer more than one plan and thus can elect to offer benefits that are within the range of what is attractive in the local market place.[14]

Finally, some of those interviewed expressed concern that standardization would shift the process of benefit package design from the marketplace to the political arena. The 1990 Medigap reform legislation instituted a process that is instructive in this regard.[15] The NAIC was given nine months to formulate as many as 10 standard policies—an unusual role for a private body, albeit one that represents state regulators. (Had it failed, HCFA would have assumed this role.) Beyond that, Congress offered little guidance regarding the content of the policies or the process for developing them. To conduct this task, the NAIC established an advisory working group composed of six insurance and six consumer representatives, which became the focal point for designing the policies.

The process is widely regarded as having worked well. Credit is given to the consensus-building roles of the two co-chairs, one an insurance industry representative and the other a consumer representative; the superior technical work of the NAIC staff; and the willingness of individual members of the work group to reconcile their differences. Some benefit issues were hotly debated, such as ones related to the inclusion of prescription drugs and preventive services, and the process was not devoid of politics. Nevertheless, agreement was reached in the end, and standardization was successfully implemented.

ALTERNATIVES TO FULL STANDARDIZATION OF BENEFITS

If the Medigap model of benefit standardization were followed, the federal government would designate a set of standardized benefit packages that would be the only ones that could be sold.[16] Retiree health plans would be exempt, and health plans would decide which of the standardized packages to market. However, options that are less far-reaching than this exist. They include:

[13] McCormack et al., 1996, p. 169.

[14] This provision would be different from the Medigap requirement that HMOs offer, at a minimum, the basic Medicare Plan A benefits package, with the marketing of any of the other nine standard plans optional.

[15] For a detailed description of the process, see Fox et al.

[16] OBRA '90 allows states to approve the sale of "innovative benefits" that would represent variations on the 10 standardized Medigap packages, and a similar provision would be adopted for HMOs. However, few states have approved the offering of innovative benefits.

1. **Standardizing the format and wording of HMOs' marketing materials.**[17] Under this approach, HCFA would promulgate a standard format and guidelines for proper wording of benefit descriptions in health plan literature. For example, if a service is covered in full, the standardized wording might be "covered in full" rather than "no charge." HCFA public information campaigns would also reflect the standardized format and wording.[18]

2. **Standardizing only within major categories of benefits.** Standardization could be limited to a few areas, such as copayments for Medicare-covered services and prescription drugs. For prescription drugs, health plans might be required to set copayments at either $5 or $10 and to state benefit limits on an annual basis only (at present, limits can be annual, quarterly, or monthly). The method for determining when benefit limits have been reached could be standardized as well. Currently, health plans differ in how they count benefit payments for this purpose: calculations may reflect the full retail price, the payment rate that plans negotiate with pharmacies, or the price at which pharmacies acquire the prescription drug. As a result, what appear to consumers as identical limits are, in fact, different. In addition, the maximum supply of prescription drugs allowed before a new copayment is charged could be set at 90 days or some other agreed-upon period. Within these constraints, plans would be free to mix and match benefits.

3. **Establishing a minimum benefit package.** With this option—which was in effect for Medigap prior to the OBRA '90 reforms—HMOs would be allowed to sell any benefit package as long as it includes certain standard benefits. However, a minimum benefit package does little to reduce beneficiary confusion, since all carriers include additional benefits in their offerings.

4. **The core-plus-rider approach.** This entails setting a minimum level of supplemental benefits plus allowing a series of riders to be sold individually. Such an approach permits enrollees to tailor their benefit package to their needs. The core plan might involve significant copayments, but the enrollee would be able to purchase separate riders for (1) lower copayments for physician services, (2) lower copayments for hospital and other institutional services, and (3) prescription drugs. A major concern with the core-plus-rider approach is that it can lead to biased selection, particularly for prescription drug coverage, which may be selected principally by individuals with

[17] HCFA staff believe that this option can be implemented under existing law; the other options would require new legislation.

