Order Code RL33300

Standardized Choices: Medigap Lessons for Medicare Part D

March 8, 2006

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Summary

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173, known as "MMA") created a new Medicare outpatient prescription drug benefit. With the rollout of the full benefit in January 2006, beneficiaries face a large number of choices from numerous insurers offering multiple plans with different benefits. A similarly complex array of choices in the private supplemental Medicare insurance (Medigap) market was one of the factors leading to the Medigap provisions in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, OBRA 90) and the Social Security Act Amendments of 1994 (P.L. 103-432, SSAA 94).

The Medigap reforms addressed the problems in the market by: (1) simplifying choices, (2) promoting competition as a means to hold down premium increases, and (3) providing consumer protections. To reduce the variation and number of products in the market, OBRA 90 limited insurers to selling ten standardized policies with precisely defined benefits.

The ten standardized policies simplified price comparisons and decision making for Medicare beneficiaries and led to a consolidation in the market with fewer products and sellers, however some problems remained. Premium increases continued, critics expressed dissatisfaction with the range of offerings, claiming that the limited choices did not fully meet the needs of some beneficiaries, and confusion persisted in some of the dimensions that were not addressed by the Medigap reforms, for instance in the methodology used to calculate premium increases over time.

There are several differences between the Medigap experience and Medicare Part D when considering whether standardizing benefits might yield improvements in the Part D market. In contrast to Medigap, Medicare Part D is new and the market is likely to change dramatically in the coming years. Many observers expect that the Medicare Part D market will consolidate in subsequent years, both in the number of carriers and the number and scope of products offered, as carriers learn which products are most attractive to Medicare beneficiaries and which ones are profitable. A strong federal presence in Medicare Part D and the additional complexities of a prescription drug benefit when compared to a supplemental insurance product also suggest that the experiences might not be entirely similar. Consequently, the policy decision should include considerations about not only whether and how to standardize benefits but also when to do so.

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The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173, known as "MMA") created a new Medicare outpatient prescription drug benefit. With the rollout of the full benefit in January 2006, beneficiaries face a large number of choices from numerous insurers offering multiple plans with different benefits. A similarly complex array of choices in the private supplemental Medicare insurance (Medigap) market was one of the factors leading to the Medigap provisions in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, OBRA 90) and the Social Security Act Amendments of 1994 (P.L. 103-432, SSAA 94).[1] This report highlights the lessons learned from the Medigap experience and how they might provide insight into the current Medicare Part D market.

Medigap

Background

The history of Medigap is noteworthy for its lessons in federal regulatory intervention in health insurance markets. Medigap plans have been in existence since the 1970s and have been sold by hundreds of insurance companies.[2] However, dissatisfaction with the Medigap market grew substantially over the years. Beneficiaries complained of marketing abuses by companies and agents, where Medicare beneficiaries were sometimes sold multiple Medigap plans or plans that duplicated coverage that they already had through retiree health plans. Other plans offered very little value. The multiplicity of offerings from numerous carriers also led to a confusing array of Medigap product choices for beneficiaries. High premium increases compounded the dissatisfaction and Congress responded to complaints of marketing abuses, high pressure sales practices, fraud, and a confusing array of choices by passing laws that set restrictions on the Medigap market.

Prior to 1980, states were solely responsible for regulating Medigap but this changed when Congress enacted Public Law 96-265. Section 507(a), known as the "Baucus Amendment," responded to widespread public dissatisfaction by establishing voluntary certification standards designed to encourage states to enact legislation that incorporated basic requirements established by the National

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[1] For additional information about Medigap, see CRS Report RL31223, *Medicare: Supplementary 'Medigap' Coverage*, by Jennifer O'Sullivan.

[2] National Association of Insurance Commissioners, *1990 Loss Ratios for Medicare Supplemental Insurance*, Kansas City, MO, 1992.

Association of Insurance Commissioners (NAIC). Medigap policies were required to meet minimum benefit package requirements, return a minimum portion of premiums to beneficiaries in the form of benefits (called a loss ratio), and comply with various disclosure provisions, including providing a consumer guide and outline of benefits to prospective policyholders.[3]

Although the Baucus Amendment achieved many of its goals, there continued to be a large number of products sold in this market as there were no limits on how many and what type of benefits could be offered in excess of the minimum standards.[4] Beneficiaries found it difficult to comparison shop effectively in the face of hundreds of policy configurations. OBRA 90 was designed to address this shortcoming.

