RESTORING CHOICE TO MEDICARE+CHOICE: THE IMPORTANCE OF STANDARDIZING HEALTH PLAN BENEFIT PACKAGES

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EXECUTIVE SUMMARY

This report looks at the changing nature of benefit designs by managed health care plans participating in the Medicare+Choice program, and the impact recent benefit changes have had on the ability of Medicare beneficiaries to compare plans on costs. It examines the 2001 benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and benefit designs of the five Medicare+Choice plans in Tampa, Florida.

In recent years, many Medicare+Choice plans have required beneficiaries to pay premiums and have added or increased copayments for prescription drugs, while imposing limits on the amount of drugs they would cover. Different plans have varying cost-sharing requirements for drugs, which have made cost comparisons between plans difficult. More recently, in some markets, Medicare+Choice plans have started to impose different cost-sharing requirements on a host of Medicare-covered and certain supplemental benefits that traditionally were very comparable among plans. These include costs associated with hospital and nursing home care.

These changes by Medicare+Choice plans leave beneficiaries living in areas with several plan offerings with a nearly impossible task of trying to compare plans on the basis of cost. Although the Medicare+Choice program was intended to help beneficiaries more easily shop and compare their health plan choices, these new and varying cost-sharing requirements imposed by Medicare+Choice plans has made comparison shopping unrealistic for most beneficiaries in areas with competing health plans.

As part of their effort, the authors consulted with health care practitioners on the care health care services and treatment required for hypothetical beneficiaries with different health conditions living in Cleveland and Tampa. The authors compared benefit packages offered by Medicare+Choice health plans in the two regions for a beneficiary with heart disease, and a beneficiary with arthritis and osteoporosis.

The study found that the lack of standardized benefit packages in the Medicare+Choice program undermines the goals of a competitive Medicare market in three ways:

1. As shown by this analysis, differing plan benefit packages make it nearly impossible for a Medicare beneficiary living in an area with plans offering several, varied benefit packages to compare plans on costs. Because Medicare Health Plan Compare (the interactive database available to

consumers on the Medicare website) does not provide all the detailed information beneficiaries need for a thorough plan comparison, they will have to spend hours calling plans and analyzing plan data to make any kind of reasonable comparison.

2. With such widely varying benefit packages, choosing a health plan resembles more a "roll of the dice" than any rational decision-making process. Unlike the hypothetical beneficiaries in this study, few beneficiaries will know or can reasonably guess what their expected medical use might be in the coming year. In the hypothetical cases, whether a beneficiary needed hospital, skilled nursing facility, outpatient rehabilitation services, or was prescribed an expensive brand medication made a substantial difference in their out-of-pocket costs.

3. The failure to require standardized benefit packages permits some Medicare+Choice plans to gain from favorable risk selection. For example, in Cleveland, two plans charge 20 percent of the costs for diabetes monitoring, while the other three plans charge nothing for these services. It is likely that, other costs being equal, a diabetic would gravitate to those plans that cover diabetic supplies. Similarly, a beneficiary who worries that he or she might require hospitalization, nursing home care, or outpatient rehabilitation services would likely eschew a plan with high cost-sharing for these benefits.

The principal argument against standardization is that it would reduce Medicare+Choice plans' ability to innovate in the design of their benefit packages. Other arguments are that standardization would make it harder for plans to respond to geographic variations in benefit levels, and that the process of benefit package design would shift from the marketplace to the political arena.[1] These arguments have merit. Nevertheless, increasingly complicated Medicare+Choice benefit packages make the case against benefit standardization less salient. The foundation upon which the Medicare+Choice program was built is undermined if beneficiaries are unable to make an informed choice among their health care options.

RESTORING CHOICE TO MEDICARE+CHOICE: THE IMPORTANCE OF STANDARDIZING HEALTH PLAN BENEFIT PACKAGES

INTRODUCTION

The Medicare+Choice program is predicated on the idea of a marketplace in which private health plans compete with each other and with original fee-for-service Medicare for members. Questions have been raised about the appropriateness of this model for the Medicare population.[2] Many Medicare beneficiaries do not understand enough about the basics of Medicare or about competing managed care plans to make an informed choice among their health care alternatives.[3]

Choosing among health plans is made more difficult by the wide range of benefits and cost-sharing requirements offered by Medicare+Choice plans. Even if beneficiaries are able to compare these plans based on premiums, quality, and provider networks, they may be unable to assess which one best meets their needs or offers the best price because of differing benefits and cost-sharing requirements.

Evidence suggests that the elderly are vulnerable to making poor purchasing decisions when insurance benefits are not standardized.[4] In fact, beneficiary confusion over the array of benefits offered by private Medigap insurers led to reforms in 1990 that standardized the benefits Medigap plans could offer. By all accounts, this standardization has proved successful.[5]

This report assesses the implications for Medicare beneficiaries when competing Medicare+Choice plans offer different benefit packages with different cost-sharing requirements. It first analyzes the confusing nature of the benefit packages offered by available plans in Cleveland, Ohio, and in Tampa, Florida, and then discusses the steps prospective Medicare+Choice enrollees need to take to collect comparative plan information. The report next takes two hypothetical beneficiaries through the process of comparing plans in Cleveland and Tampa to determine which plan is the least costly given their health care needs. Finally, the report discusses the implications of not standardizing Medicare+Choice benefit packages.

THE CONFUSING NATURE OF MEDICARE+CHOICE PLAN BENEFIT PACKAGES

In some markets, Medicare+Choice plans offer a dizzying array of benefit packages. While all Medicare+Choice plans must provide the same benefits as Medicare, they can impose

differing cost-sharing requirements on these benefits compared with traditional fee-for-service Medicare. Moreover, plans are free to offer supplemental benefits, such as outpatient prescription drugs, with widely varying cost-sharing requirements (see Tables 1 and 2 on pages 5 and 6).[6]

In past analyses of plan benefits, differences in copayments and limits on prescription drugs were difficult to understand, but the cost-sharing on most other Medicare-covered and supplemental benefits were generally comparable, especially for large-ticket benefits, such as hospitals and nursing home care. Physician copays, while somewhat varied, were generally nominal.[7]

This is no longer the case in some Medicare+Choice markets. Added to the complexity of prescription drug benefits are differing cost-sharing requirements for both Medicare-covered benefits and the supplemental benefits offered by plans. Beneficiaries have to factor in these differences on top of varying premium costs.

Premiums

It is likely that beneficiaries comparing Medicare+Choice plans will look first at premium charges. For example, in 2001, plan premiums ranged from $0 to $179 a month in Tampa, and from $0 to $95 a month in Cleveland. In general, plans offering premium products provide more generous prescription drug benefits and require less cost-sharing than plans with "zero premium" products.

Prescription Drug Benefits

Given that Medicare beneficiaries fill an average of 20 prescriptions per year, beneficiaries will likely turn their attention to prescription drug benefits after examining premiums.[8] Beneficiaries have to consider a plethora of issues in order to determine out-of-pocket costs for drugs in a particular plan or to compare drug benefits among different plans. These factors include:

- prescription drug limits;
- the level of copayments;
- whether a formulary is used, and if so, which drugs are on it;
- whether the plan provides a discount mail-order pharmacy benefit; and
- how each plan determines drug costs that count toward benefit limits.

