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**REPORT TO THE CONGRESS**

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# Assessing Medicare Benefits

**MEDPAC** Medicare  
Payment Advisory  
Commission

# MEDPAC

Medicare  
Payment Advisory  
Commission

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission’s statutory mandate is quite broad: In addition to advising the Congress on payments to health plans participating in the Medicare+Choice program and providers in Medicare’s traditional fee-for-service program, MedPAC also is tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, public health, or medicine.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at [www.medpac.gov](http://www.medpac.gov).) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlet for Commission recommendations. This report is devoted to assessing the Medicare benefit package. Annual reports each March focus on payment policy. In addition to these reports and others on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

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## Preface

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If, as many have argued, Medicare's destiny will be shaped by demography and technology, then it is critically important that the program function as efficiently as possible over the coming decades. The number of Medicare beneficiaries will nearly double over the next 30 years, while the number of workers supporting each Medicare beneficiary will decrease from four to just over two. Advances in medical science will continue to increase the numbers of diagnostic tools and therapies available, as well as the number of people who can benefit from their use. As these factors drive up program costs, Medicare will absorb an ever-increasing share of the gross domestic product and the federal budget.

For the Medicare program to ensure that the elderly and disabled continue to have access to affordable high-quality health care in the future, crucial decisions will have to be made on how to finance and possibly reform or restructure the program. The benefit design—what services the program pays for, under what circumstances, and how costs are shared with the beneficiaries—will be an important aspect of those decisions. In particular, it will be essential to understand the role of the benefit design in impeding or meeting the program's twin goals of ensuring beneficiaries' access to high-quality health care and protecting them from ruinous health care costs. We think valuable lessons can be learned from analyzing the successes and failures of the current program that stem from its benefit design, and that those lessons can help inform program choices in the future. We need to understand which aspects of the benefit design impede getting the most for the resources put into the program, and whether restructuring the benefit design (for example, changing cost sharing or including other services such as prescription drugs, or services to promote health or prevent disease) could help achieve more with the same resources. This understanding is essential whether the program continues in its current, primarily government purchased fee-for-service form or takes on new forms in the future, such as market-based competition among private health plans.

This report does not attempt to answer the question of how much of the nation's income should be spent on health care for Medicare beneficiaries, nor whether health care services for the elderly and disabled should be delivered through government, the private sector, or some combination. Rather, it tries to help us learn how well the current benefit design is working and whether a different design using equivalent resources could better meet the program's goals. Understanding the role of the benefit design in program efficiency will be essential as policymakers guide the program through the challenging times ahead.



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## **Executive summary**

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## Executive summary

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The health care benefits that Medicare provides to its beneficiaries have made a tremendous difference in their lives, their access to health care, and their financial security. Paying for those benefits as the baby boom generation enters into the program, and as technology affords ever more therapies to a broadening range of patients, will represent a major challenge to the nation. But Medicare spending by itself is only part of the story. In addition to \$260 billion Medicare will spend in 2002 on health care for its beneficiaries, those beneficiaries, their former employers, the Medicaid program, and others will spend over \$180 billion. Making the most efficient use of the massive resources that are being spent and will be spent in the future for the health care of Medicare beneficiaries is crucial, particularly as the program expands to cover nearly twice the number of beneficiaries, absorbs a larger part of the national budget, and accounts for a larger portion of the gross domestic product over the next several decades.

What is (and what is not) in the Medicare benefit package and how beneficiaries respond to it determines, in part, how efficiently the overall resources devoted to beneficiary health care are used. The benefit design determines what services the program pays for, under what circumstances, and how the costs of those services are shared with beneficiaries. Those design features affect the quantity and mix of services that beneficiaries use. They can also drive beneficiaries to seek additional coverage if key services are not covered or cost sharing is felt to be too onerous. The design of the additional coverage, in turn, further affects how many and which services beneficiaries use. Currently, many beneficiaries receive additional coverage that provides them with a more comprehensive benefit package than Medicare alone. But having multiple insurers adds administrative costs, and the combination of benefits purchased may weaken incentives for appropriate use of health care.

We examine several illustrative changes to the Medicare benefit design that could provide better access to care and financial protection to beneficiaries without increasing the overall resources devoted to their health care. First, improvements could be made in the cost-sharing structure of the program that would improve access to care, financial protection and efficient use of care. These changes could be made without significantly increasing the cost of the Medicare program. Second, benefits for important services such as prescription drugs could be added that would make the Medicare benefit package more comprehensive. Depending on how demand for supplemental coverage changes, the benefit package could be expanded in such a way that total resources devoted to beneficiary health care do not increase. Although Medicare spending itself would increase and there would be major shifts in the supplemental insurance market, more beneficiaries could enjoy better benefits because the system as a whole would be more efficient.

A comprehensive benefit package could be provided directly by the government or through private sector entities under, for example, a premium support approach or through expansion of the Medicare+Choice program. An efficient benefit design is essential in any case, either to sustain the current Medicare program or to provide a viable basis for market competition. We do not address the question of how best to provide Medicare benefits in this report. Further, we do not project spending into the future to illustrate how the inevitable confluence of demographics and technology will make paying for the health care of Medicare beneficiaries an incredible challenge for the nation's political process. Rather, we have limited this report to a discussion of how changing Medicare's benefit design could improve the lives of beneficiaries by providing more comprehensive benefits in a more rational structure that would lead to more efficient health care for the Medicare population. An improved benefit design could provide a better foundation for examining how Medicare's benefits should be financed and delivered as the aging of the baby boomers resounds over the coming decades.

## **Assessing the need for change**

By many measures, Medicare has been successful in meeting its goals of ensuring its beneficiaries access to care and financial protection from the cost of serious illness. However, demographic trends and technological advances will put increasing pressure on Medicare in the coming decades. In Chapter 1, we assess Medicare’s successes and some of its limitations. Nearly all people 65 years of age or older now have health insurance and access to essentially the same standard of medical care as the employed, insured population enjoys. Greater access to treatments and improved technology have reduced disability and contributed to longer life spans—and beneficiaries’ support for the program is overwhelming. Nevertheless, the benefit package reflects its origin as an acute-care, service-specific program, and the scope and structure of coverage may limit Medicare’s ability to meet its goals efficiently. Some beneficiaries remain at risk for large out-of-pocket expenses and attempts to defray those expenses through purchase of supplemental insurance do not fully protect them and may reduce overall program efficiency.

## **Coverage beyond the basic benefit package**

Over 90 percent of Medicare beneficiaries have coverage that supplements Medicare’s fee-for-service benefit package. In Chapter 2, we consider what this means for changes to Medicare’s benefit design. First, total spending on health care for beneficiaries is much greater than Medicare spending alone (about \$180 billion more in 2002). Second, beneficiaries’ use of health care may be influenced by their supplemental coverage, because supplements provide differing degrees of coverage for different services. Third, the overall efficiency of health care for Medicare beneficiaries is affected by supplemental coverage. Supplemental policies frequently pay beneficiaries’ cost sharing for Medicare-covered services and therefore may increase use of some services. If those services are necessary and are being underused, an increase in service use could be beneficial. On the other hand, if the services are not necessary, an increase in use could be detrimental. Also, supplemental policies require claims to be settled twice (once by Medicare and once by the supplemental insurer) and incur other expenses (such as marketing), increasing spending on administration. Finally, because some sources of additional coverage have become less common as employers cut back on retiree health care coverage and as Medicare+Choice enrollment has declined, more beneficiaries may be exposed to the limitations of the current Medicare benefit package in the future.

## **Options for changing the benefit package**

Chapter 3 examines options for addressing some of the limitations in Medicare’s benefit package. First, we look at options for modifying Medicare’s cost-sharing structure by reducing disparities in deductibles and coinsurance among services and adding protection from catastrophic expenses. Such changes could improve access to care and financial protection for beneficiaries without significantly raising Medicare spending—but would leave certain key services uncovered. Next, we look at options for expanding the benefit package to cover those key services—prescription drugs, mental health, case and disease management, preventive, vision, hearing, and dental. Although adding benefits in those areas would raise Medicare spending, spending by other payers would fall. Finally, we examine options that replace the current benefit package with a more comprehensive one that includes drug coverage and a cap on cost-sharing liability. A more comprehensive package could be designed that would increase access to care, financial protection for beneficiaries, and overall efficiency without increasing total spending on beneficiaries’ health care, but it would substantially alter existing markets and pose significant operational challenges. Our analysis shows that changing Medicare’s benefit design could improve beneficiaries’ access to health care regardless of the level of resources made available. ■

CHAPTER

1

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**Assessing the need for change**

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## Assessing the need for change

**M**edicare has provided millions of people with access to acute medical care, extending beneficiaries' lives while improving their health status and quality of life. Medicare's payments to health care providers also have financed substantial growth in the nation's health care capacity, the adoption of new technologies, and other improvements in medical practice. Ongoing changes in the demographic characteristics of the enrolled population, medical technology, and care delivery, however, have magnified the importance of limitations in Medicare's benefit design, such as its uneven cost sharing provisions, omission of coverage for outpatient prescription drugs, and lack of incentives for care coordination and management. Medicare beneficiaries who have not obtained additional insurance now face financial incentives to avoid certain products, services, and settings for care and are exposed to the risk of potentially high out-of-pocket spending in the event of serious injury or illness. Most beneficiaries obtain some type of supplemental coverage, but coverage is often costly and in many instances only partly effective in addressing the limitations of Medicare's benefit package. As a result, many who have supplemental coverage still face large financial risks for health care products and services that Medicare does not cover and incentives that may dissuade them from using the most clinically appropriate care. Moreover, demographic trends and continuing rapid changes in technology are likely to exacerbate these problems.

### In this chapter

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- Medicare's benefit design
  - Do Medicare's benefits ensure access to care and financial protection?
  - Do Medicare's benefits promote efficient care delivery?
  - Conclusion
-

The Congress created Medicare in 1965 to ensure that people age 65 and older—and later those who are disabled or have end-stage renal disease—would have access to affordable health care. Before Medicare’s enactment, many elderly people faced serious financial barriers to obtaining needed health services. Hospital care, for example, was becoming prohibitively expensive. Among elderly couples in which one member had a hospital stay, 20 percent incurred long-term debt to pay the hospital bill (U.S. Congress 1964). People without health insurance were significantly less likely to be hospitalized than those with insurance. At the same time, insurance was costly or unavailable for many elderly people. The average cost of private health insurance was estimated to be 13–20 percent of elderly couples’ median incomes (National Academy of Social Insurance 1999). Only about one-half of all people age 65 or older had health insurance; the proportion was less than one-third for people over age 75 and those with chronic conditions (U.S. Congress 1964). Moreover, many insurance policies available to the elderly provided only limited coverage, were expensive, or both (Blumenthal et al. 1988).

Medicare’s benefits were intended to ensure beneficiaries’ access to the same types of medical care then available to working Americans through employer-sponsored health insurance. Access to health care and financial protection from the costs of illness were, and remain, intertwined policy goals. Medicare accomplished both goals by providing beneficiaries with covered benefits similar to those offered in traditional health insurance, which reduced their costs of using covered services and helped insulate them and their families from the risk of impoverishment associated with serious illness or injury.

Medicare’s benefit structure, however, also reflects policymakers’ decisions about how to balance access to care and

financial protection for beneficiaries on the one hand against the financial burden on taxpayers and beneficiaries on the other. Efficiency—meeting Medicare’s goals for financial protection and access to care without imposing unnecessary burdens on the beneficiaries and taxpayers who finance program benefits—has always been an important third goal. Thus, the concept of efficiency is critical to assessing Medicare’s benefit design: To what extent does the current benefit structure—the services that are covered, and the portion of their cost Medicare pays—promote access to high-quality, clinically appropriate health care at the lowest cost?

Total spending in 2002 for health care services—other than long-term care—on behalf of Medicare beneficiaries will amount to \$446 billion. Medicare program spending for benefits and administration will account for about \$262 billion or roughly three-fifths of the total; the rest will come from other public or private third-party payers through supplemental insurance or other coverage and from beneficiaries’ direct spending for health services and supplies.<sup>1</sup>

In this report, the Medicare Payment Advisory Commission (MedPAC) examines how well Medicare’s benefit design has worked in meeting policymakers’ goals; how changes in the population, medical technology and practice, and private insurance may affect Medicare’s performance in coming years; and options policymakers might consider to improve program performance in the future. We make no recommendations.

We begin this chapter by describing Medicare’s benefit design and how its covered benefits have changed over time. Next we look at trends in medical technology and care delivery and in the beneficiary population that are likely to foster continuing rapid growth in the number of beneficiaries and health care spending per person, thereby making efficient service production and use ever

more important. Finally, we examine how Medicare’s benefit design coupled with the additional insurance coverage most beneficiaries obtain has affected their access to care, out-of-pocket spending, and incentives to use services judiciously. Chapter 2 then considers how beneficiaries get additional coverage and emerging changes in the sources of coverage that may affect beneficiaries’ abilities to address limitations in Medicare’s benefit design in the future.

Chapter 3 illustrates a range of options that policymakers might consider in thinking about changing Medicare’s benefit package. Options include changes in Medicare’s cost-sharing provisions, incremental additions to the benefit package, and more extensive reforms that would create a more comprehensive benefit package. We assess these options based on how they might affect Medicare’s performance in ensuring beneficiaries’ access to care, financial protection, and efficiency in using health care resources. Some options are designed to accommodate the scarcity of federal budget resources and could be implemented in ways that would hold program spending at about the level that would be expected under current law. These options address the question: “Could changes in Medicare’s benefit structure improve beneficiaries’ access to appropriate care and financial security without increasing Medicare program costs?” Other options might substantially increase program spending although total spending from all sources for health care services on beneficiaries’ behalf would remain unchanged. These options address the question: “Could structural changes to Medicare’s benefits improve beneficiaries’ access to care and financial security without increasing total health care spending?”

In examining the strengths and limitations of Medicare’s benefits and potential improvements, we separate questions of benefit design from the closely related

1 Our estimate of calendar year 2002 program spending was produced by the Actuarial Research Corporation based on projections from the 2002 Annual Reports of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds. Compared with our estimate, the Congressional Budget Office has estimated lower total program spending of \$248 billion for fiscal year 2002 (Crippen 2002).

issues of payment policy and program financing. Although the latter issues are of great importance, we do not address them in this report.

Because the vast majority of beneficiaries are enrolled in the traditional fee-for-service program, we rely heavily on their experience in evaluating how Medicare's benefits have performed in ensuring access to care and financial protection. We do not address the important question of how a revised benefit package might be delivered to beneficiaries—whether through a single government-operated Medicare program, privately-owned insurance plans, or some marriage of the two. Regardless of which direction Medicare reform might take, benefit revisions would be equally necessary to promote efficient use of health care services.

## Medicare's benefit design

The Medicare benefit package is generally limited to acute care services that are needed for the diagnosis or treatment of illness or injury.<sup>2</sup> Medicare beneficiaries may receive covered services in the traditional program or they may enroll in a private health insurance plan under the Medicare+Choice (M+C) program. Traditional Medicare covers health care services—furnished on a fee-for-service basis—through its two parts, the Hospital Insurance and Supplementary Medical Insurance programs, known as Parts A and B, respectively (Table 1-1). People who receive Social Security cash benefits on the basis of age or disability are automatically entitled to Part A benefits, including hospitalization, short-term care in skilled nursing facilities, post-institutional home care, and hospice services.<sup>3</sup> Part B enrollment is voluntary, although the vast majority of beneficiaries choose to enroll and pay a monthly

**TABLE  
1-1**

## Medicare benefits and cost-sharing requirements, 2002

Services	Beneficiary cost sharing
<b>Part A</b>	
Inpatient hospital (up to 90 days per benefit period plus 60 lifetime reserve days)	\$812 for the first stay in a benefit period Days 1–60: fully covered Days 61–90: \$203 per day 60 lifetime reserve days: \$406 per day
Skilled nursing facility (up to 100 days per benefit period)	Days 1–20: fully covered Days 21–100: \$101.50 per day
Hospice care for terminally ill beneficiaries	Nominal coinsurance for drugs and respite care
<b>Part B</b>	
Premium	\$54 per month
Deductible	\$100 annually
Physician and other medical services (including supplies, durable medical equipment, and physical and speech therapy)	20 percent of Medicare-approved amount
Outpatient hospital care	20 percent of 1996 national median charge updated to 2000
Ambulatory surgical services	20 percent of Medicare-approved amount
Laboratory services	None
Outpatient mental health services	50 percent of Medicare-approved amount
Preventive services	20 percent of Medicare-approved amount (none for Pap smear, pneumococcal vaccine, flu shot, prostate specific antigen (PSA) test)
<b>Both Part A and B</b>	
Home health care for homebound beneficiaries needing skilled care	None

Note: These benefits and cost-sharing requirements apply to traditional Medicare. Medicare+Choice plans can deviate from these requirements, but they must cover the same services, cost sharing cannot be higher on average, and the Centers for Medicare & Medicaid Services must approve each plan's cost-sharing and benefit package. A benefit period is defined as beginning when a patient is admitted to the hospital for inpatient care and ending when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days.

Source: Centers for Medicare & Medicaid Services 2002.