OBRA 90 and SSAA 94

The primary changes in the Medigap market were the result of the Medigap provisions of the Omnibus Budget Reconciliation Act of 1990, most of which went into effect in 1992, and the Social Security Act Amendments of 1994. These laws addressed the problems in the market by: (1) simplifying choices, (2) promoting competition as a means to hold down premium increases, and (3) providing consumer protections.

The Medigap reforms of OBRA 90 limited insurers to selling 10 standardized policies with precisely defined benefits.[5] The 10 packages, designated A through J, were designed by an advisory group convened by the NAIC with Plan A being the most basic policy and Plan J being the most comprehensive. Three of the packages, Plans H, I, and J, offered some prescription drug coverage. OBRA 90 required all Medigap carriers to offer Plan A, and carriers may choose to offer any of the other nine options to Medicare beneficiaries at the carriers' discretion.

OBRA 90 also contained numerous provisions designed to offer more consumer protections for Medicare beneficiaries. These protections include mandatory open enrollment periods; limitations on preexisting conditions; the requirement of a "free look" provision to allow beneficiaries time to decide whether the Medigap plan that they selected was appropriate for them; limits on high-pressure sales tactics and agent

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[3] A loss ratio is defined as the proportion of benefit costs to premium revenue. A low loss ratio means that the amount of benefits paid is much less than the premiums received, and so the insurer would be more profitable. Correspondingly, a high loss ratio (a value close to but less than one) indicates that premiums barely cover the cost of benefits paid and so the insurer would be less profitable. A loss ratio greater than one would mean that premiums were insufficient to cover the cost of benefits. The Baucus Amendment required a minimum loss ratio of 60% for individual policies and 75% for group policies.

[4] GAO, *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies*, October 1986, GAO/HRD-87-8.

[5] MMA established two new standardized plan options (K and L) that eliminate first-dollar coverage for most Medicare cost-sharing and limit out-of-pocket cost-sharing. See CRS Report RL31223, *Medicare: Supplementary 'Medigap' Coverage*, by Jennifer O'Sullivan for further details.

commissions; and the creation of funds for beneficiary education. In addition, OBRA 90 also set limits for carrier profitability in an attempt to curb rapidly increasing premiums; failure to meet standards would generate a requirement for the company to issue premium refunds.

One of the protections introduced by OBRA 90 made it illegal to sell duplicate Medigap coverage to beneficiaries, but it also barred the sale of policies that duplicated other coverage to which a beneficiary was entitled, for instance through a retiree health plan. As a result, some insurers refused to sell Medigap policies to beneficiaries who had any kind of retiree plan, even when the retiree plan was very limited. SSAA 94 amended the OBRA 90 requirements by narrowing the anti-duplication provisions and clarifying the circumstances when insurers would be subject to financial penalties.

Result of Reforms

The OBRA 90 Medigap legislation attempted to simplify the Medigap insurance market, to provide consumer protections and choice, to provide market stability, and to promote competition and thereby slow down premium increases. Most of these objectives were satisfied. The 10 standardized policies simplified price comparisons and decision making for Medicare beneficiaries.[6] By 1999, about 10.7 million Medicare beneficiaries (more than one-fourth of all Medicare beneficiaries) were enrolled in a Medigap policy.[7] Complaints about carrier and agent abuses also declined substantially after OBRA 90.[8]

Along with the reduction in the variety of Medigap products came a consolidation in the market. Following the 1992 implementation of OBRA 90 provisions, there were fewer products and fewer sellers, as many carriers with smaller market shares left the business.[9] Over time, the Medigap market stabilized and in the decade following OBRA 90, there was little change in market share and the number of carriers with no reported major detrimental impact on the insurance industry.[10]

Continuing Problems

Despite the achievements of the Medigap reform legislation contained in OBRA 90 and SSAA 94, some problems remained. Researchers found little effect on

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[6] MA, MN, and WI had Medigap standardization programs in place before the passage of OBRA 90 and were granted waivers allowing continued operation of those plans.

[7] GAO, *Medigap Insurance: Plans are Widely Available but Have Limited Benefits and May Have High Costs*, July 2001, GAO-01-941.