Nearly all plans offering drug coverage limit this coverage to a specific amount. Some limit all drugs, while others limit only brand and non-formulary drugs. In Tampa, for example, one plan limits coverage of all drugs to $500 a year, while another limits coverage of brand drugs to $50 a month while providing unlimited coverage of generics. Yet another plan limits coverage of both brand drugs and non-formulary generic drugs to $125 every three months.

Copays, especially for brand-name drugs, vary dramatically. In Tampa, copays for brand formulary drugs range from $15 to $40 per brand prescription. In Cleveland, the range is from $15 to $50. All but one plan in each site uses a formulary. For plans that cover non-formulary drugs, copays for drugs not on the formulary may be more than double that of formulary drugs.

Ordering a three-month supply of a drug by mail will generally reduce the amount of copayment, but this is not always the case. For example, of those plans with a prescription drug benefit, four Tampa plans and two Cleveland plans either do not have a mail order benefit or offer no savings for ordering by mail.

In comparing prescription drug benefits, beneficiaries must determine which drugs are on plan formularies. Whether a drug is on a plan's formulary has important implications for beneficiary copays and other out-of-pocket costs. The final factor that beneficiaries must take into account when comparing plan prescription drug benefits is how each plan determines costs that count toward prescription drug limits. For example, if a brand drug costs $60 and the copay is $30, will the plan count $60 or $30 toward its coverage limit?

Physician Visits

Copays for physician visits increased significantly in both Tampa and Cleveland from 1999 to 2001. Currently, with some exceptions, specialist visit copays are $10 to $20 in Cleveland and from $10 to $50 in Tampa.

Other Benefits

In 2001, some plans in both Tampa and Cleveland increased—or imposed for the first time—copays for a number of benefits, including ambulatory surgery, rehabilitation services, durable medical equipment, and diagnostic lab and X-ray services. For example, three Cleveland plans now charge enrollees 20 percent of the costs of durable medical equipment, and two plans charge up to 20 percent of the costs of radiation therapy. In

Tampa, ambulatory surgery can cost an enrollee anywhere from $0 to $500, depending on the plan. Moreover, outpatient rehabilitation services range from $10 to $40 a visit, radiation therapy from $0 to $40 a visit, while X-rays and diagnostic lab services run from $0 to $350, depending on the specific procedures required.

In 2000, only one Cleveland plan and three Tampa plans charged copays (from $200 to $350) for a hospital stay and no plan in either community charged for nursing home care. In 2001, several plans began charging or increased copays for hospital and nursing home services.

In Cleveland, Plan A charges $50 a day for inpatient hospital care, while Plan E charges $175 a day. Plan E also charges $75 a day for days 1 to 100 in a nursing home, while Plans A and C charge $75 and $97 a day, respectively, for days 21 to 100.

In Tampa, all but one plan charge copays for hospital care. Cost-sharing ranges from $100 a hospital stay to $150 per day. Days 1 to 20 in a Tampa skilled nursing facility will cost HMO enrollees anywhere from $0 to $75 a day, while days 21 to 100 are from $0 to $90 a day, depending on the plan.

Table 1. 2001 Premium and Selected Benefit Copayments: Cleveland Medicare+Choice Plans

	Plan A_1[a]	Plan A_2	Plan B_1	Plan B_2	Plan C	Plan D	Plan E
Enrollment limit	Yes	Yes	Yes	Yes	Yes	No	No
Premium	$29	$0	$95	$49	$0	$0	$0
Doctor visits: Primary care	$5	$5	$15	$15	$15	$5	$10
Specialist	$20	$20	$15	$15	$20	$10	$10
Outpatient visits: Ambulatory surgery	$50/visit	$50/visit	$15/visit	$15/visit	$0	$0	20%
Hospital visit	$50/visit	$50/visit	$15/visit	$15/visit	$0	$0	20%
Durable medical equipment	20%	20%	20%	20%	$0	$0	20%
Diagnostic tests: Clinical lab	$5–$20 (or 20% of costs)	$5–$20 (or 20% of costs)	$0	$0	$0	$0	$5 clinical lab
X-rays/diagnostic lab	$5–$20 (or 20% of costs)	$5–$20 (or 20% of costs)	$0	$0	$0	$0	$5 or 20% for X-ray[b]
Radiation therapy	$5–$20 (or 20% of costs)	$5–$20 (or 20% of costs)	$0	$0	$0	$0	$5 or 20%[c]
Outpatient rehabilitation services	$20 (or 20% of the cost)	$20 (or 20% of the cost)	$15/visit	$15/visit	$20/occ. therapy visit; $15/physical therapy/ speech and language visit	$0	20%
Inpatient hospital care	$50/day	$50/day	$0	$0	$0	$0	$175/day
Skilled nursing facility: Days 1–20	$0/day	$0/day	$0/day	$0/day	$0/days	$0/day	$75/day
Days 21–100	$75/day	$75/day	$0/day	$0/day	$97/day	$0/day	$75/day
Home health care	$0	$0	$0	$0	$0	$0	$0
Bone mass measurement	$50	$50	$0	$0	$0	$0	$0[d]
Diabetes monitoring[e]	20%	20%	20%	20%	$0	$0	$0[f]
Prescription drugs							
Formulary							
30-day supply							
Generic copay	$12	$12	$15	$15	No Coverage	$5	$12
Brand copay	$35	$35	$15	$15		$25	$50
90-day mail order							
Generic copay	$24	$24	(62 day) $15	(62 day) $15		$15	$36
Brand copay	$70	$70	(62 day) $15	(62 day) $15		$75	$150
Cap							
Generic	Unlimited	Unlimited	$1,500 for all formulary/non-formulary drugs	$600 for all formulary/non-formulary drugs		Unlimited	$500 combination limit
Brand	$175/3 months	$75/3 months				$150/3 months for formulary/non-formulary brand[g]	
Non-formulary	No coverage	No coverage	Covered same as above	Covered same as above		Covered same as above	No formulary used

[a] Because Plan A was closed to new enrollment, plan representatives would not send an information packet or answer staff questions about benefits. Information for Plan A was taken only from "Medicare Health Plan Compare."

[b] Plan E's summary of benefits states that members pay $5 for standard flat-film X-ray, and 20% for other radiological services and for therapeutic lab.

[c] See above.

[d] Office visit copay may apply.

[e] Glucose monitors, test strips, lancets, and self-management training.

[f] Office visit copay may apply.

[g] Members can carry over unused amounts from quarter to quarter.