2 Section 1862(a)(1)(A) of the Social Security Act prohibits Medicare payment for items or services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

3 People who have end-stage renal disease (kidney failure), receive Railroad Retirement benefits, or have worked more than a minimum period in Medicare-covered employment also are automatically entitled to Part A benefits; others may obtain coverage by paying a monthly premium. Part A entitlement normally begins after a 24-month waiting period for those who receive cash benefits based on disability.

premium (\$54 in 2002). Part B covers physicians' and other practitioners' services, outpatient hospital and other outpatient facility services, home care not covered under Part A, and a variety of other services, such as diagnostic tests, durable medical equipment, ambulance services, and limited preventive services.

Under the M+C program (Part C), beneficiaries living in certain areas may receive Medicare benefits by enrolling with participating private plans, such as health maintenance organizations or preferred provider organizations. Private plans must cover the same services covered in the traditional program, but the cost-sharing requirements may differ as long as they are at least actuarially equivalent—the average projected cost-sharing liability per person must be the same or smaller. Beneficiaries who enroll in M+C plans also may receive other benefits, such as reduced cost-sharing requirements or some coverage for outpatient prescription drugs or other products and services not covered by traditional Medicare.

Medicare benefits are financed primarily by payroll taxes, general tax revenues, and beneficiary premiums. In addition, beneficiaries are responsible for paying a portion of the cost for most covered services in the form of deductibles and coinsurance.

## Evolution of the benefit package

Although the basic benefit design has remained essentially unchanged since Medicare's inception, its covered benefits have been revised repeatedly through legislation, regulatory interpretations, judicial decisions, and coverage determinations by the Centers for Medicare & Medicaid Services (CMS) and its contractors. These revisions have substantially expanded Medicare's covered services, adding new technologies

and procedures, more post-acute care, and other benefits such as selected preventive services and hospice care for those at the end of life. However, the traditional program has never covered some important health care products and services.

## Adding new technologies and procedures

Over the past 35 years, CMS and its contractors have routinely expanded Medicare's covered benefits by reviewing and approving thousands of requests for coverage of new diagnostic and therapeutic technologies and procedures. Although some coverage decisions are made through a formal rule-making process, most are made by fiscal intermediaries and carriers, Medicare's contractors for claims processing (Strongin 2001). Prominent coverage additions have included:

- major surgical procedures, such as coronary artery bypass surgery, kidney, heart, and lung transplants, and knee and hip replacements, and
- less invasive diagnostic tests and procedures that can now be performed in outpatient settings, such as computed tomography and magnetic resonance imaging scans, ocular lens implants, arthroscopic procedures to repair injury and restore physical function, and laparoscopic procedures, which have replaced many invasive abdominal procedures.

These coverage expansions have enabled a growing number of Medicare beneficiaries, including the oldest and most frail, to have access to many of the improvements in care made available by advances in medical science and technology.

## Expanding post-acute care

Medicare's benefits also reflect a major expansion of coverage for post-acute care services, especially home health services and care in skilled nursing facilities (SNFs).<sup>4</sup> Initially, beneficiaries were required to have a three-day hospital stay before becoming eligible for home health services and they were limited to 100 visits per year. The Omnibus Budget Reconciliation Act of 1980 removed these restrictions. The home health benefit was further expanded in the late 1980s in *Duggan v. Bowen*, which challenged CMS restrictions on eligibility. This decision redefined "part-time and intermittent" care, making more people eligible for home health care and enabling those eligible to receive more services. To be eligible for home care now, beneficiaries must be homebound—unable to leave their homes frequently or for extended periods of time—and must need skilled care on a part-time or intermittent basis. Once these criteria are met, however, beneficiaries can receive skilled nursing, therapy, medical social, and aide services without limit.

In part because of these changes, the proportion of beneficiaries using home care rose from 4.9 percent in 1988 to 9.2 percent in 1995 (Kenney and Moon 1997). During the same period, the annual number of visits per user increased from 24 to 80, largely reflecting growth in visits among those needing care for extended periods. For example, beneficiaries with more than 200 visits per year accounted for 60 percent of the growth in home health spending between 1991 and 1994 (Feder et al. 2000).<sup>5</sup>

Although Medicare's coverage of SNF care is explicitly limited, its role in financing nursing home care has grown. SNF care is only covered after a three-day hospital stay, beneficiaries must demonstrate improvement in functional status to continue receiving benefits, and

4 Although Medicare does not cover long-term or custodial care, some post-acute care benefits—such as home health and skilled nursing facility services—are used by patients who have both post-acute and long-term care needs, raising difficult questions about when covered acute care stops and long-term care begins.

5 Recent changes in payment policy may have altered these trends. In 2000, CMS implemented a per episode prospective payment system for home health care that gives providers financial incentives to limit the quantity and cost of services furnished during a 60-day episode of care. Beneficiaries still may receive multiple treatment episodes, however, as long as they meet the eligibility criteria.



coverage is limited to 100 days per benefit period.<sup>6</sup> For most beneficiaries, a SNF stay allows additional recuperative time before they return home. However, about 30 percent of beneficiaries in SNFs continue to stay in a nursing facility after they exhaust the Medicare benefit. In 1995, Medicare financed 13 percent of nursing home care, compared with just 2 percent in 1985. Medicare's expanded role reflects growth in the volume of covered SNF stays and changes in the types of people using SNF care. By 1995, more SNF stays were for relatively short, post-hospital care and people using SNF services were older, on average, than in the past (Feder et al. 2000).

### Adding other benefits

The Congress has expanded Medicare benefits in other important ways. Adding entitlement in 1972 for people under age 65 who have end-stage renal disease (ESRD) expanded benefits to include long-term kidney dialysis and kidney transplants.<sup>7</sup> The Congress first added preventive services in 1980, beginning with coverage of the pneumococcal pneumonia vaccine; a number of other preventive services were added in the Balanced Budget Act of 1997 (see Appendix A). The hospice care benefit was added in 1982 and coverage for certain oral anti-cancer drugs was added in 1993. The Congress also expanded coverage for mental health services in the late 1980s, lifting a cap on annual payments per beneficiary for these services and allowing social workers and psychologists to receive Medicare payment for covered services. Coverage for partial hospitalization for mental health care was expanded to include services provided in community mental health centers in 1990, although patients must meet restrictive criteria to receive this benefit.

## Assessing Medicare's benefit design

Our objective in assessing Medicare's benefit design is to determine the extent to which the scope and structure of covered benefits have affected the program's ability to meet its goals thus far and might affect program performance in the future. Changes in technology and medical practice and in the beneficiary population are likely to present significant challenges in coming decades by altering:

- the kinds of services available,
- the settings in which services can be furnished,
- the kinds of patients likely to benefit from them, and
- the nature of beneficiaries' medical care needs.

After briefly reviewing how changes in science and technology may affect the Medicare program and its beneficiaries, we examine important trends in the make-up of the beneficiary population. Against this backdrop, we provide an overview of the types of medical care products and services for which Medicare does not pay and how these omissions may affect beneficiaries' access to care and out-of-pocket spending.

### Changes in medical technology and practice

It is difficult to overemphasize the role advances in science and technology have played in expanding medical capabilities and changing the number of beneficiaries able to benefit from them, the volume of services used, and the settings in which services are furnished.<sup>8</sup> Some new technologies have replaced older, less effective ones, while others have represented entirely new products and services. In many instances, both kinds of

improvements have changed the way health care is delivered by allowing serious conditions to be managed outside of the hospital. Outpatient treatment generally costs less per treatment than inpatient care. Nonetheless, many new technologies have raised total spending by making it possible to treat more beneficiaries, including many who previously were too frail or ill to be suitable candidates.

Some advances that have added new services—heart, heart-lung, bone marrow and kidney transplants, for instance—have been extremely expensive, involving hospital stays that cost tens of thousands or even hundreds of thousands of dollars. In many cases, these new technologies—transplants are again a good example, as is cardiac care—have created new demands for ongoing ambulatory maintenance care, often involving costly pharmaceuticals and lengthy rehabilitation therapy.

The shift of care from inpatient to ambulatory settings and the rapid growth in ambulatory service volume also have raised the relative importance of Medicare's coverage for products and services that are key inputs to ambulatory care. Important inputs include physician services, hospital outpatient care, and outpatient prescription drugs.

Other new technologies may eventually reduce spending for Medicare and its beneficiaries. For example, cataract surgery is less invasive, safer, and less expensive than it was two decades ago (Shapiro et al. 1999). Some new technologies also can prevent complications or deterioration in function, leading to a reduced need for acute care services over time.

Forecasting the effects of future advances in technology is always speculative. Nevertheless, it is reasonable to assume that future rates of innovation will be at

<sup>6</sup> Benefit periods begin when patients are admitted to the hospital for inpatient care and end when they have been out of the hospital or a skilled nursing facility for 60 consecutive days.

<sup>7</sup> ESRD is a chronic illness that entails permanent kidney failure. Patients who have this illness will die if they do not receive ongoing kidney dialysis or a kidney transplant.

<sup>8</sup> Chernew et al. have provided a useful overview of research describing the relationship between technology and cost growth (Chernew et al. 1998).

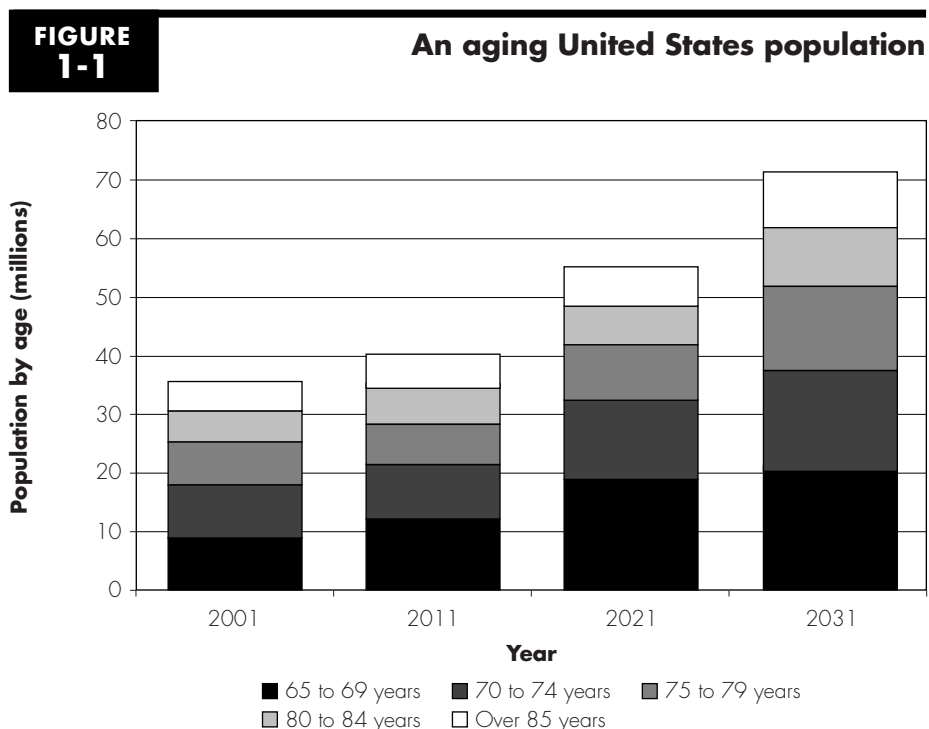
least as rapid as those of recent years. In addition, the relative importance of ambulatory care and new pharmaceutical agents in treatment and spending probably will continue to increase. These trends would only heighten the importance of the limitations in Medicare's benefit design.

### Population trends

Several strong demographic trends will likely raise total spending for care and change the composition of future service demand, giving policymakers further reason to focus attention on Medicare's benefit design. One trend is the increase in the Medicare population; another is the increase in the oldest part of that population. In addition, the under-65 disabled Medicare population has been increasing rapidly, while the rate of disability among the elderly has been decreasing—a trend with potentially important ramifications for the program.

The older population in America is growing rapidly—a trend expected to continue for at least the next three decades as the baby boom generation ages (Figure 1-1).<sup>9</sup> Today, one in eight Americans is over the age of 65. In 2030, the over-65 population will have doubled, reaching 70 million people or about 20 percent of the total population.

The over-65 population is also living longer; a person reaching the age of 65 in 2000 can expect to live almost four years longer than someone who reached 65 in 1960. Life expectancy for men at age 65 is now over 16 years; for women, it is over 19 years. In fact, the fastest-growing segment of the older population is those 85 or older: This group now numbers over 4.2 million and it is expected to reach nearly 9 million by 2030. This trend could lead to a significant increase in the demand for nursing homes or other sources of long-term care (Health Care



Source: Projections of the resident population by age, sex, and Hispanic origin: 1999 to 2100, U.S. Census Bureau, Washington, D.C.

Financing Administration 1998). Although only about 11 persons per thousand age 65 to 75 live in nursing homes, the rate is more than 190 per thousand for those over age 85 (National Center for Health Statistics 1999).

The effects of these changes on the burden of illness among beneficiaries and spending for health care will depend on the complex interactions of several trends. As people live longer, they are more likely to develop chronic diseases and conditions. Between 1984 and 1995, the prevalence of arthritis, heart disease, cancer, diabetes, and stroke all increased among people age 70 or older (Figure 1-2). Among the elderly, the most common illnesses are arthritis, hypertension (high blood pressure) and heart disease, while the most common impairments are hearing, orthopedic, and

visual. According to one estimate, nearly 90 percent of beneficiaries cope with at least one chronic condition and 70 percent cope with more than one (Hoffman et al. 1996).<sup>10</sup>

The impact of chronic conditions on beneficiaries' health and functional status varies, however. For some, chronic conditions require more attention, but are not particularly restrictive; for others they are debilitating, resulting in functional limitations as measured by limitations in activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs).<sup>11</sup> Over time, we would expect spending for care to increase because chronic conditions often progress and many people who are able to cope with their chronic conditions will later in life be in greater need of assistance with daily activities and require more medical care.

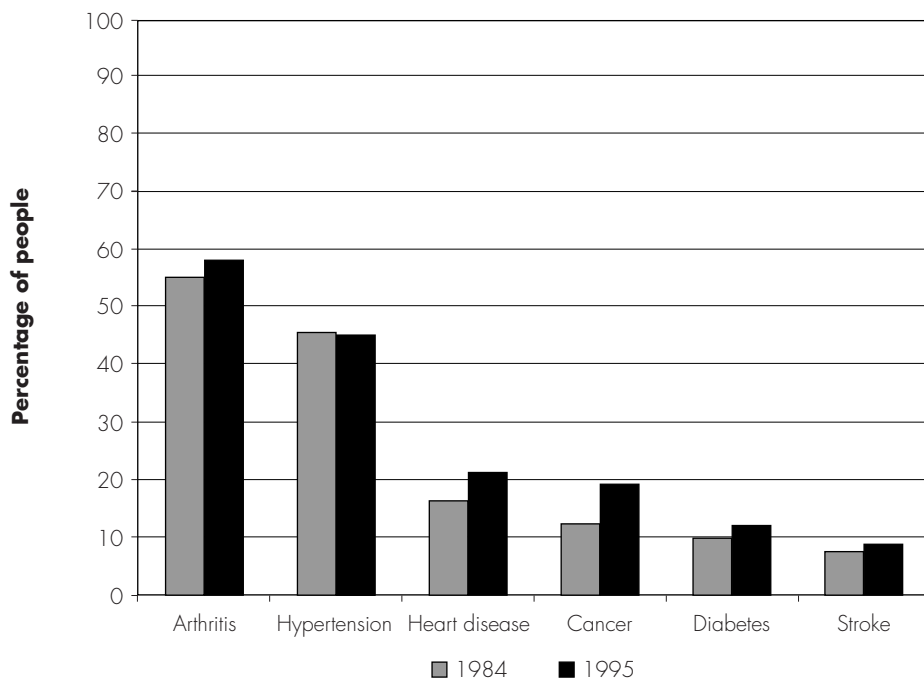
9 The baby boom generation includes people born between 1946 and 1964 (Schrammel 1998).

10 Chronic conditions include diseases such as diabetes or hypertension and impairments such as paralysis or loss of vision.

11 ADLs include eating, getting in and out of bed, getting around inside, dressing, bathing, and toileting. IADLs include heavy housework, light housework, laundry, preparing meals, shopping for groceries, getting around outside, traveling, managing money, and using a telephone.

**FIGURE  
1-2**

**Percentage of people age 70 or older  
who reported having selected  
conditions, 1984 and 1995**



Source: Federal Interagency Forum on Aging-Related Statistics 2000.

An opposite trend has been a decline in the rate of disability associated with chronic disease (Manton et al. 1997). In 1999, only 19 percent of the elderly were receiving help with ADLs or IADLs, compared with 24 percent in 1984 (Cutler 2001). Reasons for this decline can only be surmised at this point, but may include:

- medical care improvements, such as joint replacement, cataract surgery, and pharmacotherapy,
- healthier lifestyles, such as a decline in smoking, and
- increased use of assistive devices, such as walkers, canes, and handrails (Cutler 2001).

How these countervailing trends will affect spending is uncertain. The decline in disability rates among the elderly has

led some analysts to conclude that better prevention and management of chronic illness has resulted in a compression of morbidity and disability into the last few months or years of life for some people. Other research, however, suggests that some medical advances, including breakthrough therapies for illnesses with high fatality rates, can also increase the number of years and the proportion of years of life with disability.<sup>12</sup>

The under-65 disabled Medicare population also has been increasing rapidly. Medicare began providing health care services to disabled people in 1973; enrollment rose from 2.2 million people in 1975—about 1 percent of the U.S. population—to 5.6 million in 2000—about 2 percent of the population (Health Care Financing Administration 2001). The growth of the disabled population has been even greater than that of the elderly

population and is projected to reach 8.8 million in 2017 (Health Care Financing Administration 1998). Among disabled beneficiaries (excluding ESRD patients), 63 percent have physical disabilities such as back and joint problems and cardiovascular disease, while the remaining 37 percent have mental disorders. Those with mental health problems account for a disproportionate amount of Medicare spending (Foote and Hogan 2001). Given the increase in the disabled population, the question of how well the Medicare benefit design serves this population, particularly those with mental disorders, is of growing concern.