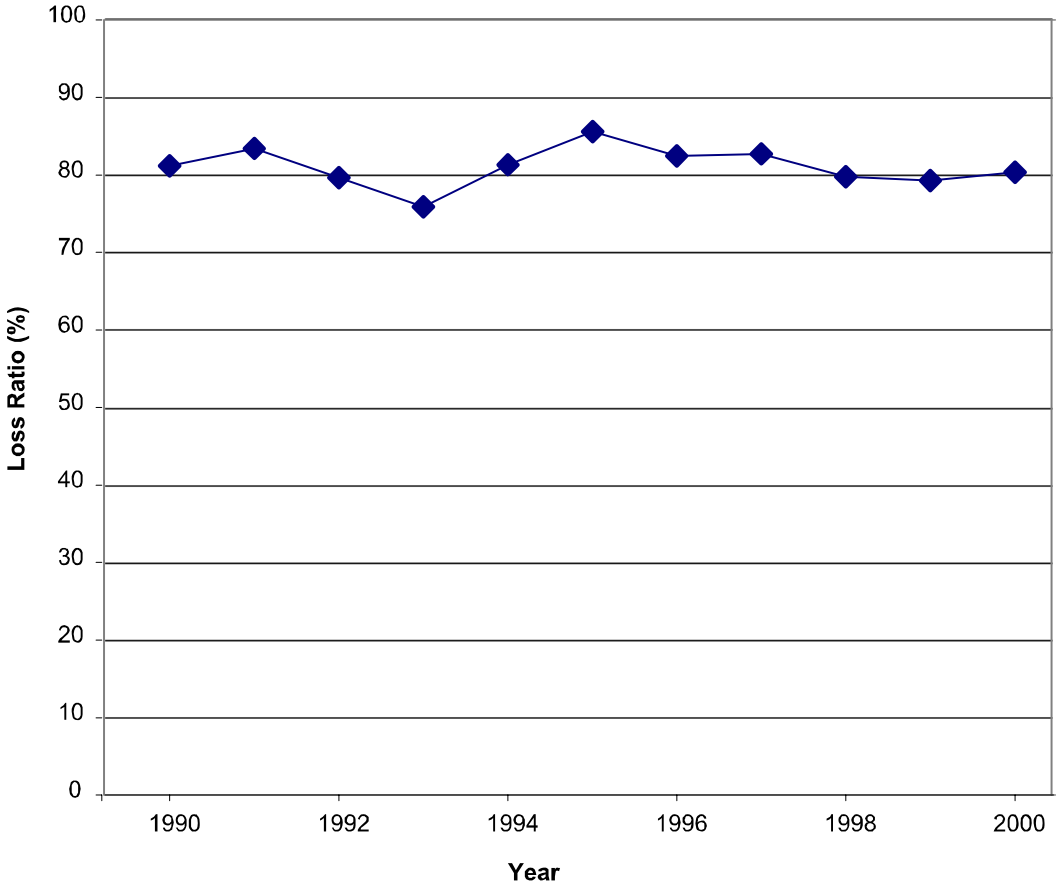
[8] U.S. Department of Health and Human Services, Office of Inspector General, *The Impact of OBRA 1990 on State Regulation of Medigap Insurance*, OEI-09-93-00230, March 1995.

[9] L.A. McCormack, P.D. Fox, T. Rice, and M.L. Graham, "Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Financing Review*, vol. 18, no. 1, fall 1996.

[10] P.D. Fox, R.E. Snyder, and T. Rice, "Medigap Reform Legislation of 1990: A 10-Year Review," *Health Care Financing Review*, vol. 24, no. 3, spring 2003.

premium increases and did not find that industry profitability decreased substantially following standardization. GAO found that the aggregate loss ratio for the industry dropped by about 10 percentage points in the first two years that OBRA 90 was in effect compared to the prior four years, from 0.93 to 0.85 for group policies and from 0.86 to 0.75 for individual policies.[11] A 10-year analysis found that aggregate loss ratios were no higher in 2000 than in 1990 and 1991, prior to the implementation of OBRA 90, indicating no decrease in profitability over the decade (see **Figure 1**).[12]

Figure 1. Average Loss Ratios for All Medigap Policies, 1990-2000



Source: Fox et al., "Medigap Reform Legislation of 1990: A 10-Year Review," *Health Care Financing Review*, vol. 24, no. 3, spring 2003.

