

Failing America's Seniors: Private Health Plans Provide Inadequate Rx Drug Coverage

Introduction

The U.S. House of Representatives will soon consider legislation to provide prescription drug coverage for America's seniors. The proposal that will be considered, developed by Ways and Means Committee Chairman William Thomas (R-CA), relies on private health insurance companies to provide drug coverage—and to bear the financial risk entailed. Insurance companies would be expected to offer “drug-only” insurance policies that cover no other health services.

In its reliance on the private sector to provide coverage, the pending bill is similar to H.R. 4680, the Medicare Rx 2000 Act, which passed the House of Representatives on a partisan basis during the last Congress. At the time H.R. 4680 was being considered, the insurance industry, acting through the Health Insurance Association of America (HIAA), made clear that it had no intention of offering drug-only policies. The industry reasoned that drug-only insurance policies would be subject to adverse risk selection, that is, they would disproportionately attract consumers who have existing health conditions, are sick or disabled, and are among the oldest of the old. As a result, the policies would be very expensive and would have few takers among younger, healthier Medicare beneficiaries. The failure to attract beneficiaries with low drug costs would further drive up premium prices and lead to an increasingly unaffordable price spiral.

This reliance on drug-only policies is not the only troubling feature of the pending proposal. In the traditional Medicare program, beneficiaries can count on a uniform benefit no matter where they

live. As the following analysis demonstrates, *relying on private insurance companies* to deliver drug coverage for Medicare beneficiaries—rather than incorporating a drug benefit into the Medicare program—virtually guarantees that coverage will be uneven in availability, cost, and value.

This unevenness is common both in the Medicare+Choice program (under which private health plans, such as HMOs, offer Medicare coverage, often with some drug coverage) and in Medigap policies (which provide private supplemental coverage for seniors in the traditional Medicare program). Experience under Medicare+Choice and Medigap policies that offer prescription drug coverage shows that these private-sector plans are very expensive; are not always available; and, when available, offer vastly different coverage and/or costs from one geographic area to another. In addition, the coverage diminishes and/or prices increase significantly over time. Because of these limitations, such private insurance policies provide an unreliable mechanism for delivering much-needed prescription drug coverage to America's seniors.

Medicare+Choice

The Medicare+Choice program was established in 1997 to offer Medicare beneficiaries more coverage options and to see if Medicare could capture savings from enrolling beneficiaries in managed care plans. Managed care plans participating in Medicare+Choice must cover all of the required Medicare services and sometimes offer additional services not covered by Medicare. Beneficiaries who enroll in Medicare+Choice plans still pay the full Part B premium of \$54 a month, and they must agree to receive all of their services through their health plan.¹ In exchange, beneficiaries may have lower cost-sharing requirements and may receive additional benefits not covered by Medicare.

No Savings from Medicare+Choice

Although the Medicare+Choice program was enacted in hopes that managed care could help curb Medicare spending, several studies have concluded that Medicare+Choice has not reaped the expected savings and that participating plans are being overpaid. A study by the General Accounting Office found that health plans participating in Medicare+Choice tend to enroll the healthiest beneficiaries and that these beneficiaries would have cost Medicare less if they had been in traditional Medicare rather than Medicare+Choice.* Another study** found that Medicare+Choice plans receive "...more than an adequate amount of funds to deliver the Medicare package of covered services" and that "...Medicare payments have been made to fund excessive administrative costs at [Managed Care Organizations]."

* U.S. General Accounting Office, *Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments*, GAO/HEHS-99-144 (Washington: General Accounting Office, June 1999).

** Office of the Inspector General, *Adequacy of Medicare's Managed Care Payments after the Balanced Budget Act of 1997*, A-14-00-00212 (Washington: Department of Health and Human Services, September 2000).

