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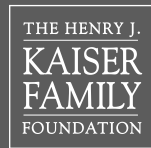

Paying for Choice:

The Cost Implications of Health Plan Options for People on Medicare

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The Cost Implications of Health Plan Options for People on Medicare

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Report Highlights

Medicare coverage alone does not provide sufficient financial protection for many program beneficiaries. Thus, the vast majority obtains supplemental coverage from four main sources: former employers, individual "Medigap" insurance policies, Medicaid, and Medicare+Choice plans. Those who are eligible for coverage from a former employer, or from Medicaid, usually take advantage of this subsidized coverage. Other beneficiaries—approximately 56%—can choose between purchasing a Medigap policy, joining a Medicare+Choice (M+C) plan, or forgoing Medicare supplementation altogether.

This report examines the financial implications associated with these different choices by calculating how much people on Medicare would spend annually out-of-pocket on costs including—premiums, cost-sharing requirements, and spending for uncovered services—under different supplemental insurance arrangements. To assess cost implications of choosing among different Medigap and M+C options, we estimated the range in health care spending for three prototype beneficiaries in eight national markets. Cost estimates were made for four Medigap plans (types A, F, H, or J) and up to five M+C plans, all compared with not purchasing supplemental coverage in each geographic market. Of particular interest is the range in out-of-pocket costs that results from the various alternatives, which highlights the importance of these choices. Costs were calculated for the following prototypical beneficiaries: a 50 year-old man with disabilities, a relatively healthy 65 year-old woman, and a frail 80 year-old woman. Findings include:

- Medicare beneficiaries face wide variations in costs associated with supplemental insurance choices. In the starkest example, the potential out-of-pocket costs for the 50 year-old with disabilities ranges from $6,010 (M+C plan, Miami, FL) to $21,857 (Medigap Plan J, Oakland, CA), depending on where he lives and the plan he chooses. Similarly, the frail 80 year-old may face high expenses ranging from $1,342 to $12,482. Perhaps most surprising are the variations in costs for the healthy 65 year-old with far fewer health care needs, who would face up to a $9,000 difference in total spending depending on the plan she chooses and where she lives. This cost difference alone reflects over half the mean annual income of women ages 65 and older (~ $16,000).

- The types of plan beneficiaries choose often affect out-of-pocket spending. In general, M+C plans are less costly (when available) than Medigap plans. In Miami, FL for example, total costs for the healthy 65 year-old beneficiary vary from $58 to $1,013 when choosing an HMO, and from $3,465 for the lowest cost Medigap Plan A to $5,163 for the highest cost Medigap plan J. The healthy 65 year-old may spend less out-of-pocket without supplemental coverage, since insurance is designed to reduce risk and not save money. However, this is not advisable

because her health status could deteriorate at any time, and because she would lose Medigap open enrollment privileges if she did not purchase coverage within six months of becoming eligible for Medicare.

- Even within a particular insurance type within a given market, the specific plan chosen affects costs as well. For example, in Minneapolis, costs for even the healthy 65 year-old who chooses Medigap Plan F vary by over $1,300 annually, depending on the insurance company. Similarly, if she chooses an M+C plan, her spending would vary by over $750, depending on the plan selected.

- Geographic location can also make a big difference in cost. The 80 year-old who chooses the least expensive Medigap Plan J would spend $6,376 in Manchester, NH but $9,520 if she lived in Miami, FL. In contrast, she could spend as little as $1,342 for the cheapest M+C plan in Miami, but as much as $7,082 for the lowest-cost M+C option in Seattle, WA.

- Premiums are a poor barometer for gauging total out-of-pocket spending. While premiums play a major role in determining overall costs, prescription drugs and other non-Medicare covered services are important "hidden" factors affecting total out-of-pocket spending. These items are important considerations because they are fully paid for by the beneficiary unless he has supplemental coverage, and even then, costs associated with supplemental plans can pose major financial burdens. In Baltimore, MD, for example, the 50 year-old man with disabilities would spend about $2,200 annually on premiums for Medigap Plan J, but still incur relatively high total out-of-pocket expenditures (over $9,650) as a result of "hidden" costs such as prescription drugs and other health services.

The supplemental insurance market presents opportunities for Medicare beneficiaries to insure themselves against future health care costs, but the choice is neither easy nor risk-free—particularly for those living on fixed incomes. Depending on beneficiaries' individual circumstances, mainly their health needs and where they live, this decision could result in expenditures that represent a sizeable share of their income. In the area of Medicare supplementation, there are no obvious "right" choices for Medicare beneficiaries. Spending is often lower in M+C plans, but this is not always the case. Forgoing supplemental coverage could save money—but only if a beneficiary remains healthy. Scope of coverage provided by supplemental insurance is often a more important determinant of total out-of-pocket costs than are premiums, but often difficult for consumers to assess and compare. Even those with chronic illnesses and predictable service and equipment needs would be challenged to project costs under alternative supplemental insurance options, due to formularies and coverage limits that are often difficult to decipher prior to enrollment. This study confirms the substantial financial stakes involved for beneficiaries choosing among supplemental coverage options.

INTRODUCTION

Medicare helps to finance health care for nearly all Americans ages 65 and older and many younger adults with permanent disabilities. Although Medicare provides some coverage for most acute care illnesses, the program has a number of gaps in coverage. Medicare's limitations fall into two main categories: patient cost sharing (e.g., deductibles, coinsurance) for Medicare covered services, and health care services and items which Medicare does not cover, including most long-term care, prescription drugs, eyeglasses, and hearing aids. As a result of these gaps, Medicare only pays 56 percent of beneficiaries' total personal health care expenditures, and the majority of beneficiaries (87%) opt for some form of insurance to supplement Medicare.

In the Fall of 1999, an estimated 33 percent of Medicare beneficiaries had supplemental coverage from a former employer, 24 percent had Medigap (individually purchased coverage designed to fill gaps in Medicare), 17 percent were enrolled in M+C,[1] 11 percent had Medicaid, and 2 percent had "other" public insurance. An estimated 13 percent of Medicare beneficiaries had no supplemental coverage (Laschober et al., 2002).

Even with supplemental coverage, out-of-pocket health care costs present a heavy financial burden to elderly and disabled Medicare beneficiaries, many of whom live on fixed incomes (Kaiser Family Foundation, 2002). In 2000, elderly Medicare beneficiaries, for example, spent an average of $3,142 for health care, which accounted for approximately 22 percent of their annual incomes (Maxwell, Moon and Storeygard, 2001). Upon adjustment for inflation and non-covered health expenditures such as prescription drugs, that dollar figure would be even higher today.

Most individuals who have access to coverage from a former employer, or who have access to Medicaid, opt for these sources of coverage because they tend to offer fairly generous benefits and are heavily subsidized. The others, who constitute more than half of all people on Medicare, confront a choice about if and/or how to fill the gaps in Medicare's benefit package. Generally, individuals can choose to buy a Medigap policy or enroll in a M+C plan, if one or more are available in their area. If they decide to purchase Medigap, they may then select from among 10 standardized plans, although they may not have the option of all plans, depending upon their age, medical history, and individual circumstances.

There is a growing body of research demonstrating the confusion seniors face when choosing among health plans (Hibbard et al., 2001), however, there are virtually no studies citing the financial implications of making these choices. The purpose of this report is to illustrate, quantitatively, the financial stakes for Medicare beneficiaries when making these supplemental insurance choices. This study examines how much people on Medicare would spend out-of-pocket—including premiums and other cost-sharing requirements—under different supplemental

insurance options. To assess the cost implications of choosing between different Medigap and M+C insurance options, we estimate the range in health care expenditures associated with three prototypical beneficiaries within and across eight distinct geographic areas. Our cost comparison included four standardized Medigap plans (A, F, H, and J), any of up to five M+C HMO options available in each geographic area—all in comparison with choosing no supplemental coverage at all.

The report seeks to answer several questions:

- How much would prototypical Medicare beneficiaries spend under each of the supplemental insurance options available to them in their area?
- Do these costs differ substantially by: type of product or plan, insurer, beneficiary characteristics, or geographic location?
- What are the primary components of out-of-pocket costs? Do premiums, cost-sharing requirements, or uncovered services constitute the largest share of out-of-pocket costs? How does this vary by type of supplemental insurance among the prototypical beneficiaries, and in different parts of the country?

The next section begins with a description of the methodology used to determine costs associated with supplemental insurance choices. We then present estimates of out-of-pocket costs under various insurance scenarios and assess cost implications of choosing one option over another. The report concludes with a discussion of the implications for policymakers as they consider proposals for reforming the Medicare program through strategies that involve a substantial degree of consumer choice.

To assess the cost of alternative supplemental insurance options for Medicare beneficiaries, we developed three illustrative prototype beneficiaries and for each, estimated the out-of-pocket costs of their health care in 2001 under various supplemental insurance scenarios or "choices." Costs were generated for eight geographically diverse communities, including: Oakland, CA; Seattle, WA; Minneapolis, MN; Chicago, IL; Dodge City, KS; Miami, FL; Baltimore, MD; and Manchester, NH.

We examined costs associated with four of the 10 standard Medigap policies A, F, H, or J (see Appendix I for more details). Medigap plan A is included because it is the most basic plan that is available to Medigap purchasers and by law is offered by every insurance carrier who sells Medigap insurance. Medigap plan F is included because it is the most popular and widely purchased Medigap plan nationwide (Chollet and Kirk, 2001). Medigap plans H and J are included in the analysis because they both offer some coverage of prescription drugs—which are not covered by Medicare but are used by nearly all people on Medicare.

We also assessed the cost of enrolling in up to five M+C HMOs available in each geographic area. In the case of Dade County, FL, where there were more than five HMOs available, the five HMOs with the highest market penetration in 2001 (according to statistics available from the Centers for Medicare and Medicaid Services) were selected for the analysis.

Finally, for comparison purposes, we estimated out-of-pocket costs for the beneficiary prototypes without any form of supplemental insurance. The study does not include employer-sponsored insurance or Medicaid because both of these sources of supplemental coverage are highly subsidized and individuals who have the option of receiving these sources of coverage usually opt into them because of their fairly comprehensive benefits.

Development of Prototype Beneficiaries

We developed three prototype beneficiaries with varying health care needs based on utilization data from the National Center for Health Statistics (NCHS, 1999) and consultations with physician researchers experienced in diagnosing and treating patients of similar age and health status as described in this report.[2] Basic descriptions of the prototypes are included below and presented in Table 1, with more detailed information on their health service use found in Appendix I.

Fifty Year-Old Man with Disabilities: The first prototype beneficiary is a 50 year-old man with disabilities in fair to poor health. In addition to being obese and a smoker, he suffers from

several chronic conditions including: paraplegia secondary to a spinal cord injury following a car accident, decubitus ulcers, non-insulin dependent diabetes, a neurogenic bladder, and bouts of depression. To manage his many chronic conditions he takes four prescription drugs daily.

Given his health profile, we assumed he would experience three acute episodes per year and be admitted to the hospital for each. In addition to hospitalization for each of his acute episodes, he has one emergency room visit during the year due to a bladder infection.

During the course of a year he has 12 physician visits and an additional four visits to specialists including an endocrinologist, a general surgeon, a urologist, and a neurologist. He uses various medical devices. Finally, he requires physical and/or occupational therapy once every three to four weeks for a total of 14 visits, as well as requiring a home health aide once a week for approximately four hours, none of which is covered by Medicare.

Healthy Sixty-Five Year-Old Woman: The second prototype beneficiary is a relatively healthy, 65 year-old woman. Despite her very good health, she has hypertension, hypercholesterolemia (high cholesterol), hypothyroidism, and is post-menopausal. She takes five prescription medications daily to manage her chronic conditions.

This woman is assumed to have one acute episode per year, (e.g., sinusitis). She has no emergency room visits or hospital admissions, but visits the doctor regularly. She sees a general physician five times a year and various specialists throughout the year, including: an ophthalmologist, a gynecologist, a gastroenterologist, and a dentist. She requires a new pair of glasses, but no other medical equipment. During her regular doctor visits, she undergoes some lab work and preventive tests that are covered by Medicare.

Frail Eighty Year-Old Woman: The third prototype is an 80 year-old woman in relatively poor health. She has multiple chronic conditions including hypertension, hypercholesterolemia, coronary artery disease, cerebrovascular disease (otherwise known as stroke), type II diabetes, dementia, an irregular heartbeat, osteoarthritis, osteoporosis, depression, and a gait disorder. To manage her conditions, each day she takes seven prescription drugs plus aspirin.