**Products and services  
that are not covered**

Medicare's traditional program has never covered certain products and services that are widely used in diagnosis and treatment (Table 1-2, p. 10). Medicare also has provided limited coverage for care coordination and management and mental health services. These benefit limitations may be important sources of financial liability for some beneficiaries, raising concerns about their access to clinically appropriate care. Their impact probably varies, however, with beneficiaries' health status and other characteristics (see text box, p. 11).

Lack of a prescription drug benefit affects almost all beneficiaries. Pharmaceuticals are becoming a more important part of medical care, particularly for the elderly, who often need multiple drugs for a variety of medical conditions and annually fill almost twice as many prescriptions as do people ages 45–64 (Agency for Healthcare Research and Quality 2001). Pharmaceutical therapies are now used to control chronic conditions and prevent acute episodes or their recurrence. Conditions for which pharmacotherapy is of particular importance include diabetes, high cholesterol, heart disease, and mental illness. Projections based on 1995 data from the Medicare Current Beneficiary Survey (MCBS) suggest that in 1999 about 86 percent of Medicare

<sup>12</sup> The compression of morbidity thesis is discussed in Fries (2002); other studies that have examined the compression of morbidity in aging populations include Nusselder et al. (1996) and Doblhammer and Kytir (2001).

**TABLE  
1-2**

**Products and services traditional Medicare does not cover, 2002**

Outpatient prescription drugs (with limited exceptions)  
Routine or annual physical exams  
Hearing exams and hearing aids  
Routine eye care and most eyeglasses  
Dental care and dentures (in most cases)  
Screening tests (except for those specifically identified by Medicare)  
Routine foot care (with limited exceptions)  
Orthopedic shoes  
Vaccinations (except for those specifically identified by Medicare)  
Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home  
Acupuncture  
Cosmetic surgery  
Health care received while traveling outside of the United States (except in limited cases)

Note: Medicare covers drugs not usually self-administered, oral anti-cancer drugs, drugs used following an organ transplant, erythropoietin for beneficiaries on dialysis, and injectable drugs used for treatment of postmenopausal osteoporosis. Screening tests covered by Medicare include bone mass measurement for some at-risk beneficiaries; colorectal cancer screening; glucose monitors, test strips, and lancets for all diabetics; diabetes self-management training for at-risk diabetics; glaucoma screening for at-risk enrollees; mammograms; Pap tests and pelvic exams (including clinical breast exams) for all women; and prostate cancer screening for all men age 50 and over. Vaccinations covered by Medicare include those for flu, pneumococcal pneumonia, and hepatitis B (for those at medium to high risk).

Source: Centers for Medicare & Medicaid Services 2002.

beneficiaries would have had some drug expenditures, paid either out of pocket or through insurance coverage; about 32 percent would have had expenses of more than \$1,000, and 6 percent more than \$3,000 (Gluck 1999).

Assistive devices such as eyeglasses and hearing aids can increase mobility, promote independent living, and help prevent injury (Cassel et al. 1999). These products and related services as well as dental care, however, are not covered by traditional Medicare. The costs of these products and services (particularly eyeglasses and hearing aids) can easily amount to hundreds or thousands of dollars.

Some preventive services also are not covered. Because preventive services are broadly excluded from Medicare

coverage, adding coverage for specific services requires new legislation. The Congress has enacted coverage for a number of preventive services, including screening for colorectal, cervical, breast, and prostate cancer. However, Medicare does not cover some preventive services that are recommended by the U.S. Preventive Services Task Force and covers some that it has not recommended (see Appendix A).

Many factors besides insurance coverage may influence beneficiaries' use of preventive services (see text box, p. 12). Nonetheless, lack of coverage and Medicare's cost-sharing provisions may be associated with underuse of preventive services by some beneficiaries. Before Medicare started covering flu shots and mammography, for example, beneficiaries who had no additional coverage were less

likely to receive these services than those enrolled in managed care, those who had supplemental insurance, or those receiving Medicaid benefits. Some evidence suggests that these differences narrowed after Medicare began covering these services (Carrasquillo et al. 2001).

Traditional Medicare's benefits and payment policies also do not promote extensive care coordination and management across multiple providers and sites of care.<sup>13</sup> Effective coordination may be essential to furnishing high quality care for beneficiaries who have complex medical problems.<sup>14</sup> In 1999, the average beneficiary with one or more chronic conditions was seen by eight different physicians (Anderson and Knickman 2001).

Medicare—like most employer-sponsored and individual market health insurance plans—faces difficult barriers to promoting care coordination and management:

- Medicare's benefits and payment policies follow an acute care, fee-for-service model that focuses on individual services furnished on a discrete service-by-service basis rather than episodes of illness.
- The medical care delivery system is highly fragmented by setting and specialty, with few mechanisms or financial incentives for providers to follow patients with multiple problems across all settings in which they receive services.
- The acute-care orientation of Medicare benefits limits coverage of custodial care and other assistive or supportive services that often may (or should) support beneficiaries' medical care.

Medicare's limited benefits for mental health care also reflect the dichotomy that prevails in the wider insurance market in which coverage of mental health services

13 Medicare pays for physicians' coordination activities in its payment for some services. For example, payments for evaluation and management visits are intended to include preparation for the visit, such as reviewing the chart, the exam itself, and any follow-up activities such as coordination with other providers.

14 In the M+C program, managed care plans may coordinate services to varying degrees in response to the monthly capitation payments they receive.

## The effects of Medicare's benefit limitations depend on beneficiaries' characteristics

The importance of different types of coverage or gaps in coverage—prescription drugs, preventive services, protection from cost-sharing—differs among beneficiaries. To illustrate this, it may be useful to think of the beneficiary population as divided into three groups by health status. The first consists of those who are basically healthy except for episodes of acute illness; they need assured access to care and protection against catastrophic costs. The second group includes beneficiaries with serious chronic conditions who are at significant risk of further deterioration and may represent significant future costs to the program. They may need ongoing care with close coordination among providers to make sure the care they receive is appropriate and its delivery is efficient. The third segment includes beneficiaries who are terminally ill and nearing the end of life. Hospice and palliative care are

of particular importance to them. Beneficiaries may move into different groups at different times in their lives.

As the baby boomers move into the Medicare population, if the trend toward decreasing disability among the elderly continues, the size of the first, healthy group of beneficiaries will increase significantly. Benefits designed to maintain the health of this group will become more important for the Medicare program. Thus, increased understanding of and use of preventive services might be most relevant to this group. Advances in prescription drugs are also relevant for this group. Coverage of new therapeutic agents may be particularly important to beneficiaries with serious health problems and people who are terminally ill. Better coordination of services would likely have a greater impact on those with chronic illness or those who are seriously and terminally ill. ■

services. Many effective drug treatments have been developed in the past 10 years. Research has shown that many disorders—such as depression, substance abuse, and schizophrenia—can be treated effectively with outpatient pharmacologic and psychosocial interventions. For example, treatment for depression among the elderly achieves response rates of 60 to 80 percent (Department of Health and Human Services 1999).

Medicare does not pay for the drugs that beneficiaries may need, however, and limits payment for outpatient psychotherapy as well. By law, Medicare payment for many mental health services is set at 62.5 percent of the fee schedule amount. Because Medicare pays only 80 percent of that amount (80 percent of 62.5 percent), beneficiaries face a copayment of 50 percent for outpatient psychotherapy services.

### Do Medicare's benefits ensure access to care and financial protection?

By many measures, the Medicare program has been tremendously successful. It has provided millions of elderly and disabled beneficiaries access to state-of-the-art medical care generally similar to that available to the employed, insured population (see text box, p. 14). Nearly all people 65 years of age or older have health insurance, compared with about 50 percent in 1965. Greater access to treatment and improved technology, particularly for heart disease and stroke, have reduced morbidity and disability and helped people live longer.

Beneficiaries' support for the program is overwhelming, even among those with generally negative views of the federal government (National Academy of Social Insurance 1999). Surveys show that almost all beneficiaries are satisfied or

is generally more restrictive than that for other forms of health care. Some elements of Medicare's mental health coverage, such as that for hospital inpatient care, may actually be relatively generous compared with employer-sponsored insurance benefits, but Medicare's overall coverage for mental health care remains more restrictive than its benefits for other types of illness. When Medicare was established in 1965, mental health care was more likely to be delivered in the inpatient than the outpatient setting because outpatient therapies were not seen as effective and few pharmaceutical treatments were available (Lave and Goldman 1990; Department of Health and

Human Services 1999). Medicare covered inpatient psychiatric care delivered in general hospitals on the same terms as all inpatient medical care. The Congress placed a 190-day lifetime limit on care delivered in free-standing psychiatric hospitals.<sup>15</sup> This restriction was intended to limit Medicare's responsibility for long-term custodial care for beneficiaries with mental disorders, a service traditionally provided by state mental hospitals (Frank 2000).<sup>16</sup>

In 2002, treatment protocols for many types of mental illness focus on managing patient care outside of the hospital, with drug treatment and case management

15 Beneficiaries are subject to the deductible, copayment, benefit period, and lifetime reserve provisions that apply to any hospital inpatient care.

16 This restriction may cause problems for beneficiaries in psychiatric hospitals who reach the 190-day lifetime limit and must find another way to pay for their care, be discharged, or transfer to a general hospital. Between 1965 and 1990, however, only 17,000 beneficiaries reached the lifetime limit, suggesting that the restriction has not had a pervasive impact on access to care (Lave and Goldman 1990).

## Use may not follow coverage for some preventive services

**B**eneficiaries' use of preventive services is not always closely tied to Medicare coverage.

Medicare beneficiaries obtain some preventive services even when they are not covered. For example, although periodic physical and gynecological exams were not covered (Pap smears and pelvic exams were not added until July 2001), over 85 percent of elderly beneficiaries reported a routine checkup in the preceding two years (Janes et al. 1999). Similarly, cholesterol measurement was not covered, but over 85 percent of elderly beneficiaries reported a blood cholesterol check in the preceding five years. In contrast, beneficiaries do not use some preventive services even when they are covered. For instance, fewer than half of all men reported ever having received a proctoscopy or

sigmoidoscopy and less than one-third of the elderly reported a fecal occult blood test within the past 2 years.

Factors besides insurance coverage that affect use of preventive services include education, age, and the availability of information (Kenkel 2000, Greene et al. 2001). These factors also affect service use among Medicare beneficiaries. For example, those with a grade-school education had significantly lower use rates for all services, compared with those for beneficiaries with higher education levels. Beneficiaries age 65 to 74 had higher use rates for mammograms and Pap smears and lower rates for flu vaccinations and eye exams than other age groups. Beneficiaries in health maintenance organizations had significantly higher rates for all services (Greene et al. 2001). ■

On more general access measures, few beneficiaries report problems in obtaining care. In studies conducted over the past five years, we found that 8 to 11 percent of beneficiaries living in the community (not institutionalized) reported that they had delayed getting care because of cost; only 3 to 4 percent reported that they had trouble getting care (MedPAC 2000, Physician Payment Review Commission 1997). A new analysis based on the 1999 MCBS showed similar results: 6 percent reported delaying care because of cost, and less than 4 percent reported trouble getting care (Table 1-3).

Beneficiaries also appear to have better access to care, on average, than many younger adults (ages 18–64) who are not eligible for Medicare. For example:

- They are less likely to avoid getting care because of financial barriers (National Center for Health Statistics, 2002).
- Those who need urgent care because of illness or injury are more likely to get care as soon as they want it (Agency for Healthcare Research and Quality 2002).
- Those who want to make an appointment with a health care provider are more likely to get one as soon as they want it (Agency for Healthcare Research and Quality 2002).

Medicare has been successful in ensuring access to care for most beneficiaries, but less so for some people who are in poor health, have low incomes, or lack supplemental insurance coverage. Disabled beneficiaries under age 65 were more than twice as likely to report trouble getting care in 1999 compared with all beneficiaries; over 18 percent reported delaying care because of cost. Similarly, 17 percent of beneficiaries in poor health said they had delayed care because of cost in 1999, and over 10 percent reported trouble getting care. Low-income

very satisfied with the availability of medical care and the overall quality of their care (MedPAC 2000). Although physicians need not accept Medicare beneficiaries, nearly all do; in 2000, nearly 500,000 physicians billed Medicare for their services.<sup>17</sup>

### Access

Medicare benefits have helped millions of beneficiaries gain access to state-of-the-art health care. The benefit package has expanded to encompass a burgeoning array of diagnostic and therapeutic technologies and procedures that significantly extend life and enhance functional capacity. The rates at which beneficiaries have had surgery to restore or increase function and enhance quality of life—for instance, coronary angioplasty, coronary artery bypass graft

(CABG), or knee replacements—have risen dramatically over the past three decades, demonstrating that enrollees have fully shared in the benefits of improvements in medical science (Lubitz et al. 2001). In fact, many important advances in medical technology have been of particular value to older Medicare beneficiaries (Cutler and McClellan 2001). In 1986, people age 65 or older were about as likely to have coronary angioplasty or CABG procedures as people ages 45–64. By 1998, those 65 or older were about twice as likely as people ages 45–64 to have angioplasty or a CABG. Similarly, the rate of knee replacements has risen steeply among beneficiaries ages 65 to 74, and the highest rate of hip replacement surgery is among those over age 75 (Lubitz et al. 2001).

<sup>17</sup> The number of physicians providing services (billing Medicare) increased by 6.7 percent—from 460,700 in 1995 to 491,547 in 2000. Although overall Medicare enrollment rose 5.3 percent during this period, enrollment in traditional Medicare declined from 34.5 million to 32.8 million.

**TABLE  
1-3**

**Self-reported access to care for community-dwelling beneficiaries, by selected characteristics, 1999**

Characteristics	Had trouble getting care	Delayed care due to cost	No usual source of care
All beneficiaries	3.4%	6.0%	5.4%
Age			
Under 65 (disabled)	8.7	18.3	7.0
65-69	3.1	5.5	5.7
70-74	2.6	4.3	5.4
75-79	2.9	4.4	5.0
80-84	2.4	3.5	4.4
85+	1.9	3.1	5.5
Health status			
Excellent/very good	2.0	3.2	6.6
Good/fair	3.4	6.7	4.6
Poor	10.4	17.2	4.4
Poverty status			
At or below poverty	5.0	8.9	8.1
100 to 125% of poverty	4.3	10.1	5.6
125 to 200% of poverty	3.7	8.3	6.5
200 to 400% of poverty	2.9	4.3	4.5
Above 400% of poverty	2.1	1.7	3.5
Residence			
Urban	3.6	5.3	5.4
Rural	2.5	8.3	5.4
Supplemental insurance			
Yes	3.2	5.3	4.9
No	8.5	20.1	16.9

Note: Sample of 10,718 consists of community-dwelling beneficiaries in 1999. Poverty status is based on individual income for single people and joint income with spouse for married people. Poverty level in 1999 was \$7,990 if living alone and \$10,075 if living with a spouse. Urban includes beneficiaries living in metropolitan statistical areas (MSAs). Rural includes beneficiaries living outside MSAs. Supplemental insurance = yes indicates a beneficiary has private-sector or public-sector supplemental coverage.

Source: MedPAC analysis of 1999 Medicare Current Beneficiary Survey Access to Care and Cost and Use files.

beneficiaries—those with incomes less than 200 percent of the federal poverty standard—were more likely than those with higher incomes to report problems obtaining care or delaying care because of

cost. Beneficiaries who lack supplemental insurance also report serious access problems. For instance, about 20 percent reported delaying care because of cost in 1999.

Some evidence suggests that barriers to care coordination associated with Medicare's acute care, fee-for-service orientation may impede access to high-quality care. This problem is not unique to Medicare. Recent surveys show that fewer than half of all U.S. patients with hypertension, depression, diabetes, or asthma are receiving appropriate treatment (Wagner et al. 2001). Another national survey found that 16 percent of those with chronic illness received contradictory information from different health care providers (Anderson and Knickman 2001).

The effects of poor care coordination may be more serious for Medicare beneficiaries than for other people because of the high prevalence of chronic illness in the aged population. The adverse effects of these care deficiencies can be measured in a number of ways. One study found that about 13 percent of beneficiaries with 5 or more chronic conditions were hospitalized with a condition that could have been avoided with appropriate ambulatory care (Anderson and Knickman 2001). Another study found that 30 percent of beneficiaries, many of whom had chronic conditions, were not getting the follow-up care they needed (Foote and Hogan 2001).

Finally, Medicare beneficiaries are apparently having difficulty in obtaining needed mental health services.<sup>18</sup> Despite the availability of proven treatments, one recent analysis found that of those beneficiaries over 65 who needed treatment, 63 percent did not receive it (Goplerud 2002). The likelihood of people with mental health conditions receiving services was significantly lower if they were Medicare beneficiaries, compared with those who had employment-based insurance or Medicaid coverage. Even excluding people with severe cognitive impairments, current estimates suggest that about 20 percent of people over age 55—and a higher proportion of disabled beneficiaries—have a diagnosable mental

18 A report by the U.S. Surgeon General attributes this large unmet need to patient barriers (reluctance to discuss psychological problems) provider barriers (difficulty in diagnosing and treating mental illness) and health care system barriers (payment and coverage policies) (Department of Health and Human Services, 1999).