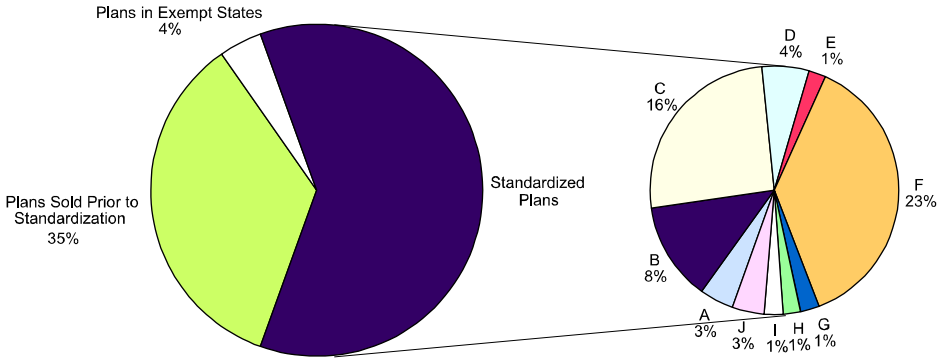
Critics of the Medigap market and the legislative modifications have also argued that the standardized benefit packages did not and may not meet consumers' needs or policy objectives. Only a few of the packages are popular with beneficiaries; plans C and F account for over half of the market for standardized plans (see **Figure 2**), while some packages, such as the ones that include prescription drug benefits (H, I, and J) often have premiums that far exceed the actuarial value of the benefit for the

[11] GAO, *Medigap Insurance: Insurers' Compliance With Federal Minimum Loss Ratio Standards, 1988-93*, August 1995, GAO/HHS-95-151.

[12] Ibid.

average beneficiary and have much smaller market share.[13] Standardized choices may facilitate decision making, but limited choices may fall short of providing the range of options that would serve many beneficiaries.[14]

Figure 2. Distribution of Medigap Plans, 1999



Source: CRS analysis of data in the GAO report Medigap. *Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives*, GAO-02-533T.

Despite the efforts at standardization, some have criticized the OBRA 90 reforms for falling short and allowing too much state leeway. Some insurers and consumer advocates have complained about inconsistent regulation across states, and that variation in wording requirements and the presentation of policy forms resulted in less consistency than desired.[15]

Finally, some confusion has remained in the market, particularly in how ratings methodologies are applied in setting premiums and how this affects beneficiary choice. Medigap carriers can rate policies in three ways: (1) using community rating without any age differentiation, (2) with issue-age rating, or (3) with attained-age rating. The choice of rating methodology has implications for the cost of the premium over time. Community-rated premiums do not change as the policy holder ages. Issue-age premiums are based on the age of the beneficiary when the policy is issued and increase with inflation but not age. Attained-age premiums can be less expensive initially when purchased, but increase as the beneficiary ages.

Decision Making and the Number of Choices

The effect of having many choices on decision making is not fully understood. Traditional economic theory argues that more choices lead to greater satisfaction

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[13] Ibid.

[14] While data on Medicare beneficiaries' choices across Medicare drug plans are not yet available, CMS administrator Mark McClellan stated on February 8, 2006 before the Senate Finance Committee that the "vast majority" of Part D enrollees have selected plans that offer something other than the standard benefit described in MMA.

[15] L.M.B. Alecxih et al., "Can Regulation Improve Long-Term Care Insurance? Lessons from the Medigap Experience," *Journal of Aging and Social Policy*, vol. 7, no. 2, 1995.

since the decision maker can select the choice that is most closely aligned with the individual's preferences. However, some behavioral economists, psychologists and others argue that the cost associated with having to evaluate each choice could offset the gains provided by achieving the "best fit." Some research suggests that individuals faced with many choices may find that having more alternatives can be counterproductive. Particularly when the differences are small, the prospect of having too many choices can be demotivating, leading the decision maker to avoid making any decisions at all. Having more options may lead to less confidence that the decision maker's choice is optimal and subsequently a lower willingness to commit to a single choice.

Some recent empirical studies appear to support this theory. One study found that plans that offered more 401(k) options had lower participation rates compared to plans that offered only a handful of choices; "every ten funds added, other things equal, is associated with a 1.5% to 2% drop in [the] participation rate."[16] Another study found that while grocery store consumers were initially more attracted to a booth displaying 24 jam choices, a higher percentage of consumers who saw only six choices subsequently purchased the jam by a factor of 10. Related work also showed that *ex poste* satisfaction was higher among those who had fewer than those who had more choices.[17]

At the other extreme, having too few choices can also inhibit participation. If the limited choices available do not provide the decision maker with an improvement over the status quo, then choosing not to participate will be optimal. Therefore, other things being equal, the more varied the preferences across the population, the less likely that one choice will be optimal for the majority.