Table 2. 2001 Premium and Selected Benefit Copayments: Tampa Medicare+Choice Plans

	Plan V_1	Plan V_2	Plan W	Plan X_1	Plan X_2	Plan Y	Plan Z_1	Plan Z_2
Enrollment limit	No	No	Yes	No	No	No	No	Yes
Premium	$63	$0	$63	$179	$0	$0	$0	$19
Doctor visits: Primary care Specialist	$10 $5–$200	$15 $15–$400	$10 $25	$10 $15	$10 $15	$15 $20	$10 $15	$5 $10
Outpatient visits: Ambulatory surgery Hospital visit	$200 $200	$500 $500	$0 $50	$35 $35	$50 $50	$100 $50	$25 $25	$25 $25
Durable medical equipment	$0	$0	$0	$0	$0	20%	$0	$0
Diagnostic tests: Clinical lab X-rays/diagnostic lab	$0 $40–$200	$0 $40–$350	$0 $0	$0 $0	$0 $0	$5 $5 X-ray; $50 other radiation services	$0 $0	$0 $0
Radiation therapy	$40/visit	$40/visit	$0	$0	$0	$5–$50	$15/service	$10/service
Outpatient rehabilitation services	$40/visit	$40/visit	$25/visit	$10–$15/visit	$10–$15/visit	$25/visit	$15/visit	$10/visit
Inpatient hospital care	$500 per admiss.; $200/day for days 7–30 at network hospital	$500 per admiss.; $200/day for days 7–30 at network hospital	$150/day	$100/stay	$300/stay	$150/day	$200/stay	$0
Skilled nursing facility: Days 1–20 Days 21–100	$0/day $85/day	$0/day $90/day	$0 $97	$0 $0	$0	$75 $75	$0 $0	$0 $0
Home health care	$0	$0	$0	$0	$0	$0	$0	$0
Bone mass measurement	$10/physician's office, $40 non-physician clinic	$15/physician's office, $40/non-physician clinic	$0	$0	$0	$0	$0	$0
Diabetes monitoring	$10/PCP; $40/specialist; $20/diabetic supplies	$15/PCP; $50/specialist.; diabetic supplies not covered	$0	$0	$0	$0	$0	$0

	Plan V_1	Plan V_2	Plan W	Plan X_1	Plan X_2	Plan Y	Plan Z_1	Plan Z_2
Prescription drugs								
Formulary drugs								
30–31-day supply							(31-day)	(31-day)
Generic copay	$10	No prescription	$5	$5	$10	$8	$7	$5
Brand copay	$20 preferred	drug coverage	$20	$15	Not covered	$40	$20	$15
90-day mail order								
Generic copay	$20		$15	$15	$30	$24	Not available	Not available
Brand copay	$40 preferred		$60	$45	Not covered	$120		
Cap								
Generic	$150/3 months		Unlimited	Unlimited	Unlimited	$500/year	Unlimited	Unlimited
Brand	generic and preferred & non-preferred brand		$250/6 month formulary & non-formulary brand	$50/month formulary & non-formulary brand	Not covered		$125/3 months non-formulary generic & all brand drugs	$125/3 months non-formulary generic & all brand drugs
Non-formulary								
30–31-day supply					Not covered	Plan has no		
Generic copay	$10		$35	$30		formulary	$30	$30
Brand copay	$40		$35	$30			$30	$30
90-day mail order								
Generic copay	$10		$105	$90			Not available	Not available
Brand copay	$80		$105	$90				
Cap	See above		See above	See above			See above	See above

[a] Plan Y has a $3,500 out-of-pocket limit protection for combined inpatient and outpatient services, not including certain office visit copays, prescription drugs, medical supplies, and selected other benefits.

[b] $40 specialist per visit copay, except $10/visit to Allergy physicians, $5/specimen to hospital pathologists, $5/interpretation to hospital radiologists, $50/visit to ER physician, $200 for cataract surgery, $50/each allergy skin testing, and 40% of charges for non-plan second medical opinion.

[c] $50 specialist per visit copay, except $15/visit to Allergy physicians, $15/specimen to all hospital pathologists, $15/interpretation to hospital radiologists, $50/ visit to ER physicians, $400 for cataract surgery, and 50% of charges for non-plan second medical opinion.

[d] $200 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copay for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.

[e] $350 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copayment for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.

[f] $1,000 per admission and $200/day for days 7-30 at non-participating hospitals.

[g] $1,000 per admission and $300/day for days 7-30 at non-participating hospitals.

[h] Glucose monitors, test strips, lancets, and self-management training.

OBTAINING INFORMATION AND COMPARING PLAN BENEFIT PACKAGES

Before beneficiaries can compare Medicare+Choice plans to assess which one best meets their needs, they will need to collect benefit information. This process takes time and effort.

Step 1. Obtaining Basic Benefit Information

For Medicare beneficiaries with the use of a computer, an easy way to obtain health plan information is through the Medicare Health Plan Compare interactive database (Medicare Compare) found on the Medicare website (www.medicare.gov.) Beneficiaries can use Medicare Compare to obtain benefit, cost, and quality information for all plans in their community.

The quality of the benefit and cost information on Medicare Compare has improved markedly since the Centers for Medicare and Medicaid Services first began providing this data in 1998.[9] However, in some instances, the information remains vague, misleading, or confusing. Medicare Compare also does not provide information on which drugs are on plan formularies or how plans calculate costs that count toward their prescription drug limits.

Examples of Vague, Confusing, Complicated, and Missing Information on Medicare Compare

Vague Information: One Tampa plan is listed as charging from $10 to $200 for each specialist visit for Medicare-covered benefits.

Confusing Information: The description of hospital cost-sharing for one Tampa plan: "You pay $200 for each Medicare-covered day in a network hospital. You pay $500 for each Medicare-covered stay in a network hospital. You pay $0 per day for each additional day in a network hospital. You are covered for unlimited days each benefit period." The plan's "Summary of Benefits" states that enrollees pay $500 per admission plus $200 per day for days seven through 30 at a participating hospital. They also pay $1,000 per admission plus $200 per day for days seven through 30 at a nonparticipating hospital.

Complicated Information: The prescription drug benefits offered by one Cleveland plan are listed as follows: "For prescription drugs on plan approved list, you pay for each prescription or refill: $5 for generic drugs up to a 30-day supply; $25 for brand name drugs up to a 30-day supply; $15 for mail order generic drugs up to a 90-day supply; and $75 for mail order brand name drugs up to a 90-day supply. Ask. . . [the HMO] for our formulary. There is no annual limit on generic drugs. There is a $150 limit every three months for formulary-brand. For prescription drugs that are NOT on plan approved list (formulary), you pay for each prescription or refill: $5 for generic drugs up to a 30-day supply; $25 for brand name drugs up to a 30-day supply; $15 for mail order generic drugs up to a 90-day supply; and $75 for mail order brand name drugs up to a 90-day supply. There is no annual limit on non-formulary generic drugs. There is a $150 limit every three months for non-formulary brand drugs. There is a $600 limit each year for combined formulary-brand and non-formulary-brand prescription drugs. There is a $150 limit every three months for combined formulary brand and non-brand prescription drugs. Plans can calculate the part you pay in different ways. Please ask … [the HMO] about how we determine drug costs that count towards these limits. You may use designated retail pharmacies. You may use mail order. Additional restrictions may apply. Ask . . . [the HMO] for details. Authorization is required for formulary drugs. Authorization is required for non-formulary drugs."

Missing Information: One Tampa plan failed to list any information on brand drugs and a second plan provided no information on mail order drugs. In both instances, Medicare Compare should have noted that these benefits are not covered.

Step 2. Obtaining Detailed Benefit Information

Although Medicare Compare provides a good starting point from which to compare plans, even beneficiaries with access to the Internet, or those who call the toll-free Medicare hotline for comparison information, will need additional information.[10] To make a detailed comparison of plans in their community, beneficiaries will need to contact plans' Medicare Consumer service offices and request plan benefit information unavailable on Medicare Compare.