She is also assumed to have four acute episodes per year, two of which require emergency room visits—one via ambulance because of the fall that led to her broken hip—and all episodes except the angina lead to hospital admissions. To treat the acute episodes, she requires an additional three temporary prescriptions.

Because she suffers from so many ailments, this woman sees a primary care doctor 16 times and has ten specialist visits during the year. She also needs a variety of medical equipment, some of which is covered by Medicare, and some of which is not. Due to her hospitalizations and frail condition, she requires seven days in a rehabilitation hospital, two days in a skilled nursing facility, 33 physical therapy appointments, seven occupational therapy appointments, four home health visits, and a variety of lab work and x-rays.

TABLE 1
Description of Three Prototype Medicare Beneficiaries

	Male with Disabilities Age 50	**Healthy Female Age 65**	**Frail Female Age 80**
Health Status	**Fair/Poor**	**Very Good**	**Fair/Poor**
Chronic Conditions	1) Paraplegia secondary to spinal cord injury (auto accident) 2) Obesity 3) Decubitus Ulcers 4) Type II Diabetes 5) Neurogenic bladder 6) Depression 7) Smoking	1) Hypertension 2) Hypercholesterolemia 3) Hypothyroidism 4) Post-Menopausal	1) Hypertension 2) Hypercholesterolemia 3) Coronary artery disease 4) Cerebrovascular disease (stroke) 5) Type II Diabetes 6) Dementia 7) Depression 8) Gait disorder 9) Atrial fibrulation (irregular heartbeat) 10) DJD–osteoarthritis 11) Osteoporosis
Number of Prescription Drugs	8 (4 chronic; 4 acute)	8 (6 chronic; 2 acute)	11 (8 chronic; 3 acute)
Number of Hospital Admissions	3	None	3
Number of Physician Visits	12	5	16
Number of Specialist Visits	4–endocrinologist, general surgeon, urologist, neurologist	4–ophthalmologist, gynecologist, gastroenterologists, dentist	10–cardiologist (2x), endocrinologist, neurologist, orthopedic surgeon (2 post-surgery visits), podiatrist, ophthalmologist, audiologist, dentist
Other	Physical Therapy Occupational Therapy Home Health Skilled Nursing Facility	Lab Work Mammogram Bone Density Pap and Pelvic Sigmoidoscopy	Skilled Nursing Facility Rehab/Physical/ Occupational Therapy Home Health Lab Work X-ray/MRI/EKG

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Estimating Out-of-Pocket Health Care Costs

Total beneficiary costs are defined in this study as the sum of premiums paid and out-of-pocket costs incurred when using services in a year. The latter include coinsurance, copayments, and deductibles for Medicare-covered services, as well as the full costs associated with using services that are not covered by either Medicare or by supplemental insurance coverage. A basic description of the main methods used is described below with a more detailed description presented in Appendix II. Where possible, the costs of services are region-specific.[3]

Premiums: Medigap premiums for 2001 were culled from premium comparison guides compiled by state insurance departments. The range of premiums was determined by the lowest and highest premiums listed in the handbooks for each plan (A, F, H, and J). If information was missing, the range was determined by calling four Medigap carriers in each area. Because this report is intended to demonstrate the implications of choice, each Medigap plan is priced as though the beneficiary newly purchased it in 2001 and therefore the analysis reflects the consequences of choice *at a specific point in time*.[4] M+C premiums were determined by obtaining 2001 marketing materials from each M+C plan.

Future premiums, of course, will depend on who actually purchases the different forms of coverage. Suppose that in the future more unhealthy Medicare beneficiaries choose Plan J than is the case now because of its prescription drug coverage. This adverse selection would undoubtedly result in higher premiums for Plan J, and thus could affect the ranges of premiums faced by beneficiaries, but such a dynamic cannot be captured in a report like this, which is based on the current premium levels.

Prescription Drugs: Prescription drugs were priced on-line using the website www.anymed.com, an Internet site that sells prescription drugs nationally. It was assumed that generic drugs would be used in place of brand-name drugs whenever both were listed on the website. Prescriptions for acute episodes were priced according to the exact dosage and number of pills prescribed.

To estimate drug costs for M+C HMOs that cover prescription drugs, copayments were calculated. Again, it was assumed that generic drugs would be used in place of brand-name drugs whenever possible. Where HMOs had drug limits, the limit was based on the same costs for drugs as those used for the non-HMO drugs, using www.anymed.com. Any amount over the limit was assumed charged directly to the beneficiary.

Emergency Room Visits: Under Medicare rules, beneficiaries only pay a portion of emergency room costs if they are not admitted to the hospital for the same condition within one day of the emergency room visit; if beneficiaries are not admitted, then they are obligated to pay 20 percent of emergency room facility costs. Ambulance charges are also highly variable and depend on the area in which the services are used. For the purposes of this study, the cost of ambulance services was assumed to be $200. If use of the ambulance is medically necessary and to the nearest hospital, Medicare covers the transport, subject to 20 percent coinsurance.

Hospital Admissions: Hospital admissions are fully covered by Medicare after a beneficiary pays a deductible of $776 (in 2001). In the case of the two prototype beneficiaries with the three hospital admissions, we assume that the admissions did not occur during the same spell of illness.

Physician Visits: Physician visits are billed to Medicare according to procedure codes. Medicare then pays 80 percent of the geographically-adjusted cost of the visit. We used procedure codes for office visits to obtain the Medicare-approved amount for each geographic region in our study. We assume here that all doctors accept Medicare assignment, meaning that they bill beneficiaries no more than 20 percent of the Medicare-approved amount.

Specialist Visits: Like physician visits, specialist visits are billed using procedure codes. To estimate the cost of Medicare-covered specialist visits we assigned the highest level of intensity to each of the specialist visits for the 50 year-old man and the 80 year-old woman and the intermediate level of intensity to the 65 year-old woman.

Non Medicare-covered specialist visits—routine dental, podiatrist, and ophthalmologist visits—were estimated by calling a variety of providers in the Los Angeles area to determine their current charges for a routine visit and assigning an average cost to the service. Dentist visits were assumed to cost the beneficiary $65, vision care $50, and a visit to the podiatrist $60.

Medical Devices or Equipment: All Medicare-covered durable medical equipment is billed using procedure codes and is adjusted for geographic costs. Beneficiaries pay 20 percent of the Medicare-approved costs in their geographic area. For non-covered medical devices such as glasses, dentures, hearing aids, and raised toilet seats the beneficiary pays 100 percent of costs. We estimated costs of non-covered services by calling a variety of providers in the Los Angeles area and assigning a medium to low-end cost for each item.

Other Health Services: Qualified home health visits are fully covered by Medicare and are not subject to copayments. Additionally, the first 20 days in a skilled nursing or rehabilitation facility, certain preventive services (pap smears), and Medicare-approved lab services do not require a copayment. For all other covered health services examined in this study—physical and occupational therapy, mammograms, bone mass measurement, colorectal screenings, and x-rays—beneficiaries pay 20 percent of the Medicare-approved amounts.

Summary of Total Costs

The cost of supplemental insurance varies widely depending on an individual's health status and health care needs, the type of coverage selected, and geographic location.

Health Status: Total out-of-pocket health care costs were not insignificant for all three prototypical beneficiaries, but the range in potential costs tends to be highest and widest for those individuals with the most extensive health care needs (Table 2). In the starkest example, the potential out-of-pocket costs for the prototype 50 year-old man with disabilities range between $6,010 and $21,857, depending on the plan he chooses and the area of the country in which he lives. In contrast, the frail 80 year-old woman with multiple chronic conditions would also face relatively high health care expenses and a fairly wide range in potential costs ($1,342 to $12,482), but considerably less than the younger man with disabilities. Surprisingly, variations in costs are even a consideration for the healthiest prototype with far fewer health care needs, who may face up to a $9,000 difference in total spending depending on the plan she chooses and the community in which she lives.

Premiums appear to make up a smaller portion of total out-of-pocket medical costs than do other health expenses, especially for beneficiaries who are in poorer health and who therefore tend to use more services. This appears to be especially the case for beneficiaries with HMO coverage. Premiums for M+C HMO coverage range from $0 to $1,194 for all three prototype beneficiaries, but cost-sharing requirements associated with both covered and non-covered services are substantially higher, ranging from $1,342 to $8,134 for our frail 80 year-old woman and as much as $6,010 to $11,049 for the 50 year-old man with disabilities (Table 2). The interaction of wide variations in premiums and wide variations in non-premium costs create an even broader range of total costs, which can make spending projections and decision-making difficult for beneficiaries trying to select an insurance option that will lower their future health costs.

Type of Coverage: The type of supplemental coverage, whether Medigap or a M+C plan, has a large impact on total out-of-pocket costs. For each of the three prototype beneficiaries, total spending was considerably lower for those enrolled in M+C plans than it was for those with Medigap policies (Table 3). For example, the 80 year-old woman would face total costs between $9,060 and $11,436 if she purchases Medigap Plan A, but far lower costs ranging from $1,342 to $8,962 if she enrolls in a M+C HMO. Yet while M+C HMOs appear to offer beneficiaries substantial out-of-pocket savings relative to Medigap, even HMOs vary tremendously in costs for each prototype beneficiary, depending on the M+C plan selected. The 50 year-old man with disabilities, for example, would spend anywhere from $6,010 to $11,049 for total health care

Table 2
Range of Annual Premium, Non-Premium, and Total Costs for Each Prototype, by Type of Supplemental Coverage (includes all geographic areas)

	Medigap	Medicare+ Choice HMO	No Supplemental Coverage	Range of Costs Across All Sources
50 Year-Old Man With Disabilities				
Premium range	$432–14,412	$0–1,194	$0	$0–14,412
Non-premium range	$7,445–11,058	$6,010–11,049	$12,335–12,380	$7,445–12,380
Total range of costs	$8,541–21,857	$6,010–11,049	$12,335–12,380	$6,010–21,857
Healthy 65 Year-Old Woman				
Premium range	$407–8,074	$0–1,194	$0	$0–8,074
Non-premium range	$1,587–2,808	$58–2,848	$2,924–2,950	$58–2,950
Total range of costs	$2,683–9,661	$58–3,922	$2,924–2,950	$58–9,661
Frail 80 Year-Old Woman				
Premium range	$528–8,074	$0–1,194	$0	$0–8,074
Non-premium range	$4,408–8,532	$1,342–8,134	$10,546–10,673	$1,342–10,673
Total range of costs	$6,376–12,482	$1,342–8,962	$10,546–10,673	$1,342–12,482

Note: Ranges represent highest and lowest costs for all geographic areas combined.

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

costs associated with M+C coverage. While spending for HMO coverage may be lower than spending for some Medigap policies available, total out-of-pocket costs are still relatively high and could consume a substantial share of resources for a disabled person with modest income.[5]

TABLE 3
Range of Total Costs for Individual Prototypes, by Type of Coverage (includes all geographic areas)

Type of Coverage	50 Year-Old Man with Disabilities	Healthy 65 Year-Old Woman	Frail 80 Year-OldWoman
Medigap Plan A	$11,490–14,394	$3,215–4,543	$9,060–11,436
Medigap Plan F	$9,458–15,650	$3,536–5,192	$7,112–10,808
Medigap Plan H	$8,541–14,457	$2,683–5,059	$6,766–8,752
Medigap Plan J	$9,125–21,857	$3,267–9,661	$6,376–12,482
Medicare+Choice HMO	$6,010–11,049	$58–3,922	$1,342–8,962

Note: Total costs include premium and all other out-of-pocket costs. Ranges represent highest and lowest costs for all geographic areas.