[18] HCFA has announced that in 1999 it will issue regulations to standardize the manner in which at least some benefits are presented in marketing materials.

chronic conditions requiring ongoing medication.[19] However, Wisconsin's Medigap core-plus-rider plan, which was adopted in 1989 and includes a freestanding prescription drug rider, has apparently worked well over the years.[20]

DISCUSSION AND RECOMMENDATIONS

Although the November 1998 health insurance reform meeting that informed this paper was never intended to reach a consensus, there was agreement on many issues.[21] In general, participants regarded the standardization approach adopted by OBRA '90 for Medigap insurance policies as overly rigid for HMOs given the current high level of innovation in benefit design. Participants also agreed that the nature and scope of the benefits offered by individual health plans were difficult to understand from reading plans' marketing materials. Standardizing the wording and format of benefit descriptions, it was felt, would facilitate comparisons for potential and current enrollees. Meanwhile, health plan representatives agreed that regulations governing the information provided to Medicare beneficiaries should be exclusively a HCFA responsibility and that states should be precluded from issuing contradictory requirements.[22]

A greater divergence of views existed with regard to whether any benefit standardization was appropriate. Of particular concern to several meeting attendees who opposed standardizing benefits was the potential for stifling innovation in copayment structure and other areas. These individuals felt that although the many benefit variations resulting from ongoing innovation may have contributed to consumers' confusion, they are nonetheless part of an adaptive process whereby health plans attempt to control costs while still offering features that will be attractive to consumers.

Some participants also suggested that the distinction between standardizing the presentation of benefits and standardizing the benefits themselves was not as clear-cut as might appear. For example, a benefit offered by one plan that appears to be identical to a benefit offered by another plan—based on the information provided to consumers by the two plans—may in fact not be, because of differences in how the HMOs count expenses toward the benefit limit. Therefore, any meaningful requirement to standardize the presentation of benefits in health plan literature would potentially have to dictate the manner in which plans calculate

[19] McCormack et al. present evidence that the three standardized Medigap policies (Plans H, I, and J) do, in fact, face adverse risk selection.

[20] On the other hand, McCormack et al. found significant evidence of adverse risk selection in the three standardized plans (H, I, and J) that cover prescription drugs. Wisconsin is one of three states that is exempt from the federal standardization requirements because it had a program in place at the time 1990 legislation was enacted.

[21] See the introduction to this paper for background on the meeting.

[22] HCFA representatives said that activity was already underway to standardize wording and format.

benefit limits. Such a requirement could be viewed as restricting plans' ability to structure the benefits they offer.

Among those favoring standardization, two approaches were advanced, which are not mutually exclusive. The first is to establish a minimum benefit package that would be broader than the current requirement to cover standard Medicare benefits. The second is to standardize a limited number of benefit package features, including particularly confusing ones such as prescription drug coverage; for example, a standard might be set for the maximum-day supply allowed. In addition, the sentiment among consumer representatives was to prohibit benefits whose actual value they doubted. They cited as an example "discounted" dental and other services that in reality offer only minimal real savings to patients and are used primarily as a loss-leader to attract patients.

The authors believe that some minimal level of benefit standardization, in addition to standardization in plans' presentation of benefit information in their marketing materials, would be appropriate. However, concern over stifling HMOs' creativity in designing benefits, combined with reluctance to impose too much additional regulatory burden on health plans at this time, leads us to recommend that only a limited number of benefit package features be standardized. A good place to start would be to require that physicians be given the discretion to prescribe up to a 90-day supply of drugs, that any benefit package dollar limit be annual, and that the method used by HMOs to calculate when a particular benefit limit has been reached be standardized.

Finally, several meeting participants argued that any standardization runs the risk of being a slippery slope to comprehensive interventions that could end up restricting productive innovation. The authors believe, on the contrary, that consumer confusion will remain a major problem without some level of benefit standardization. By starting out modestly, the results of standardization can be assessed before further expansion is undertaken. In this way, the unintended consequences that could result from a comprehensive standardization program can hopefully be avoided.