Even with plan literature in hand, beneficiaries will need to ask plan customer service representatives (1) if their prescription drugs are on the plans' formularies; (2) what their prescription drug costs are; and (3) how plans calculate costs that count toward their prescription drug limits.

Step 3. Comparing Plan Premiums and Benefits

To compare plans on price, beneficiaries will need to estimate their expected use of medical services and then calculate the potential costs they might incur by enrolling in one plan or another.

COMPARING COSTS OF PLANS IN CLEVELAND AND TAMPA

To assess the ease or difficulty of comparing Medicare+Choice plans, project staff took two hypothetical Medicare beneficiaries with chronic conditions through a plan comparison exercise in each study site. Following data collection on prescription drug costs and interviews with physicians who treat the elderly, staff estimated the potential prescription drug use and use of medical services for each beneficiary (Appendix C). The prescription drugs chosen for the hypothetical cases are among the most commonly prescribed for the elderly. Estimates of medical care utilization are meant to provide only an approximation of what services these two patients would use.

In order to obtain the total yearly cost for the two hypothetical beneficiaries under each health plan in Cleveland and in Tampa, staff totaled the costs of each patient's premiums, medical services, and prescription drugs for the year (Tables 3–6 in Appendix A). For most benefits, the cost-sharing was readily calculated from information available on Medicare Compare or in plan enrollment packages. For cases in which a plan charged 20 percent of the cost of a service (common for benefits such as durable medical equipment and complex tests), staff first had to obtain an approximate total cost of the service (Appendix C). The total cost of prescription drugs for the year (including cost-sharing and out-of-pocket spending) was more difficult to calculate. This calculation involved several steps, including determining whether or not each drug was on the formulary (Tables 7–8 in Appendix B), determining how each plan calculates costs that count toward their drug limits, and determining when the limit is reached and drugs purchased out of pocket.

The medical use and cost data presented demonstrate the difficulty of comparing plan benefit packages and calculating differences in plan costs.

Ms. Johnson: A Beneficiary with Arthritis and Osteoporosis. Ms. Johnson is a frail 78-year-old widow who lives alone in a two-story house. She has degenerative arthritis and osteoporosis and is currently taking two medications: Celebrex for her arthritis and Fosamax for her osteoporosis. Her physician prescribed Celebrex only after he had tried other anti-inflammatory drugs, which severely upset her stomach. Ms. Johnson needs a knee replacement. The procedure would land her in the hospital for several days, and possibly require a few days of nursing home care if complications arise. She will also need physical therapy.

In choosing an HMO, Ms. Johnson will look at premiums, prescription drug benefits, and the costs of physician visits. She will also need to examine costs related to hospital and nursing home days, lab and X-ray services, home health, physical therapy visits, outpatient rehabilitation, diagnostic tests, and a walker and cane.

Ms. Johnson's Expected Annual Use of Medical Services

Medications:
Celebrex (a brand drug), 200 mg per month for arthritis—estimated cost $84
Fosamax (a brand drug), 10 mg per month for osteoporosis—estimated cost $65
Two generic drugs (one prescription for each drug)—estimated costs $12/drug

Physician Visits:	Internist—4 Rheumatologist—2 Orthopedic surgeon—7 (including hospitalization)
Hospital Stay:	Knee replacement—5 days
Nursing Home Stay:	7 days
Tests/Procedures:	Bone density test—1 X-ray—1 Blood panel—1
Home Health:	Physical therapy visits—10
Durable Medical Equipment:	Walker, cane (estimated Medicare costs–$99)
Outpatient Rehabilitation:	18 visits (estimated Medicare cost—$78/visit)

Mr. Smith: A Beneficiary with Heart Disease. Mr. Smith is a 66-year-old man with heart disease. Over the past three years, he has undergone two angioplasties for clogged arteries. If he has additional problems he will likely have to undergo another angioplasty or a heart bypass operation that will require five to seven days in the hospital. Mr. Smith is on medication for high blood pressure, high cholesterol, and non-insulin-dependent diabetes mellitus.

Mr. Smith is considering joining an HMO. In choosing a plan, he will consider premiums, prescription drug benefits, and the costs of physician visits, lab and X-ray services, and hospital days. He has estimated the amount of services he might require based on conversations with his doctor. Mr. Smith decided to compare HMOs based on the worst-case scenario—that he would need a heart bypass operation in the coming year.

Mr. Smith's Expected Annual Use of Medical Services

Medications:
Glucophage (a brand drug), 500 mg per month for diabetes—estimated cost $34
Pravachol (a brand drug), 20 mg per month for cholesterol—estimated cost $63
Nifedipine (a generic drug), 60 mg per month for blood pressure—estimated cost $56
Two generic drugs (one prescription for each drug)—estimated $12/drug

Physician Visits:	Internist—6 Cardiologist—2 Cardiac surgeon—7 (including hospital visits) Other specialist visits—2
Hospital Stay:	Heart bypass operation—7 days
Tests/Procedures:	Cardiac catheterization—1 (estimated Medicare cost $2,613) Blood panels—2 Thallium stress test—1 (estimated Medicare cost $1,294)

Cleveland Cost Comparison

In Cleveland, costs for Ms. Johnson ranged from $1,173 to $3,076. She incurred the lowest costs under Plan D, a $0 premium plan with no cost-sharing for inpatient hospital care, unlimited generic drugs, and a $150 limit on brand drugs every three months. The most costly plan for Ms. Johnson was Plan E, also a $0 premium plan, but with substantial cost-sharing requirements for brand drugs, inpatient hospital care, and skilled nursing facility care. Surprisingly, the second least expensive plan, Plan B_1—$2,024 per year—had the highest premium in Cleveland ($1,140). Ms. Johnson was able to achieve cost savings under Plan B_1 because she did not exceed its relatively high $1,500 per year drug limit. However, for someone with low prescription drug costs, Plan B_1 would likely not be the plan of choice because of high premiums.

Prescription drug copays, along with the number of months an enrollee's drug costs remained below the plan's prescription drug cap, proved to have a substantial effect on total enrollee costs. In Cleveland, costs for Mr. Smith ranged from $810 to $3,543. Mr. Smith also had the lowest costs under Plan D. His use of one generic drug made a large difference in his total cost: had he used the brand version of nifedipine (Procardia XL), his

copays would not only be larger, but he would have exceeded the cap on brand drugs much sooner, requiring higher out-of-pocket costs. Because of Plan D's small copays for generic drugs and an unlimited generic drug benefit, Mr. Smith was able to obtain a year's supply of nifedipine for $60—only slightly more than the drug would have cost him out-of-pocket for one month.

Analysis of Cleveland's Medicare+Choice plans suggests that comparisons based only on premiums and drug benefits may not provide an accurate estimate of total costs, as a result of varying and sometimes substantial cost-sharing requirements for inpatient hospital care and diagnostic tests. By examining only premiums and prescription drug benefits, beneficiaries might well have concluded that Plan E was a better value than Plan C, which offered no prescription drug benefit. In fact, Plan E would have cost Mr. Smith about $1,000 more than Plan C because of its high cost-sharing for inpatient hospital and diagnostic lab services.