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

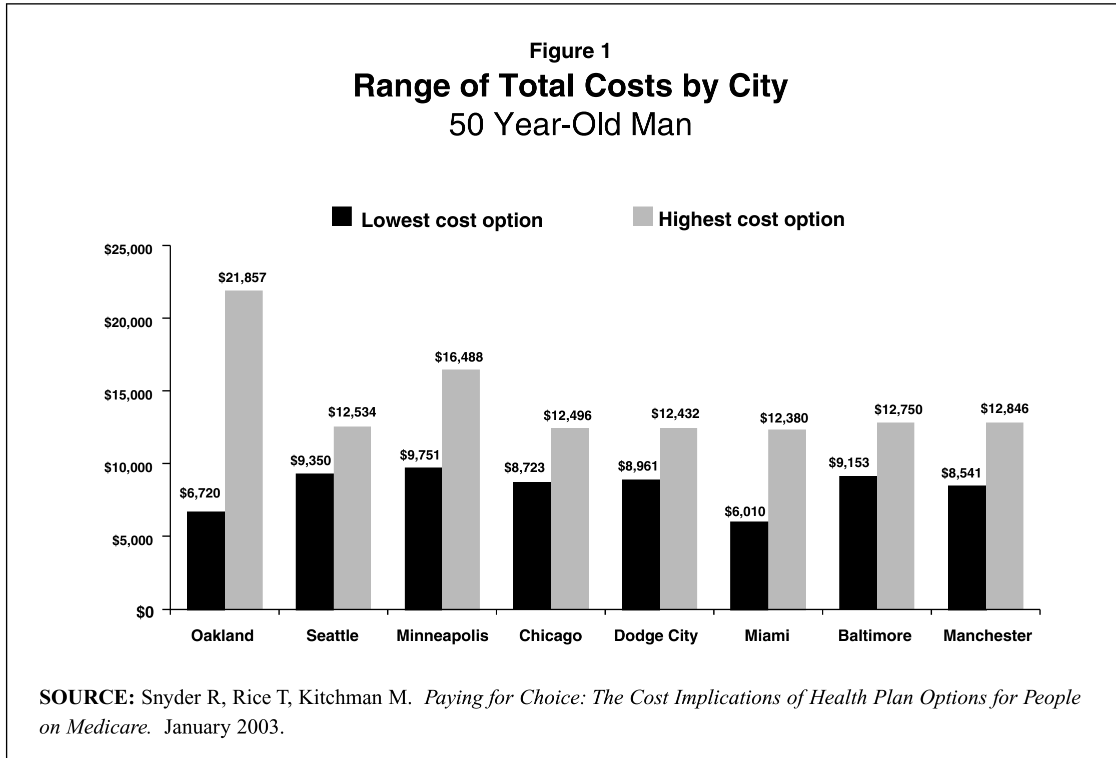


Figure 1
Range of Total Costs by City
50 Year-Old Man

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Medigap supplemental insurance plan choices result in expenditures that can span several thousand dollars, especially for plans H and J, both of which provide some coverage of prescription drugs. The recent growth in pharmaceuticals has been a major cost driver for Medigap insurers. As a result, many Medigap plans have hiked premiums for these policies. Selecting Medigap Plan J, which offers the most comprehensive drug benefit of all Medigap plans, would result in costs between $3,267 and $9,661 for a healthy 65 year-old woman, costs between $6,376 and $12,482 for a frail 80 year-old woman, and costs between $9,125 and $21,857 for the 50 year-old younger man with disabilities. By contrast, the high-end of total costs for our prototypes who selected Medigap Plan F, which offers fairly similar benefits to Plan J (except no drug coverage), are far lower than the high end costs associated with Plan J.

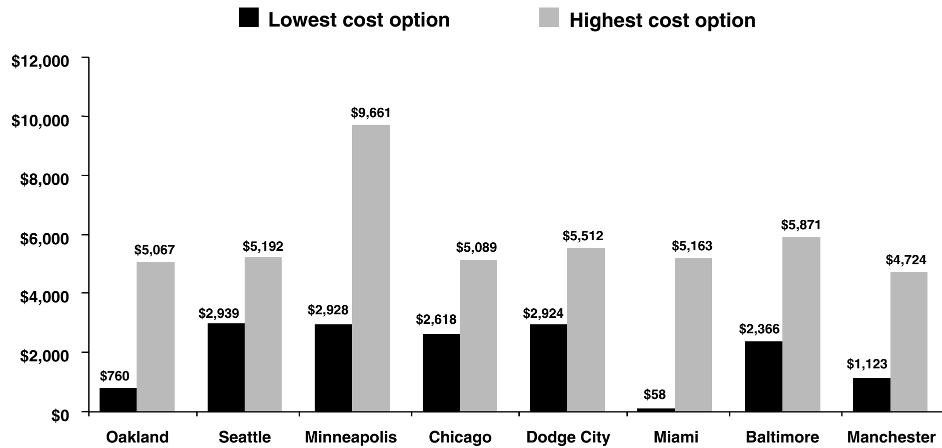
Geographic Location: Another way to consider the span of costs faced by beneficiaries is to examine the range of total costs for each prototype in each of the eight cities. Not surprisingly, there are major differences in total out-of-pocket costs across geographic region, but perhaps more surprising is the wide range in potential costs within certain markets for the different prototype beneficiaries. For example, in Oakland, CA there is nearly a $15,137 difference in costs between the most expensive and the least expensive choices available for the 50 year-old disabled man (Figure 1). This wide disparity is partially attributed to one insurer offering a high-cost Medigap plan J product that would cost an Oakland man with disabilities nearly $22,000 out-of-pocket.

The widest variation in health care costs for the healthy 65 year-old beneficiary is found in Minneapolis, MN where there is a difference of $6,733 between the most expensive supplemental insurance option and least expensive alternative, which is having no supplemental insurance (Figure 2). As in the Oakland market, the disparity in potential spending observed in

Figure 2

Range of Total Costs by City

65 Year-Old Woman

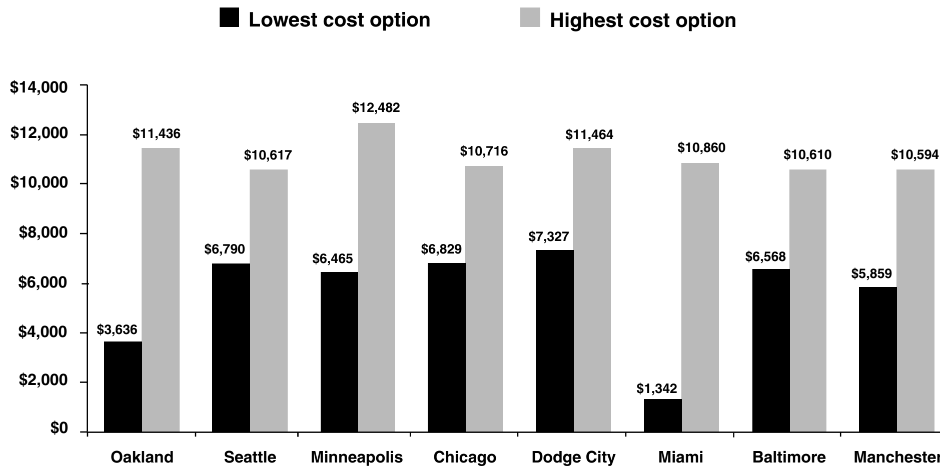


SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Figure 3

Range of Total Costs by City

80 Year-Old Woman



SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Minneapolis is at least in part attributed to a high-cost Medigap plan J product, charging a premium of over $8,000 annually. The widest disparity in the cost of health plan choices for a frail 80 year-old woman is found in Miami, FL, where she would pay from $1,342 to $10,860 for the overall costs of her care, depending on her choice of supplemental coverage (Figure 3). In this particular case, her extensive utilization of prescription drugs to manage multiple chronic conditions appears to drive her overall spending. As a result, Medigap plans A and F, neither of which include drug coverage, are much more costly alternatives for the frail 80 year-old ($10,860 and $10,808, respectively) than are the M+C plans, which tend to provide relatively inexpensive drug coverage. Thus, there is no simple formula to help determine where health care costs are likely to be higher and for whom.

It is apparent, however, that the range in costs appears to be smallest in areas such as Dodge City, KS, where there are no available M+C options from which beneficiaries may choose. M+C HMOs have typically charged lower premiums than Medigap plans and offered coverage for a variety of services that Medicare does not, potentially lowering overall costs for enrollees. However, even in cities with more than one HMO option such as Seattle and Minneapolis, the least expensive options may still be costly to beneficiaries.

Geographic Location and Type of Coverage: Overall costs are consistently highest for the younger beneficiary with disabilities regardless of insurance type, and insurance coverage only minimally protects him from the burden of high out-of-pocket costs. Costs for the frail, 80 year-old beneficiary are also relatively high, although supplemental insurance coverage goes further to lessen her out-of-pocket responsibilities. Interestingly, in most areas, Medigap plan H (with prescription drug benefits)—is found to be less expensive than plan F, which covers numerous benefits but not prescription drugs. Most impressive is the extent to which M+C HMOs were found to save beneficiaries money in several areas of the country, especially Oakland and Miami.

TABLE 4
Range of Total Out-of-Pocket Costs (in dollars), by City and Type of Coverage: 50 Year-Old Man with Disabilities

	Medigap Plan A		Medigap Plan F		Medigap Plan H		Medigap Plan J		HMO		
	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	None
Oakland, CA	$12,114	14,394	10,166	15,650	9,285	14,457	21,857	none	6,720	10,548	12,372
Seattle, WA	11,862	12,534	9,998	11,222	9,441	None	9,857	10,997	9,350	9,408	12,359
Minneapolis, MN	11,744	12,793	9,751	11,098	none	None	10,931	16,488	10,044	10,959	12,354
Chicago, IL	12,496	none	10,668	none	none	None	None	none	8,723	11,049	12,378
Dodge City, KS	11,556	12,432	9,508	10,777	8,961	10,014	9,833	11,370	none	none	12,335
Miami, FL	12,102	12,342	10,682	10,946	10,581	None	11,297	none	6,010	7,430	12,380
Baltimore, MD	11,898	12,750	10,046	none	9,429	None	9,653	none	9,153	none	12,368
Manchester, NH	11,490	12,846	9,458	11,078	8,541	10,401	9,125	10,709	9,190	none	12,363

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

TABLE 5
Range of Total Out-of-Pocket Costs (in dollars), by City and Type of Coverage: Healthy 65 Year-Old Woman

	Medigap Plan A		Medigap Plan F		Medigap Plan H		Medigap Plan J		HMO		
	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	None
Oakland, CA	$3,396	4,044	3,656	4,856	3,067	3,547	3,663	5,067	760	3,676	2,950
Seattle, WA	3,336	3,924	3,716	5,192	3,523	5,059	4,035	4,983	2,998	3,246	2,939
Minneapolis, MN	3,494	4,543	3,829	5,176	none	none	5,073	9,661	3,170	3,922	2,928
Chicago, IL	3,275	4,035	3,562	4,569	3,115	3,742	3,834	5,089	2,618	2,833	2,944
Dodge City, KS	3,272	4,182	3,586	4,656	3,103	4,156	3,975	5,512	none	none	2,924
Miami, FL	3,465	4,126	3,907	5,079	3,564	4,560	4,170	5,163	58	1,013	2,944
Baltimore, MD	3,215	4,262	3,561	4,250	3,318	3,977	3,789	5,871	2,366	none	2,937
Manchester, NH	3,240	3,852	3,536	4,724	2,683	3,499	3,267	3,555	1,123	none	2,936

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

50 Year-Old Man with Disabilities: Of all the supplemental insurance options, in most instances Medigap plan A is significantly more expensive than any of the other options available to him (Table 4). It may be explained, at least in part, by the fact that Medigap plan A is a less generous plan than any of the others, and therefore the beneficiary has higher cost-sharing requirements with plan A than with other plans. In particular, plan A does not cover the deductible for hospital admissions, resulting in greater out-of-pocket costs to beneficiaries who require hospital care.

Healthy 65 Year-Old Woman: In almost every area, a healthy 65 year-old beneficiary would pay more for supplemental insurance coverage than if she had purchased no supplemental coverage whatsoever (Table 5). This is not surprising in that insurance is intended to reduce risk, but is not designed to save money. In general, healthy people subsidize sicker ones, so our 65 year-old would be expected to pay more in premiums than she ultimately receives in benefits. The exceptions are for several of the HMOs—most notably those in Florida, which in 2001 had no monthly premiums and offered relatively generous benefits. The healthy 65 year-old woman could save thousands of dollars in Miami if she opted for an HMO plan. The only other situation in which the purchase of insurance may result in lower out-of-pocket costs to her is under Medigap plan H in Manchester, NH.

Frail 80 Year-Old Woman: Examining potential total out-of-pocket costs for the 80 year-old woman demonstrates that the more Medicare-covered services an individual uses, the more Medicare supplemental insurance works to protect the beneficiary against out-of-pocket costs (Table 6). Even though Medigap plan A was once again found to be more expensive than most of the other Medigap options, the majority of insurance options are less costly for her than going without supplemental coverage all together.