APPENDIX A

PARTICIPANTS AT THE MEDICARE HMO STANDARDIZATION MEETING HELD ON NOVEMBER 13, 1998

Christine Boesz
Aetna/US Health Care

Bonnie Burns
California HICAP Association

Gary Claxton
U.S. Department of Health and Human Services

Carol Cronin
Health Care Financing Administration

Joyce Dubow
American Association of Retired Persons

Sandra Foote
Health Insurance Reform Project

Thomas Gustafson
Health Care Financing Administration

Peter Hickman
Health Care Financing Administration

John Iglehart
Health Affairs

Nora Super Jones
National Health Policy Forum

Judith Mears
Kaiser Foundation Health Plans

Marianne Miller
Health Insurance Association of America

Marilyn Moon
Urban Institute

Patricia Neuman
Henry J. Kaiser Family Foundation

Susan Raetzman
The Commonwealth Fund

Guenther Ruch
Wisconsin Office of the Commissioner of Insurance

William Scanlon
General Accounting Office

Mary Beth Senkewicz
National Association of Insurance Commissioners

Joel Slackman
BlueCross BlueShield Association

Richard Smith
American Association of Health Plans

George Strumpf
Alliance of Community Health Plans

APPENDIX B

BENEFITS COMPARISON FOR LOS ANGELES

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
PREMIUM (monthly)	"Low or no monthly plan premiums."	$0	Must continue making Medicare Part B premium payments monthly.
INPATIENT HOSPITAL SERVICES	Paid in full for unlimited days.	Paid in full.	Paid in full for an unlimited number of days, as long as the stay is medically necessary according to Medicare guidelines.
OUTPATIENT HOSPITAL SERVICES			
Surgical services	Paid in full.	Paid in full.	Paid in full.
Rehabilitation	Paid in full.	Paid in full.	Paid in full.
Renal dialysis	Paid in full.	Paid in full.	Paid in full.
Blood transfusions and blood components	Paid in full.	Paid in full.	Paid in full.
SKILLED NURSING FACILITY CARE			
Copayment beyond 20 days	Paid in full.	Paid in full.	Paid in full.
Coverage beyond 100 days	0	0	50
PHYSICIAN SERVICES AND VISITS TO SPECIALISTS	Paid in full.	$3 copayment.	$3 copayment.
PHYSICAL AND OCCUPATIONAL THERAPY	Paid in full.	Paid in full.	Paid in full.
SECOND OPINION	Paid in full.	Covered.	$3 copayment.
MEDICAL SUPPLIES	Paid in full.	Paid in full.	Paid in full.
LABORATORY SERVICES	Paid in full.	Paid in full.	Paid in full.
X-RAY SERVICES	Paid in full.	Paid in full.	Paid in full.

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
PREVENTIVE SERVICES			
Annual physical exams	Paid in full.	$3 copayment.	$3 copayment (one exam/12 months)
Mammography	Paid in full.	Covered.	If doctor is seen only for this service, there is no copayment.
Pap smears	Paid in full.	Not specified.	If doctor is seen only for this service, there is no copayment (every one to three years).
Colorectal cancer screenings	Not specified.	Not specified.	Paid in full.
Immunizations: Influenza Pneumonia Hepatitis B Other vaccines	 Paid in full. Other immunizations for adults as recommended by Medicare.	Paid in full for generally available immunizations. Half of nonmember rates for other immunizations.	 Paid in full if doctor is seen only for this service. Office copayment only. Office copayment only. Office copayment only.
Allergy tests and treatment	Paid in full.	Paid in full.	Office copayment only.
EMERGENCY SERVICES			
In-area	$20 copayment (waived if admitted).	Standard copayments apply.	$25 copayment or 20% of charges, whichever is less (waived if admitted).
Out-of-area	$20 copayment (waived if admitted). Coverage is worldwide.	Paid in full (as well as could be determined).	$10 copayment (waived if admitted). Coverage is worldwide.
Ambulance services	Paid in full, worldwide.	Paid in full, worldwide.	Paid in full when services are medically necessary according to Medicare guidelines.