Tampa Cost Comparison

In Tampa, costs for Ms. Johnson ranged from $1,681 under Plan Z_2 to $3,735 under Plan V_2. Plan V_2 would cost Ms. Johnson more than two times that of Plan Z_2. Plan Z_2, the least expensive plan, was not a zero-premium plan, but it did charge Ms. Johnson the least for her doctors' visits, diagnostic tests, and among the least for drugs. The most expensive plan, V_2, imposed no premium but had the highest cost-sharing for doctors' visits and diagnostic tests; moreover, it offered no drug coverage.

In Tampa, Mr. Smith would also pay the least amount out-of-pocket for Plan Z_2 and the most for Plan V_2, which did not cover prescription drugs. However, plan X_2, which covered only generic drugs, was one of the least costly alternatives for both Mr. Smith and Ms. Johnson, despite their high drug costs.

Example. Calculating Ms. Johnson's Out-of-Pocket Prescription Drug Costs Under Tampa Plan Z_2

Plan Benefit Information

- $7 generic copay; $15 brand copay; and $30 non-formulary brand copay;
- Unlimited generic formulary drugs; limit $125/3 months for brand and non-formulary drugs (the cost of the drug, minus the copay, is counted towards the limit); and
- Prescription drug use: two brand drugs (Celebrex, a formulary drug and Fosamax, a non-formulary drug); two generic drugs prescribed once each during the year.

Assumptions

- Generic drugs are prescribed after the three-month cap has been reached.
- Ms. Johnson is approved to obtain Celebrex.
- Ms. Johnson obtains drugs monthly from her local pharmacy (rather than mail order).

Calculations

1. First month every quarter: $15 copay for Celebrex and $30 copay for Fosamax = $45
2. Amount toward cap: combined costs of drugs ($136.91) – copays ($45) = $91.91
3. 2nd month of every quarter: $45 copays + amount exceed cap ($91.91 x 2) – cap ($125) = $103.82
4. 3rd month of every quarter: because cap has been exceeded, Ms. Johnson pays out-of-pocket for total costs of drugs = $136.91
5. Costs every 3 months for Celebrex and Fosamax: ($45 + $103.82 + $136.91) = $285.37
6. Yearly costs for Celebrex and Fosamax: $285.27 x 4 = $1,142.92
7. Copays for 2 generic drugs (each prescribed once after cap has been exceeded) = $14
8. Total prescription drug costs for the year = $1,343.30 + $14 = $1,152.92

Comparing and Estimating Total Costs Proves Difficult

The results of the above exercise suggest that the complexity of benefit packages makes calculating and comparing the total costs of different Medicare+Choice plans difficult, even for beneficiaries who have a good idea of what their future health needs will be. The complicated limits and restrictions on drug benefits make these comparisons especially hard. Project staff required 10 to 20 minutes per plan to calculate Ms. Johnson and Mr. Smith's costs, not including the time required to call plans to request enrollment packages, to clarify benefit information, and to determine which drugs were on plans' formularies. Even though working with the same information, project staff's cost totals often did not match on the first attempt, demonstrating how easily costs can be miscalculated. Further, it was difficult to obtain even approximate estimates of the costs of prescription drugs, as well as other services needed to assess total plan costs.

Although this comparison exercise was based on the assumption that Mr. Smith and Ms. Johnson had a firm idea of their medical needs for the next year, health status and medical needs are often not predictable.[11] To address this reality, research staff recalculated plan costs in Cleveland assuming that Ms. Johnson did not need a knee replacement

during the year and, thus, used no durable medical equipment, no hospital or nursing home care, and no outpatient therapy. During the year, Ms. Johnson made six physician visits—four to her primary care doctor and two to a specialty physician—and continued to take her medications. Under this scenario, Plan D remained the lowest-cost plan, but Plan E—the costliest plan if Ms. Johnson needed surgery and rehabilitation services—became the second-least-expensive choice.

DISCUSSION

The ability of Medicare beneficiaries to understand the cost implications of their choices in health coverage is critical to the success of the Medicare+Choice program, as well as any Medicare reform that depends on a competitive market place. The lack of standardized benefit packages in the Medicare+Choice program undermines the goals of a competitive Medicare market in three ways.

First, as shown by this analysis, differing plan benefit packages make it nearly impossible for a Medicare beneficiary living in an area with plans offering several, varied benefit packages to compare plans on costs. Because Medicare Compare does not provide all the detailed information beneficiaries need for a thorough plan comparison, they will have to spend hours calling plans and analyzing plan data to make any kind of reasonable comparison. Moreover, it seems likely that prospective plan enrollees would have at least as difficult a time collecting cost estimates as did project staff. Even with all the needed information, the calculations to assess plan costs are difficult, especially when factoring in prescription drugs.

Second, with such widely varying benefit packages, choosing a health plan resembles more a "roll of the dice" than any rational decision-making process. Unlike the hypothetical beneficiaries in this study, few beneficiaries will know or can reasonably guess what their expected medical use might be in the coming year. In our hypothetical cases, whether a beneficiary needed hospital, skilled nursing facility, or outpatient rehabilitation services, or was prescribed an expensive brand medication made a big difference in out-of-pocket costs. Thus, the costs of Medicare+Choice plans are highly unpredictable and depend largely on whether an enrollee becomes ill during the year and what services he or she will need.

Numerous policy experts have concluded that the failure to standardize benefits makes plan comparisons and informed decision-making difficult at best.[12] Many large public and private employers and employer purchasing groups have reached the same conclusion. The Pacific Business Group on Health, Southern California Edison, the

Health Insurance Plan of California, the Connecticut Business and Industry Association, Denver's Cooperative for Health Insurance Purchasing, and Wisconsin's Employer Trust Fund all require participating insurers to offer the same benefits to employees. One study of the Medicare market concluded:

> among plans, it is difficult for consumers to weigh the relative costs and benefits of a large number of plans. If this comparison also involves many service coverage
>
> make rational choices is significantly reduced. The number of variables to compare and weigh against one another can simply be too great to be manageable.[13]

Finally, the failure to require standardized benefit packages permits some Medicare+Choice plans to gain from favorable risk selection. For example, in Cleveland, two plans charge 20 percent for diabetes monitoring (glucose monitors, test strips, lancets, and self-management training), while the other three plans charge nothing for these services. In Tampa, Plan V_1 charges $20 for diabetic supplies, while Plan V_2 provides no coverage for diabetic supplies, according to its 2001 marketing materials.[14] The other plans in Tampa provide diabetic supplies without charge. It is likely that, other costs being equal, a diabetic would gravitate to those plans that cover diabetic supplies.

Similarly, a beneficiary who worries that he or she might require hospitalization, nursing home care, or outpatient rehabilitation services would likely eschew a plan with high cost-sharing for these benefits. As described above, if the hypothetical Ms. Johnson was age 65, in good health, and expecting to need little medical care in the coming year, she might have chosen Cleveland Plan E over Plan D. However, Plan E was unequivocally the most expensive option for a sicker and older Ms. Johnson.

The principal argument against standardization is that it would reduce Medicare+Choice plans' ability to innovate in the design of their benefit packages. Other arguments against standardization are that plans would have a harder time responding to geographic variations in benefit levels, and that the process of benefit package design would shift from the marketplace to the political arena.[15] These arguments have merit. Nevertheless, increasingly complicated Medicare+Choice benefit packages make the case against benefit standardization less salient. The Medicare+Choice market may have reached a point similar to that of the Medigap market prior to the 1990s reforms, where the confusion caused by differing benefit packages outweighed any advantages associated with these differences. The foundation upon which the Medicare+Choice program was built is undermined if beneficiaries are unable to make an informed choice among their health care options.