TABLE 6
Range of Total Out-of-Pocket Costs (in dollars), by City and Type of Coverage: Frail 80 Year-Old Woman

	Medigap Plan A		Medigap Plan F		Medigap Plan H		Medigap Plan J		HMO		
	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	None
Oakland, CA	$9,168	11,436	7,616	9,596	6,910	8,098	7,300	9,712	3,636	8,962	10,673
Seattle, WA	9,060	9,648	7,112	8,588	6,790	8,326	6,856	7,804	7,082	7,264	10,617
Minneapolis, MN	9,218	10,267	7,225	8,572	none	none	7,894	12,482	6,465	7,671	10,568
Chicago, IL	9,274	10,716	7,604	9,261	7,009	8,218	6,934	10,084	6,829	7,541	10,640
Dodge City, KS	9,171	10,435	7,327	9,119	7,423	8,752	7,384	11,464	none	none	10,546
Miami, FL	9,960	10,860	8,804	10,808	8,974	none	9,520	none	1,342	4,954	10,634
Baltimore, MD	9,372	9,624	7,520	8,192	6,838	7,690	6,616	9,064	6,568	none	10,610
Manchester, NH	9,264	10,200	7,460	8,816	6,766	7,810	6,376	7,864	5,859	none	10,594

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Variations in Costs Across Same-Type Plans within a Geographic Area

Within a given community, there is also tremendous variation in the total range of health care costs, across the same type of plans. To demonstrate these variations in out-of-pocket costs, we present potential costs for the three prototype beneficiaries purchasing supplemental coverage in the Oakland area (Alameda County, CA) (Tables 7–9). The Oakland area has had a strong managed care presence for an extended time and there are four M+C HMOs from which beneficiaries can choose. In addition, the HMOs in Northern California offer a wide range of coverage for prescription drugs. Two of the four HMOs do not offer drug coverage, while the two that do have substantial differences in their drug benefit limits. Thus, the Oakland area demonstrates the problems associated with the shift that Medicare HMOs across the country are making away from prescription drug coverage; Medicare beneficiaries out-of-pocket spending increases while their choices and coverage decrease. See Appendix III for detailed costs for each of the three Medicare beneficiaries in each of the eight areas.

Fifty Year-Old Man with Disabilities: For a 50 year-old disabled man in Oakland, the variation in premiums alone across all supplemental options ranges from zero for no coverage to over $14,000 annually for Medigap Plan J. For a given Medigap plan, the range in premiums also varies widely. The difference between the highest and lowest-cost Medigap plan A is $2,280, despite the fact that these policies are required by law to provide the exact same benefits. The difference in the range of premium costs for plan F is even greater at $5,484.

Equally notable, the annual premiums for M+C HMOs are found to be markedly lower than Medigap premiums for a 50 year-old disabled man in Oakland. The annual premiums for Kaiser and Health Net, which offer the lowest annual premiums of all HMOs ($360) are only two percent of the premium of Medigap plan J ($14,412) and only 34 percent of the cost of the lowest Medigap Plan A premium.

In every case, the sum of all of his non-premium costs under a supplemental insurance plan is lower than the total cost he would incur if he had no supplemental insurance. This suggests that the total out-of-pocket costs for the disabled man are driven by supplemental insurance *premiums*, in addition to other expensive items and services such as prescription drug costs, hospital admissions, physical and occupational therapy, and home health visits. Where supplemental insurance covers high costs, as is the case of hospital admissions under most plans and prescription drugs under some plans, supplemental Medicare insurance can indeed help to protect him from excessive out-of-pocket costs. This is especially true if he has coverage through one of the HMOs that provides comprehensive supplemental coverage at low premiums. However, he will bear the burden of high out-of-pocket health care costs regardless of his insurance decisions because the physical and occupational therapy and home health visits he requires are not covered by either the Medicare program or the supplemental plans that he may purchase to fill Medicare's gaps.

Healthy Sixty-Five Year-Old Woman: For a senior in Oakland living in good health, the situation is somewhat more uniform and costs are less variable within and across plan types. Annual Medigap premiums are far less expensive for her than for the man with disabilities. The range between high and low premiums for the same Medigap plan is narrower, with a minimum difference of $480 for plan H and a maximum difference of $1,404 for plan J. For all but the Blue Cross Medicare HMO, M+C premiums are consistently lower than Medigap premiums.

For our healthy female prototype, the sum of all non-premium costs under all supplemental insurance ranges from $1,587 to $2,848, with the exception of Kaiser's extremely comprehensive plan that covers all but $400 of her out-of-pocket costs. Similar to our disabled beneficiary, the sum of all of her non-premium costs under any supplemental insurance plan is less than the sum of all costs had she had no supplemental insurance, although the differences are much smaller for this older but healthier beneficiary. The real difference in her case is apparent once each plan's premiums are added into the equation; at this point, all of the Medigap plans and two of the four HMO plans become more expensive options for her than simply going without supplemental insurance.

In addition to the cost of premiums, her out-of-pocket costs are driven primarily by the use of prescription drugs to control her chronic conditions. Her out-of-pocket drug costs range from $255 under Kaiser, the HMO with the most generous drug benefit, to $2,493 for the full out-of-pocket cost of the prescription medications.

Frail Eighty Year-Old Woman: For an 80 year-old woman purchasing Medigap coverage in Oakland, premiums range from $636 annually for the least expensive plan (Plan A) to over $5,300 for the most expensive plan (Plan J). Similar to the disabled man, the range in Medigap premiums for the 80 year-old woman is also wide, with the difference between the least and most expensive plan A close to $2,300. By contrast, the difference in her range for the more expensive plans that cover prescription drugs is $1,188 for Plan H and $2,412 for Plan J, far narrower than the range in potential costs for the man with disabilities. In all cases except for the lowest rate plan A premiums, HMO premiums are found to be substantially lower than Medigap premiums. In fact, the lowest HMO premiums are about half the cost of the least expensive Medigap premiums. Nevertheless, except the highest cost Medigap plan A, every form of supplemental coverage would reduce out-of-pocket costs for this beneficiary.

It is noteworthy that in the case of M+C HMO coverage higher premiums do not necessarily equate to more generous coverage of benefits. At $828 annually, Blue Cross premiums are more than double the premiums of both Health Net and Kaiser, yet Blue Cross does not provide prescription drug coverage and charges higher copayments than any other plan. Kaiser coverage, the HMO with the lowest premiums and most generous benefit structure for enrollees, ultimately costs this beneficiary $5,326 *less* than Blue Cross.

Similarly to the other two beneficiaries, prescription drugs are a major cost driver for older, frail Medicare beneficiaries who have chronic conditions. These out-of-pocket costs are mitigated by supplemental coverage that extends beyond basic Medicare to cover prescription drugs. Depending on the generosity of the drug benefit, this beneficiary pays from $314 with Kaiser for her prescription drug needs, to the full retail cost of $3,642 with Medigap plans A and F as well as Blue Cross and Health Net health plans, none of which covers drugs. The extensive range in drug costs suggests that a prescription drug benefit can greatly affect a beneficiary's financial position. Even Medigap plans H and J, which cover drug benefits, leave her exposed to substantial drug costs of $2,392 and $1,946, respectively.

Other high-cost services that our 80 year-old woman requires include hospital care, durable medical equipment, and other health services such as physical and occupational therapy and various x-rays. Although virtually all supplemental insurance plans cover most out-of-pocket costs for hospitalizations and the coinsurance costs associated with the use of physical and occupational therapy and x-rays, this woman—like the younger man with disabilities—is burdened by health-related costs outside of the Medicare program. Since most HMOs do not cover non-Medicare covered items such as hearing aids, raised toilet seats, glasses, and dentures, she would be responsible for 100 percent of these costs.

Summary of Variation in Costs

While premiums are important, they only tell part of the story. Coverage for prescription drugs and other non-Medicare-covered services is extremely important in determining the total out-of-pocket portion of a beneficiary's total annual health care costs. Prescription drugs and other non-Medicare-covered services and items such as eye exams and hearing aids represent "hidden costs" that can have a major impact on total out-of-pocket spending. These services and items are important considerations because they are fully paid by the beneficiary unless she has supplemental coverage that exceeds Medicare coverage (as is the case with some HMOs). A beneficiary who is shopping for supplemental coverage typically looks at premiums as the deciding factor in what coverage to purchase and may fail to consider other potential costs including, prescription drugs, home health care outside of Medicare-allowed charges, and hearing aids which may drive up beneficiary costs considerably. When choosing a plan, beneficiaries may not realize what services are not covered, nor understand the possible impact of non-premium costs.

TABLE 7
Health Care Costs by Type of Coverage (in dollars) Male with disabilities, Age 50
OAKLAND, CALIFORNIA—ALAMEDA COUNTY

	MEDIGAP				HMOs				NONE
	A	F	H	J	BLUE CROSS	HEALTH NET	KAISER	PACIFI-CARE	
Premiums: low	$1,056	$1,536	$1,740	$14,412	$828	$360	$360	$480	$0
high	3,336	7,020	6,912	none					
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	2,499	2,499	160	1,299	2,499
acute episodes	121	121	60	60	121	121	10	121	121
Emergency room visits	0	0	0	0	20	50	20	40	370
Hospital admissions	2,328	0	0	0	750	600	0	300	2,328
Physician visits	100	0	100	0	240	60	120	60	339
Specialist visits	0	0	0	0	80	20	40	20	103
Medical devices or equipment	0	0	0	0	0	0	0	0	602
Other health services	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$9,720	$9,360	$6,360	$7,850	$1,2372
TOTAL COSTS low premium	$12,114	$10,166	$9,285	$21,857	$10,548	$9,720	$6,720	$8,330	$1,2372
TOTAL COSTS high premium	$14,394	$15,650	$14,457	none					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003

TABLE 8
Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
OAKLAND, CALIFORNIA—ALAMEDA COUNTY

	MEDIGAP				HMOs				NONE
	A	F	H	J	BLUE CROSS	HEALTH NET	KAISER	PACIFI-CARE	
Premiums: low	$588	$948	$1,380	$2,076	$828	$360	$360	$480	$0
high	1,236	2,148	1,860	3,480					
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	2,404	2,404	235	1,659	2,404
acute episodes	89	89	45	45	89	89	20	60	89
Emergency room visits	0	0	0	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0	0	0	0
Physician visits	100	0	100	0	100	25	50	25	163
Specialist visits	115	115	115	115	155	80	95	80	150
Medical devices or equipment	100	100	100	100	100	100	0	45	100
Other health services	0	0	0	0	0	0	0	0	44
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$2,848	$2,698	$400	$1,869	$2,950
TOTAL COSTS low premium	$3,396	$3,656	$3,067	$3,663	$3,676	$3,058	$760	$2,349	$2,950
TOTAL COSTS high premium	$4,044	$4,856	$3,547	$5,067					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003

TABLE 9
Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
OAKLAND, CALIFORNIA—ALAMEDA COUNTY

	MEDIGAP				HMOs				NONE
	A	F	H	J	BLUE CROSS	HEALTH NET	KAISER	PACIFI-CARE	
Premiums: low	$636	$1,512	$1,956	$2,892	$828	$360	$360	$480	$0
high	2,904	3,492	3,144	5,304					
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	3,574	3,574	284	960	3,574
acute episodes	68	68	68	34	68	68	30	68	68
Emergency room visits	0	0	0	0	0	0	0	25	160
Hospital admissions	2,328	0	0	0	750	600	0	300	2,328
Physician visits	100	0	100	0	320	80	160	80	447
Specialist visits	115	115	115	115	275	110	155	110	361
Medical devices or equipment	2,347	2,347	2,347	2,347	2,347	2,347	2,247	2,267	2,399
Other health services	0	0	0	0	800	0	400	0	1,336
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$8,134	$6,779	$3,276	$3,810	$10,673
TOTAL COSTS low premium	$9,168	$7,616	$6,910	$7,300	$8,962	$7,139	$3,636	$4290	$10,673
TOTAL COSTS high premium	$11,436	$9,596	$8,098	$9,712					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003

CONCLUSION AND IMPLICATIONS

Findings from this report show that the insurance choices that Medicare beneficiaries make have substantial and often dramatic effects on their out-of-pocket medical spending. We found that a number of factors affect how much a person on Medicare would likely spend out-of-pocket. First, and perhaps not surprisingly, is health status. In terms of total costs, our relatively healthy 65 year-old would tend to spend less (an average of $58—$9,661) than the frail 80 year-old ($1,342–$12,482), who in turn would tend to spend less than the beneficiary with disabilities ($6,010–$21,857). Regardless of source of coverage or geographic location, those with the greatest health needs would tend to have the highest out-of-pocket spending and the greatest variability in their range of out-of-pocket spending.