## Comparing Medicare's benefits to those offered to employees in group plans

Medicare's benefits were originally modeled after those commonly included in employer-sponsored group plans in the mid-1960s. Consequently, the coverage generally offered in today's employer-sponsored plans might be considered a reasonable standard of comparison for current Medicare benefits.

Over time, the two sets of benefits have diverged in important ways. Medicare has retained the distinction between Part A (inpatient hospital and facility care) and Part B (physician and other care). Employer-sponsored group policies have shed this distinction, developing combined plans with combined deductibles.

Employers generally offer health insurance to attract and retain staff. Many large employers offer their workers a choice among several types of insurance plans. The choice usually includes some type of managed care plan—such as a health maintenance organization (HMO) or preferred provider organization (PPO)—in addition to, or increasingly instead of, the traditional indemnity plans that were the model for Medicare. In 2001, only 7 percent of employees were enrolled in indemnity plans, 48 percent were in PPO plans, and the remaining 45 percent were evenly split between HMOs and point-of-service plans (Gold 2002).

Many employer-sponsored plans also offer benefits that are not covered by Medicare, such as:

- outpatient prescription drugs,
- certain preventive services, and
- protection against high expenses (catastrophic coverage).

These plans often introduce some management of service use, limitations on the network of providers the plans agree to pay, or differential copayments among tiers of providers and tiers of products (such as prescription drugs included in, or excluded from, plans' formularies). As with the Medicare benefit package, however, employer group plans focus primarily on acute medical care, offer limited coverage for mental health services, and do not focus heavily on care management.

Medicare and employer group plans cover populations with different characteristics and health care needs. Aged and disabled people are much more likely to have complex chronic care needs than the working population. In contrast, working people are often much more concerned with health issues related to raising children. Thus, it is uncertain to what extent a benefit package designed for working people with dependents offers a good model for Medicare. ■

families from the risk of impoverishment associated with serious illness. This protection is especially important because spending for all health care services—other than long-term care—is highly variable among beneficiaries (Figure 1-3). On average, annual health care spending for the 10 percent of beneficiaries with the lowest expenses in 1999 was \$124, compared with \$39,000 for those in the top 10 percent of the spending distribution.

Medicare provides considerable financial protection to its enrollees; most would be much worse off without its benefits. On average, beneficiaries consumed \$7,500 in health care services in 1999, of which Medicare covered 58 percent (Table 1-4).<sup>19</sup> Moreover, Medicare covered a substantially larger share of the total for beneficiaries with the highest spending (Figure 1-4, p. 16). For instance, on average, Medicare covered about 73 percent of the total for the 10 percent of beneficiaries with the highest total spending.

Nevertheless, Medicare's benefit design—with substantial cost sharing for many covered services and no coverage for some important health care products and services—leaves beneficiaries at risk for large out-of-pocket expenses (scanlon 2001). For example, in 1999, the 27 percent of total spending that Medicare did not cover for beneficiaries with the highest total spending averaged \$11,000 per person. The potential for high out-of-pocket spending would be a serious problem if it reduced beneficiaries' abilities to seek needed care, comply with care recommendations, or forced them to forgo or cut back on other necessities.

### Limiting financial risk through additional coverage

About 90 percent of Medicare beneficiaries obtain some type of additional coverage that protects them—to varying degrees—from the potential consequences of traditional Medicare's coverage limits. Supplements have been

disorder during a given year (Department of Health and Human Services 1999), but only 4 percent of beneficiaries used an outpatient mental health service in 1992 (Rosenbach and Ammering 1997).

### Financial protection

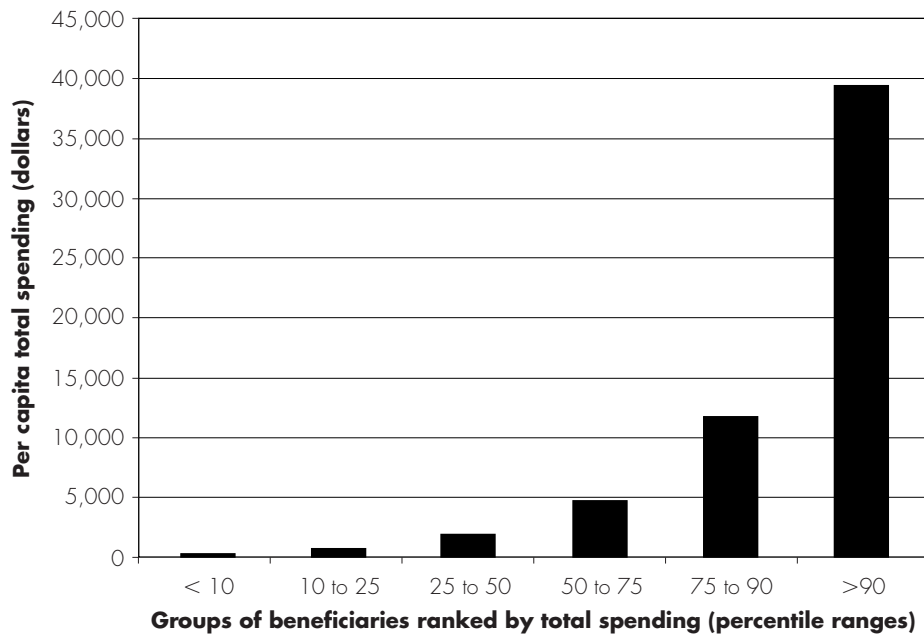
Medicare beneficiaries need substantial protection from the cost of acute illness to ensure access to clinically appropriate care and to insulate them and their

<sup>19</sup> These estimates of per capita spending differ in three ways from the aggregate estimates presented earlier (and in Chapter 2): they are for 1999 rather than 2002; they reflect spending by non-institutionalized beneficiaries enrolled in the traditional program, while the aggregate numbers include people in institutions and those enrolled in the M+C program; they exclude administrative costs that are included in the aggregate figures.



**FIGURE 1-3**

**Per capita total spending on health services, 1999**



Note: Sample of 9,674 consists of community-dwelling beneficiaries who participated in traditional Medicare in 1999. The vertical bars represent per capita total spending (excluding long-term care) for each group. For example, the <10 group illustrates per capita total spending for the 10 percent of beneficiaries with the lowest total spending. Likewise, the >90 group illustrates per capita total spending for the 10 percent of beneficiaries with the highest total spending. Total spending includes spending by all sources of payment on all acute-care services received by beneficiaries.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 1999.

available since Medicare was implemented in 1966, when it looked quite similar to the private sector insurance packages offered to the general population (Atherly 2001). Beneficiaries may obtain supplemental coverage for a variety of reasons. Many—particularly those with relatively low incomes—may prefer the known cost of a premium to the unknown costs that may be associated with an unexpected illness, and even to the predictable costs of routine medical services (Vistnes and Banthin 1997). Also, large employers in certain industries historically have been generous with retiree coverage, reflecting collective bargaining agreements, tax advantages for

employers and retirees, and other factors. Moreover, as non-covered services have accounted for a growing share of beneficiaries' health care, obtaining additional coverage has become more important as one means of limiting financial risk.

Sources of additional coverage include supplements sponsored by former or current employers, individually purchased Medigap plans, Medicaid coverage provided for low-income individuals, or additional benefits offered by some M+C or other Medicare managed care plans. About 33 percent of all Medicare beneficiaries have employer-sponsored supplemental insurance. Most have it as a

retirement benefit; about 70 percent have it because of their own employment and the remaining 30 percent are covered spouses (Gold and Mittler 2001) (Figure 1-5, p. 17).<sup>20</sup>

Medigap—private health insurance specifically designed to wrap around Medicare's benefit design—is the second most common form of additional coverage. Twenty-seven percent of beneficiaries had Medigap policies in 1999. All policies issued since 1992, except those sold in certain states, have been limited to 10 standard benefit packages (see Chapter 2).

State Medicaid programs provide additional coverage for certain low-income, sick, and disabled Medicare beneficiaries—about 11 percent of community-dwelling beneficiaries in

**TABLE 1-4**

**Spending on health services for Medicare beneficiaries, by source of payment, 1999**

Source	Amount per capita	Percent of total
Medicare	\$4,370	58%
Supplemental payers	1,984	26
Beneficiaries' direct spending	1,158	15
Total	7,512	100

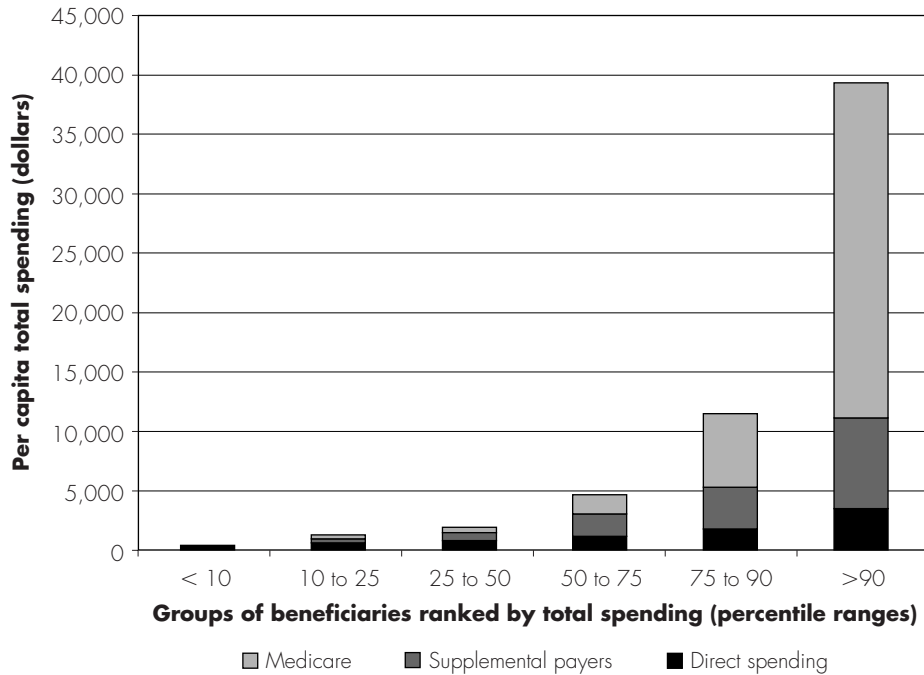
Note: Sample of 9,647 consists of community-dwelling beneficiaries who participated in traditional Medicare in 1999. Supplemental payers include all public and private sources of supplemental coverage. Beneficiaries' direct spending includes their out-of-pocket spending on covered and non-covered acute care services but excludes premiums and long-term care services. Percentages do not sum to 100 because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 1999.

20 The percentages presented here come from MedPAC analysis of the 1999 MCBS Cost and Use file and include only community-dwelling individuals. Other analyses based on the MCBS Access to Care file have yielded higher estimates for the proportion of beneficiaries without additional coverage (i.e., Laschober et al. 2002). Part of the difference is that the Access to Care file provides a point-in-time snapshot while our analysis of the Cost and Use file assigned people to the coverage they had for at least 6 months of the year. Estimates from these sources also differ because insurance status in the Cost and Use file can be checked against data on paid claims, while estimates from the Access to Care file rely on beneficiaries' statements about their insurance status.

**FIGURE 1-4**

**Per capita total spending on health services, by source of payment, 1999**



Note: Sample of 9,674 consists of community-dwelling beneficiaries who participated in traditional Medicare in 1999. The vertical bars represent per capita total spending (excluding long-term care), divided into three sources of payment, for each group. For example, the <10 group illustrates per capita total spending for the 10 percent of beneficiaries with the lowest total spending. Likewise, the >90 group illustrates per capita total spending for the 10 percent of beneficiaries with the highest total spending. Total spending includes spending by all sources of payment on all acute-care services received by beneficiaries. Supplemental payers includes all public and private sources of supplemental coverage. Direct spending includes beneficiaries' out-of-pocket spending on covered and non-covered acute care services but excludes premiums and long-term care services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 1999.

1999.<sup>21</sup> People with full dual eligibility receive Medicare benefits, coverage of Medicare cost-sharing, and full Medicaid benefits, including some health care products and services—notably prescription drugs—not covered by Medicare. Other Medicaid programs pay for Medicare premiums and/or cost sharing for services covered by Medicare.<sup>22</sup>

Medicare managed care plans may offer reduced cost sharing requirements or other benefits beyond those covered in the traditional program, such as some coverage for outpatient prescription drugs. Medicare's managed care options consist primarily of private managed care plans that participate in the M+C program, but also include a few private fee-for-service

plans, several plans paid on a cost basis, and those participating in various demonstration projects. About 18 percent of Medicare beneficiaries were enrolled in some form of Medicare managed care in 1999, although this share has declined to about 15 percent in 2002.<sup>23</sup>

Other sources of additional coverage, held by about 2 percent of beneficiaries, include benefits obtained through the Department of Veterans Affairs or the TRICARE program for military retirees (see Appendix B).<sup>24</sup>

About 12 percent of Medicare beneficiaries had more than one source of additional coverage in 1998:

- Five percent had retiree health coverage and were also enrolled in Medicare managed care plans; these people represent about one-third of all Medicare managed care enrollees.
- Four percent were enrolled in Medicare managed care and also reported Medigap coverage; they may maintain duplicate coverage for fear of losing access to Medicare managed care (Gold and Mittler 2001).
- Three percent were enrolled in Medicaid and also had other coverage, most likely Medicare managed care. Medicare beneficiaries fully eligible for Medicaid were less likely to have other sources of additional coverage, probably because Medicaid generally provides sufficient protection.
- Four percent of beneficiaries had both Medigap and employer-sponsored coverage.

21 A much larger share of institutionalized beneficiaries are also in Medicaid. When they are included in the distribution, about 17 percent of Medicare beneficiaries received some benefits from Medicaid in 1997 (Clark and Hulbert 1998).

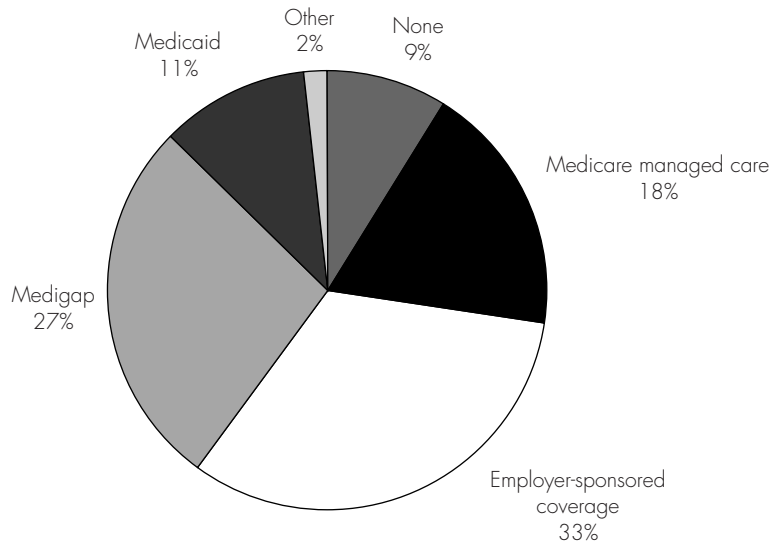
22 The Qualified Medicare Beneficiary program pays for Medicare's premiums, deductibles, and coinsurance for beneficiaries whose incomes are below 100 percent of the federal poverty level and who have limited assets. The Specified Low-income Medicare Beneficiary program pays for the Medicare Part B premium for beneficiaries with incomes between 100 and 120 percent of the federal poverty level. Temporary programs (the Qualified Individual 1 and 2 programs, and the Qualified Disabled and Working Individual program) offer some payments toward the Part B premium for other low-income beneficiaries.

23 The data for 1999 on the distribution of beneficiaries among sources of supplemental coverage are the latest available.

24 TRICARE is the name of this program in law, not an acronym.

**FIGURE  
1-5**

**Sources of additional health coverage  
for Medicare beneficiaries, 1999**



Note: Sample of 11,859 consists of community-dwelling Medicare beneficiaries in 1999. Medigap includes those with both Medigap and employer-sponsored coverage, as well as those with only Medigap coverage.

Source: Medicare Current Beneficiary Survey, Cost and Use file, 1999.

Some beneficiaries have no additional coverage. In 1999, about 9 percent of beneficiaries had no additional coverage for at least 6 months and were therefore responsible for Medicare’s full cost sharing requirements, as well as the costs of non-covered services. About one-half reported that they could not afford coverage; only 15 percent reported that they did not need it because they were never sick or they thought that Medicare was sufficient (Gold and Mittler 2001). Medicare beneficiaries who lack additional insurance differ in a number of respects from those who have coverage:

- They are more likely to be under age 65 and entitled to Medicare benefits because of disability or ESRD; many of these people lack additional coverage because they do not have the same federally guaranteed access to Medigap as do the elderly.

- They tend to have low incomes; beneficiaries with incomes below the federal poverty standard are at least three times more likely to lack additional insurance than those with incomes over 200 percent of the standard (13 percent compared with 3 to 4 percent).<sup>25</sup> About 15 percent of those who have incomes between 100 and 125 percent of the poverty standard—and do not qualify for Medicaid in many states—lack additional insurance.
- They are more likely to live in a rural area than an urban one.
- They are more likely to have low educational attainment (Pourat et al. 2000).