APPENDIX A

Table 3. Costs for Ms. Johnson, Cleveland
2001 Premium and Selected Benefit Copays: Cleveland Medicare+Choice Plans

	Plan A_1	Plan A_2	Plan B_1	Plan B_2	Plan C[a]	Plan D	Plan E
Annual premium	$348	$0	$1140	$588	$0	$0	$0
Doctor visits							
Primary care	$20	$20	$60	$60	$60	$20	$40
Specialist	$200	$200	$150	$150	$200	$100	$100
Durable medical equipment	$20	$20	$20	$20	$0	$0	$20
Diagnostic tests							
Clinical lab	$10	$10	$0	$0	$0	$0	$5
X-rays/diagnostic lab							$5
Inpatient hospital care	$250	$250	$0	$0	$0	$0	$875
Skilled nursing facility care	$0	$0	$0	$0	$0	$0	$525
Home health care	$0	$0	$0	$0	$0	$0	$0
Bone mass measurement	$50	$50	$0	$0	$0	$0	$0
Outpatient rehabilitation	$282[b]	$282[c]	$270	$270	$270	$0	$282
Prescription drugs	$967	$1,367	$384	$1,067	$1,900	$1,053	$1,224
Total annual costs	$2,147	$2,199	$2,024	$2,155	$2,430	$1,173	$3,076

[a] Out-of-pocket costs for brand and generic prescription drugs under Plan C were assumed to be 14% higher than the cost to plans (the cost listed in the text). See Appendix C.
[b] Assumed that Ms. Johnson paid 20% of the cost of each visit rather than the $20 copay.
[c] Assumed that Ms. Johnson paid 20% of the cost of each visit rather than the $20 copay.

Table 4. Costs for Mr. Smith, Cleveland
2001 Premium and Selected Benefit Copays: Cleveland Medicare+Choice Plans

	Plan A_1	Plan A_2	Plan B_1	Plan B_2	Plan C[a]	Plan D	Plan E
Annual premium	$348	$0	$1,140	$588	$0	$0	$0
Doctor visits							
Primary care	$30	$30	$90	$90	$90	$30	$60
Specialist	$220	$220	$165	$165	$220	$110	$110
Diagnostic tests							
Clinical lab	$10	$10	$0	$0	$0	$0	$5
X-rays/diagnostic lab	$781	$781					$781
Inpatient hospital care	$350	$350	$0	$0	$0	$0	$1225
Prescription drugs	$993	$1,034	$564	$1,262	$2,122	$670	$1,362
Total annual costs	$2,732	$2,425	$1,959	$2,105	$2,432	$810	$3,543

[a] Out-of-pocket costs for brand and generic prescription drugs under Plan C were assumed to be 14% higher than the cost to plans (the cost listed in the text). See Appendix C.

Table 5. Costs for Ms. Johnson, Tampa

2001 Premium and Selected Benefit Copays: Tampa Medicare+Choice Plans

	Plan V_1	Plan V_2[a]	Plan W	Plan X_1	Plan X_2[b]	Plan Y	Plan Z_1	Plan Z_2
Annual premium	$756	$0	$756	$2148	$0	$0	$0	$228
Doctor visits								
Primary care	$40	$60	$40	$40	$40	$60	$40	$20
Specialist	$400	$500	$250	$150	$150	$200	$150	$100
Durable medical equipment	$0	$0	$0	$0	$0	$19.80	$0	$0
Diagnostic tests								
Clinical lab	$0	$0	$0	$0	$0	$5	$0	$0
X-rays/diagnostic lab	$40	$40	$0	$0	$0	$5	$0	$0
Inpatient hospital care	$500	$500	$750	$100	$300	$750	$200	$0
Skilled nursing facility care	$0	$0	$0	$0	$0	$525	$0	$0
Home health care	$0	$0	$0	$0	$0	$0	$0	$0
Bone mass measurement	$10	$15	$0	$0	$0	$0	$0	$0
Outpatient rehabilitation	$720	$720	$450	$180	$180	$450	$270	$180
Prescription drugs	$1,223	$1,900	$1,153	$1,053	$1,893	$1,167	$1,157	$1,153
Total Annual Costs	$3,689	$3,735	$3,399	$3,671	$2,563	$3,182	$1,817	$1,681

[a] Out-of-pocket costs for brand and generic prescription drugs under Plan V_2 were assumed to be 14% higher than the cost to plans (the cost listed in the text). See Appendix C.

[b] Out-of-pocket costs for brand prescription drugs under Plan X_2 were assumed to be 14% higher than the cost to plans (the cost listed in the text). See Appendix C.

Table 6. Costs for Mr. Smith, Tampa

2001 Premium and Selected Benefit Copays: Tampa Medicare+Choice Plans

	Plan V_1	Plan V_2[a]	Plan W	Plan X_1	Plan X_2[b]	Plan Y	Plan Z_1	Plan Z_2
Annual premium	$756	$0	$756	$2148	$0	$0	$0	$228
Doctor visits								
Primary care	$60	$90	$60	$60	$60	$90	$60	$30
Specialist	$440	$550	$275	$165	$165	$220	$165	$110
Diagnostic tests								
Clinical lab			$0	$0	$0	$10	$0	$0
X-rays/diagnostic lab	$400	$700	$0	$0	$0	$100	$0	$0
Inpatient hospital care	$700	$700	$1050	$100	$300	$1050	$200	$0
Prescription drugs	$1,462	$2,122	$736	$636	$1,469	$1,362	$764	$736
Total annual costs	$3,818	$4,162	$2,877	$3,109	$1,994	$2,832	$1,189	$1,104

[a] Out-of-pocket costs for brand and generic prescription drugs under Plan V_2 were assumed to be 14% higher than the cost to plans (the cost listed in the text). See Appendix C.

[b] Out-of-pocket costs for brand prescription drugs under Plan X_2 were assumed to be 14% higher than the cost to plans (the cost listed in the text). See Appendix C.

APPENDIX B

Table 7. Formulary Information for Cleveland Plans[16]

	Plan A_1	Plan A_2	Plan B_1	Plan B_2	Plan C	Plan D	Plan E
Glucophage	Yes	Yes	Yes	Yes	No prescription drug coverage	Yes	No formulary used
Pravachol			Yes	Yes		Yes	
Nifedipine[17]	Yes	Yes	Yes	Yes		Yes	
Celebrex	Yes, but restricted	Yes, but restricted	Only if similar drugs have "failed"	Only if similar drugs have "failed"		No	
Fosamax	Yes	Yes	Yes	Yes		Yes	
Costs counted toward cap	What the plan pays minus the copay[18]	What the plan pays minus the copay[19]	What the plan pays minus the copay	What the plan pays minus the copay		Based on what the plan pays minus the copay	

Table 8. Formulary Information for Tampa Plans[20]

