

enrolling in new “regional” preferred provider organizations (PPOs). The Medicare drug benefit is somewhat notorious for having a large “doughnut hole.” In 2006, those choosing a stand-alone prescription drug plan (PDP) would face a \$2,850 gap in coverage after paying an initial \$250 deductible and receiving 75 percent coverage on the next \$2,000 in annual drug spending. Only after spending \$5,100 annually would they obtain 95 percent “catastrophic” coverage.

The demand for coverage is difficult to predict. On the one hand, the several choices of both managed care and PDP coverage might be expected to encourage more enrollment. On the other hand, the proliferation of companies may complicate the choice of a particular plan and, as the evidence indicates, thus reduce demand.

Medicare beneficiaries will face what Berenson (2004, W4-576) called “bewildering complexity” under the new drug benefit. We developed Figure 1 to illustrate the range of choices. At the top of the figure, Medicare beneficiaries are divided into two groups based on income. Those with incomes below 150 percent of the federal poverty level (FPL) who meet certain restrictions, such as very few assets, may qualify for subsidized prescription drug coverage as well as subsidized nondrug coverage through Medicaid or the Qualified Medicare Beneficiary Program (QMB) or the Specified Low-Income Medicare Beneficiary Program (SLMB). Those who are eligible and enroll will receive discounted medical services and will choose a Medicare drug plan and seller for subsidized drug coverage. Those people who do not qualify for subsidized drug coverage, as well as everyone whose income exceeds 150 percent of the FPL, have the following choices: If they are offered drug coverage by a former employer and choose to accept it, they will not buy Medicare drug coverage. If they are not offered an employer’s drug coverage or choose not to buy it, then they face the following:

1. They must choose either traditional Medicare or one of several Medicare Advantage plans. The two main choices are HMOs and PPOs, and beneficiaries may buy drug coverage from these companies. Other, less common choices are private fee-for-service plans, medical savings accounts, or local specialized plans for special-needs beneficiaries (Berenson 2004).
2. If they choose an HMO or PPO, they also must choose basic drug coverage, extended coverage, or no coverage. In reality, the range of drug coverage is much larger because it is not standardized

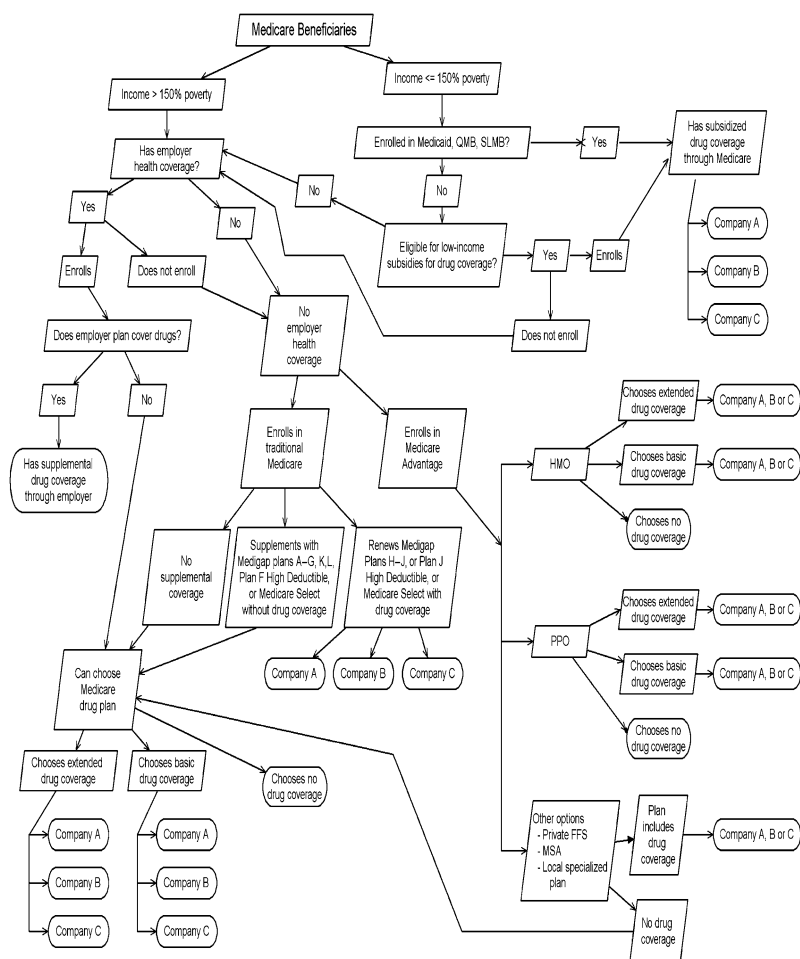


FIGURE 1. Health Insurance Decisions Facing the Elderly

but needs only to be actuarially equivalent to or greater than the benefits specified in the regulations. For simplicity, Figure 1 lists only basic versus extended coverage. Then, buyers must choose a company from which to buy their drug coverage.

3. Those people choosing traditional Medicare must make two more choices:

- If they currently have Medigap plans H, I, or J or the high-deductible plan J, they must decide whether to renew it.

- If they do not, they must decide whether to buy one of Medigap plans A through G, Medicare Select, high-deductible plan F, or new plans K and L.
- If they do not renew their supplemental drug coverage (first bullet point), they must decide whether to buy a stand-alone PDP and, if so, whether to choose basic or extended drug coverage.

At the time of this writing, PDPs and Medicare Advantage plans have had to notify the Centers for Medicare and Medicaid Services (CMS) as to whether they will offer drug benefits to beneficiaries. Many have chosen to do so. Our county of residence (Los Angeles County) has thirty-eight Medicare Advantage plan choices from eighteen companies: thirty-three HMOs and five PPOs. In addition, forty-seven stand-alone PDPs are offered by eighteen companies, making a total of eighty-five choices of plans. Rural states have fewer, but still numerous, choices. Arkansas, for example, has seventy-five counties, but only eight will have Medicare HMOs in 2006, with most offering only a handful of HMOs from a single company. The beneficiaries of most of the state's counties have three PPO choices from a single company, but fifteen companies offer forty PDPs (<http://www.medicare.gov/medicarerereform/map.asp>).

When asked about the number of drug plans to choose from (in October 2005, the month before open enrollment commenced), only 5 percent of seniors from a nationally representative sample estimated that they would have more than twenty choices. When told that they would have at least forty to choose from, only 22 percent said that this would be helpful in finding the best plan, with 73 percent saying that it would instead make it "confusing and difficult" (Kaiser Family Foundation 2005b).

This discussion and Figure 1 concentrate on the *number* of choices facing the elderly. What we may not have made clear is the complexity of the choices. Although space does not allow for a full discussion here, consider just two of the many choices: whether to join a Medicare Advantage plan, and how to choose a stand-alone prescription drug plan.

Deciding whether or not to choose an HMO has always been difficult for Medicare beneficiaries. On the one hand, for those without supplemental coverage from an employer, HMOs tend to be cheaper than Medigap plans and often offer more benefits. But determining whether a particular plan does offer more benefits is extremely difficult because