Second, type of plan matters in determining beneficiary healthcare costs. In general, spending is found to be lower in M+C plans than for Medigap. For example, our frail 80 year-old would spend between $1,342 and $8,962 in a M+C plan, compared to $6,376 and $12,482 in a Medigap plan. Having no coverage was often a reasonable choice for the healthy 65 year-old, but not for the other two prototype beneficiaries, who would tend to spend far more without supplemental coverage. Nevertheless, "going bare" is not advisable even for healthy beneficiaries for two major reasons: 1) their health status could deteriorate at any time, and 2) they would lose their Medigap open enrollment privileges if they did not purchase coverage within six months of becoming eligible for Medicare. The option that generates the lowest total out-of-pocket costs at age 65 will not necessarily be the option that would be most cost-effective throughout a beneficiary's lifetime. More comprehensive plans may be more expensive at younger ages, but may result in savings at older ages.

Third, within a particular insurance type, the specific plan chosen affects costs as well. To illustrate in one geographic area—Oakland, CA—costs for a 65 year-old who chooses to purchase Medigap plan F would vary by $1,200 annually depending on which company is chosen. Similarly, if that person chooses an HMO, her spending would vary by over $3,000 depending on the particular HMO.

Fourth, there is a great deal of variation in costs for non-covered services like pharmaceuticals. Our frail 80 year-old in Oakland would pay as little as $284 for her regimen of seven prescription drugs but as much as $3,574, depending on the insurance option she chooses. Providing a Medicare drug benefit—depending, of course, on how it is structured—could do much to reduce this uncertainty.

Finally, in some instances there are large differences in costs by geographic areas. This is most true of those who choose Medigap Plan J or an HMO. Our 80 year-old woman who picks the cheapest Plan J available would spend $6,376 on medical expenses if she lives in Manchester,

NH, but $9,520 if she lives in Miami, FL. In contrast, if she lives in Miami and chooses the cheapest HMO she would spend as little as $1,342, but as much as $7,082 if she picks the cheapest HMO in Seattle.

Of particular importance is that fact that these costs differences are often hidden because they are not reflected in the premiums paid, but rather through cost-sharing requirements and uncovered services. Thus, when engaging in comparison-shopping, consumers may put too much emphasis on cheaper premiums without considering the more difficult to assess cost-sharing requirements for covered services and costs for other non-covered services. Needless to say, it may be difficult for an individual to engage in these cost calculations and level of analysis when shopping for coverage. To illustrate, for our healthy 65 year-old in Oakland, CA, annual costs over and above premiums range from as little as $400 to as much as $2,800 depending on which plan she chooses—a $2,400 difference. The difference for the frail 80 year-old and disabled beneficiary is even greater—approximately $5,200 and $4,700, respectively. The difficulty that beneficiaries face in making good supplemental insurance choices is magnified by the fact that health plan options as well as their own particular medical circumstances may change each year.

The supplemental insurance market presents opportunities for Medicare beneficiaries to insure themselves against future health care costs, but the choice is neither easy nor risk-free—particularly for those living on fixed incomes. There are no steadfast rules for beneficiaries to make the "right" choice in selecting a supplemental insurance plan. Scope of coverage provided by supplemental insurance is often a more important determinant of total out-of-pocket costs than are premiums, but often difficult for consumers to assess and compare. Even those with chronic illnesses and predictable service and equipment needs would be challenged to project costs under alternative supplemental insurance options, due to formularies and coverage limits that are often difficult to decipher prior to enrollment. Generally, policymakers favor providing consumers more health plan choices, and indeed, studies have shown the more choice tends to increase satisfaction (Ullman et al., 1997; Davis et al., 1995). This study has shown, however, that providing more choices also increases *risk* of uncertain costs, since costs will vary in ways that are not readily apparent to beneficiaries.

APPENDIX I
Medigap Benefits: Plans A–J

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F[a]	Plan G	Plan H	Plan I	Plan J[a]
Coverage for: —Part A Coinsurance —365 Additional Hospital Days During Lifetime —Part B Coinsurance —Blood Products	X	X	X	X	X	X	X	X	X	X
Skilled Nursing Facility Coinsurance			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Balance Billing[b]						X	X		X	X
Foreign Travel Emergency			X	X	X	X	X	X	X	X
Home Health Care				X			X		X	X
Prescription Drugs								X[c]	X[c]	X[c]
Preventive Medical Care				X						X

[a] Plans F and J also have a high-deductible option that requires the beneficiary to pay $1,580 before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs ($250 per year for plan J) and foreign travel emergency ($250 per year for plans F and J) which are required in these plans with or without the high-deductible option.

[b] Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payment rate. Plan G pays 80 percent of balance billing; plans F, I, and J cover 100 percent of these charges.

[c] Plan H and I pay 50 percent of drug charges up to $1,250 per year and have a $250 annual deductible. Plan J pays 50 percent of drug charges up to $3,000 per year and has a $250 annual deductible.

SOURCE: General Accounting Office analysis of NAIC Data, July 2001.

Detailed Description of Prototype Beneficiaries and Their Health Care

Fifty Year-Old Man with Disabilities

The first prototype beneficiary is a 50 year-old man with disabilities in fair to poor health. He suffers from several chronic conditions in addition to being obese and a smoker. His conditions include paraplegia secondary to a spinal cord injury following a car accident, decubitus ulcers, non-insulin dependent diabetes, a neurogenic bladder, and bouts of depression. To manage his chronic conditions he takes four prescription drugs daily.

Given this health profile, we assumed he would experience two or three acute episodes per year, in this case a significant kidney infection called pyelonephritis, an infected decubitus ulcer, and an episode of diabetic insulin attacks. He is admitted to the hospital for each of the three acute episodes. For the pyelonephritis he is treated as an inpatient with ceftriaxone, and then with a prescription for Cipro. For the decubitus ulcer he is given a surgical debridement of the wound and an antibiotic in the operating room, and for the diabetes he is treated with an insulin IV and a saline IV plus potassium and magnesium. In addition to hospitalization for each of his acute episodes, he has one emergency room visit during the year due to a bladder infection.

During the course of a year he has12 physician visits and an additional four visits to specialists including an endocrinologist, a general surgeon, a urologist, and a neurologist. He uses various medical devices including self-catheterization equipment, a motorized wheelchair, and durable equipment in his home due to his paralysis, wound dressings, a hospital bed, a foam mattress, and specialty pillows. Finally, he requires physical and/or occupational therapy once every three to four months for a total of 14 visits, as well as requiring a home health aide once a week for approximately four hours, none of which is covered by Medicare.

Healthy Sixty-Five Year-Old Woman

The second prototype beneficiary is a fairly healthy, 65 year-old woman. Despite her very good health, she has hypertension, hypercholesterolemia (high cholesterol), hypothyroidism, and is post-menopausal. To manage these chronic conditions, she takes five prescription medications and calcium supplements daily.

This woman is assumed to have one acute episode per year, such as a case of sinusitis for which she is prescribed two prescription medications. She does not have any emergency room visits or hospital admissions, but she visits the doctor regularly. She sees a general physician five times a year and makes four trips to various specialists: an ophthalmologist, a gynecologist, a gastroenterologist, and a dentist. She does not require any medical devices other than a new pair of glasses. As part of her regular visits to her doctors, she undergoes some lab work and preventive tests that are covered by Medicare.

Frail Eighty Year-Old Woman

The third prototype beneficiary is an 80 year-old woman in relatively poor health. She has multiple chronic conditions including hypertension, hypercholesterolemia, coronary artery disease, cerebrovascular disease (otherwise known as stroke), type II diabetes, dementia, an irregular heartbeat, osteoarthritis, osteoporosis, depression, and a gait disorder. To manage her conditions, each day she takes seven prescription drugs plus aspirin.

She is also assumed to have four acute episodes per year; for example, one each from a case of pneumonia, angina, a broken hip, and a temporary ischemic accident (TIA). Two of these episodes require emergency room visits—one via ambulance because of the fall that led to her broken hip—and all episodes except the angina lead to hospital admissions. To treat the acute episodes, she requires an additional three temporary prescriptions.

Because she suffers from so many ailments, this woman sees a primary care doctor 16 times and has ten specialist visits during the year. She also needs a variety of medical equipment, some of which is covered by Medicare, and some of which is not. Her hearing aid, raised toilet seat, glasses, and dentures are not Medicare-covered, but a walker, wheel chair while she recovers from her broken hip, and glucose monitoring strips are covered. Due to her hospitalizations and frail condition, she requires seven days in a rehabilitation hospital, two days in a skilled nursing facility, 33 physical therapy appointments, seven occupational therapy appointments, four home health visits, and a variety of lab work and x-rays.

Table A.1
Prototype Medicare Beneficiaries

Gender & Age	Health Status	Chronic Conditions	Prescription Drugs for Chronic Conditions	Acute Episodes	Prescription Drugs for Acute Conditions
Male with Disabilities, 50 Years Old	Fair/ Poor	1) Paraplegia secondary to spinal cord injury (auto accident) 2) Obesity 3) Decubitus Ulcers 4) Type 2 diabetes 5) Neurogenic bladder 6) Depression 7) Smoking	1) Glipizide (20mg/day) 2) Glucophage/Metforman for diabetes (500mg/day) 3) Macrodantin (100mg/day) 4) Prozac/Fluoxetine (40mg/day)	3 per year 1) Pyelonephritis 2) Infected decubitus ulcer 3) Diabetes out of control	1) ceftriaxone (1gm IV 1x/day x 5 days) 2) cipro (500mg by mouth 2x daily x 2 weeks) 3) Surgical debridement of wound in OR 4) Insulin IV for 2 days; IV saline plus potassium and magnesium.
Healthy Female, 65 Years Old	Very Good	1) Hypertension 2) Hypercholesterolemia 3) Hypothyroidism 4) Post-Menopausal	1) Benazelpril/Lotensin (20mg/day, low dose) 2) Lipitor (20mg/day) 3) Levothyroxine (100mcg/day) 4) Fosamax (or generic, Alendronate; 10mg/day) 5) Calcium (1200mg/day) 6) Hormone Replacement Therapy (Prempro/Premarin)	1 per year 1) Sinusitis 2) Weak/dizzy episode "vertigo"	1) Azithromycin (500mg for 1 day, then 250m for 4 days) 2) Vancenase nasal inhaler or Flonase (1x daily x 2 wks)
Frail Female, 80 Years Old	Fair/ Poor	1) Hypertension 2) Hypercholesterolemia (expensive drugs but very common) 3) Coronary artery disease 4) Cerebrovascular disease (stroke) 5) Type 2 diabetes 6) Dementia 7) Depression 8) Gait disorder 9) Atrial fibrulation (irregular heartbeat) 10) DJD (osteoarthritis) 11) Osteoporosis	1) Benazepril or Lotensin (20mg/day, low dose) 2) Aspirin (325mg/day) 3) Metoprolol (50mg/day) 4) Glyburide (2.5mg/day, low dose) 5) Aricept (10mg/day OR Donepezil 10mg/day) 6) Celexa/Citalopram (20mg/day) (anti-depressant) 7) Coumadin/Warfarin Sodium (3mg/day) (anti-coagulant) 8) Fosamax (or generic, Alendronate; 10mg/day)	4 per year 1) Pneumonia 2) Angina 3) Broken hip 4) TIA	1) Azithromycin (500mg x 1 day, then 250mg x 4 days) 2) Nitrostat (Sublinqual nitroglycerine) 1/250mg (outpatient, not ER) 3) Vicodin (660/10 x 40, 2 pills every 4-6 hours x 7 days)