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
PRESCRIPTION DRUGS			
Limits	Unlimited.	Total annual maximum limit of $2,000, based on Kaiser's acquisition costs. (prescription cost less member copayment)	$900 limit per quarter for brand-name drugs *only*. No limit for generic drugs.
Brand-name drugs	$15 copayment for 30-day prescription.	$7 copayment for 100-day supply.	$12 copayment for 31-day supply.
Generic drugs	$5 copayment for 30-day prescription.	$7 copayment for 100-day supply.	$7 copayment for 31-day supply.
Mail-order	$30 copayment per 90-day formulary prescription for brand-name drugs; $10 copayment for 90-day prescription for generic.	$7 copayment for 100-day supply.	$18 copayment for 90-day brand-name supply. $12 copayment for 90-day generic supply.
Medicare-approved outpatient drugs	Immunosuppresive drugs covered at 80% within the first 36 months following a Medicare-approved organ transplant; thereafter coverage is 50% of charges. Injectable drugs for osteoporosis covered in full for post-menopausal homebound women under a doctor's supervision. Self-administered Erythropoietin and chemotherapy drugs covered in full.	Not specified.	Same as Medicare. Immunosuppresive drugs covered at 80% following a Medicare-approved organ transplant. (note: benefits not subject to $900 quarterly limit for brand-name drugs)

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
DENTAL			
Office visit	$5 copayment.	$5 copayment.	$5 copayment.
Diagnostic services	Paid in full for necessary X-rays.	Paid in full for X-rays, exam, and diagnosis.	Copayments for services by contracting providers range from $35 for an abstraction and $150 for a root canal to $400 for a partial denture.
Preventive services	Cleanings every 6 months: $10 for first cleaning; $20 for second cleaning.	No cost for prophylaxis, preventive dental education, or topical fluoride.	Not specified.
Restorative services	Not specified.	Copayments range from $15 for simple fillings to $75 for composite restorations.	Not specified.
Oral surgery	Not specified.	Copayments range from $35 for extractions to $150 for complete bony impaction.	Not specified.
Emergency services	Not specified.	$35 copayment for emergency treatment (palliative per visit).	Not specified.
MENTAL HEALTH			
Outpatient	$10 copayment/visit for unlimited visits when authorized.	$20 copayment/individual visit and $10 copayment/group therapy visit for first 20 outpatient visits per calendar year.	$3 copayment/visit for unlimited visits.
Inpatient	Paid in full (190 days lifetime limit).	Paid in full (190 days lifetime limit) plus 45 additional days of hospital care.	Paid in full (190 days lifetime limit).
Partial hospitalization psychiatric program	Paid in full.	Paid in full plus 90 additional days.	Office copayment only.

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
VISION CARE			
Eye exam	No charge for annual exam (refraction).	$3 copayment.	$5 copayment in network. Up to $30 reimbursement out of network. (once/12 months)
Spectacle lenses	$20 at contracting providers (once/24 months).	No charge for selected types of lenses (once/24 months; replacement lenses after 12 months if significant vision change).	$10 copayment in network. Up to $35 reimbursement out of network. (once/12 months)
Frames	$20 at contracting providers (selected frames once/24 months, if needed).	$60 allowance can be applied to frames purchased through plan.	$10 copayment in network if under $100 purchase; $10 + difference if over $100. Up to $35 reimbursement out-of-network. (once/24 months).
Contact lenses	Not specified.	Paid in full after cataract surgery or when used to significantly improve visual acuity or binocular vision not obtainable with regular lenses.	20% discount from retail price.
Other optical services	Not specified.	Not specified.	Additional frames and lenses—including those for a non-member spouse—are available at discounted prices. Other items not listed above are subject to a 20% discount from retail prices. All Medicare-approved services covered with $3 copayment.