**Out-of-pocket spending**

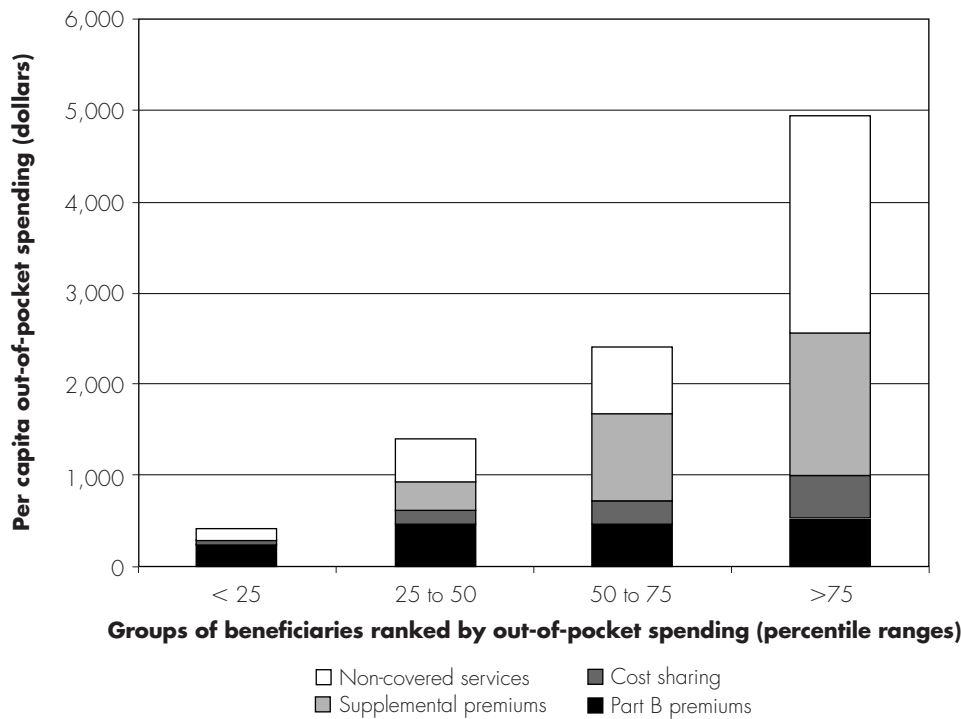
Although the vast majority of beneficiaries obtain some type of additional insurance, they still face

potentially large out-of-pocket spending (Figure 1-6, p. 18). This spending includes their direct spending on services—or the associated cost sharing—and their payments for insurance premiums, including those for Medicare Part B and any amounts for additional insurance. Both direct spending and premium expenses represent potential financial burdens for beneficiaries, but they generally have different implications. Direct spending for services often entails financial risk, especially when it is associated with unexpected illness, including the need to use savings or other resources in unplanned ways and the possibility of taking on debt. In contrast, premium payments are predictable and can be budgeted with little uncertainty.

Medicare beneficiaries who have low out-of-pocket spending generally fit one of two profiles. The first group includes relatively young and healthy people, between ages 65 and 74, for instance, and disabled beneficiaries with stable conditions who use few services. Within this group are people who have only Medicare coverage and those who have additional coverage, but do not have to pay the associated premiums. The second group includes people with comprehensive supplemental coverage, including beneficiaries eligible for Medicaid and relatively high-income people with good employer-sponsored coverage. In contrast, people who have high out-of-pocket spending pay more for supplemental coverage and non-covered services; they tend to be older, use many services, have relatively high incomes, and are more likely to have supplemental coverage, primarily Medigap.

Beneficiaries’ out-of-pocket spending for covered and non-covered services tends to persist over several years, although for different reasons. Spending patterns for covered services reflect the program’s focus on acute-care benefits. When beneficiaries at any age experience acute illness or acute flare-ups of chronic conditions, Medicare spends large

25 The federal poverty standard in 1999 was \$7,990 for an individual living alone and \$10,075 for a person living with a spouse. Less than one-half of beneficiaries with incomes below the poverty standard have Medicaid benefits; some do not meet other eligibility criteria, while others do not apply for benefits (see Chapter 2).

**FIGURE 1-6****Composition of out-of-pocket spending, by out-of-pocket spending level, 1999**

Note: Sample of 9,647 consists of community-dwelling beneficiaries who participated in traditional Medicare in 1999. Out-of-pocket spending includes beneficiaries' direct spending in four categories: the Part B premium, cost sharing for covered services, supplemental premiums, and non-covered services. The vertical bars represent per capita out-of-pocket spending, divided into the four categories, for each group. For example, the <25 group illustrates per capita out-of-pocket spending for the 25 percent of beneficiaries with the lowest out-of-pocket spending. Likewise, the >75 group illustrates per capita out-of-pocket spending for the 25 percent of beneficiaries with the highest out-of-pocket spending.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 1999.

amounts for covered inpatient and outpatient care. Although people with high Medicare spending in one year also tend to have higher-than-average program spending in subsequent years, high mortality rates for heavy users of care tend to limit the duration of high spending (Garber et al. 1997). The focus here is on acute care services, but other research has shown that when long-term care is taken into consideration, spending for non-covered services also shows some persistence, particularly among the very old, who often use non-covered long-term care for extended periods toward the end of life (Spillman and Lubitz 2000).

### Supplemental insurance and out-of-pocket spending

Per capita out-of-pocket spending varies widely among groups with different types of supplemental coverage (Figure 1-7).<sup>26</sup> These spending differences primarily reflect differences in premium payments for supplemental coverage and direct payments for non-covered services. As might be expected, the roughly 4 million people who qualify for Medicaid benefits have relatively small out-of-pocket spending and most of what they spend goes for services that are not covered by Medicare or Medicaid. About 10 million

people buy Medigap policies to reduce their exposure to out-of-pocket expenses for health services. On average, these beneficiaries annually spend about \$1,200 for non-covered services and about \$1,400 for supplemental insurance premiums. Even those who have employer-sponsored supplemental insurance, which usually provides generous benefits, still have relatively high spending for non-covered services. These findings raise questions about the extent to which beneficiaries can successfully use supplemental coverage—which is often costly—to address the limitations of Medicare's benefits.

### Out-of-pocket spending and risk of impoverishment

High out-of-pocket spending may push some Medicare beneficiaries into poverty. About 18 percent of beneficiaries have incomes below national poverty standards and 28 percent have incomes below 125 percent of poverty. Our analysis shows that about 11 percent with total incomes above poverty have out-of-pocket spending large enough to push them into poverty. Those with incomes just above the poverty line (100 to 110 percent) clearly have a much greater likelihood of falling into poverty than those with higher incomes. Nevertheless, substantial proportions of beneficiaries with higher incomes, including those with supplemental coverage, appear to be at risk. This raises questions about how well Medicare's benefits—and those of supplemental insurance policies—protect beneficiaries from the financial consequences of serious illness.

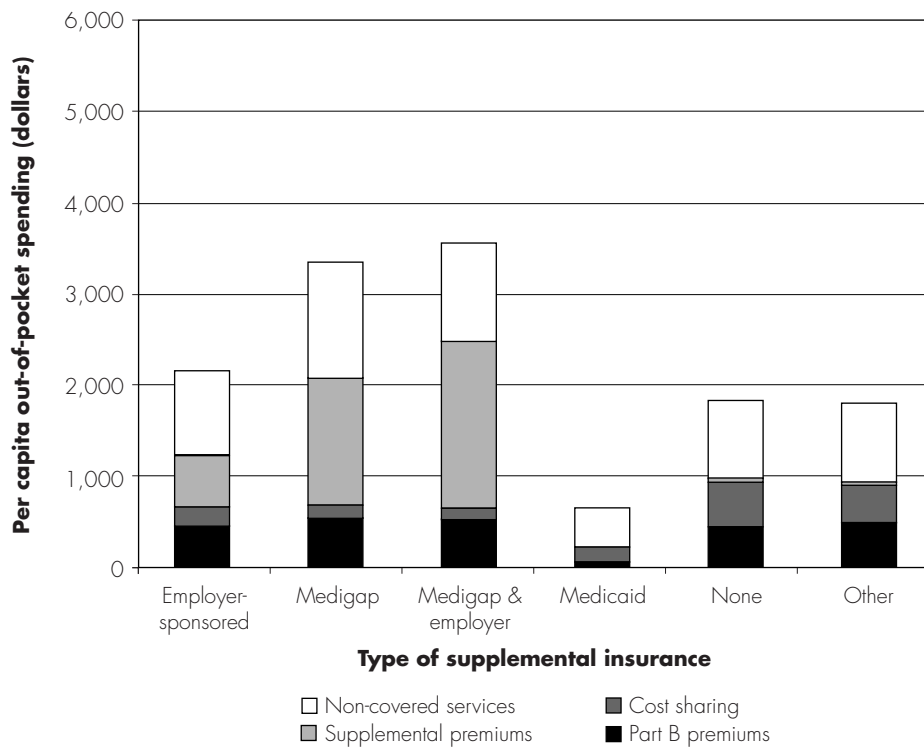
### The trend in Medicare's financial protection for beneficiaries

Beneficiaries' annual out-of-pocket spending for health services has been rising. In 1999 dollars (adjusted for inflation), per capita out-of-pocket spending increased from \$1,921 in 1993 to \$2,296 in 1999. Most of this growth reflects rising premiums for supplemental coverage and increases in beneficiaries' direct spending for non-covered services,

26 Average total health care spending per capita in 1999 varied relatively little (\$7,650 to \$8,200) among beneficiaries with different types of supplemental coverage. In contrast, spending averaged about \$4,600 for people who have only Medicare coverage.

**FIGURE 1-7**

**Composition of out-of-pocket spending, by type of supplemental insurance, 1999**



Note: Sample of 9,647 consists of community-dwelling beneficiaries who participated in traditional Medicare in 1999. Beneficiaries in the other category have benefits obtained through the Department of Veterans Affairs or the TRICARE program for military retirees. Out-of-pocket spending includes beneficiaries' direct spending in four categories: the Part B premium, cost sharing for covered services, supplemental premiums, and non-covered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 1999.

such as outpatient prescription drugs, dental care, or hearing aids. Per capita out-of-pocket spending on supplemental premiums increased from \$597 in 1993 to \$715 in 1999, while direct spending on non-covered services rose from \$692 to \$945.

### Do Medicare's benefits promote efficient care delivery?

Medicare's benefit design affects the prices beneficiaries face when they use health care services, thereby potentially influencing their decisions—or those of providers who act as their agents—about

whether to seek care and what mix of services to use. The benefit design affects service prices through two features:

- the structure of the cost sharing requirements, particularly the extent to which Medicare covers varying proportions of costs for different types of services, leaving beneficiaries responsible for the remainder, and
- the exclusion of clinically important products and services, leaving beneficiaries responsible for the full amount of providers' fees or charges.

We cited many of the implications of excluding clinically important services in earlier discussions of the services Medicare does not cover and the effects of

Medicare's benefit design on beneficiaries' access to care and out-of-pocket spending. In addition to the risk that some beneficiaries may find it necessary to delay getting care because of cost, the lack of coverage for important services may lead to less effective care if beneficiaries are less likely to comply with care recommendations that involve using uncovered services.

Some recent research suggests that lack of coverage for outpatient prescription drugs may lead to underuse of effective care modalities. One study, for instance, found that beneficiaries who lack drug coverage received 2.4 percent fewer prescriptions in 1998 than in 1997, while those with coverage received 9 percent more (Poisal and Murray 2001). Another compared prescription drug use among Medicare beneficiaries with coronary heart disease by type of health insurance. Using 1997 data from the MCBS, the authors found that beneficiaries who lacked supplemental drug coverage had larger drug expenditures and lower use rates for statins, drugs that improve patient survival (Federman et al. 2001). A third study found that beneficiaries who lack drug coverage are less likely to use anti-hypertensives, and those who do purchase these drugs buy fewer tablets annually (Blustein 2000).

### The structure of Medicare's cost-sharing requirements

Medicare's cost-sharing provisions also vary considerably among covered services and these variations may lead to inefficient choices by beneficiaries and providers. For example, the deductibles for Parts A and B may create inappropriate incentives. Insurance theory suggests that random, non-discretionary events should be covered more fully than events that are within the insured person's discretion. In Medicare, however, the Part A hospital inpatient deductible is large (\$812 in 2002), while that for physician services or other ambulatory care under Part B is small (\$100) even though inpatient care is generally believed to be less discretionary and more difficult to predict than ambulatory care. Further, the

low Part B deductible provides little incentive to use covered services judiciously.<sup>27</sup> The high hospital inpatient deductible, however, may contribute to beneficiaries' perceived need for supplemental insurance.

The structure of Medicare's coinsurance and copayment requirements is inconsistent across services, which may foster inefficiencies. Medicare has high copayment requirements for days 60–90 for hospital inpatient stays, yet stays of this length almost certainly reflect unusually serious acute illnesses, which are not likely to be discretionary. Conversely, home health services, the first 20 days of skilled nursing home care, and laboratory services have no cost sharing. As we discuss in Chapter 3, cost-sharing provisions should be structured to reduce potential barriers to care and the costs of administration while maintaining incentives to avoid inappropriate use of services (including incentives to favor some settings over others).

In some cases, Medicare's cost-sharing provisions appear to merit reexamination. For instance, the coinsurance liability for hospital outpatient services is substantially higher—at almost 50 percent—than the coinsurance that applies for ambulatory surgery centers or physicians' offices. These discrepancies could inappropriately affect patients' or providers' decisions about the setting for care, with decisions reflecting the relative levels of cost sharing requirements rather than clinical considerations. The high (50 percent) copayment for outpatient mental health services and similar coinsurance for outpatient hospital services may create barriers to the appropriate use of these services.

The existence of multiple options for supplementing Medicare raises several concerns about incentives and system

efficiency. First, multiple forms of insurance generate additional administrative costs if each Medicare bill entails two or more claims. Second, the form that supplements have taken, particularly the standardized options for Medigap required by law, may provide complete, or “first-dollar” coverage, so that beneficiaries do not have to pay any portion of the deductible or coinsurance out of pocket when they use covered services. In some instances, when decisions to seek care are discretionary, this could lead beneficiaries to seek care or providers to order services that may be of marginal value.

The design of supplemental options poses barriers to efficient market competition. Beneficiaries must navigate complicated insurance provisions, few retirees can influence the benefits offered by their former employers, and Medigap benefits are standardized by law. Most Medigap options cover cost sharing for Medicare-covered services, and only a small number of these policies include coverage for outpatient prescription drugs or preventive care (see Appendix B). Some benefits available in employer-sponsored plans or through M+C plans (such as expanded coverage of prescription drugs, particular types of drugs, or mental health or dental services) might be of greater value than others to individuals, based on their specific health care needs. Beneficiaries must choose among what may appear to them to be arbitrary, incomplete sets of benefit options. It may be difficult, or even impossible, for beneficiaries to put together packages of Medicare and one or more forms of supplementation that optimize coverage across all benefit categories. Allowing beneficiaries to customize their benefits based on their health care needs also could foster risk

selection, potentially making supplemental insurance unaffordable for those with greater needs.

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## Conclusion

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Although Medicare has succeeded for the most part in ensuring access to care and financial protection from the cost of serious illness, the structure of Medicare's benefits and cost sharing is uneven across services, creating incentives that could dissuade beneficiaries and practitioners from choosing the most clinically effective care options. For the same reasons, Medicare works better or worse for beneficiaries depending on the nature of their illnesses. Equally important, beneficiaries and taxpayers face rising financial demands resulting from greater longevity, improvements in medical capabilities, and rising costs for medical services. Because Medicare's benefit design is not comprehensive, beneficiaries rely on assorted combinations of supplemental insurance coverage, benefits from other federal and state programs, and out-of-pocket spending in addition to Medicare. Even with this added coverage, beneficiaries' out-of-pocket costs, particularly for services not covered by Medicare and supplemental insurance, have been increasing, which for some population groups may result in reduced access to care or impoverishment. In the following chapters, we examine the issues surrounding Medicare supplementation in greater detail, then explore options for changing Medicare's benefit design to address the problems we have identified in access and financial protection.

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27 At \$100, the Part B deductible is unchanged since it was raised in 1991 and only about one-half as high as ambulatory care deductibles commonly required by preferred provider organizations for services furnished by favored (in-network) providers (Gold 2002).

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CHAPTER

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**Coverage beyond the basic  
benefit package**

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## Coverage beyond the basic benefit package

To fill the gaps in Medicare's fee-for-service benefit package, most beneficiaries obtain additional coverage either through a Medicare managed care plan or by supplementing Medicare with an employer-sponsored plan, an individually purchased Medigap plan, or Medicaid. Additional coverage provides beneficiaries with financial protection against some, but not all, of Medicare's cost-sharing requirements and non-covered services and is associated with improved access to care and greater use of necessary services. Beneficiaries do not have equal access to the various sources of additional coverage, however, and recent trends suggest that such coverage may be less available in the future. Moreover, the benefits of additional coverage come at a price. The patchwork of additional sources of coverage leads to greater administrative costs and increased use of services, leading to increased costs for the Medicare program, beneficiaries, and those who sponsor their coverage. It also creates administrative burdens and complexity for beneficiaries, those who sponsor their coverage, and providers. Given the inefficiencies within the Medicare program and across sources of additional coverage, the question arises whether it might be possible to provide more beneficiaries with better financial protection and access to appropriate care without increasing total spending for their health care.