	Emergency Room Visits	Hospital Admissions	Physician Visit (#)	Specialists (Type and # of visits)	Medical Devices or Equipment	Other Health Services (Rehab, SNF, HH, PT, OT) and Labs
Male 50 Years Old	Prior to each hospitalization (3) plus additional ER visit for bladder infection	3 Same as acute episodes	12	1 visit each: 1) Endocrinologist 2) General surgeon 3) Urologist 4) Neurologist	1) Self-catheterization equipment 2) Motorized wheelchair 3) Equipment in home due to paralysis	**General:** • PT/OT every 3-4 wks (14 visits annually) • Home health aide 1x wkly (4 hours). **For debridement:** • SNF: 2 wks
Female 65 Years Old	None	None	5	1) Opthamologist to check eyes 2) Gynecologist 3) Gastro-enterologist 4) Dentist	Glasses	**Lab work (Blood Chemistry):** • Thyroid • Cholesterol • Electrolytes (diabetes/hypertension) **Other:** • Mammogram • Pap and pelvic • Bone density • Sigmoidoscopy
Female 80 Years Old	1) Fall – includes ambulance to hospital 2) Pneumonia	3 Admissions from ER visits: 1) broken hip (hip replace-ment) 2) Pneumonia 3) Short admission after TIA	16	1) Cardiologist - 2x/yr for previous heart attack 2) Endocrinologist for diabetes 3) Neurologist (dementia/ stroke) 4) Orthopedic surgeon (2 post-surgery visits) 5) Podiatrist 6) Ophthalmologist 7) Audiologist 8) Dentist	1) Hearing aid 2) Walker 3) Raised toilet seat 4) Wheel chair after she breaks hip (3 months) 5) Glucose monitor strips 6) Glasses 7) Dentures	**For fall/broken hip:** • Rehabilitation: 7 days • PT: 2x/day then 3x/wk (4 wks) • OT: 1x daily x 7 days • HH: 2x wkly x 2 wks **For pneumonia:** • SNF: 2 days • PT: 2x/day x 2 days then 3x/wk x 1 wk **Lab work:** • Blood Chemistry – 15/yr (CBC, electrolytes, coagulation, etc.) • MRI (stroke, dementia) • Chest x-rays • Hip x-rays • 4 EKGs

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Complete Methods for Calculating Costs

Profiling beneficiaries and assigning out-of-pocket costs is more craft than science. Therefore some of the services assigned, and the costs associated with them, are derived as much through educated assumptions as through scientific discovery. Second, not only do the costs of services vary by region, but in many cases medical practice also varies regionally, such that the same individual might not receive the exact same services in Minneapolis, MN as she would receive in Dodge City, KS. However consistent methods were used to determine costs across regions, which helps to strengthen our methodology. Detailed description of the methods used to determine costs are found below.

Premiums

Various sources were used to obtain premium information. Medigap premiums were culled from state handbooks that are compiled by most state governments and posted on the Internet to help Medicare beneficiaries contact and price various Medigap options in their state. Rates are for Medigap plans in 2001. The range of premiums was determined by the lowest and highest premiums listed in the handbooks for each plan (A, F, H, and J). If information was missing we determined the range by calling four Medigap carriers in each area to personally request the Medigap premium for each plan; the carrier with the lowest costs listed for 65 year-olds in that geographic area, the carrier with the highest costs, the state's Blue Cross/Blue Shield carrier, and United Healthcare (the AARP carrier). For example, in some states the handbook included prices for a new, 65 year-old beneficiary, but not for an 80 year-old beneficiary; in those cases we called each of the four plans listed and asked for their rates for a new, 80 year-old beneficiary for plans A, F, H, and J. In some states their handbook noted a disclaimer that the premiums listed are subject to change and that the list of Medigap insurance carriers may only be a partial listing. Limitations of the state data are reflected in the data in this report.

Because this report is intended to demonstrate the implications of choice, each Medigap plan is priced as though it were newly purchased by the beneficiary as of 2001. Thus we are showing the consequences of choice *at this point in time.* If a beneficiary made a choice and purchased a Medigap plan at age 65, she would be unlikely to switch to a different type of coverage now, precluding the intention of the study. The impact of this aspect of the methodology on the results depends on whether a policy is community rated, issue-age rated, or attained-age rated, which is discussed in Endnote 4 .

M+C premiums were determined by obtaining 2001 marketing materials from each individual M+C HMO. M+C are community rated and therefore do not differ according to the age of the beneficiary. All premiums were calculated annually.

Prescription Drugs

Prescription drugs were priced on-line using the web site www.anymed.com, an Internet website that sells prescription drugs nationally. Other web sites (for example www.cvs.com) were also sampled and had similar prices with minor variations. It was assumed that generic drugs would be used in place of brand-name drugs whenever both were listed on the web site. Prescriptions for chronic conditions were priced for 90-day supplies because that is the longest period for which most doctors will prescribe drugs; the cost of the 90-day supply was then pro-rated to 365 days for the full year's estimate. Prescriptions for acute episodes were priced according to the exact number of pills prescribed.

To estimate drug costs for M+C HMOs that cover prescription drugs, copayments were calculated according to 90-day supplies (or 100-day supplies in the case of the HMOs that use a 100-day supply as their maximum). Again, it was assumed that generic drugs would be used in place of brand-name drugs whenever possible. Where HMOs had drug limits, the limit was based on the same costs for drugs as those used for the non-HMO drugs, using www.anymed.com. Any amount over the limit was expected to be charged to the beneficiary. It was assumed that a beneficiary would purchase non-prescription items such as aspirin and calcium supplements on their own because the cost of purchasing those items was lower than the cost of copayments for them.

Despite repeated attempts to acquire formulary information from the health plans that offer prescription drug coverage, most of the representatives we spoke to were unwilling or unable to give us a copy of the plan's formulary. In the end, we obtained formularies for two of the M+C carriers; the two had differences but were approximately comparable in what they covered. Therefore we chose one of them as the template from which to calculate drug costs for the Medicare HMOs that based their drug benefit on a formulary. However, we based the price of the copayment on the prices listed in each individual HMO's marketing materials, not on the copayments of the one plan from which we used the formulary.

Emergency Room Visits

Under Medicare rules, beneficiaries only pay for emergency room visits if they are not admitted to the hospital for the same condition within one day of the emergency room visit; if beneficiaries are not admitted, then they are obligated to pay 20 percent of emergency room facility costs. For the one emergency room visit for the disabled man that did not result in an inpatient admission, we assumed that the costs of the visit would fall in line the average range for emergency room services at the University of California, Los Angeles. We calculated that the full costs of emergency room services would total $650, plus physician costs of $300.

Ambulance charges are also highly variable and depend on the area in which the services are used. In some areas ambulances are private and in others they are owned and operated by the cities or counties in which they run; some cities charge for ambulance services and others do not.

Similarly, sometimes paramedics are paid by the city, while others are not. There is a Medicare fee schedule for ambulance services, but as of 2001 it had yet to be fully implemented. Thus for the purposes of this study, the cost of ambulance services was assumed to be $200—in the middle of the $100 to $300 range for ambulance services at the University of California, Los Angeles. If use of the ambulance is medically necessary and to the nearest hospital, the transport is covered by Medicare. Twenty percent of ambulance charges must be paid by Medicare beneficiaries. We assume that both of these criteria are met for our 80 year-old beneficiary.

Hospital Admissions

Hospital admissions are fully covered by Medicare after a beneficiary pays a deductible of $776. We assume that there is no overlap between the three hospital admissions. In other words, each of the three visits for the 50 year-old man were in a different benefit period, and each of the three visits for the 80 year-old woman were also in a different benefit period.[6]

Physician Visits

Physician visits are billed to Medicare according to procedure codes. The codes allow physicians to bill office visits according to the needs of the patient, with sicker patients meriting greater reimbursement for the higher intensity of services they require. For the 50 year-old man we estimated two visits at a basic billing level, five at the next level and five at the highest level. For the 65 year-old woman we estimated four visits at the basic billing level and one at the intermediate level. For the 80 year-old woman we assumed eight visits at the intermediate level and another eight visits at the highest level.

Medicare then pays 80 percent of the geographically-adjusted cost of the visit. We used procedure codes for office visits to obtain the Medicare-approved amount for each geographic region in our study. We assume here that all doctors accept Medicare assignment, meaning that they bill beneficiaries no more than 20 percent of the Medicare-approved amount. In addition, the Medicare Part B $100 deductible is added to this is the category of beneficiary costs.

Specialist Visits

Like physician visits, specialist visits are billed using procedure codes. To estimate the cost of Medicare-covered specialist visits we assigned the highest level of intensity to each of the specialist visits for the 50 year-old man and the 80 year-old woman and the intermediate level of intensity to the 65 year-old woman.

Non Medicare-covered specialist visits—routine dental, podiatrist and ophthalmologist visits—were estimated by calling a variety of providers in the Los Angeles area to determine their current charges for a routine visit and assigning an average cost to the service. From these calls dentist visits were assumed to cost the beneficiary $65, vision care was assumed to cost $50 and a visit to the podiatrist was assumed to cost $60.

Medical Devices or Equipment

All Medicare-covered durable medical equipment is billed using current procedural terminology (CPT) codes and is adjusted for geographic costs. Beneficiaries pay 20 percent of the Medicare-approved costs in their geographic area. For non-covered medical devices such as glasses, dentures, hearing aids, and raised toilet seats the beneficiary pays 100 percent of costs; we have estimated these costs based on a medium to low-end cost for the range of the item in question. For example, the cost of new glasses may range from $35 to several hundred dollars; using the range of costs noted above, we assumed a cost of $100 for a pair of new glasses.

Other Health Services

Beneficiaries pay nothing for qualified home health benefits, the first 20 days in a skilled nursing or rehabilitation facility, certain preventive services (pap smears) and Medicare-approved lab services. For all other health services—physical and occupational therapy, mammograms, bone mass measurement, and colorectal screenings, and x-rays—beneficiaries pay 20 percent of the Medicare-approved amounts.

We estimated physical and occupational therapy charges by assuming the community rate established for Medicare services that is used by the University of California. Using that rate, physical and occupational therapy visits cost $147 per visit. Costs for the preventive services and x-rays were determined using diagnostic codes that are geographically adjusted.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
OAKLAND, CALIFORNIA—ALAMEDA COUNTY

	MEDIGAP				HMOs				NONE
	A	F	H	J	BLUE CROSS	HEALTH NET	KAISER	PACIFI-CARE	
Premiums: low	$1,056	$1,536	$1,740	$14,412	$828	$360	$360	$480	$0
high	3,336	7,020	6,912	none					
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	2,499	2,499	160	1,299	2,499
acute episodes	121	121	60	60	121	121	10	121	121
Emergency room visits	0	0	0	0	20	50	20	40	370
Hospital admissions	2,328	0	0	0	750	600	0	300	2,328
Physician visits	100	0	100	0	240	60	120	60	339
Specialist visits	0	0	0	0	80	20	40	20	103
Medical devices or equipment	0	0	0	0	0	0	0	0	602
Other health services	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010
SUM of non-premium costs non-premium costs	$11,058	$8,630	$7,545	$7,445	$9,720	$9,360	$6,360	$7,850	$12,372
TOTAL COSTS low premium	$12,114	$10,166	$9,285	$21,857	$10,548	$9,720	$6,720	$8,330	$12,372
TOTAL COSTS high premium	$11,058	$15,650	$14,457	none					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
OAKLAND, CALIFORNIA—ALAMEDA COUNTY

	MEDIGAP				HMOs				NONE
	A	F	H	J	BLUE CROSS	HEALTH NET	KAISER	PACIFI-CARE	
Premiums: low	$636	$1,512	$1,956	$2,892	$828	$360	$360	$480	$0
high	2,904	3,492	3144	5304					
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	3,574	3,574	284	960	3,574
acute episodes	68	68	68	34	68	68	30	68	68
Emergency room visits	0	0	0	0	0	0	0	25	160
Hospital admissions	2,328	0	0	0	750	600	0	300	2,328
Physician visits	100	0	100	0	320	80	160	80	447
Specialist visits	115	115	115	115	275	110	155	110	361
Medical devices or equipment	2,347	2,347	2,347	2,347	2,347	2,347	2,247	2,267	2,399
Other health services	0	0	0	0	800	0	400	0	1336
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$8,134	$6,779	$3,276	$3,810	$10,673
TOTAL COSTS low premium	$9,168	$7,616	$6,910	$7,300	$8,962	$7,139	$3,636	$4,290	$10,673
TOTAL COSTS high premium	$11,436	$9,596	$8,098	$9,712					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
OAKLAND, CALIFORNIA—ALAMEDA COUNTY