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
HEARING			
Hearing test	No charge for routine screening through primary care physician. 35% discount off standard published price through contracting providers.	$3 copayment.	Paid in full.
Hearing aids	Not specified.	Not specified.	30% discount on hearing aids purchased from a contracting provider.
Other	Not specified.	Not specified.	Paid in full for hearing aid orientation, auditory training, hearing aid evaluation or hearing aid checkup, when done through a contacting provider.
CHIROPRACTIC	Paid in full if medically needed. $10 copayment/ office visit for self-referred care to a contracting provider; limited to 12 self-referred visits per calendar year, including $10 copayment/set of X-rays and $50 allowance/calendar year for routine appliances.	Not covered.	Medicare coverage.
FOOT CARE			
Podiatry	Paid in full when Medicare-approved.	Covered when Medicare-approved.	$3 copayment/visit for Medicare-approved services.
Orthotics	Paid in full.	Covered when Medicare-approved.	Members can receive a 20% discount on certain prosthetics, orthotics, footwear and related supplies if purchased through the contacting provider.
Orthotic shoes	Paid in full when Medicare-approved.	Not specified.	Paid in full when Medicare-approved. Other services eligible for 20% discount.

Benefit	LOS ANGELES COUNTY, CA PacifiCare of Southern California	Kaiser Permanente Senior Advantage	CareAmerica Health Plan 65 Plus
HOME HEALTH SERVICES	Paid in full when Medicare-approved.	Paid in full when Medicare-approved. Also no charge for hospice care when selected as an alternative to traditional covered services.	Paid in full when Medicare-approved. 20% discount for benefits beyond Medicare-covered services.
RESPITE CARE	Up to 80 hours/calendar year, subject to guidelines.	Not specified.	Up to 80 hours/calendar year.
OTHER BENEFITS			
Chemical dependency	Not specified.	$3 copayment/individual visit or $1.50/group therapy visit for counseling for chemical dependency, or medical management of withdrawal symptoms.	Not specified.
Health club	Not specified.	Not specified.	10%–30% percent discounts
Health education classes	Paid in full.	Brochures and group health education and nutritional counseling classes are free of charge. $3/individual visit for health education and nutritional counseling. "Reasonable charge" for recorded health education programs and general health education classes.	Free classes, brochures, and video loans are offered.

CareAmerica Health Plan offers the following riders:

- For $12.50/month, supplemental benefits for dental services are offered.
- For $6.95/month, supplemental benefits for chiropractic services are offered.

APPENDIX C

BENEFITS COMPARISON FOR CHICAGO

Benefit	COOK COUNTY, IL					
	Humana Health Care Plans		United HealthCare of Illinois		Principal Health Care of Illinois	
	Gold Plus–Value Option	Gold Plus–Premium Option	Medicare Complete–Prestige Plan	Medicare Complete–Premier Plan	Principal Health Care 65–Option 1	Principal Health Care 65–Option 2
PREMIUM (monthly)	Not specified.	Not specified.	$0	$21.25	$0 (Not clear.)	$29
INPATIENT HOSPITAL SERVICES	Paid in full.	Paid in full.	Paid in full.	Paid in full.	Paid in full.	Paid in full.
OUTPATIENT HOSPITAL SERVICES						
Surgical services	$10 copayment.	Paid in full.	Not specified.	Not specified.	$5 copayment.	Paid in full.
Rehabilitation	$10 copayment.	Paid in full.	Not specified.	Not specified.	$5 copayment.	Paid in full.
Renal dialysis	Not specified.	Not specified.	Not specified.	Not specified.	$5 copayment.	Paid in full.
Blood transfusions and blood components	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.
SKILLED NURSING FACILITY CARE						
Copayment beyond 20 days	Paid in full.	Paid in full.	Not specified.	Not specified.	Paid in full (3-day hospital stay may be waived).	Paid in full (3-day hospital stay may be waived).
Coverage beyond 100 days	0	20	0	0	0	0
PHYSICIAN SERVICES AND VISITS TO SPECIALISTS	$10 copayment.	Paid in full.	$10 copayment.	Paid in full.	$5 copayment.	Paid in full.
PHYSICAL AND OCCUPATIONAL THERAPY	$10 copayment.	Paid in full.	Not specified.	Not specified.	$5 copayment.	Paid in full.
SECOND OPINION	$10 copayment.	Paid in full.	Not specified.	Not specified.	$5 copayment.	Paid in full.
MEDICAL SUPPLIES (DME)	Paid in full.	Paid in full.	20% copayment.	Paid in full.	Paid in full.	Paid in full.
LABORATORY SERVICES	$10 copayment.	Paid in full.	Not specified.	Not specified.	Paid in full (when copayment met for office visit).	Paid in full (when copayment met for office visit).
X-RAY SERVICES	$10 copayment.	Paid in full.	Not specified.	Not specified.	$5 copayment.	Paid in full.