While these theories might partly explain the early enrollment experience of Medicare Part D, the late enrollment penalty adds a significant incentive whose effects have not yet been fully realized. A late-enrollment penalty helps to create and maintain a broad base of enrollees so that pooling the collective experience can significantly reduce the average risk for all enrollees. Without such a penalty, beneficiary enrollment decisions would reflect an appropriate self-assessment of risk; in the aggregate, this could lead to a premium-inflating spiral where only the highest-risk beneficiaries choose to enroll, leading to even higher premiums and riskier enrollees with each iteration. Although Medicare Part B is voluntary and offers one choice (to participate or not), the participation rate is 94% due in part to the late enrollment penalty.[18]

The early experience with Medicare Part D enrollment may reflect both the demotivating aspect of having many choices as well as the fact that the late

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[16] G. Huberman and W. Jiang, "Offerings vs. Choice by 401(k) Plan Participants: Equity Exposure and Number of Funds," *Journal of Finance*, to appear.

[17] S.S. Iyengar and M.R. Lepper, "When Choice Is Demotivating: Can One Desire Too Much of a Good Thing?" *Journal of Personality and Social Psychology*, vol. 79, pp. 995-1006, 2000.

[18] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2005 Annual Report*.

enrollment penalty has not yet been imposed. As of mid-February, 2006, about 24% of Medicare beneficiaries who were not automatically enrolled or did not have other creditable coverage[19] had signed up for a Medicare Part D plan.[20] While more beneficiaries may enroll as the late-enrollment penalty deadline nears, trying to make the decision in the face of an impending deadline may also elevate accompanying stress levels.

Evaluating proposals to extend the open enrollment period before imposing the late enrollment penalty requires balancing a complex set of costs and benefits to Medicare beneficiaries, insurers, CMS, and taxpayers. Medicare beneficiaries who simply need more time to gather and incorporate information to assist in decision making would be well-served by an extension of the open enrollment period, however, there are likely to be beneficiaries for whom the extension is simply an opportunity to delay the choice. For these individuals, the decision process would not change materially, except that it would occur later. Additionally, insurers calculated premiums based on expected enrollment linked to a predetermined open enrollment period. Extending the sign-up period could affect the enrollment and the covered expenditures in a biased manner. If fewer beneficiaries enroll in the early part of the year there would be proportionally fewer covered costs incurred if this happened in a random or unbiased manner. However, extending the open enrollment period might provide the opportunity for beneficiaries who were low risk (those who did not use or expect to use many prescription drugs) to postpone enrollment until the last possible minute, providing an additional period during which no late enrollment penalty would be in effect. The effect of this scenario would be to create an enrolled population that differs from the one insurers projected when formulating their plans and bids.

Standardization Options for Medigap and Medicare Part D

The Medigap market of the 1980s and the current Medicare Part D market both present the beneficiary with a great many choices, but the standardization approach applied to the Medigap market through OBRA90 has limited parallels and applicability to the current Medicare Part D market. Before the Medigap reforms, there were no federal restrictions on how vendors could structure their offerings.

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[19] A Medicare beneficiary is not subject to a Part D late enrollment penalty if the individual is enrolled in another insurance plan that provides coverage of prescription drugs costs and the actuarial value to the individual equals or exceeds the actuarial value of the standard prescription drug coverage under Part D. A plan that meets this criteria is deemed to be "creditable coverage."

[20] Out of 43.4 million total Medicare beneficiaries, 10.5 million were either dual eligibles (6.2 million), enrolled in a Medicare Advantage plan prior to 2006 (4.3 million), or retirees with creditable coverage (10.0 million). Of the remaining 22.9 million, 4.9 million signed up for a stand-alone plan and 0.5 million enrolled in a Medicare Advantage drug plan as of February 13, 2006. See Kaiser Family Foundation policy brief, *Tracking Prescription Drug Coverage Under Medicare: Five Ways to Look at the New Enrollment Numbers*, February 2006.

OBRA 90 required vendors to conform to 10 standardized Medigap options, Plan A through Plan J, that vary by the scope of covered services.[21] Plan A is the basic package that covers Part A hospital coinsurance (for days 61-90 in a benefit period and 60 lifetime reserve days) and 365 days of hospital care after the exhaustion of Medicare benefits, Part B cost-sharing, and the first three pints of blood. The nine remaining plans, B through J, offer combinations of additional coverage including the Part A and/or Part B deductibles, skilled nursing facility care, emergency medical care in foreign countries, at-home recovery, preventive care, and Part B excess charges.[22] Therefore, since the creation of standards, vendors compete on dimensions *other* than covered services, including price (premiums and cost-sharing) and customer service.