	MEDIGAP				HMOs				NONE
	A	F	H	J	BLUE CROSS	HEALTH NET	KAISER	PACIFI-CARE	
Premiums: low	$636	$1,512	$1,956	$2,892	$828	$360	$360	$480	$0
high	2,904	3,492	3,144	5,304					
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	3,574	3,574	284	960	3,574
acute episodes	68	68	68	34	68	68	30	68	68
Emergency room visits	0	0	0	0	0	0	0	25	160
Hospital admissions	2,328	0	0	0	750	600	0	300	2,328
Physician visits	100	0	100	0	320	80	160	80	447
Specialist visits	115	115	115	115	275	110	155	110	361
Medical devices or equipment	2,347	2,347	2,347	2,347	2,347	2,347	2,247	2,267	2,399
Other health services	0	0	0	0	800	0	400	0	1,336
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$8,134	$6,779	$3,276	$3,810	$10,673
TOTAL COSTS low premium	$9,168	$7,616	$6,910	$7,300	$8,962	$7,139	$3,636	$4290	$10,673
TOTAL COSTS high premium	$11,436	$9,596	$8,098	$9,712					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
MARYLAND— BALTIMORE CITY COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	KAISER FOUNDATION HEALTH PLAN	
Premiums: low	$840	$1,416	$1,884	$2,208	$948	$0
high	1,692					
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	1,242	2,499
acute episodes	121	121	60	60	121	121
Emergency room visits	0	0	0	0	50	370
Hospital admissions	2,328	0	0	0	0	2,328
Physician visits	100	0	100	0	120	322
Specialist visits	0	0	0	0	40	96
Medical devices or equipment	0	0	0	0	622	622
Other health services	6,010	6,010	6,010	,6010	6,010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$8,205	$12,368
TOTAL COSTS low premium	$11,898	$10,046	$9,429	$9,653	$9,153	$12,368
TOTAL COSTS high premium	$12,750					

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
MARYLAND—BALTIMORE CITY COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	KAISER FOUNDATION HEALTH PLAN	
Premiums: low	$407	$853	$1,631	$2,202	$948	$0
high	1,454	1,542	2,290	4,284		
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	1144	2,404
acute episodes	89	89	45	45	89	89
Emergency room visits	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0
Physician visits	100	0	100	0	50	158
Specialist visits	115	115	115	115	60	147
Medical devices or equipment	100	100	100	100	75	100
Other health services	0	0	0	0	0	39
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$1,418	$2,937
TOTAL COSTS low premium	$3,215	$3,561	$3,318	$3,789	$2,366	$2,937
TOTAL COSTS high premium	$4262	$4250	$3977	$5871		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
MARYLAND—BALTIMORE CITY COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	KAISER FOUNDATION HEALTH PLAN	
Premiums: low	$840	$1,416	$1,884	$2,208	$948	$0
high	1,092	2,088	2,736	4,656		
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	2,448	3,574
acute episodes	68	68	68	34	68	68
Emergency room visits	0	0	0	0	0	160
Hospital admissions	2,328	0	0	0	0	2,328
Physician visits	100	0	100	0	160	422
Specialist visits	115	115	115	115	170	343
Medical devices or equipment	2,347	2,347	2,347	2,347	2,374	2,399
Other health services	0	0	0	0	400	1,316
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$5,620	$10,610
TOTAL COSTS low premium	$9,372	$7,520	$6,838	$6,616	$6,568	$10,610
TOTAL COSTS high premium	$9,624	$8,192	$7,690	$9,064		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
ILLINOIS—COOK COUNTY

	MEDIGAP				HMOs		NONE
	A	F	H	J	HUMANA HEALTH PLAN	UNITED HEALTHCARE OF IL	
Premiums: low high	$1,438	$2,038	none	none	$468	$0	$0
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	1,914	2,499	2,499
acute episodes	121	121	60	60	121	121	121
Emergency room visits	0	0	0	0	50	50	370
Hospital admissions	2,328	0	0	0	0	2,500	2,328
Physician visits	100	0	100	0	120	240	331
Specialist visits	0	0	0	0	40	80	100
Medical devices or equipment	0	0	0	0	0	619	619
Other health services	6,010	6,010	6,010	6,010	6,010	6, 010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$8,255	$12,119*	$12,378
TOTAL COSTS low premium	$12,496	$10,668	none	none	$8,723	$12,119	$12,378
TOTAL COSTS high premium							

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

*United Healthcare has a $1,500 annual out-of-pocket limit for covered services not including prescription drugs or durable medical equipment. Therefore, total out-of-pocket costs for the 50 year-old male with disabilities equal $10,749.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
ILLINOIS—COOK COUNTY

	MEDIGAP				HMOs		NONE
	A	F	H	J	HUMANA HEALTH PLAN	UNITED HEALTHCARE OF IL	
Premiums: low	$467	$854	$1,428	$2,247	$468	$0	$0
high	1,227	1,861	2,055	3,502			
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	1,816	2,404	2,404
acute episodes	89	89	45	45	89	89	89
Emergency room visits	0	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0	0
Physician visits	100	0	100	0	50	100	160
Specialist visits	115	115	115	115	95	125	149
Medical devices or equipment	100	100	100	100	100	100	100
Other health services	0	0	0	0	0	15	42
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$2,150	$2,833	$2,944
TOTAL COSTS low premium	$3,275	$3,562	$3,115	$3,834	$2,618	$2,833	$2,944
TOTAL COSTS high premium	$4,035	$4,569	$3,742	$5,089			

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
ILLINOIS—COOK COUNTY

	MEDIGAP				HMOs		NONE
	A	F	H	J	HUMANA HEALTH PLAN	UNITED HEALTHCARE OF IL	
Premiums: low	$742	$1,500	$2,055	$2,526	$468	$0	$0
high	2,184	3,157	3,264	5,676			
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	3,156	3,574	3,574
acute episodes	68	68	68	34	68	68	68
Emergency room visits	0	0	0	0	75	100	160
Hospital admissions	2,328	0	0	0	0	2,500	2,328
Physician visits	100	0	100	0	160	320	435
Specialist visits	115	115	115	115	155	245	350
Medical devices or equipment	2,347	2,347	2,347	2,347	2,347	2,399	2,399
Other health services	0	0	0	0	400	3060	1,326
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$6,361	$12,266*	$10,640
TOTAL COSTS low premium	$9,274	$7,604	$7,009	$6,934	$6,829	$12,266	$10,640
TOTAL COSTS high premium	$10,716	$9,261	$8,218	$10,084			

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

*United Healthcare has a $1,500 annual out-of-pocket limit for covered services not including prescription drugs or durable medical equipment. Therefore, total out-of-pocket costs for the frail 80 year-old female equal $7,541.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
FLORIDA—DADE COUNTY

	MEDIGAP				HMOs					NONE
	A	F	H	J	FOUNDATION HEALTH	HEALTH OPTIONS INC (BC/BS)	HUMANA	NEIGHBORHD HEALTH PARTNERSHIP	UNITED HEALTHCARE of FL	
Premiums: low	$1,044	$2,052	$3,036	$3,852	$0	$0	$0	$0	$0	$0
high	1,284	2,316								
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	240	499	0	99	999	2499
acute episodes	121	121	60	60	10	121	0	121	121	121
Emergency room visits	0	0	0	0	0	50	0	0	50	370
Hospital admissions	2,328	0	0	0	0	0	0	0	250	2,328
Physician visits	100	0	100	0	0	60	0	0	0	330
Specialist visits	0	0	0	0	0	60	0	0	0	100
Medical devices or equipment	0	0	0	0	0	0	0	0	0	622
Other health services	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$6,260	$6,800	$6,010	$6,230	$7,430	$12,380
TOTAL COSTS low premium	$12,102	$10,682	$10,581	$11,297	$6,260	$6,800	$6,010	$6,230	$7,430	$12,380
TOTAL COSTS high premium	$12,342	$10,946								

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
FLORIDA—DADE COUNTY

	MEDIGAP				HMOs					NONE
	A	F	H	J	FOUNDATION HEALTH	HEALTH OPTIONS INC (BC/BS)	HUMANA	NEIGHBORHD HEALTH PARTNERSHIP	UNITED HEALTHCARE OF FL	
Premiums: low	$657	$1,199	$1,877	$2,583	$0	$0	$0	$0	$0	$0
high	1,318	2,371	2,873	3,576						
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	720	404	275	0	904	2,404
acute episodes	89	89	45	45	20	89	0	58	89	89
Emergency room visits	0	0	0	0	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0	0	0	0	0
Physician visits	100	0	100	0	0	25	0	0	0	160
Specialist visits	115	115	115	115	0	145	0	0	0	149
Medical devices or equipment	100	100	100	100	0	100	0	0	20	100
Other health services	0	0	0	0	0	0	0	0	0	42
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$740	$763	$275	$58	$1,013	$2,944
TOTAL COSTS low premium	$3,465	$3,907	$3,564	$4,170	$740	$763	$275	$58	$1,013	$2,944
TOTAL COSTS high premium	$4,126	$5,079	$4,560	$5,163						

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
FLORIDA—DADE COUNTY

	MEDIGAP				HMOs					NONE
	A	F	H	J	FOUNDATION HEALTH	HEALTH OPTIONS INC (BC/BS)	HUMANA	NEIGHBORHD HEALTH PARTNERSHIP	UNITED HEALTHCARE of FL	
Premiums: low	$1,428	$2,700	$4,020	$5,112	$0	$0	$0	$0	$0	$0
high	2,328	4,704								
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	840	1,574	240	1,174	2,074	3,574
acute episodes	68	68	68	34	30	68	0	68	68	68
Emergency room visits	0	0	0	0	0	50	0	0	0	160
Hospital admissions	2,328	0	0	0	0	0	0	0	250	2,328
Physician visits	100	0	100	0	0	80	0	0	0	434
Specialist visits	115	115	115	115	5	235	10	60	0	350
Medical devices or equipment	2,347	2,347	2,347	2,347	467	2,347	1,547	847	1867	2,394
Other health services	0	0	0	0	0	600	0	0	0	1,326
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$1,342	$4,954	$1,797	$2,149	$4,259	$10,634
TOTAL COSTS low premium	$9,960	$8,804	$8,974	$9,520	$1,342	$4,954	$1,797	$2,149	$4,259	$10,634
TOTAL COSTS high premium	$10,860	$10,808								

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
KANSAS—FORD COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	None	
Premiums: low	$498	$878	$1,416	$2,388		$0
high	1,374	2,147	2,469	3,925		
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375		2499
acute episodes	121	121	60	60		121
Emergency room visits	0	0	0	0		370
Hospital admissions	2,328	0	0	0		2,328
Physician visits	100	0	100	0		301
Specialist visits	0	0	0	0		87
Medical devices or equipment	0	0	0	0		619
Other health services	6,010	6,010	6,010	6,010		6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445		$12,335
TOTAL COSTS low premium	$11,556	$9,508	$8,961	$9,833		$12,335
TOTAL COSTS high premium	$12,432	$10,777	$10,014	$11,370		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
KANSAS—FORD COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	None	
Premiums: low	$464	$878	$1,416	$2,388		
high	1,374	1,948	2,469	3,925		
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327		2,404
acute episodes	89	89	45	45		89
Emergency room visits	0	0	0	0		0
Hospital admissions	0	0	0	0		0
Physician visits	100	0	100	0		152
Specialist visits	115	115	115	115		144
Medical devices or equipment	100	100	100	100		100
Other health services	0	0	0	0		35
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587		$2,924
TOTAL COSTS low premium	$3,272	$3,586	$3,103	$3,975		$2,924
TOTAL COSTS high premium	$4,182	$4,656	$4,156	$5,512		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
KANSAS—FORD COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	None	
Premiums: low	$639	$1,223	$2,469	$2,976		
high	1,903	3,015	3,798	7,056		
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912		3,574
acute episodes	68	68	68	34		68
Emergency room visits	0	0	0	0		160
Hospital admissions	2,328	0	0	0		2,328
Physician visits	100	0	100	0		392
Specialist visits	115	115	115	115		328
Medical devices or equipment	2,347	2,347	2,347	2,347		2,398
Other health services	0	0	0	0		1,298
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408		$10,546
TOTAL COSTS low premium	$9,171	$7,327	$7,423	$7,384		$10,546
TOTAL COSTS high premium	$10,435	$9,119	$8,752	$11,464		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
MINNESOTA—HENNEPIN COUNTY