■ Availability of Drug Coverage Is at the Whim of the Plan

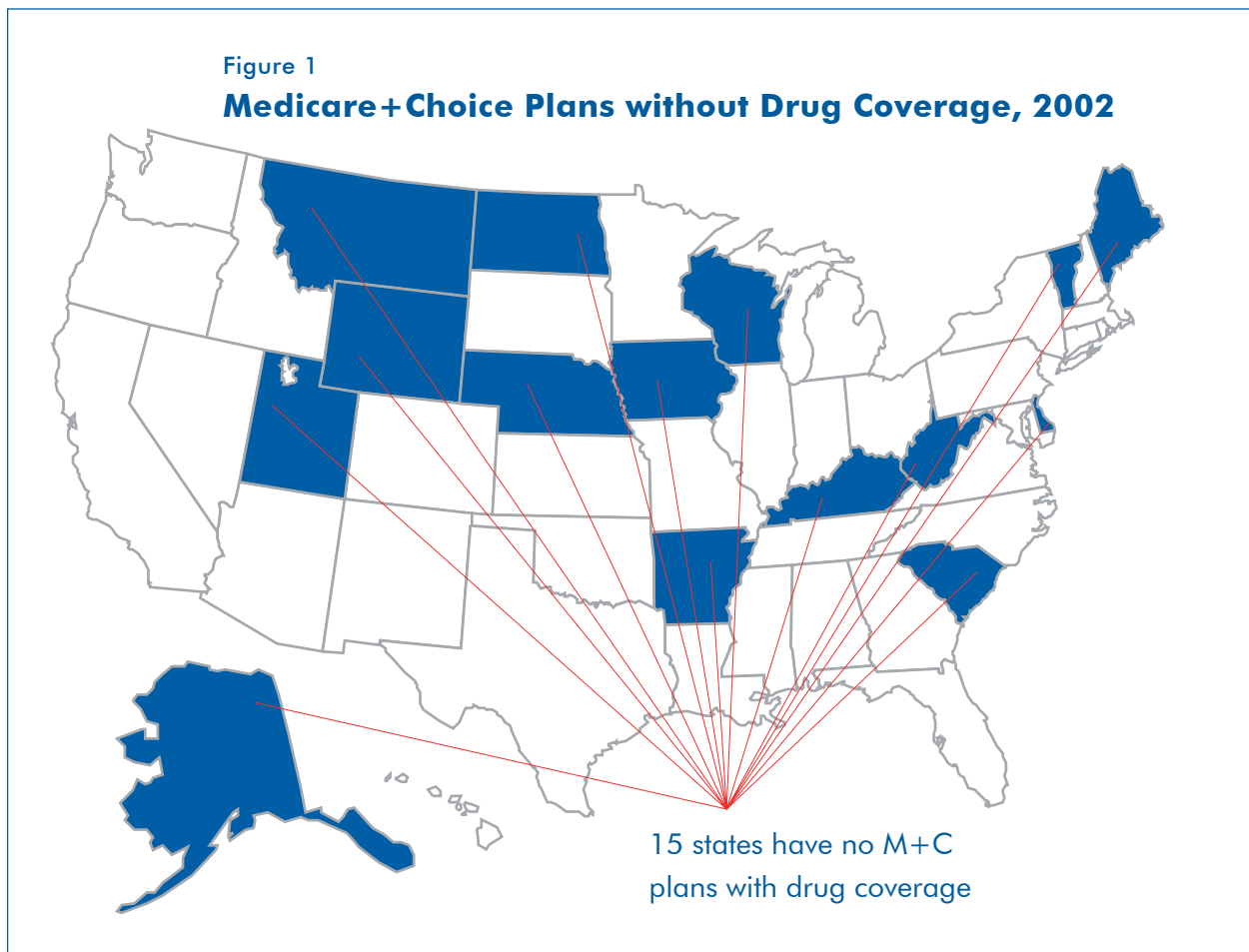
Medicare+Choice is not an option for every Medicare beneficiary who needs prescription drug coverage. In fact, despite several increases in payments to Medicare+Choice plans, today there are fewer Medicare+Choice plans with prescription drug coverage than there were in 1999. In 1999, 41 states had plans that offered drug coverage, but only 35 states plus the District of Columbia have plans with drug coverage in 2002.²

The availability of Medicare+Choice plans varies from state to state and even within states. The number of states where no

Medicare+Choice plan offers prescription drug coverage has grown by half from 1999 to 2002. In 1999, nine states and the District of Columbia had no Medicare+Choice plan with prescription drug coverage. Those states were Alaska, Delaware, Iowa, New Hampshire, South Carolina, South Dakota, Utah, Vermont, and Wyoming. In 2002, beneficiaries in 15 states (Alaska, Arkansas, Delaware, Iowa, Kentucky, Maine, Montana, Nebraska, North Dakota, South Carolina, Utah, Vermont, West Virginia, Wisconsin, and Wyoming) had no Medicare+Choice plan offering prescription drug coverage. (See Figure 1.)