### In this chapter

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- Scope of additional coverage by source
  - Impact of additional coverage on access to care and use of appropriate treatments
  - Access to sources of additional coverage
  - Impact of supplemental coverage on program and system efficiency
  - The future of additional coverage
  - Total spending and sources of payment for beneficiaries' health care
  - Conclusion
-

As discussed in Chapter 1, the fee-for-service Medicare benefit package has significant cost-sharing requirements and does not cover some important services; these gaps leave beneficiaries at risk for considerable expenses. Most beneficiaries—91 percent of community dwellers in 1999—have found some source of additional coverage that fills these gaps. In 1999, they did so either by obtaining a supplement to the fee-for-service benefit package through an employer-sponsored plan (33 percent), an individually purchased (Medigap) plan (27 percent), or eligibility for the Medicaid program (11 percent), or by replacing the fee-for-service benefit package with a Medicare managed care plan (18 percent).<sup>1</sup> About 2 percent of beneficiaries obtained additional coverage through other programs, such as the Department of Defense (DoD), the Department of Veterans Affairs (VA), or state pharmacy assistance programs. This approach to filling the gaps in the benefit package results in a patchwork of coverage, with each source providing a different set of additional benefits. They all, however, allow beneficiaries to obtain more comprehensive coverage than they would have with only fee-for-service Medicare.

Additional coverage provides beneficiaries with financial protection against some, but not all, of Medicare’s gaps. This coverage is associated with improved access to care and greater use of necessary services. However, access to additional sources of coverage is not universal and varies with income, place of residence, age, and health status.

Although additional coverage helps to ensure access, the patchwork of multiple sources creates some inefficiencies. The various supplements provide different degrees of coverage, but most are quite generous at filling in Medicare’s cost-

sharing requirements.<sup>2</sup> The generosity of these provisions may undermine incentives to be judicious in the use of services that are inherent in cost-sharing structures.

In addition, recent trends suggest that the availability of these sources of additional coverage may be declining, leaving more people with only the basic Medicare benefit package. Increasing numbers of beneficiaries could face greater financial risks and may experience access problems if the current sources of additional coverage are diminished and not replaced by other, perhaps more efficient, sources.

The total amount spent on beneficiaries’ health care is considerable. The Medicare program is the largest source of funds, followed by out-of-pocket spending, private supplemental products, and, lastly, public supplemental sources. As we discuss in Chapter 3, reducing some of the inefficiencies in the current patchwork of cost sharing and benefits could make it possible to provide more beneficiaries with better financial protection and access to appropriate care without increasing total spending for their health care.

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## Scope of additional coverage by source

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The fee-for-service benefit package has two types of gaps: high cost-sharing requirements and uncovered services (such as prescription drugs, preventive services, long-term care, and dental, hearing, and vision services). The extent to which these gaps are filled varies by the source of additional coverage. This section describes the scope of benefits provided by each source of additional coverage. See Appendix B for detailed descriptions of the various sources of additional coverage.

## Employer-sponsored insurance

Employer-sponsored coverage for Medicare-eligible retirees is generally quite comprehensive. It is most common among large firms and governments, which offer the most benefits. The amount of Medicare’s cost sharing that employers cover depends on their approach to coordinating benefits. Although few large firms reimburse beneficiaries for their Part B premium, most employers reduce cost sharing to low levels. In addition, most employers include an out-of-pocket maximum, averaging \$1,500 among large employers (Watson Wyatt Worldwide, in press). Employer-sponsored plans also cover many services that the Medicare fee-for-service program does not. Most importantly, virtually all Medicare beneficiaries with retiree health coverage receive prescription drug coverage, although the extent of that coverage varies by firm type. Large firms are most likely to offer generous prescription drug coverage to retirees and few retiree health plans place annual limits on prescription drug coverage. Typically, prescription drugs make up at least half the cost of retiree health plans for Medicare beneficiaries (McArdle et al. 1999, McArdle et al. 2000). Beyond drug coverage, about 40 percent of large employers offered dental, vision or hearing coverage for Medicare-eligible retirees (Hewitt Associates 2001).

## Medigap insurance

Medigap insurance is primarily designed to cover Medicare’s cost sharing, and offers coverage of fewer benefits outside the fee-for-service Medicare package than do most employer-sponsored plans. Since 1992, federal law and regulation has permitted 10 types of Medigap plans to be sold. These plans, labeled A through J, have specific, defined benefits.<sup>3</sup> Most of

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1 The distribution presented here comes from MedPAC analysis of the 1999 Medicare Current Beneficiary Survey, Cost and Use file. We allocated beneficiaries according to the type of coverage that they held for at least six months of the year. Medicare managed care includes those in Medicare+Choice, as well as those in cost plans, managed care demonstrations, and other forms of Medicare managed care.

2 In the case of the Medigap market, federal statute and regulations developed in consultation with industry and beneficiary representatives determine the benefit structure.

3 Any Medigap plan type can also be sold as a Medicare SELECT policy, meaning that the insurer may limit coverage to a network of providers. Insurers in only a few states have offered this type of coverage (HCFA 2001).

the plans cover Medicare's hospital deductible and coinsurance, Part B coinsurance, and skilled nursing facility coinsurance. Plans with limited coverage of Medicare's cost sharing tend to be less popular. Plans with more extensive home health coverage and preventive care are also less popular. Plans H, I, and J are distinct from other plan options by their inclusion of prescription drug coverage, but enrollment in these plans is low (9 percent of beneficiaries in standardized plans in 2000).<sup>4</sup> This low enrollment is probably due to high premiums, limited drug benefits, and the use of medical underwriting by insurers outside of open enrollment periods.

The Medigap plan standards have not been updated since the early 1990s, with the exception of allowing high-deductible options.<sup>5</sup> Moreover, policies issued before August 1, 1992 are not subject to these standards. Similarly, three states (Massachusetts, Minnesota, and Wisconsin) received waivers from the standards because they already had their own standards in effect before 1992. In 2000, about 65 percent of beneficiaries with Medigap coverage were in standardized policies, 4 percent were in waiver states, and 31 percent were in prestandardized plans.

## Medicaid

Medicaid generally offers the most complete supplemental coverage. People dually eligible for both Medicare and Medicaid are the only Medicare beneficiaries who have supplemental coverage for the full range of health services. They are not liable for Medicare's cost sharing.<sup>6</sup> In addition, they receive a comprehensive prescription drug benefit, are protected against long-term care costs, and are generally eligible for some preventive, dental, vision, and hearing services. These benefits are

important because the population that Medicaid serves—the poor elderly, poor people with disabilities, and people who are impoverished by health care costs—have health care needs that would pose a significant financial burden for them. Medicaid also offers partial benefits to cover Medicare cost sharing for certain low-income groups.

## Medicare managed care

Medicare managed care plans often offer relatively low cost sharing, possibly making out-of-pocket spending more predictable. They may also cover benefits outside the fee-for-service Medicare package, including some preventive services, dental services, eyeglasses, and outpatient prescription drugs. The drug benefit has been particularly popular in recent years as the cost of prescription drugs has risen rapidly. In addition, Medicare+Choice (M+C) plans typically charge lower premiums than Medigap plans or other forms of supplemental insurance. However, beneficiaries who join M+C plans generally give up the freedom to see any provider they choose; most plans cover only services provided by designated health care providers who participate in their networks. Where beneficiaries live influences how much they must pay to join the plan and how generous the plan's benefits are. Beneficiaries living in urban areas typically pay lower premiums and receive more generous coverage than do beneficiaries living in rural areas. Recent changes in the M+C market that have made it a less available and less generous means of obtaining coverage beyond the fee-for-service benefit package, and particularly drug coverage, will be discussed below.

Table 2-1 (p. 30) provides a comparison of the benefits offered by each type of supplemental coverage, as well as

eligibility criteria and average premiums. People dually eligible for Medicare and Medicaid receive the most comprehensive benefits, with coverage of Medicare's cost sharing and many important uncovered benefits, such as prescription drugs and long-term care. Employer-sponsored coverage for Medicare-eligible retirees is also fairly comprehensive, although it is becoming less so. The benefit structure resembles that of active workers, covering prescription drugs and some additional services and buying down Medicare's cost sharing to low levels. Medigap insurance, except for plans with prescription drugs or preventive benefits, focuses on eliminating Medicare's cost sharing rather than expanding its benefits. Medicare managed care provides some extra benefits—which have been diminishing in recent years—and reduces cost sharing.

Recently, policymakers have focused on Medicare's lack of a prescription drug benefit. Although some of the sources of additional coverage fill this gap, others do not. In addition, the coverage offered is sometimes limited. Medicaid and retiree health plans typically offer enrollees a comprehensive prescription drug benefit, although strategies to limit drug costs have been introduced in both settings. Medigap and Medicare managed care plans, the only types of supplemental coverage designed to be open to all beneficiaries, often do not. Considering only the standardized plans (those sold since 1992), more than 90 percent of Medigap enrollees are in plans that do not offer prescription drug coverage. The most generous standard Medigap drug benefit (Plan J) provides its full \$3,000 benefit when a beneficiary spends \$6,250 on prescription drugs; beneficiaries with higher costs get no additional coverage. In 2001, about one-third of Medicare managed care enrollees were in plans that did not have a prescription drug benefit. Among those in plans that offered drug

4 Unless otherwise noted, all of the data on premiums for Medigap plans and the distribution of enrollees across plan types come from MedPAC analysis of data from the National Association of Insurance Commissioners.

5 Plans F and J have high-deductible (\$1,620) options that are not sold or purchased by many. The Bush administration has recommended two new plans, K and L, which cover less of Medicare's cost sharing but include a limit on out-of-pocket spending for Medicare services and drug coverage similar to that in plans J and H, respectively.

6 Medicaid programs may not cover beneficiaries' cost-sharing obligations in full, however; their contribution is limited to the difference between Medicare's payment and the Medicaid payment amount for the same service.

**TABLE  
2-1**

**Eligibility, premiums, and benefits by source of additional coverage**

	<b>Employer-sponsored insurance</b>	<b>Medigap insurance</b>	<b>Medicaid</b>	<b>Medicare managed care</b>
Eligibility or other restrictions	Based on employment history	Based on age and health status (outside of open enrollment periods)	Based on income and assets	Based on place of residence
Enrollees' average monthly premiums	\$50 in 2001	\$115 in 2000	\$0	\$31 in 2002
Coverage of Medicare cost sharing	Reduces to nominal or eliminates	Eliminates most	Eliminates	Reduces
Coverage of non-Medicare benefits				
Prescription drugs	Yes (typically with nominal copayments)	Limited coverage for minority (15%) who purchase plans with drug coverage	Yes	Some, but becoming limited
Preventive services	Yes	Yes for minority (6%) who purchase plans with preventive benefits	Yes	Yes
Vision, hearing, dental	Yes for some	No	Yes	Yes, but becoming limited
Long-term care	No	No	Yes	No
Enrollment in 1999	33% of beneficiaries	27%	11%	18%

Note: Description of benefits for Medicaid applies only to beneficiaries eligible for full Medicaid benefits. Enrollment numbers do not sum to 100 percent because 2 percent of beneficiaries had another source of additional coverage (such as military or veterans' benefits) and 9 percent had only Medicare fee-for-service benefits. We allocated beneficiaries according to the type of coverage they held for at least 6 months of the year.

coverage, nearly half (48 percent) had a benefit that was capped at \$1,000 or less (Gold and Achman 2001).

The majority of Medicare beneficiaries pay premiums for supplemental coverage. The average monthly premium for M+C enrollees was \$31 in 2001.<sup>7</sup> For Medicare-eligible retirees with employer-sponsored coverage, the average monthly premium was \$50 in 2001, or 26 percent of the total premium paid. The remainder was paid by former employers (Henry J. Kaiser Family Foundation et al. 2002).<sup>8</sup> For Medigap plans, the average premium was about \$115 per month in 2000. Medigap insurance is the most expensive option for

beneficiaries, in part because it is unsubsidized, but also because it is generally marketed to individuals, raising administrative costs. In contrast, retirees often receive a subsidy from their former employer and benefit from the savings generated from coverage in the group market. Beneficiaries who are dually eligible for Medicaid and Medicare receive a direct federal or state subsidy, and therefore pay no premium for their Medicaid benefits.

**Impact of additional coverage on access to care and use of appropriate treatments**

Over time, people with additional coverage have consistently reported better access to health care than those without (MedPAC 2000). In 1999, beneficiaries with only fee-for-service Medicare were more than four times as likely as those with employer-sponsored or Medigap insurance to report trouble getting care (Table 2-2). Beneficiaries without additional coverage were nearly six times as likely to have delayed care due to cost

<sup>7</sup> MedPAC analysis of adjusted community rate proposal data submitted by Medicare managed care plans.

<sup>8</sup> In comparison, active workers in the same set of firms paid 13 percent of total premium costs.



**TABLE  
2-2**

**Self-reported access to care for community-dwelling beneficiaries, by source of additional coverage, 1999**

Type of additional coverage	Percent of beneficiaries		
	Had trouble getting care	Delayed care due to cost	No usual source of care
All	3.4%	6.0%	5.4%
Employer-sponsored insurance	2.2	3.5	4.2
Medigap insurance	1.8	3.8	4.8
Medicaid and other public programs	5.5	11.2	7.0
Medicare managed care	4.2	4.3	2.8
Medicare fee-for-service only	8.5	20.1	16.9

Note: We allocated beneficiaries according to the type of coverage they held for at least 6 months of the year.

Source: MedPAC analysis of 1999 Medicare Current Beneficiary Survey, Access to Care and Cost and Use files.

and about four times as likely to lack a usual source of care, compared to those with employer-sponsored or Medigap insurance.<sup>9</sup> The type of additional coverage also leads to differences in access; those with coverage from public programs (Medicaid, DoD, and the VA) are less likely to report access problems than those without supplemental coverage, but more likely to report problems than those with private supplemental coverage.

Other research has shown that people with supplemental coverage also have higher use of medically appropriate therapies for conditions such as hypertension and coronary heart disease (Blustein 2000, Seddon et al. 2001). These studies have focused particularly on the use of prescription drugs (Federman et al. 2001, Adams et al. 2001, Blustein 2000).

To assess the relationship between supplemental coverage and use of necessary clinical services, MedPAC analyzed differences in the use of services selected to measure access to care for people age 65 or older. Developed by a team of physicians and health services researchers under the Access to Care for the Elderly Project, these indicators represent the views of clinical experts on what care is deemed necessary. They include use of preventive services, such as an annual physical exam; use of services considered necessary for a given condition, such as an electrocardiogram during a visit to the emergency department for unstable angina; and avoidable outcomes, such as nonelective admission for congestive heart failure

(Asch et al. 2000).<sup>10</sup> The indicators represent a “floor” of care and can be used to measure underuse.

Beneficiaries without a supplemental source of coverage use fewer services deemed clinically necessary than those with a supplement.<sup>11</sup> We analyzed 22 indicators that were applicable to at least 20 individuals in our sample with only Medicare fee-for-service coverage. Ten indicators showed less use of necessary care by those without supplemental coverage, 1 showed greater use, and 11 indicated no statistically significant difference (Table 2-3, p. 32).

Differences were most apparent in the use of preventive services. On all three indicators, those without supplemental coverage were considerably less likely to obtain needed care.<sup>12</sup> For example, 62 percent of female beneficiaries under the age of 75 with supplemental coverage got a mammogram every 2 years, compared with only 27 percent of those without it. Preventive services for beneficiaries diagnosed with a specific condition also were less common among those without supplemental coverage. For example, only 30 percent of diabetics without supplemental coverage had an annual eye exam, compared with 47 percent of those with coverage. Monitoring visits for specific conditions are also less frequent among those without supplemental coverage, although the majority of these beneficiaries were being monitored. Among those with congestive heart failure, for example, 96 percent of those with supplemental coverage and 89 percent of those without it had a visit

9 While these numbers do raise concerns about access to care for those without an additional source of coverage, other factors, such as education or income, may be correlated with both the access measures and insurance status, and may therefore confound our results. Multivariate analysis might show a smaller impact from having additional coverage, but would not be likely to eliminate the effect.

10 The indicators were developed by the RAND Corporation with funding from the Physician Payment Review Commission. A team of clinicians selected them to be clinically valid and evidence based, and to apply to the average beneficiary seeing the average physician. Aside from the preventive care indicators applicable to the general elderly population, they focus on 14 medical or surgical conditions common among the elderly, such as hypertension, diabetes, hip fracture, and depression. Necessary care was defined as that for which “(1) the benefits of the care outweigh the risks, . . . (2) the benefits to the patient are likely and substantial, and (3) physicians have judged that not recommending the care would be improper” (Asch et al 2000).

11 We analyzed the Medicare Current Beneficiary Survey (MCBS), Cost and Use files, including inpatient and outpatient claims, for 1996 through 1999. Insurance status was determined using the MCBS and is defined consistently with other analyses in this chapter. However, the sample did not include those with Medicare managed care because they lack claims information. Most indicators were measured on two-year cohorts to track use of services over time. The analysis was performed under contract with Direct Research, LLC.

12 Recent expansions of coverage for preventive services may lead to smaller differences in the rates at which the two groups obtain services in the future.