	MEDIGAP				HMOs			NONE
	A	F	H	J	HEALTH-PARTNERS	MEDICA	UCARE MINNESOTA	
Premiums: low	$686	$1,121	none	$3,486	$912	$1,194	$432	$0
high	1,735	2,468		9,043				
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	2,499	2,499	2,499	2,499
acute episodes	121	121	60	60	121	121	121	121
Emergency room visits	0	0	0	0	30	50	40	370
Hospital admissions	2,328	0	0	0	0	300	450	2,328
Physician visits	100	0	100	0	120	120	120	310
Specialist visits	0	0	0	0	40	40	60	91
Medical devices or equipment	0	0	0	0	312	625	625	625
Other health services	6,010	6,010	6,010	6,010	6,010	6,010	6,010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$9,132	$9,765	$9,925	$12,354
TOTAL COSTS	$11,744	$9,751	none	$10,931	$10,044	$10,959	$10,357	$12,354
TOTAL COSTS high premium	$12,793	$11,098		$16,488				

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
MINNESOTA—HENNEPIN COUNTY

	MEDIGAP				HMOs			NONE
	A	F	H	J	HEALTH-PARTNERS	MEDICA	UCARE MINNESOTA	
Premiums: low	$686	$1,121	none	$3,486	$912	$1,194	$432	$0
high	1,735	2,468		8,074				
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	2,404	2,404	2,404	2,404
acute episodes	89	89	45	45	89	89	89	89
Emergency room visits	0	0	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0	0	0
Physician visits	100	0	100	0	50	50	50	154
Specialist visits	115	115	115	115	20	85	95	145
Medical devices or equipment	100	100	100	100	100	100	100	100
Other health services	0	0	0	0	0	0	0	36
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$2,663	$2,728	$2,738	$2,928
TOTAL COSTS low premium	$3,494	$3,829	none	$5,073	$3,575	$3,922	$3,170	$2,928
TOTAL COSTS high premium	$4,543	$5,176		$9,661				

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
MINNESOTA—HENNEPIN COUNTY

	MEDIGAP				HMOs			NONE
	A	F	H	J	HEALTH-PARTNERS	MEDICA	UCARE MINNESOTA	
Premiums: low high	$686 1,735	$1,121 2468	none	$3,486 8,074	$912	$1,194	$432	$0
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	3,574	3,574	3,574	3,574
acute episodes	68	68	68	34	68	68	68	68
Emergency room visits	0	0	0	0	0	25	0	160
Hospital admissions	2,328	0	0	0	0	300	450	2,328
Physician visits	100	0	100	0	160	160	160	404
Specialist visits	115	115	115	115	80	195	230	334
Medical devices or equipment	2,347	2,347	2,347	2,347	1,671	1,755	2,395	2,395
Other health services	0	0	0	0	0	400	0	1,305
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$5,553	$6,477	$6,877	$10,568
TOTAL COSTS low premium	$9,218	$7,225	none	$7,894	$6,,465	$7,671	$7,309	$10,568
TOTAL COSTS high premium	$10,267	$8,572		$12,482				

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
NEW HAMPSHIRE—HILLSBOROUGH COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	HARVARD PILGRIM HEALTH CARE OF N.E.	
Premiums: low	$432	$828	$996	$1,680	$780	$0
high	1,788	2,448	2,856	3,264		
Prescription costs: chronic conditions	2,499	2,499	1,375	1,375	2,199	2,499
acute episodes	121	121	60	60	121	121
Emergency room visits	0	0	0	0	0	370
Hospital admissions	2,328	0	0	0	0	2,328
Physician visits	100	0	100	0	60	317
Specialist visits	0	0	0	0	20	94
Medical devices or equipment	0	0	0	0	0	624
Other health services	6,010	6,010	6,010	6,010	6,010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$8,410	$12,363
TOTAL COSTS low premium	$11,490	$9,458	$8,541	$9,125	$9,190	$12,363
TOTAL COSTS high premium	$12,846	$11,078	$10,401	$10,709		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
NEW HAMPSHIRE—HILLSBOROUGH COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	HARVARD PILGRIM HEALTH CARE OF N.E.	
Premiums: low	$432	$828	$996	$1,680	$780	$0
high	1,044	2,016	1,812	1,968		
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	104	2,404
acute episodes	89	89	45	45	89	89
Emergency room visits	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0
Physician visits	100	0	100	0	25	157
Specialist visits	115	115	115	115	125	147
Medical devices or equipment	100	100	100	100	0	100
Other health services	0	0	0	0	0	39
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$343	$2,936
TOTAL COSTS low premium	$3,240	$3,536	$2,683	$3,267	$1,123	$2,936
TOTAL COSTS high premium	$3,852	$4,724	$3,499	$3,555		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
NEW HAMPSHIRE—HILLSBOROUGH COUNTY

	MEDIGAP				HMOs	NONE
	A	F	H	J	HARVARD PILGRIM HEALTH CARE OF N.E.	
Premiums: low	$732	$1,356	$1,812	$1,968	$780	$0
high	1,668	2,712	2,856	3,456		
Prescription costs: chronic conditions	3,574	3,574	2,324	1912	2,274	3,574
acute episodes	68	68	68	34	68	68
Emergency room visits	0	0	0	0	0	160
Hospital admissions	2,328	0	0	0	0	2,328
Physician visits	100	0	100	0	80	415
Specialist visits	115	115	115	115	210	339
Medical devices or equipment	2,347	2,347	2,347	2,347	2,247	2,395
Other health services	0	0	0	0	200	1,315
SUM of non-premium costs	$8,532	$6,104	$4954	$4,408	$5,079	$10,594
TOTAL COSTS low premium	$9,264	$7,460	$6,766	$6,376	$5,859	$10,594
TOTAL COSTS high premium	$10,200	$8,816	$7,810	$7,864		

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Male with Disabilities, Age 50
WASHINGTON—KING COUNTY

	MEDIGAP				HMOs		NONE
	A	F	H	J	GROUP HEALTH COOPERATIVE OF PUGET SOUND	PACIFICARE OF WASHINGTON	
Premiums: low	$804	$1,368	$1,896	$2,412	$648	$360	$0
high	1,476	2,592		3,552			
Prescription costs: chronic conditions	2,499	24,99	1,375	1,375	2,499	2,499	2,499
acute episodes	121	121	60	60	121	121	121
Emergency room visits	0	0	0	0	50	200	370
Hospital admissions	2,328	0	0	0	0	0	2,328
Physician visits	100	0	100	0	60	120	324
Specialist visits	0	0	0	0	20	40	97
Medical devices or equipment	0	0	0	0	0	0	612
Other health services	6,010	6,010	6,010	6,010	6,010	6,010	6,010
SUM of non-premium costs	$11,058	$8,630	$7,545	$7,445	$87,60	$8,990	$12,361
TOTAL COSTS low premium	$11,862	$9,998	$9,441	$9,857	$9,408	$9,350	$1,261
TOTAL COSTS high premium	$12,534	$11,222		$10,997			

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Healthy Female, Age 65
WASHINGTON—KING COUNTY

	MEDIGAP				HMOs		NONE
	A	F	H	J	GROUP HEALTH COOPERATIVE OF PUGET SOUND	PACIFICARE OF WASHINGTON	
Premiums: low	$528	$1,008	$1,836	$2,448	$648	$360	$0
high	1,116	2,484	3,372	3,396			
Prescription costs: chronic conditions	2,404	2,404	1,327	1,327	2,404	2,404	2,404
acute episodes	89	89	45	45	89	89	89
Emergency room visits	0	0	0	0	0	0	0
Hospital admissions	0	0	0	0	0	0	0
Physician visits	100	0	100	0	25	50	158
Specialist visits	115	115	115	115	80	95	148
Medical devices or equipment	100	100	100	100	0	0	100
Other health services	0	0	0	0	0	0	40
SUM of non-premium costs	$2,808	$2,708	$1,687	$1,587	$2,598	$2,638	$2,939
TOTAL COSTS low premium	$3,336	$3,716	$3,523	$4,035	$3,246	$2,998	$2,939
TOTAL COSTS high premium	$3,924	$5,192	$5,059	$4,983			

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

Health Care Costs by Type of Coverage (in dollars) Frail Female, Age 80
WASHINGTON—KING COUNTY

	MEDIGAP				HMOs		NONE
	A	F	H	J	GROUP HEALTH COOPERATIVE OF PUGET SOUND	PACIFICARE OF WASHINGTON	
Premiums: low	$528	$1,008	$1,836	$2,448	$648	$360	$0
high	1,116	2,484	3,372	3,396			
Prescription costs: chronic conditions	3,574	3,574	2,324	1,912	3,574	3,574	3,574
acute episodes	68	68	68	34	68	68	68
Emergency room visits	0	0	0	0	0	150	160
Hospital admissions	2,328	0	0	0	0	0	2,328
Physician visits	100	0	100	0	80	160	425
Specialist visits	115	115	115	115	165	205	344
Medical devices or equipment	2,347	2,347	2,347	2,347	2,347	2,347	2,398
Other health services	0	0	0	0	200	400	1,320
SUM of non-premium costs	$8,532	$6,104	$4,954	$4,408	$6,434	$6,904	$10,617
TOTAL COSTS low premium	$9,060	$7,112	$6,790	$6,856	$7,082	$7,264	$10,617
TOTAL COSTS high premium	$9,648	$8,588	$8,326	$7,804			

SOURCE: Snyder R, Rice T, Kitchman M. *Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare.* January 2003.

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ENDNOTES

1 Since that time, enrollment in M+C has fallen as low as 13 percent (CMS, 2002).

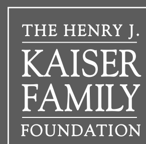
2 Health care service utilization patterns for each of the prototypes were developed with a team of physicians from the UCLA School of Medicine and the Centers for Medicare and Medicaid Services, all of whom have expertise in the diagnosis and treatment of geriatric populations and individuals with disabilities. However, the prototypes are limited to the practice experiences of the health care professionals with whom we consulted and may not be representative.

3 Estimates for the following services are region-specific: Medicare-covered physician and specialist visits, Medicare-covered durable medical equipment, mammograms, bone mass measurement, colorectal screenings, and x-rays (including EKGs). Region is determined by state according to the Centers for Medicare and Medicaid Services regulations, and in the case of some states, is further divided into substate areas.

4 Premiums also depend on how a Medigap policy is age-rated. They can be "community rated," where all policyholders in a geographic area are charged the same amount; "issue-age rated," where premiums are based on the age at initial purchase; or "attained-age" rated, where premiums rise as beneficiaries age. In this study, there is no ambiguity in premiums when premiums are community rated or attained-age rated. Under community rating, everyone is charged the same amount, so the premium comparison guide rates will apply to all ages. Under attained-age rating, rates are specific to particular ages, and thus, premiums should be the same whether a person renews a policy at age 80 or purchases one new at that age. (Note that open enrollment provisions do not apply after the initial six-month open enrollment period so a frail 80-year old might not be offered coverage. For purposes of this study, however, we assume that the person will not be denied coverage.) In contrast, when a policy is issue-age rated, premiums will differ depending on whether a person is renewing a policy purchased earlier, vs. purchasing the policy for the first time. Since we are examining the implications of choice, we use the premiums that apply to a new purchase rather than a renewal. Finding the appropriate premium for an 80-year old sometimes involved contacting carriers directly, as discussed in Appendix II. Of the eight study states, Minnesota and Washington require that all Medigap policies be community rated, and Florida requires issue-age rating. In other states carriers can choose; most choose attained-age rating.

5 Note that not all plans are available in all areas. For instance, there is no M+C HMO available in Dodge City, KS, and only one in Baltimore, MD and Manchester, NH. In addition, the selection of Medigap plans may be limited in some geographic areas, especially for disabled beneficiaries to whom carriers are not mandated to extend their Medigap offerings in most states. There was only one carrier offering coverage to Medicare disabled beneficiaries for the following cities and plans respectively: Oakland, CA plan J; Baltimore, MD plans F, H, and J; Chicago, IL plans A and F (and no offerings of H and J); Miami, FL plans H and J; Seattle, WA plan H. In Minneapolis, MN, there is no plan corresponding to plan H for any beneficiary.

6 A "benefit period" begins the day a beneficiary goes to the hospital or skilled nursing facility and ends when she has not received hospital or skilled nursing care for 60 days in a row.



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