Benefit	COOK COUNTY, IL					
	Humana Health Care Plans		United HealthCare of Illinois		Principal Health Care of Illinois	
	Gold Plus–Value Option	Gold Plus–Premium Option	Medicare Complete–Prestige Plan	Medicare Complete–Premier Plan	Principal Health Care 65–Option 1	Principal Health Care 65–Option 2
PREVENTIVE SERVICES						
Annual physical exams	Not specified.	Not specified.	Not specified.	Not specified.	$5 copayment.	Paid in full.
Mammography	$10 copayment for self-referral to OB/GYN.	Paid in full for self-referral To OB/GYN.	Not specified.	Not specified.	$5 copayment.	Paid in full.
Pap smears			Not specified.	Not specified.	$5 copayment.	Paid in full.
Colorectal cancer screenings	Not specified.	Not specified.	Not specified.	Not specified.	$5 copayment.	Paid in full.
Immunizations: Influenza Pneumonia Hepatitis B	Paid in full for drugs and vaccines covered under Medicare.	Paid in full for drugs and vaccines covered under Medicare.	Not specified.	Not specified.	Paid in full (all routine immunizations, exceeding Medicare coverage).	Paid in full (all routine immunizations, exceeding Medicare coverage).
Allergy tests and treatment	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.
EMERGENCY SERVICES	Worldwide.	Worldwide.	Worldwide.	Worldwide.	Worldwide.	Worldwide.
In-area	$50 per ER visit.	$25 per ER visit.	$50 copayment.	$25 copayment.	$25 copayment.	$25 copayment.
Out-of-area	$10 for urgent care (waived if admitted).	$10 for urgent care (waived if admitted).	Urgent care paid in full (waived if admitted).	Urgent care paid in full (waived if admitted).	$5 for urgent care (waived if admitted).	$5 for urgent care (waived if admitted).
Ambulance services	$25 each time.	Paid in full.	Paid in full.	Paid in full.	Not specified.	Not specified.

Benefit	COOK COUNTY, IL					
	Humana Health Care Plans		United HealthCare of Illinois		Principal Health Care of Illinois	
	Gold Plus–Value Option	Gold Plus–Premium Option	Medicare Complete–Prestige Plan	Medicare Complete–Premier Plan	Principal Health Care 65–Option 1	Principal Health Care 65–Option 2
PRESCRIPTION DRUGS						
Limits	No limit for generic drugs. Combined pharmacy and mail order limit $180 per quarter and $600 annually for brand-name drugs.	No limit for generic drugs. Combined pharmacy and mail order limit $360 per quarter and $1,100 annually for brand-name drugs.	$800 annually.	$800 annually.	$750 annually on suggested list price of medications (Medicare-covered drugs do not count toward limit).	$1,350 annually on suggested list price of medications (Medicare-covered drugs do not count toward limit).
Brand-name drugs	$15	$15	$10 for 31-day supply.	$10 for 31-day supply.	$5 for drugs purchased through Formulary Prescription Unit.	$5 for drugs purchased through Formulary Prescription Unit.
Generic drugs	$5	$5	$5 for 31-day supply.	$5 for 31-day supply.		
Mail-order	Two copayments per 90-day supply.	Two copayments per 90-day supply.	$25 for 90-day supply for brand-name drugs; $12.50 for 90-day supply for generic.	$25 for 90-day supply for brand-name drugs; $12.50 for 90-day supply for generic.	$5 for 90-day supply for only two prescription unit copayments.	$5 for 90-day supply for only two prescription unit copayments.