	Plan V_1	Plan V_2	Plan W	Plan X_1	Plan X_2	Plan Y	Plan Z_1	Plan Z_2
Glucophage	Yes	No prescription drug coverage	Yes	Yes	Brand drugs not covered	No formulary used	Yes	Yes
Pravachol	Yes		No	No			Yes	Yes
nifedipine[21]	Yes		Yes	Yes	Yes		Yes	Yes
Celebrex	Restricted, prior authorization required[22]		No	Need authorization	Brand drugs not covered		Yes	Yes
Fosamax	Restricted, prior authorization required		Yes	Yes			No	No
Costs counted toward cap	What the plan pays (do NOT subtract the copay)		What the plan pays minus the copay	What the plan pays minus the copay	What the plan pays minus the copay	What the plan pays minus the copay	What the plan pays minus the copay	What the plan pays minus the copay

APPENDIX C

METHODOLOGY

To compare Medicare+Choice plans on the costs of their benefit packages for the two hypothetical Medicare beneficiaries, project staff had to first obtain information on the likely use of prescription drugs and medical services for the beneficiaries and, then, estimate costs of those drugs and services. It was sometimes difficult to obtain the information needed to estimate the costs of different plan benefit packages. It took several telephone calls to obtain even basic information about drug and benefit costs. However, in some cases, plan representatives seemed more reluctant to provide information to researchers than they would be to plan members.

Information on the Use of Services

Three physicians—an internist with expertise on the elderly, a geriatrician who is also the medical director of a continuing care community, and an orthopedic surgeon—and a physical therapist provided rough estimates of the use of prescription drugs and medical services for the two hypothetical Medicare patients.

Information on Plan Benefit Packages

Project staff obtained plan benefit information from "Medicare Health Plan Compare" on Medicare's Internet site, www.medicare.gov. In addition, staff collected the Summary of Benefits of all but two plans, one in Cleveland and one in Tampa, both of which refused to send the information. In these two instances, benefit information was taken solely from the Centers for Medicare and Medicaid Services Internet site.

Formulary Information

Some plan formulary information can be found on the Internet. Of the 10 plans in the two study areas, only four provided their formularies on their websites. Following a web search, project staff were able to find information on all but one plan's formularies at www.oh.formularies.com and www.fl.formularies.com. However, in some cases, staff phone calls to all Medicare+Choice plans in the study sites provided information about plan formularies that conflicted with that found on the Internet. For purposes of this report, staff assumed the information provided by plan representatives was correct. When formulary information could not be obtained from plan representatives (in two cases), staff used the information obtained from the Internet.

Prescription Drug Cost Information

The two hypothetical Medicare beneficiaries used five prescription drugs for their chronic conditions. Information on the average cost to HMOs of Glucophage, Pravachol, and

Fosamax was provided by the Centers for Medicare and Medicaid Services from the 1998 Medicare Current Beneficiary Survey, Cost and Use Series.

The two other drugs—Celebrex and nifedipine—are too new to have been included in the Centers for Medicare and Medicaid Services 1998 database. Nifedipine is a very recent generic substitute for Procardia XL, a commonly prescribed blood pressure medication. Celebrex is a relatively new drug for the treatment of arthritis. Staff had difficulty obtaining even rough estimates of the costs to Medicare+Choice plans of these drugs. A pharmacist at a pharmacy benefit management company provided the average wholesale price (AWP) of 100 pills of Celebrex and nifedipine. Project staff divided these numbers by three to obtain an estimate of the AWP of one month's supply. Because Medicare+Choice plans generally obtain discounts to the AWP, staff multiplied the AWP by 86 percent to estimate plans' costs for these drugs.[23]

The cost estimates for Celebrex and nifedipine used in this exercise may be higher than actual costs paid by HMOs. However, costs of the other three drugs used in the hypothetical cases are likely less than the actual costs to plans, as prices for these drugs have been increasing since 1998.[24] Moreover, it is likely that plans pay different amounts for these drugs. For these reasons, the estimates used likely do not represent the true cost of these drugs to Medicare+Choice plans.

Information on the Costs of Services

Because several plans charged enrollees 20 percent of the cost of specified services, staff collected information on the costs of these services. Estimates were based on the Medicare-approved amount. To obtain the Medicare-approved amount for a cardiac catheterization, staff obtained the CPT codes for the procedure from a hospital billing office and called a Part B carrier for the Medicare-approved amount associated with these codes. Staff obtained the estimated Medicare-approved amount for a Thallium stress test from a supplemental insurer, the estimated outpatient physical therapy costs from an outpatient rehabilitation facility, and the average costs for Medicare canes and walkers from several durable medical equipment providers. The actual payment rates for Medicare+Choice plans likely differ from those included in the hypotheticals for several reasons. These include: Medicare-approved amounts vary by community and are dependent on severity indices; the cost information provided to researchers was not verified; plans may pay their network providers more or less than the Medicare-approved amounts; and plans differ in their payment rates.

Payment amounts were collected in order to demonstrate the ease or difficulty of calculating costs, not to show actual costs that a Medicare beneficiary would incur. Based on the difficulty staff had in obtaining payment rates for medical services, it is likely that Medicare beneficiaries would also have difficulty obtaining any information on what plans pay their providers for specified services.

Calculating Drug Costs

The report contains an example of the steps taken to calculate the costs of prescription drugs for the hypothetical Medicare beneficiaries. In making these calculations, project staff made the following assumptions:

- The costs of the prescribed drugs were the same for all Medicare+Choice plans;
- Once a plan's prescription drug cap had been reached, the beneficiaries continued to obtain plan discounts for their prescription drugs;
- All plans included nifedipine in their formularies;[25]
- Any prior authorization required was approved;
- The beneficiaries obtained prescribed drugs monthly from their local pharmacy (rather than obtaining a three-month supply through mail order);
- If a plan's brand copay exceeded the cost of the brand drug, the beneficiary purchased the drug out-of-pocket rather than paying the brand copay;
- The two generic drugs prescribed once in each hypothetical were obtained after the cap had been reached;
- If a plan did not cover prescription drugs or covered only generic drugs, enrollees would pay the retail price for their prescription drugs; and
- The retail price of drugs for beneficiaries was 114 percent above rates negotiated by Medicare+Choice plans.[26]

NOTES

[1] P. Fox, R. Snyder, and G. Dallek, "Should Medicare HMO Benefits Be Standardized? *Health Affairs* 18 (July/August 1999): 40–52.

[2] B. Smith and S. Rosenbaum, "Potential Effects of the 'Premium-Support' Proposal on the Security of Medicare," *Journal of the American Medical Association* 282 (November 10, 1999): 1760–1763.

[3] P. Neuman and K. M. Langwell, "Medicare's Choice Explosion? Implications for Beneficiaries," *Health Affairs* 18 (January/February 1999); J. H. Hibbard, J. J. Jewett, and M. W. Legnini, "Can Medicare Beneficiaries Make Informed Choices?" *Health Affairs* 17 (November/December 1998).

[4] General Accounting Office. *Medigap Insurance: Better Consumer Protection Should Result from 1990 Changes to Baucus Amendment* (Washington, D.C.: GAO/HRD-91-49, March 1991).

[5] P. D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* (Spring 1995): 31–47; L. A. McCormack et al., "Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Financing Review* (Fall 1996): 157–174; and T. Rice, M. L. Graham, and P. D. Fox, "The Impact of Policy Standardization on the Medigap Market," *Inquiry* (Summer 1997): 106–116.