In contrast, vendors participating in the Medicare Part D market have faced at least two constraints from the beginning of the program. MMA states that each Part D eligible individual is entitled to obtain either (a) the standard prescription drug coverage with access to negotiated prices,[23] or (b) alternative prescription drug coverage with at least actuarially equivalent benefits and access to negotiated prices.[24, 25] Thus, vendors may vary their products and compete on premiums and cost-sharing requirements, so long as they meet the actuarial equivalence test as determined by CMS. The early experience has shown that despite this constraint, plans have found sufficient flexibility to vary their product offerings substantially.

Second, the MMA also put guidelines in place regarding the scope of drugs that each plan must cover. United States Pharmacopeia (USP), as directed by MMA, produced a model formulary that CMS used to evaluate proposed plan formularies. Plans are required to cover:(1) at least two drugs in each therapeutic category and pharmacologic class described in the USP Medicare Prescription Drug Benefit Model Guidelines or an acceptable alternative; (2) substantially all drugs in a handful of classes dealing with mental health treatments;(3) at least one product representing each of 119 key drug types defined by USP, and (4) a majority or substantially all

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[21] The Balanced Budget Act of 1997 (BBA 97, P.L.105-33) added two high deductible plans to the 10 standard plans. With the exception of the high deductible feature, the benefit packages under the high deductible plans are the same as for Plan F or Plan H.

[22] Prior to MMA, Plans H and I also offered a basic drug benefit and Plan J offered an extended drug benefit, but these drug benefits can not be included in any new policy sold after December 21, 2005.

[23] The standard benefit for Medicare Part D is defined by a monthly premium ($35), deductible ($250), co-insurance rate (25% up to the initial coverage limit), and catastrophic coverage threshold ($5,000). For further details about beneficiary cost-sharing, see CRS Report RL31525, *Beneficiary Cost-Sharing Under the Medicare Part D Benefit*, by Jim Hahn.

[24] Social Security Act, Sec. 1860D-2. [42 U.S.C. 1395w-102]

[25] The American Academy of Actuaries and the Society of Actuaries state that two plans are to be considered actuarially equivalent if, for the same population and covered services, the total costs under each plan design and the net plan per member per month (PMPM) costs (total costs less member cost sharing) are the same. However, the premiums and cost sharing structures for individual members could vary between the plan designs. [http://www.actuary.org/pdf/medicare/briefing_072103.pdf].

available products in six drug categories — antidepressants, antipsychotics, anticonvulsants, antineoplastics, immunosuppressants, and HIV/AIDS drugs.[26]

Despite these constraints, plans were able to generate and CMS approved a great diversity of prescription drug benefit designs. Plans differ widely in the number of covered drugs, their use of cost-sharing tiers, deductibles, and whether or not the plan includes a gap in coverage. Prescription Drug Plans (PDP) are covering an average of 1,526 drugs with a maximum of 3,891, while the average for Medicare Advantage-Prescription Drug (MA-PD) plans is 1,456 with a maximum of 5,823.[27] More than half of the PDP and MA-PD plan offerings include more than four cost-sharing tiers, with some plans offering up to eight cost-sharing tiers (see **Table 1**). Most plans offer variations on the standard benefit; about a third (34%) of the plans will offer the standard $250 deductible, while 58% will include no deductible, with the remaining 8% offering a deductible somewhere in-between. About one plan in six (15.6%) will not have a coverage gap.[28]

Table 1. Use of Cost-Sharing Tiers in Medicare Part D Plans

	PDPs		MA-PDs	
	# of plans	% of plans	# of plans	% of plans
One tier	15	1%	36	2%
Two tiers	111	8%	274	18%
Three tiers	582	40%	250	17%
Four tiers	561	39%	599	40%
Five tiers	167	12%	314	21%
Six tiers	3	<1%	18	1%
Seven tiers	0	0%	7	<1%
Eight tiers	0	0%	3	<1%

Source: Avalere Health, LLC, *DataFrame News*, December 2005.