Many other beneficiaries are unable to enroll in a Medicare+Choice plan offering drug coverage, even though their state has at least one such plan. In 2002, beneficiaries in seven states (Idaho, Indiana, Mississippi, New Hampshire, New Jersey, North Carolina, and South Dakota) and the District of Columbia have only one Medicare+Choice plan with drug cover-

age available. With the exception of the plan in the District of Columbia, none of these plans serves the entire state. Thus, access to drug coverage through Medicare+Choice depends on where one lives. Today, millions of beneficiaries are without access to drug coverage through Medicare+Choice because they live in the wrong place.



■ **Coverage Is Costly**

For those beneficiaries who do have access to a Medicare+Choice plan with drug coverage, that prescription drug coverage is growing increasingly expensive. In the early years of Medicare+Choice, prescription drug coverage was often available to beneficia-

ries for little or no cost. In 1999, there were 29 states with plans providing drug coverage that required no additional monthly premium. In 2002, there are 18 states with plans that offer drug coverage at no additional premium. (See Figure 2.)

Premiums for Medicare+Choice plans offering prescription drug coverage increased dramatically from 1999 to 2002. Thirty-three states had Medicare+Choice plans with drug coverage in both 1999 and 2002. In roughly half of these states (16 states), the average premium for a Medicare+Choice plan with

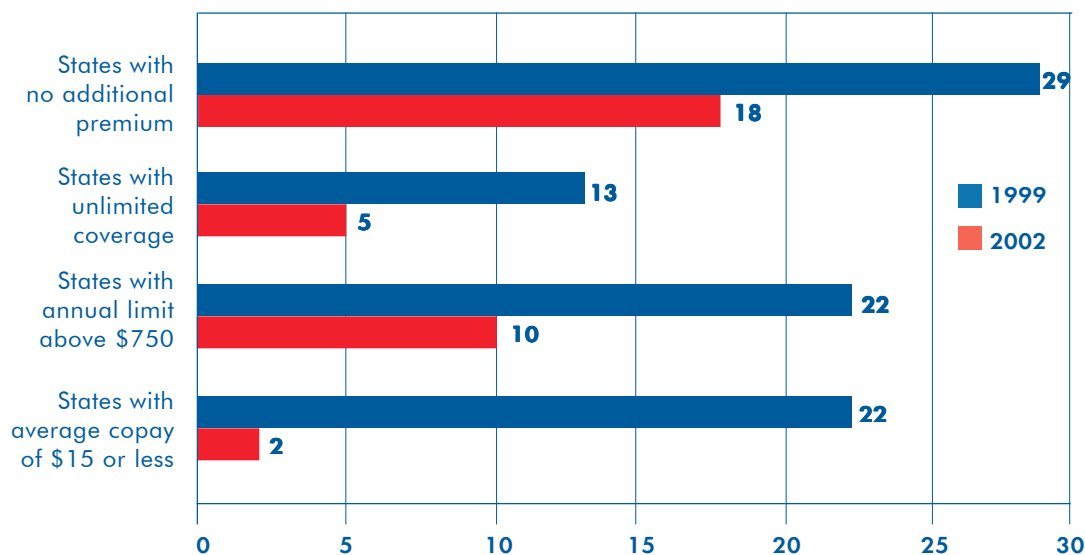
drug coverage increased more than 100 percent during this three-year period. In 10 states, the average premium for plans with drug coverage increased by more than 300 percent. During this same period, employer-sponsored health coverage increased by an average of 35.4 percent.³

■ **The Value of Drug Coverage Is Declining**

Prescription drug coverage in Medicare+Choice plans is often limited: Either the amount of coverage is capped, or the scope of coverage is limited beyond the customary use of formularies. Further, the value of the coverage offered has declined dramatically in the last three years. In the early years of Medicare+Choice, many plans offered coverage of a wide range of prescription drugs with no dollar limit on coverage and low cost-sharing requirements. Today, plans have established absolute dollar limits on the amount of drug coverage they will provide, and this coverage cap has gotten lower over time. Some plans now limit the coverage to only generic drugs, and beneficiary cost-sharing has increased.