[6] Although Medicare+Choice managed care plans can require enrollees to pay premiums, deductibles, copayments, and coinsurance for Medicare-covered services, these out-of-pocket costs cannot exceed the actuarial value of beneficiary cost-sharing in original Medicare. Premiums and cost-sharing charged for supplemental benefits cannot exceed those for the plans' commercial population.

[7] See G. Dallek and D. Jones. *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (New York: The Commonwealth Fund, August 2000).

[8] B. Stuart, D. Shea, and B. Briesacher. *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (New York: The Commonwealth Fund, January 2000).

[9] "Medicare Health Plan Compare" did not initially provide information on all HMO benefits and the information on prescription drugs was limited. See G. Dallek and D. Jones. *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (New York: The Commonwealth Fund, August 2000).

[10] In 1999, 21.3 percent of Medicare beneficiaries had access to the Internet. *Medicare Current Beneficiary Survey,* available at http://www.Medicare.gov/faqs/.

[11] R. Kronick and J. de Beyer. *Medicare HMOs: Making Them Work for the Chronically Ill* (Chicago: Health Administration Press, 1999).

[12] E. Hoy, E. Wicks, and F. Rolfe, "Best Practices and Facilitating Consumer Choice of Health Plans," (Institute for Health Policy Solutions, Washington, D.C.) in Institute of Medicine, *Improving the Medicare Market: Adding Choice and Protections* (Washington, D.C.: National Academy Press, 1996); T. Elkin, "What Should Be the Basic Ground Rules for Plans Being Able to Participate in the Medicare Managed Care Market? Case Study: The California Public Employee' Retirement System," in Institute of Medicine, *Improving the Medicare Market: Adding Choice and Protections* (Washington, D.C.: National Academy Press, 1996); National Academy of Social Insurance, *Structuring Medicare Choices: Final Report of the Study Panel on Capitation and Choice* Washington, D.C.: NASI, March 1998); L. McCormack, P. Fox, T. Rice, and M. Graham,

"Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Financing Review* 18 (Fall 1996): 157.

[13] E. Hoy, E. Wicks, and F. Rolfe, "Best Practices and Facilitating Consumer Choice of Health Plans," (Institute for Heath Policy Solutions, Washington, D.C.) in Institute of Medicine, *Improving the Medicare Market: Adding Choice and Protections* (Washington, D.C.: National Academy Press, 1996).

[14] Plan V_2's stated non-coverage of diabetic supplies does not meet Medicare's requirement that Medicare+Choice plans provide all Medicare-covered benefits.

[15] P. Fox, R. Snyder, and G. Dallek, "Should Medicare HMO Benefits Be Standardized? *Health Affairs* 18 (July/August 1999): 40–52.

[16] Information was obtained by searching plans' websites and www.oh.formulary.com, as well as calling plans requesting formulary information. When website and plan administrative staff information differed, the information provided by plan staff was used.

[17] Originally, Procardia XL was prescribed for Mr. Jones, the hypothetical heart patient. However, when calling plans to check on their formularies, staff found that some, but not all, plans had begun substituting nifedipine, the new generic drug for Procardia XL. Staff made the assumption that all plans would soon make this substitution, and thus switched Mr. Jones' prescription to nifedipine.

[18] Project staff was unable to obtain information from Plan A about its prescription drug benefit. Staff assumed that information provided on www.oh.formulary.com was correct and that costs were calculated in a manner similar to that of other plans in the community.

[19] See footnote 3 above.

[20] Information was obtained by searching plans' websites and www.fl.formulary.com, as well as calling plans requesting formulary information. When website and plan administrative staff information differed, the information provided by plan staff was used.

[21] See footnote 2 above.

[22] In all cases in which a drug required prior authorization, it was assumed granted.

[23] See Health Care Financing Administration, Office of Strategic Planning, Information and Methods Group, "Medicare Current Beneficiary Survey CY 1996 Cost and Use, Public Use File Documentation" (Baltimore, Maryland: Health Care Financing Administration, 1999) as cited in Earl P. Steinberg, Benjamin Gutierrez et al., "Beyond Survey Data: A Claims-Based Analysis of Drug Use and Spending by the Elderly," *Health Affairs* 19 (March/April 2000): 210.

[24] See Robert Pear, "Spending on Prescription Drugs Increases by Almost 19 Percent," *The New York Times,* May 8, 2001, pp. A1, A16; Families USA, *Cost Overdose: Growth in Drug Spending for the Elderly, 1992-2010,* (Washington, D.C.: Families USA, 2000).

[25] When calls were made to plans asking about Procardia XL, several plan representatives noted that their plans covered only nifedipine, the new generic for Procardia XL. Project staff assumed that all plans would soon include the drug in their formularies, although we did not specifically ask about the drug.

[26] Because staff received different estimates on the retail costs of the drugs included in the hypotheticals, staff decided to multiply estimated costs to plans for the drugs by 114 percent (the average difference between the AWP and what plans pay for drugs). Because beneficiaries who pay out-of-pocket are likely charged more that the AWP, the estimated costs to beneficiaries without a prescription drug benefit is likely higher than that estimated in the paper.

RELATED PUBLICATIONS

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#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this report, the authors argue that policymakers contemplating changes to the entitlement program for the elderly and disabled must take steps to protect the most vulnerable beneficiaries—those with chronic or acute physical or cognitive ailments—from incurring out-of-pocket expenses that are even higher than what they currently bear.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/ gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing , the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review,* vol. 2, no. 1. Reprinted from *New Jersey Medicine,* March 2000. Available online at http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, New England Journal of Medicine, P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

#430 *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries* (January 2001). Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#371 *An Assessment of the President's Proposal to Modernize and Strengthen Medicare* (June 2000). Marilyn Moon, The Urban Institute. This paper discusses four elements of the President's proposal for Medicare reforms: improving the benefit package, enhancing the management tools available for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the *Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries,* reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to the President. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs,* vol. 18, no. 4. 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. In this article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. 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. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#308 *Medicare Beneficiaries: A Population at Risk—Findings from the* Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries (December 1998). Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland. This survey report, based on beneficiaries' own accounts of their incomes and health status, points to serious challenges in insuring an aging, vulnerable population.

#294 *Improving Coverage for Low-Income Medicare Beneficiaries* (December 1998). Marilyn Moon, Niall Brennan, and Misha Segal, The Urban Institute. The authors examine ways in which the Qualified Medicare Beneficiary and related programs could be modified to increase participation and protect more sick and low-income Medicare beneficiaries.

#302 *The Future of Medicare* (November 1998). Brian Biles, Susan Raetzman, Susan Joseph, and Karen Davis. This issue brief discusses the two ways in which the National Bipartisan Commission on the Future of Medicare is examining the Medicare program and making recommendations to keep it fiscally healthy into the twenty-first century: through the development of incremental reforms and the analysis of major restructuring. The authors also discuss projections of the future costs of care and sources of revenues to finance care for the elderly and disabled.

#272 *Shaping the Future of Medicare* (April 1998). Karen Davis. Presented as invited testimony before the National Bipartisan Commission on the Future of Medicare's hearing on "Medicare and the Baby Boomers" on April 21, 1998, this report suggests ways to prepare the Medicare program for the challenge of coping with unprecedented numbers of elderly and disabled Americans. The author identifies several principles to guide the debate.