Given these variations, standardization options for Medicare Part D would be quite different from the approach applied to the Medigap market, where covered services were grouped into 10 packages. The major dimensions for consideration are beneficiary cost-sharing through deductibles, coinsurance and copayment rates and levels, and drug coverage through formulary design. The interaction of these variables with the plans' enrolled population, projected drug consumption patterns, negotiated prices, efficiency of operation and desired profit level will determine the premium insurers can set for the products.

Within these parameters, potential standardized options can be loosely or more strictly defined. Standardized formularies can explicitly specify certain products or provide more general outlines, with guidance on the number or types of included products (e.g., "at least *y* products per class, including the most commonly prescribed

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[26] CMS, *Medicare Modernization Act Final Guidelines — Formularies,* available at [http://new.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidance.pdf].

[27] Avalere Health, LLC, *Understanding the 2006 Medicare Part D Marketplace,* January 2006.

[28] Goldman Sachs Global Investment Research, *Healthcare Services*, Oct. 10, 2005.

product"). Vendors would compete on prices (through premiums and cost-sharing requirements), service (e.g., through their retail networks and mail order programs, exceptions and grievance procedures) and scope of covered drugs on the formularies.

Differences Between Medigap and Part D Experiences

While the problem of confusion due to a wide array of choices is common to both the Medigap market in the 1980s and the current Medicare Part D market, there are also notable differences between the two experiences.

Market Maturity

Medigap had a long history prior to the federal interventions of the 1980s and 1990s. While the market may have been confusing for beneficiaries at the time, the market was mature and there were relatively few major changes from year to year in the number of products offered and the number of carriers in the business. In fact, the continuing diversity of offerings was a defining characteristic of the market.

In contrast, Medicare Part D is new and the market is likely to change dramatically in the coming years. The plethora of current choices (see **Table 2**) may reflect a deliberate strategy on the part of insurers to cast as wide a net as possible to appeal to many different kinds of Medicare beneficiaries. Many observers expect the Medicare Part D market to consolidate in subsequent years, both in the number of carriers and the number and scope of products offered, as carriers learn which products are most attractive to Medicare beneficiaries and which ones are profitable. Under this scenario, the choices beneficiaries face in coming years may become fewer.[29]

[29] Humana, which offers plans with some of the lowest monthly premiums available, calls this strategy, "enroll and migrate." See "New Medicare Drug Benefit Sparks an Industry Land Grab," *Wall Street Journal*, Jan. 25, 2006.

Table 2. Summary of Prescription Drug Plan Offerings Across Regions

PDP region	States	Number of providers	Number of plans
1	NH,ME	16	41
2	CT,MA,RI,VT	17	44
3	NY	20	46
4	NJ	17	44
5	DE,DC,MD	18	47
6	PA,WV	19	52
7	VA	16	41
8	NC	16	38
9	SC	18	45
10	GA	18	42
11	FL	18	43
12	AL,TN	16	41
13	MI	17	40
14	OH	17	43
15	IN,KY	16	42
16	WI	17	45
17	IL	16	42
18	MO	15	41
19	AR	15	40
20	MS	15	38
21	LA	16	39
22	TX	20	47
23	OK	23	42
24	KS	15	40
25	IA,MN,MT,ND,NE,SD,WY	18	41
26	NM	17	43
27	CO	17	43
28	AZ	18	43
29	NV	17	44
30	OR,WA	20	45
31	ID,UT	18	44
32	CA	18	47
33	HI	12	29
34	AK	11	27

Note: The counts of the number of providers in each region include all providers offering products in the region. The total number of providers nationwide will be less than the sum across all regions because of duplicate counts.

Source: Centers for Medicare and Medicaid Services.

This abundance of choices is reflected in the diversity of plan characteristics. The monthly premiums for a Part D plan can vary from $0 to $125 in the same

region. Similarly, beneficiaries in one region deciding between plans can face a difference in the number of covered drugs that ranges from 626 to 3,360.[30]

Not only is the Medicare Part D benefit new, but the existence of a free-standing prescription drug product in the insurance market is also novel and the long-term viability of this market is unknown.[31] Since most of the potential cost-savings from increased availability and use of prescription drugs are likely to accrue to the insurers of Parts A and B through decreased hospitalization and physician visits, there would appear to be an advantage for insurers that cover Parts A and B in addition to Part D. Thus, some industry observers have suggested that some companies may be offering free-standing Part D plans to entice Medicare beneficiaries who have traditionally preferred fee-for-service over managed care (for example, Medicare Part C), with the hope of converting them to managed care enrollees under the companies' Medicare Advantage plan over time. This would also result in fewer choices for beneficiaries in the future.