- **Unlimited Coverage Has Declined.** In 1999, 13 of the 41 states with a Medicare+Choice plan that covered drugs had at least one plan with drug coverage that had no dollar limit on the drug benefit.⁴ In 2002, there are only five states that have Medicare+Choice plans with prescription drug coverage that is unlimited. (See Figure 2.) In one of these states (Hawaii), the “unlimited” plan covers only 15 percent of the cost of prescriptions.
- **Dollar Limits Are Lower.** Limits on the amount of coverage have gotten more stringent since 1999. In 1999, there were 22 states where the average annual limit among plans was higher than \$750. In

Figure 2
Medicare+Choice Plans with Drug Coverage



2002, there were only 10 states with an average annual limit higher than \$750. (See Figure 2.) The combination of lower caps and rapidly rising drug prices sharply reduces the value of the prescription drug coverage provided to beneficiaries in these plans.

- **Coverage Is Often Limited to Generic Drugs.** In 1999, no Medicare+Choice plan in any state limited prescription drug coverage to only generic drugs. In 2002, plans in more than half of the states (19 of 36) with Medicare+Choice plans offering drug coverage have at least one plan that limits coverage to generic drugs. In some cases, the generic drug coverage is unlimited, and in others, coverage of generic drugs is

capped. While generic drugs offer a high-quality, lower-cost alternative to many brand-name drugs, not all drugs used by Medicare beneficiaries have generic equivalents. For beneficiaries who need brand-name medications, generic-only plans offer very limited coverage.

- **Cost-Sharing Has Increased.** Beneficiary cost-sharing for prescription drugs also increased for both brand-name and generic drugs. In 1999, more than half of the states with plans offering drug coverage (22 of 41) had an average copay for brand-name drugs that was \$15 or less. In 2002, only two states, Tennessee and Virginia, have plans with an average brand-name copay that is \$15 or less. (See Figure 2.)

Medigap and Prescription Drugs

Medicare beneficiaries aged 65 or older can purchase private supplemental insurance (Medigap) to cover their Medicare deductibles and coinsurance and to cover other benefits not included in traditional Medicare, such as prescription drugs. Insurers who offer Medigap policies must offer one or more of 10 standardized plans, designated by letters A to J, with A offering the least, and J the greatest, additional coverage (see Table 1). Plans H, I, and J offer limited coverage of prescription drugs (see Table 2). The limited appeal of these policies is reflected in the low participation among Medicare beneficiaries. In 1999, roughly 2.3 million⁵ Medicare beneficiaries (approximately 6 percent) had Medigap policies with prescription drug coverage, a relatively small share of the overall Medicare population.

Under federal law, when beneficiaries first enroll in Medicare Part B (which covers outpatient services), they have a six-month opportunity to purchase any of the 10 standardized Medigap policies. During this

Private Medigap Policies Offer Little Help with Prescription Drug Coverage

Private market prescription drug coverage has been available to Medicare beneficiaries for more than a decade, but few beneficiaries purchase such policies. A recent General Accounting Office (GAO) report examined the availability and cost of Medigap. The GAO cited three likely reasons for beneficiaries' reluctance to purchase Medigap policies that include drug coverage: fewer plans with drug benefits are offered; the cost is relatively high; and the prescription drug coverage offered is limited. The GAO also found that beneficiaries who purchased Medigap policies with drug coverage still face "...substantial out-of-pocket costs for prescription drugs and other health care services."

⁵ U.S. General Accounting Office, *Medigap Insurance: Plans are Widely Available but Have Limited Benefits and May Have High Costs*, GAO-01-941 (Washington: General Accounting Office, July 2001).

six-month period, coverage is guaranteed: Insurers may not reject beneficiaries for coverage. However, beneficiaries who do not purchase a Medigap policy with drug coverage during this period may find they are unable to purchase one in the future. While insurers issue coverage during other periods, coverage is not generally guaranteed for any of the policies offering prescription drug coverage. Because Medigap plans with drug coverage are ex-

pensive, beneficiaries with low drug costs may opt for a less expensive plan without realizing that they cannot later buy a policy that includes drug coverage. And beneficiaries who choose to enroll in a Medicare+Choice plan with drug coverage instead of purchasing a Medigap policy may be out of luck if their Medicare+Choice plan pulls out: Federal law does not require Medigap insurers to sell policies with drug coverage to beneficiaries who lose Medicare+Choice coverage.