Benefit	COOK COUNTY, IL					
	Humana Health Care Plans		United HealthCare of Illinois		Principal Health Care of Illinois	
	Gold Plus–Value Option	Gold Plus–Premium Option	Medicare Complete–Prestige Plan	Medicare Complete–Premier Plan	Principal Health Care 65–Option 1	Principal Health Care 65–Option 2
DENTAL						
Office visit	Not specified.	Not specified.	Not specified.	Not specified.	Paid in full.	$7 copayment.
Diagnostic services	$18 copayment per visit for up to 2 exams and routine cleanings per year.	$10 copayment.	Paid in full.	Paid in full for one oral exam and routine cleaning per year.	Exam and diagnosis paid in full.	Exam and diagnosis paid in full.
Preventive services	Not specified.	Not specified.	$10 copayment for bitewing X-rays.	$10 copayment for bitewing X-rays.	Paid in full.	Paid in full.
Restorative services	Not specified.	Not specified.	Not specified.	Not specified.	Payments range from $20–$100.	Payments range from $13–$52.
Oral surgery	Not specified.	Not specified.	Not specified.	Not specified.	Payments range from $48–$75 (some services not covered).	Payments range from $35–$175.
Emergency services	Not specified.	Not specified.	Not specified.	Not specified.	None.	$30 copayment.
MENTAL HEALTH						
Outpatient	$10 copayment.	Paid in full.	$10 copayment.	Paid in full.	$5 copayment, unlimited visits.	Paid in full, unlimited visits.
Inpatient	Same as Medicare, plus 10 additional days per year.	Same as Medicare, plus 10 additional days per year.	Paid in full.	Paid in full.	Same as Medicare, plus 10 additional days per year.	Same as Medicare, plus 10 additional days per year.
VISION CARE						
Eye exam	Paid in full (once every 12 months).	Paid in full (once every 12 months).	Paid in full (once every 12 months).	Paid in full (once every 12 months).	$5 copayment (once every 24 months).	Paid in full (once every 24 months).
Spectacle lenses	Paid in full for eyeglasses and contact lenses following cataract surgery.	Paid in full for eyeglasses and contact lenses following cataract Surgery.	Discount program.	$50 credit.	$20 payment for standard frames and lenses (once every 24 months).	Paid in full for standard frames and lenses (once every 24 months).
Frames						
Contact lenses			Not specified.	Not specified.	Not specified.	Not specified.

Benefit	COOK COUNTY, IL Humana Health Care Plans Gold Plus–Value Option	Gold Plus–Premium Option	United HealthCare of Illinois Medicare Complete–Prestige Plan	Medicare Complete–Premier Plan	Principal Health Care of Illinois Principal Health Care 65–Option 1	Principal Health Care 65–Option 2
HEARING						
Hearing test	Paid in full (once per year).	Paid in full (once per year).	Paid in full.	Paid in full.	$5 copayment.	Paid in full.
Hearing aids	Not specified.	Not specified.	Discount program.	One hearing aid at $500 or two at $1,000 once per three-year period.	Paid in full for exam; 30% discount retail price for hearing aid.	Paid in full for exam; 30% discount retail price for hearing aid, plus a $50 allowance toward price.
CHIROPRACTIC	Not specified.	Not specified.	Same as Medicare.	Same as Medicare.	$5 copayment; limited coverage is same as Medicare.	Paid in full; limited coverage is same as Medicare.
FOOT CARE						
Podiatry	$10 copayment (two visits per year).	Paid in full (two visits per year).	Not specified.	Not specified.	$5 copayment; routine footcare is covered for 6 visits per year.	Paid in full; routine footcare is covered for 6 visits per year.
Orthotic shoes	Not specified.	Not specified.	Not specified.	Not specified.	Paid in full (after $5 copayment for office visit is paid).	Paid in full.
HOME HEALTH SERVICES	Paid in full.	Paid in full.	Paid in full.	Paid in full.	Paid in full.	Paid in full.
RESPITE CARE	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.	Not specified.
OTHER BENEFITS						
Chemical dependency	Not specified.	Not specified.	Not specified.	Not specified.	Up to 10 days per year for substance abuse rehabilitation.	Up to 10 days per year for substance abuse rehabilitation.
Transportation	Not specified.	Not specified.	11 round-trips.	11 round-trips.	Not specified.	Not specified.