**TABLE  
2-3**

**Use of clinically necessary services by supplemental coverage status**

Indicator	No supplemental coverage	Some supplemental coverage	Difference between no coverage and some	
			Difference	Statistical significance
<b>Use of preventive services</b>				
Visit every year	72.8%	91.7%	-18.9%	Yes
Assessment of visual impairment every 2 years	30.6	56.4	-25.7	Yes
Mammography every 2 years in female patients	27.4	62.2	-34.7	Yes
<b>Use of necessary care for specific conditions</b>				
Eye exam every year for patients with diabetes	29.9	47.1	-17.2	Yes
Visit every 6 months for patients with diabetes	89.7	95.0	-5.3	Yes
Glycosylated hemoglobin or fructosamine test every 6 months for patients with diabetes	36.3	41.7	-5.4	No
Visit every 6 months for patients with chronic stable angina	91.8	96.7	-5.0	No
Visit every year for patients with diagnosis of TIA	100.0	99.0	1.0	No
Visit every 6 months for patients with CHF	89.2	96.4	-7.2	Yes
Chest X-ray within 3 months of initial diagnosis of CHF	76.7	65.6	11.1	Yes
Visit within 4 weeks following discharge of patients hospitalized for CHF	91.9	87.1	4.7	No
EKG within 3 months of initial diagnosis of CHF	72.1	62.7	9.4	No
GI workup for patients with iron deficiency anemia	22.6	32.8	-10.2	No
Hematocrit/hemoglobin test between 1 and 6 months following initial diagnosis of anemia	25.3	38.9	-13.7	Yes
Visit every 6 months for patients with COPD	87.4	95.2	-7.8	Yes
Follow-up visit within 4 weeks of initial diagnosis of gastrointestinal bleed	54.0	73.3	-19.3	Yes
Arthroplasty or internal fixation of hip during hospital stay for hip fracture	80.0	89.7	-9.7	Yes
<b>Incidence of avoidable outcomes</b>				
Among patients with known diabetes: admission for hyperosmolar or ketotic coma	0.6	0.1	0.5	No
Among patients with known angina: 3 or more ER visits for cardiovascular-related diagnoses in 1 year	6.0	5.2	0.8	No
Nonelective admission for congestive heart failure	2.8	3.1	-0.3	No
Among patients with known COPD: subsequent admission for respiratory diagnosis	22.0	22.8	-0.7	No
Among patients with pneumonia: diagnosis of lung abscess or empyema	0.0	0.7	-0.7	No
Among patients with known cholelithiasis: diagnosis of perforated gallbladder	0.0	0.2	-0.2	No

Note: CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), EKG (electrocardiogram), ER (emergency room), GI (gastrointestinal), TIA (transient ischemic attack). Statistical significance determined using two-tailed t-test; difference considered statistically significant if  $p < 0.05$ . Some supplemental coverage applies to individuals with at least 6 months of additional coverage in a year.

Source: MedPAC analysis of 1996-1999 Medicare Current Beneficiary Survey, Cost and Use files by Access to Care for the Elderly project indicators under contract with Direct Research, LLC.

every 6 months. The analysis yielded sufficient sample size to look at one surgical procedure. Beneficiaries hospitalized for hip fracture were less likely to have the hip repaired if they had no supplemental coverage (80 percent) than if they did (90 percent). Beneficiaries without supplemental coverage were no more likely than those with it to experience an avoidable outcome. However, the relative infrequency of those events makes it difficult to detect differences.<sup>13</sup>

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## Access to sources of additional coverage

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The relationships between supplemental insurance and access to care and use of appropriate services raise distributional issues. Beneficiaries' access to sources of additional coverage is not universal and varies by age, income, geography, and health status. For example, beneficiaries with lower incomes are more likely to be without supplemental coverage than those with higher incomes. Those under 65, and therefore eligible for Medicare because of a disability or end-stage renal disease, are also of special concern: 21 percent lack supplemental coverage, compared with about 9 percent of Medicare beneficiaries overall.

Each source of supplemental coverage has some restrictions on eligibility. Employer-sponsored insurance is limited to beneficiaries (and their spouses) who worked for employers who offered such coverage. Medicaid is limited to beneficiaries who meet income and asset requirements. Enrollment in Medicare managed care products is limited to beneficiaries who reside in counties where plans participate. For example, 76 percent of beneficiaries living in predominantly urban areas have the option of joining an

M+C plan, compared with only 13 percent of beneficiaries living in rural areas. Medigap insurance appears to be a more important option in areas that lack Medicare managed care options and is available to all elderly beneficiaries. During the first 6 months of enrollment in Medicare Part B, all beneficiaries aged 65 and older have the right to purchase a Medigap policy of their choice, subject to plan availability in their area. Outside of this open-enrollment period and certain other limited periods, however, access is not guaranteed.<sup>14</sup> Insurers may refuse to sell a policy or charge a higher premium based on a person's health status.

Enrollment in supplemental coverage varies by a number of sociodemographic factors (Table 2-4, p. 34):

- **Age.** In 1999, beneficiaries under age 65 were least likely to have supplemental coverage, especially Medigap insurance. Those over age 80 were most likely to have Medigap coverage.
- **Income.** Among low-income beneficiaries, Medicaid was most common, covering 45 percent of those who are poor and 21 percent of the near poor (those with incomes between 100 and 125 percent of poverty). At the other end of the income distribution, 48 percent of those with high incomes (greater than 400 percent of poverty) had employer-sponsored insurance. One study found that low-income beneficiaries were more likely to be in Medicare managed care than to have Medigap insurance, most likely because of its lower premiums (Pourat et al. 2000).
- **Residence.** Rural Medicare beneficiaries were more likely than their urban counterparts to have

Medigap coverage (39 versus 23 percent), less likely to be in Medicare managed care (4 versus 23 percent), and more likely to lack any type of supplemental coverage (14 versus 7 percent).

- **Health status.** Compared with those reporting excellent or very good health, beneficiaries in poor health were less likely to have employer-sponsored insurance (28 versus 35 percent), less likely to have Medigap coverage (19 versus 30 percent), more likely to have Medicaid (24 versus 6 percent), and more likely to lack any type of supplemental coverage (14 versus 7 percent).

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## Impact of supplemental coverage on program and system efficiency

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Medicare managed care is a substitute for the fee-for-service program. The other sources of additional coverage—employer-sponsored insurance, Medigap coverage, and Medicaid—supplement the fee-for-service benefit package. The supplemental products respond to beneficiaries' desire to limit their financial risk. They also allow beneficiaries to budget for known premiums rather than face unknown expenditures when they become ill. In this way, the supplements provide beneficiaries with important financial protection, but at a price. Some of the additional costs of these products come from the benefit design, while some come from the administrative burden of managing multiple systems. The number of options also complicates the process of determining who pays for services and increases the paperwork for both beneficiaries and providers.

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13 As with the findings regarding access to care, other factors, such as education or income, may be correlated with both the necessary care indicators and insurance status, and may therefore confound our results. Multivariate analysis might show a smaller impact from having additional coverage, but would not be likely to eliminate the effect.

14 Beneficiaries are guaranteed the right to purchase a Medigap plan in a number of situations, such as when their Medicare managed care plan is terminated. In most cases (but not all), these guaranteed issue rights are limited to plans that do not include drug coverage. See Appendix B for a full description of the guaranteed issue provisions.

**TABLE  
2-4**

**Sources of additional coverage by selected beneficiary characteristics, 1999**

	Percent distribution						
	Percent of all beneficiaries	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other	Medicare only
All beneficiaries	100.0%	33.0%	27.0%	11.1%	18.5%	1.6%	8.8%
Age							
Under 65	13.2	27.9	6.1	32.1	10.2	2.8	21.0
65-69	23.8	36.9	22.2	7.8	22.1	1.4	9.6
70-74	22.6	35.0	29.9	8.1	18.9	1.7	6.4
75-79	19.2	33.0	33.4	7.0	20.4	1.2	5.0
80-84	12.1	31.5	37.6	6.7	17.9	0.6	5.7
85+	9.1	27.1	35.6	10.6	17.1	2.1	7.5
Income status							
Below poverty	16.6	11.3	16.6	44.7	11.8	2.9	12.8
100 to 125% of poverty	10.2	16.9	25.6	20.7	19.6	2.7	14.6
125 to 200% of poverty	21.9	26.6	30.3	5.6	22.8	2.1	12.6
200 to 400% of poverty	32.1	44.8	28.2	0.7	20.0	0.8	5.5
Over 400% of poverty	19.0	48.2	31.4	0.2	16.3	0.6	3.4
Residence							
Urban	76.0	34.8	23.2	10.2	23.5	1.1	7.2
Rural	24.0	27.7	39.3	12.8	4.4	2.1	13.7
Health status							
Excellent/very good	41.1	35.3	29.5	5.6	21.6	1.2	6.8
Good/fair	49.9	32.0	26.4	13.2	17.0	1.8	9.7
Poor	8.7	28.4	18.9	24.1	12.7	2.3	13.6

Note: Income status is defined in relationship to the poverty level in 1999 (\$7,990 if living alone and \$10,075 if living with a spouse). Urban includes beneficiaries in metropolitan statistical areas (MSAs). Rural includes beneficiaries living outside MSAs. We allocated beneficiaries according to the type of coverage they held for at least 6 months of the year. Numbers may not sum to 100 due to rounding or incomplete data.

Source: MedPAC analysis of 1999 Medicare Current Beneficiary Survey, Cost and Use file.

All of the Medigap plans, Medicaid, and most employer-sponsored plans provide generous coverage of Medicare's cost-sharing requirements. Most products pay for the lion's share of beneficiaries' deductibles and coinsurance, and some cover all of them. This so-called first-dollar coverage protects beneficiaries from financial liability from the first dollar of expenditure beyond their premium. The supplements also provide cost-sharing coverage for routine and predictable services.

First-dollar coverage may respond to beneficiaries' desire to limit financial risk to the maximum extent possible, but it may not be the most efficient policy. For

the Medicare program, extensive coverage of deductibles and coinsurance diminishes many of the incentives embedded in the cost-sharing structures that are meant to encourage people to be judicious in their use of services. Therefore, both current coinsurance or deductibles, and any revised cost-sharing structures, may not affect use as expected or desired. Because fee-for-service Medicare has no care management tools, program spending may be excessive as a result. For beneficiaries and those that sponsor their coverage, first-dollar coverage also raises the premiums for supplemental coverage. In addition, the costs of predictable expenditures such as the Part B deductible are automatically included in the

premium, with insurers incurring costs to administer these benefits, which also must be incorporated into the premiums. More efficient supplemental products might expand offered benefits while limiting coverage of deductibles and other cost-sharing requirements.

Medicare beneficiaries with supplemental insurance cost the program more than those without such coverage. Although the degree of extra spending varies, studies have consistently found that beneficiaries with private supplemental coverage (employer-sponsored or Medigap) have higher Medicare spending (Atherly 2001). A MedPAC analysis of the 1998 Medicare Current Beneficiary

Survey found that Medicaid dual-eligible beneficiaries cost the Medicare program the most, followed by beneficiaries with Medigap coverage, and then those with employer-sponsored coverage. Medicare beneficiaries without any supplemental coverage cost the Medicare program the least (data not shown).

Researchers have not successfully isolated the extent to which the differences in use of care reflect people with supplemental coverage getting unnecessary care or those without supplemental coverage going without needed care. Econometric studies suggest that the former is occurring, while the evidence on access to care and use of necessary care suggests that the latter is occurring. It is likely that both are occurring, but we cannot isolate the impact of each factor.

Multiple sources of coverage also increase administrative expenses for providers, beneficiaries, and insurers in processing claims and managing multiple systems. All Medicare supplemental products have administrative costs. For Medigap plans, the minimum loss ratio (the percentage of premiums spent on medical services) established in regulations is 65 percent for individual policies, meaning that up to 35 percent of premium revenues can fund marketing, overhead, and profits for the insurers. Most plans have higher loss ratios, however, meaning that a greater portion of their premium revenue is spent on medical services. Administrative costs for Medigap plans average about 20 percent; in comparison, administrative costs are about 11 percent for M+C plans and about 2 percent for program management of traditional Medicare (deParle 2000). The administrative costs for the Medicare program, however, are thought to be both understated and insufficient (Health Affairs 1999).<sup>15</sup> In addition, both Medicare and M+C plans spread overhead costs over a larger

volume of spending, leading to lower administrative costs as a percent of the total. Employer plans also incur considerable costs in coordinating their benefits with those covered by Medicare. In addition, administrative costs are duplicated when beneficiaries have multiple supplemental products.

The multiple sources of supplemental coverage create a maze of options for beneficiaries and create additional administrative work for providers. Beneficiaries have a difficult time navigating the choices, in part because they lack a basic understanding of the Medicare program. (Of course, understanding of the health care system by the general population is also limited.) For example, only about one-third of beneficiaries say they know most or all of what they need to know. Only about half know that they have health plan choices available. Beneficiaries are frequently unclear about the difference between traditional Medicare and Medicare managed care, often not knowing whether they are enrolled in a health maintenance organization or in traditional Medicare. Beneficiaries also have difficulty understanding their Medigap insurance options, not knowing, for example, that if they drop a Medigap policy they may only be able to purchase another one under certain conditions (Stevens and Mittler 2000, Gold et al. 2001, McCormack et al. 2001). Once they have chosen a supplement, beneficiaries will receive multiple claims and statements that can cause confusion. Medigap insurers attempt to reduce this confusion by working with providers and the Centers for Medicare & Medicaid Services to process claims, which means that beneficiaries do not have to submit claims to their Medigap insurers.

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## The future of additional coverage

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Emerging trends suggest that the prevalence of supplemental coverage may decline:

- the number of beneficiaries enrolled in Medicare managed care has fallen,
- employers have scaled back on coverage for future retirees and increased premium contributions for current retirees, and state that they will continue to do so in the future, and
- Medigap premiums have continued to rise, albeit more slowly than in the 1990s, raising questions about the affordability of this form of supplemental coverage.

## Medicare managed care

During the past four years, the M+C program has seen plan participation, beneficiary enrollment, and the value of plan benefit packages decline, while the premiums that plans charge have risen. Between January 1999 and January 2002, enrollment in Medicare managed care fell by about 15 percent. Consequently, we estimate that the fraction of beneficiaries with some form of Medicare managed care has fallen from 18 percent to about 15 percent.<sup>16</sup>

In addition, most plans remaining in the M+C program have scaled back the benefits they offer. About half of beneficiaries still have access to a plan that offers a drug benefit, although the value of that benefit has declined, particularly in the past year. Plans are increasing beneficiary copayments, limiting the total dollar amount of coverage, restricting coverage to a formulary, or limiting coverage to generic drugs only. Cost sharing for other health

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15 For example, the administrative budget for the Centers for Medicare & Medicaid Services does not include the costs of collecting payroll taxes for the Part A Trust Fund that are borne by the Treasury Department or the costs of withholding Part B premiums from Social Security checks that are borne by the Social Security Administration.

16 This figure reflects 13 percent of beneficiaries in M+C plans and about 2 percent in cost plans, managed care demonstrations, and other forms of Medicare managed care.

care services—such as hospital admissions and physician visits—also has increased. At the same time, the monthly premiums that plans charge increased from an average of \$23 in 2001 to about \$31 in 2002, and fewer M+C plans now offer coverage for no additional premium than in previous years.

## Medigap

A large share of the beneficiaries who no longer have Medicare managed care coverage probably now have Medigap plans. Data from 2000 suggest that Medigap enrollment is increasing as managed care enrollment declines. A 1999 survey found that 75 percent of beneficiaries involuntarily disenrolled from M+C plans (who did not join a different managed care plan) found a different source of supplemental coverage (Barents Group 1999), although the benefits offered may not have been as rich or the premiums may have been higher than in their M+C plan. If we assume that people disenrolled from the M+C market between 1999 and 2002 obtained supplemental coverage in the same proportions as the survey respondents reported, then the fraction of beneficiaries with no additional coverage has grown from 9 percent in 1999 to an estimated 11 percent in 2002.<sup>17</sup>

## Employer-sponsored insurance

Employer-sponsored insurance, the largest source of supplemental coverage, has also been declining. Over the past decade, the proportion of employers offering retiree health coverage has declined, even during the strong economy of the late 1990s. A nationally representative survey of public and private employers with 500 or more employees found that 23 percent offered health coverage to Medicare-eligible retirees in 2001, down from 40 percent in 1994 (Mercer 2002). The declines have accelerated in recent years: The

percentage of firms with 200 or more workers offering coverage to retirees over age 65 declined by 10 points between 1999 and 2001. The same survey found that the percentage of small firms (those employing 3-199 workers) offering retiree health coverage fell from 9 percent in 2000 to 3 percent in 2001 (Henry K. Kaiser Family Foundation et al. 2002). Few, if any, employers have added health coverage for Medicare-eligible retirees (Mercer 2001). In fact, the declining proportion of firms offering health insurance may have occurred because fewer new firms offer such coverage, not because established firms are dropping it. These declines generally affect future, rather than current, retirees. In 2001, five percent of large employers had plans that covered only current retirees, or those hired before a certain year (Mercer 2002). Employers also have increased the number of years of service required to qualify for retiree health benefits (Watson Wyatt Worldwide, in press).

A change in accounting standards in the early 1990s forced employers to account for their retiree health coverage in ways that encouraged them to reduce such coverage.<sup>18</sup> Similarly, recent litigation around age discrimination may prevent firms from offering different health benefits to pre- and post-Medicare retirees, further discouraging them from offering retiree coverage (Fronstin 2001, GAO 2001). Most of the impact of this change has yet to be felt. It is not apparent in current coverage trends, but will appear gradually over time as today's workers, who have less generous employer contributions or no retiree health benefits at all, begin to retire (GAO 2001).