■ **Cost of Coverage Is Variable**

Since Medigap policies are regulated at the state level, beneficiaries in different states pay different amounts for the same policy, even if they are perfectly healthy. A comparison of premiums from 27 states for Plan I found that the premium for the lowest-cost plan ranged from a low of \$173.83 per month (\$2,086 a year) in Oregon to a high of \$300.25 per month (\$3,603 a year) in both Illinois and Nevada. For exactly the same coverage, beneficiaries in Illinois and Nevada are paying 73 percent more than Medicare beneficiaries in Oregon.⁶

Table 1: The 10 Standard Medigap Plans

| | A | B | C | D | E | F | G | H | I | J |
|--|---|---|---|---|---|-----------|----------|---|-----------|-----------|
| Basic Benefits (primarily Part A and Part B Coinsurance) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Skilled Nursing Facility Coinsurance | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Part A Deductible | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Part B Deductible | | | ✓ | | | ✓ | | | | ✓ |
| Part B: Excess Charges | | | | | | 100% ✓ | 80% ✓ | | 100% ✓ | 100% ✓ |
| Foreign Travel (Emergency) | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| At-Home Recovery | | | | ✓ | | | ✓ | | ✓ | ✓ |
| Basic Drugs (\$1,250 limit) | | | | | | | | ✓ | ✓ | |
| Extended Drugs (\$3,000 limit) | | | | | | | | | | ✓ |
| Preventive Care | | | | | ✓ | | | | | ✓ |

Table 2
Medigap Plans with Drug Coverage

| Medigap Plan | Deductible | Coinsurance | Maximum Plan Payment |
|--------------|------------|-------------|----------------------|
| Plan H | \$250 | 50% | \$1,250 |
| Plan I | \$250 | 50% | \$1,250 |
| Plan J | \$250 | 50% | \$3,000 |

■ Coverage Is Costly

Medigap policies with prescription drug coverage are expensive considering the limited coverage offered. The standard drug coverage offered in plans H and I is structured in the following manner: \$250 deductible, 50 percent coinsurance once the deductible is reached, up to \$1,250 in prescription expenses. Plan J offers similar coverage with a limit of \$3,000 rather than

\$1,250. A comparison of Plan F, the most popular of the non-drug plans, and Plan J, the most popular drug plan, shows that beneficiaries would pay, on average, an additional \$1,140 per year in premiums for the coverage offered in Plan J. However, this amount will vary from state to state and from plan to plan.⁷

Conclusion

Experience with Medicare+Choice and Medigap policies demonstrates that these private-sector plans are a costly and unreliable means of providing prescription drug coverage for America's seniors. The proposal introduced by Rep. Thomas is likely to be even less satisfactory than either Medicare+Choice or Medigap. The Thomas proposal not only builds on private-sector plans, but it also relies on *drug-only* private sector plans—a questionable approach in light of the private insurance industry's unwillingness and/or inability to provide reliable and cost-effective prescription drug coverage. Given Medicare's successful track record in providing seniors inpatient hospital care and outpatient physician care, it would make much more sense to provide prescription drug coverage within the Medicare program.

¹ Beneficiaries can go to out-of-network providers for emergency care or urgently needed care.

² Families USA analysis of Medicare Compare database for 1999 and 2002. Data for 2002 are based on data available on April 1, 2002.

³ Families USA calculations based on Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans (New York: Mercer Human Resource Consulting, March 2002).

⁴ Nearly all plans limit the drugs they cover through the use of formularies. Although a plan may offer coverage with no dollar limit, that coverage typically applies to those drugs on the plan's formulary. Drugs not on the formulary are either not covered by the plan, or, if they are covered, the beneficiary cost-sharing is substantially higher than cost-sharing for formulary drugs.

⁵ Families USA calculations based on data in Mary A. Lachober, Michelle Kitchman, Patricia Neuman, and Allison A Strabic, "Trends In Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," *Health Affairs* 21 no. 1 (February 2002).

⁶ Based on Families USA comparison of premiums for the lowest-cost Plan I in the 27 states that had such plans on Quotesmith.com on April 30, 2002. Premiums were collected for 75-year-old, non-smoking females. Tables are available from Families USA.

⁷ Based on Families USA comparison of premiums for the AARP/United Healthcare policies for Plans F and J. Premiums for plans for 75-year-old, non-smoking females were collected from the Web sites for insurance commissioners in the 26 states where such information was available. This information was collected in April 2002. Tables are available from Families USA.

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Families USA Publication No. 02-103

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This publication is available online at

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