Strong Federal Role

Regulation of the Medigap industry has been and continues to be the province of states. However, unlike the Medigap market prior to 1990, there will always be a significant role for the federal government in the Medicare Part D market. Variation across insurance products, including Medigap, is due in part to differences in state regulation. Medigap regulation is one of the only areas of insurance regulation where the federal government has imposed a standard of consistency across states.[32] In contrast, the Centers for Medicare and Medicaid Services (CMS) reviews and approves every Part D plan offered by every insurer. Thus, problems that the Medigap market faced, such as duplicate coverage and low-value policies, are unlikely to become problems that would require the legislation of standardized benefits under Medicare Part D.

Transitional Nature of the Prescription Drug Market

The market for prescription drug evolves continually as a consequence of scientific, legal, and economic factors. New research and innovation eventually leads to new drugs that can either expand the frontiers of medical science or provide alternatives to existing practices or products. Approved drugs eventually go off-patent, possibly leading to the introduction of generic competitors. Advances in scientific research may bring to light new information on the safety and effectiveness of prescription drugs. An actively managed formulary will change to reflect the entry of new medications, as prices change with new competitors and practice patterns, and as new evidence about drug effectiveness and safety becomes available. In this light,

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[30] Avalere Health ,LLC, *DataFrame News,* December 2005.

[31] Former CMS administrator, Tom Sculley, on March 20, 2003, testified at a hearing before the Senate Special Committee on Aging that a drug-benefit only insurance plan, "doesn't exist in nature," reflecting the rarity of such offerings.

[32] Alecxih et al.

standardization may be overly restrictive if there is not a concomitant ability to revise and update formularies as situations change.

Standardization Issues

Standardizing benefits implies policy tradeoffs. Creating simplicity and ease of understanding needs to be balanced with restrictions on industry autonomy and market choices. In addition, the appropriateness of federal intervention in standardizing benefits must be weighed carefully when applied to a nascent market.

The level of standardization determines many parameters in the policy debate. OBRA 90 required the NAIC to develop 10 packages of benefits; while proponents have touted the simplicity the 10 choices created, others have argued that the packages are not sufficiently varied and that some beneficiaries are not well-served by any of the choices for the Medigap market. Consensus on Part D standardization may also be difficult as to whether there is a manageable number of standardized packages that can be agreed upon, and the dimensions to be standardized. The Medigap experience with premium rating illustrates the difficulties and trade-offs inherent in standardizing a benefit. OBRA 90 did not specify how carriers could set their premiums and as a result, three methods were used across Medigap products. Beneficiaries and consumer advocates dislike attained-age rating since the premiums increase with age as incomes tend to decline. In contrast, most insurance carriers prefer to have the option to choose the rating methodology so that they can offer more choices and products in the market.

While the OBRA 90 and SSAA 94 reforms that led to standardized benefits stabilized the Medigap market, it is not clear that this action would have a similar effect on the Medicare Part D market; such an approach could be premature. The problems in the Medigap market were well-established and persistent. The Medicare Part D market is likely to undergo significant changes as all parties — beneficiaries, insurers, drug manufacturers, pharmacy benefit manages, CMS — learn about the new benefit and how it develops. The Medicare Part D market will likely consolidate over the next few years and some insurers will exit while others enter the market. However, beneficiaries and plans are likely to face difficulties and challenges while the market moves through this transition.

Intermediate interventions might help alleviate the difficulties associated with the great breadth and number of choices without placing restrictions on specific options before the optimal set of standardized packages are clearly identified. Whether such actions are most appropriately addressed through legislation or regulation will depend on the specific objectives. One possible intermediate intervention would be to limit each plan sponsor to no more than two offerings, as suggested by a draft "call letter" from CMS to plans considering participating in 2007. While this restriction would reduce the number of choices, it would also force companies that currently offer more than two choices to change their business practices.[33]

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[33] J. Reichard, "'Medicare Part D 2.0' — Fewer Plans, Better Service in 2007?" *CG* (continued...)

Given the uncertainty surrounding the market, more information on what plans beneficiaries have chosen and which plans will continue to be offered in subsequent years will be important in determining the variety of choices under Medicare Part D. Consequently, the policy decision should include considerations about not only whether and how to standardize benefits but also when to do so.

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[33] (...continued)
HealthBeat News, at
[http://www.cq.com/display.do?docid=2061095&productId=5&binderName=healthbeat-20060307].