APPENDIX D

DISCREPANCIES BETWEEN MARKETING MATERIALS AND MEDICARE COMPARE FOR THREE HEALTH PLANS IN LOS ANGELES

PACIFICARE OF SOUTHERN CALIFORNIA

Benefit	Health Plan	Medicare Compare
Number of benefit plans offered	One	Two*****
Limits on outpatient prescription drugs	Unlimited.	"Prescription drugs are covered with limits."
Dental preventive services	$5 copayment for office visits Cleanings every 6 months: $10 for first cleaning; $20 for second cleaning.	"You are covered for 2 preventive dental exams every 1 year(s)." "You pay $5 per preventive dental exam." "You pay $5 per visit to the dentist for basic Medicare benefits."
Chiropractic care	Paid in full if medically needed. $10 copayment per office visit for self-referred care to a contracting provider; limited to 12 self-referred visits per calendar year, including $10 copayment per set of X-rays and $50 allowance per calendar year for routine appliances.	"You pay nothing to see a chiropractor." "You are covered for 12 visits per year." "You are covered for routine care beyond the basic Medicare benefit."

***** Copayments are from Plan 1 of HCFA's Medicare Compare web site. Under the second plan listed by Medicare Compare, the copayments for chiropractic care are listed as $12.50 rather than $5.00. Otherwise, descriptions of the two plans noted in Medicare Compare are the same for each of the two plans.

KAISER PERMANENTE

Benefit	Health Plan	Medicare Compare
Outpatient hospital services	This category is not explicitly defined in the brochure. However, the services under this category (surgical services, rehabilitation, renal dialysis, and blood transfusions and components) are listed as "no charge."	$3 copayment per visit
Annual physical exam	$3 copayment per visit	"You are covered for an unlimited number of physical exams per year."
Immunizations	No charge for generally available injected medications and generally available immunizations. Half of nonmember rates for other immunizations.	"You pay nothing for flu or pneumonia vaccine." "You pay nothing for hepatitis B vaccine."
Outpatient mental health	$20 for each individual visit and $10 for each group therapy visit for first 20 outpatient visits per calendar year; then 50% of nonmember rate for each additional visit.	"You pay $20 per individual session/visit." "You pay $10 per group therapy session/visit." "You are covered for an unlimited number of outpatient mental health visits per year."

CAREAMERICA HEALTH PLAN

Benefit	Health Plan	Medicare Compare
Number of benefit plans offered	One	Four [Note: the only differences between the four plans described are in (1) premiums and (2) number of chiropractic visits allowed per year]
Preventive services: physical exams	$3 copayment (one exam per year)	"You are covered for 1 physical exam(s) per year."
Preventive services: influenza immunization	If doctor is seen only for this service, there is no copayment.	"You pay $3 per flu or pneumonia vaccine."
Hearing aids	30% discount on hearing aids purchased from a contracting provider.	"Hearing aids covered. You are covered for 1 hearing exam per 1 year(s)." "You receive a 30% discount off hearing aids."