In addition to the recent declines in firms offering coverage to their retirees, those that offer coverage have been scaling back on drug benefits and increasing retirees' premium contributions. Among firms that offer retiree health benefits, 32 percent

increased cost sharing for prescription drugs and 53 percent increased retirees' share of the premium between 1999 and 2001. About 36 percent of large employers have capped their contribution towards retiree coverage either for current or future retirees (Hewitt Associates 2001).

## Medicaid

State governments have been experiencing tight budgets in recent years, with Medicaid accounting for a large fraction of their expenditures (Kaiser Commission on Medicaid and the Uninsured 2001). These fiscal pressures should not have a dramatic effect on Medicare beneficiaries already enrolled in Medicaid because the criteria for dual eligibility are mandated in federal law and regulations. However, they may affect the level of outreach that states undertake to encourage new enrollment. In addition, states are adopting strategies to limit drug expenditures that may limit the availability of pharmaceuticals for poor elders (Cunningham 2002). Furthermore, a few states are considering ways to introduce cost sharing by Medicaid beneficiaries. For example, a Texas commission has recommended introducing a voluntary enrollment fee and other cost-sharing measures (Kaiser Commission on Medicaid and the Uninsured 2002).

Finally, all sources of supplemental coverage will be affected by accelerating health care cost inflation. Premiums for the nonelderly and health care costs in general have been rising at rates that are at least double that of general inflation, at a time when the economy has slowed (Mercer 2001). In addition, the rapid rise in spending on prescription drugs will play a crucial role in determining the costs of supplemental products that cover them.

17 These are MedPAC estimates based on the distribution in 1998, the change in Medicare managed care enrollment between 1998 and 2002, and the survey results regarding the sources of supplemental coverage obtained by those who lost their M+C plan. Note that this estimate of uncovered beneficiaries may be conservative. A survey of beneficiaries conducted in 2000 found that 17 percent had no supplemental coverage (Gold and Mittler 2001).

18 The Financial Accounting Standards Board approved Financial Account Statement No. 106 in 1990. It required employers to report annually on their current and future retiree health benefit liabilities and include them on their balance sheets, beginning with fiscal years after December 15, 1992.

These trends will probably make supplemental insurance less affordable for employers, states, and beneficiaries.

## Total spending and sources of payment for beneficiaries' health care

The additional coverage purchased by or on behalf of Medicare beneficiaries contributes a substantial share of the total spending for beneficiaries' health care. In this section, we look at spending by all sources—Medicare, beneficiaries, private supplemental plans, and public supplemental programs—to gain a more complete picture of the total amount being spent on beneficiaries' health care. According to estimates produced for MedPAC, total projected spending in 2002 (excluding long-term care) is \$446 billion, including administrative costs (Table 2-5).<sup>19</sup> Of that, Medicare is projected to account for about

\$262 billion, or 59 percent of total spending. Other payers are projected to account for about \$184 billion, or 41 percent of the total (Figure 2-1, p. 38).

The portion of total spending not covered by Medicare is shared among beneficiaries and supplemental payers. In addition to the \$262 billion spent by Medicare, beneficiaries spend \$82 billion on services (excluding Medicare and supplemental insurance premiums), or 18 percent of the total. Private supplemental insurance plans (Medigap and employer-sponsored insurance) account for \$69 billion (including administrative costs), or 15 percent of the total. Other government programs (Medicaid, VA, and DoD) account for \$33 billion (including administrative costs), or 7 percent of the total.

The administrative costs of insurance—marketing, claims processing, reinsurance, profits, and so forth—vary by source. Private supplemental insurers incur the

highest administrative costs; of the \$69 billion they are projected to spend in 2002, 15 percent will go toward administration. Administrative costs are projected to be 2 to 3 percent for both public supplemental insurance and for Medicare.

In considering whether to revise Medicare's benefit package, policymakers could view total spending in a different way. Looking at the type and cost of all services currently received by beneficiaries—both covered and uncovered—shows how much of the care they consume is currently inside the benefit package and how much is not. Excluding administrative costs, spending on Medicare-covered services is \$301 billion, about 71 percent of total spending. Medicare accounts for the majority of spending on Medicare-covered services (85 percent). Spending on non-covered services (excluding administrative costs)

**TABLE 2-5**

**Estimated spending on medical services for Medicare beneficiaries, by source, 2002**

	Total		Medicare program		Beneficiary OOP		Private supplements		Public supplements	
	\$ billion	% of total	\$ billion	column %	\$ billion	column %	\$ billion	column %	\$ billion	column %
Medical expenditures										
Medicare-covered services	\$301.1	67.5%	\$254.8	97.4%	\$11.1	13.5%	\$24.3	35.5%	\$10.9	32.5%
Non-covered drugs	86.9	19.5	0.0	0.0	39.1	47.4	29.5	43.0	18.3	54.7
Other non-covered services	39.7	8.9	0.0	0.0	32.3	39.1	4.3	6.3	3.1	9.3
Administration	18.4	4.1	6.9	2.6	0.0	0.0	10.4	15.2	1.2	3.5
Total	\$446.1	100.0%	\$261.7	100.0%	\$82.5	100.0%	\$68.5	100.0%	\$33.5	100.0%

Note: OOP (out of pocket). Estimates exclude costs of long-term care, but include other services not covered by Medicare such as vision, dental, equipment, and supplies. Beneficiary OOP estimates exclude Part B and supplemental premiums to avoid double-counting. Private supplements include employer-sponsored retiree coverage, Medigap insurance, and some payments from Medicare+Choice plans. Public supplements include Medicaid (acute care only), Department of Veterans Affairs, Department of Defense, and state programs.

Source: Actuarial Research Corporation estimates based on data from the 1998 Medicare Current Beneficiary Survey, Cost and Use file, the 1998 Medical Expenditures Panel Survey, the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Finance Committee, March 7, 2002. Spending on other non-covered services has been projected to 2002 based on growth in Medicare spending. These numbers also reflect MedPAC's estimates of the distribution of supplemental insurance in 2002.

19 These estimates were produced for MedPAC by the Actuarial Research Corporation. They are based on data from the 1998 Medicare Current Beneficiary Survey, Cost and Use file, the 1998 Medical Expenditures Panel Survey, the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

is \$127 billion, about 29 percent of the total. Most of this spending, \$87 billion, is on prescription drugs (Figure 2-2).

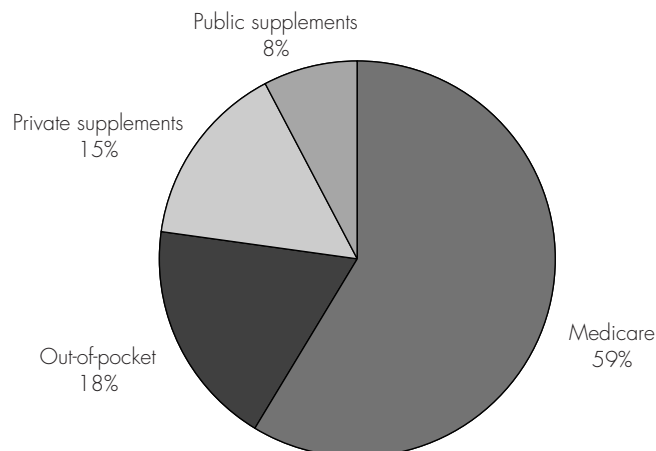
## Conclusion

Over 90 percent of Medicare beneficiaries obtain additional coverage by either supplementing the fee-for-service benefit package or replacing it with a managed care plan. Given the current Medicare fee-for-service benefit structure, additional coverage provides important financial protection for beneficiaries, which helps to ensure access to care and use of necessary services. At the same time, very generous supplemental coverage may increase beneficiaries' premiums, employers' premiums, and program costs unnecessarily by softening the incentives for judicious use of services inherent in Medicare's cost-sharing structure. In the future, beneficiaries may be less able to obtain additional coverage as the availability of Medicare managed care and employer-sponsored insurance declines and Medigap plans become more expensive. Beneficiaries may face access problems if the current sources of additional coverage are not replaced by other sources.

As policymakers consider changes to the Medicare program and the benefit package, it will be important to consider the interplay between the program and sources of additional coverage, as well as the total resources spent on beneficiaries' health care. There may be more effective and efficient ways to pay for beneficiaries' health care. The current system has inefficiencies both within the Medicare program and across sources of supplemental coverage. If resources currently spent by all payers were redirected, the potential exists to improve efficiency and provide better financial protection and access to appropriate care for beneficiaries. The next chapter considers ways to improve the benefit package and outlines issues to consider if such changes were to be made. ■

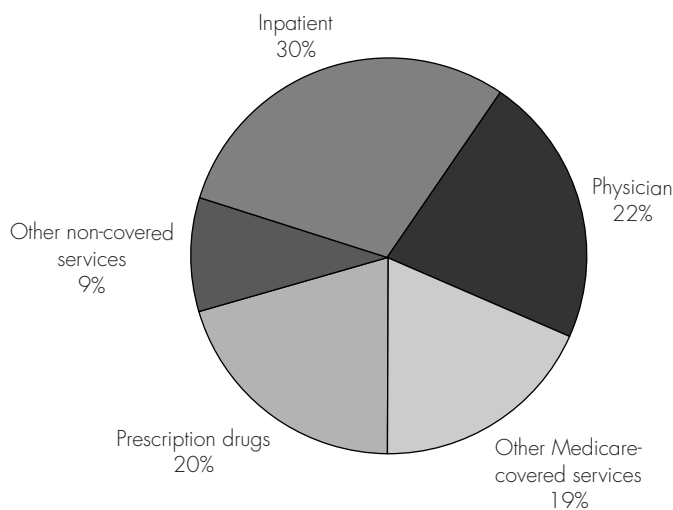
**FIGURE 2-1**

**Total spending on Medicare beneficiaries' health care services, by source, 2002**



**FIGURE 2-2**

**Spending on Medicare beneficiaries' health care, by type of service, 2002**



Note: Figure 2-1 includes spending on Medicare-covered and non-Medicare-covered services, exclusive of long-term care, by all payers. Includes administrative costs incurred by Medicare and other payers. Out-of-pocket spending does not include beneficiary premiums for Part B or supplemental coverage to avoid double-counting. Private supplements include employer-sponsored retiree coverage, Medigap insurance, and some payments from Medicare+Choice plans. Public supplements include Medicaid (acute care only), Department of Veterans Affairs, Department of Defense, and state programs.

Figure 2-2 includes spending on Medicare-covered and non-Medicare-covered services, exclusive of long-term care, by all payers. Does not include administrative costs. Other Medicare-covered services include postacute care and all Part B services other than physician services. Other non-covered services include dental, vision, equipment, and some supplies.

Source: Actuarial Research Corporation estimates based on data from the 1998 Medicare Current Beneficiary Survey, Cost and Use file, the 1998 Medical Expenditures Panel Survey, the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002. Spending on other non-covered services has been projected to 2002 based on growth in Medicare spending. These numbers also reflect MedPAC's estimates of the distribution of supplemental insurance in 2002.



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CHAPTER

3

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**Options for changing  
the benefit package**

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## Options for changing the benefit package

**T**his chapter examines several alternatives for addressing limitations in Medicare’s benefit package. Each option would involve tradeoffs among various goals, such as financial protection and access to care for beneficiaries, efficient use of services, feasibility, and affordability. Our analysis suggests that: (1) Modifying Medicare’s cost-sharing structure alone could improve financial protection, access to care, and efficiency with little increase in spending, but would not remedy lack of coverage for important services. (2) Expanding the benefit package to cover prescription drugs and other services would enhance financial protection and access to care. Although expanding coverage could require substantial new Medicare resources, spending by other payers would decline. (3) Creating a more comprehensive benefit package—offered directly by the government or through private sector entities—that includes a prescription drug benefit and a cap on cost sharing could improve financial protection, access to care, and efficiency. This type of change could be accomplished without increasing total spending on beneficiaries’ health care, but it would substantially redistribute existing resources.

### In this chapter

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- Changing Medicare’s cost-sharing structure
  - Expanding the Medicare benefit package
  - Creating a comprehensive benefit package by reallocating resources
  - Conclusion
-

In previous chapters, we described the success Medicare has had in achieving its basic goals: protecting elderly and disabled people from high health care costs and assuring them access to high-quality care. However, we also identified significant challenges facing the program: some beneficiaries continue to bear severe financial burdens, the benefit package provides better coverage for certain conditions than others, changes in medical practice have put additional pressure on the adequacy of the benefit package, and the widespread use of supplemental coverage to fill gaps in Medicare's benefits leads to inefficiencies. This chapter illustrates options that policymakers might use to address these problems. The Commission does not recommend specific options.

In addressing these challenges, we recognize that resources—both in terms of federal spending and beneficiaries' ability to pay—are limited and therefore ask whether there is a better way to allocate the resources currently spent on beneficiaries' care. In other words, could the \$262 billion currently spent by Medicare and the \$446 billion currently spent by all payers on behalf of beneficiaries buy more benefits or a more equitable distribution of benefits?

Some options could address the limitations of the current Medicare benefit package with minimal impact on Medicare spending. Other options could increase Medicare spending (and therefore federal spending, beneficiaries' premiums, or both). If Medicare spending increased as a result of covering more services already used by many beneficiaries, it would replace spending by beneficiaries, supplemental insurers, or other government programs. Accordingly, total health care spending could remain roughly the same, even as Medicare spending increased. However, total spending could increase or decrease depending on whether:

- broader Medicare coverage increased the likelihood that beneficiaries used services, or

- Medicare used its market power to reduce prices for newly covered services.

## Options

The options we present are organized into three sections based on the degree of change—from least to most—they represent for the program and the health care system: 1) changing the cost-sharing structure of existing benefits, 2) covering new benefits, and 3) creating a more comprehensive benefit package that includes cost sharing changes and new benefits.

The first section presents a set of illustrative changes to address problems in the cost-sharing structure (deductibles, coinsurance, and copayments) for currently covered services. Such problems include disparities in cost sharing among different treatments and the lack of protection from catastrophic out-of-pocket costs. As part of this discussion, we address the role of supplemental coverage in reducing beneficiaries' sensitivity to health care costs and offer options for reform. The options in this section could be implemented with little increase in program spending.

The second section lays out options to expand and modernize the Medicare benefit package to cover additional goods and services, reflecting the need to improve benefits to address the demographic trends and changing health care needs among Medicare beneficiaries and changes in the practice of medicine since the inception of the program. We consider expanding or adding coverage for prescription drugs, case and disease management programs, preventive services, mental health care, vision and hearing care, and dental services. Some of these options probably would not require additional program spending, while others would require the substantial redirection of spending from other payers to Medicare and perhaps additional system spending.

The third section outlines a comprehensive benefit package that would incorporate both cost-sharing changes and a broader range of benefits and could improve financial protection, access to care, and efficiency. This package could be provided directly by Medicare or through private entities under a premium support approach or an expanded Medicare+Choice (M+C) program. Under this option, beneficiaries could purchase a single insurance product and would no longer need to rely on a patchwork of insurance policies. Resources currently spent by beneficiaries and supplemental payers would be redirected through Medicare, which could reduce administrative overhead. Depending on how the availability of this comprehensive package affected the demand for supplemental coverage, total current spending on beneficiaries' health care could stay about the same. However, this approach would have significant implications:

- if a comprehensive package were provided directly by Medicare, it would expand Medicare's influence over the health care market;
- it would create an entitlement to new benefits at a time when the program prepares to face financial pressure from rapidly growing health spending and an influx of new beneficiaries;
- to the extent that additional Medicare spending was financed by taxes, rather than higher premiums, the fiscal burden would shift from older to younger generations; and
- depending on the design and financing of the new benefit package, some beneficiaries would fare better and some would fare worse.

## Criteria

We evaluate options for changing the benefit package based on their potential to improve financial protection for beneficiaries, access to care, and efficient

provision of services. In addition, we consider each option's implementation feasibility and potential costs.

- **Financial protection.** Would the option improve the financial security of beneficiaries, on average or for specific subgroups? Would it protect beneficiaries from impoverishment or severe financial difficulty due to high cost-sharing expenses?
- **Access to care.** Would the option improve access to high-quality health care services in the most appropriate settings? Would it reduce disparities in access to care for beneficiaries with different health conditions?<sup>1</sup>
- **Efficiency.** Would the option promote the purchase of appropriate care at the lowest cost? Would it improve incentives for beneficiaries to use health care services (and, similarly, for providers to supply services) only when they are clinically necessary and worth their costs? In addition, would the option reduce administrative costs associated with health care spending on behalf of beneficiaries?
- **Feasibility.** Could the change be implemented without undue disruptions to beneficiaries, providers, and payers? For example, could a proposed change make use of Medicare's current administrative systems or would it require a different mechanism?
- **Cost implications.** Would the option require additional Medicare spending? If so, could it be implemented without increasing total spending on beneficiaries' health care? How would costs be distributed among Medicare, beneficiaries, and other payers?

Because carrying out many of these options would involve tradeoffs, some criteria overlap or conflict with one another.

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## Changing Medicare's cost-sharing structure

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Changes in Medicare's cost-sharing structure could improve beneficiaries' financial protection from the cost of expensive medical care, reduce financial barriers that limit access to care, reduce cost-sharing disparities for beneficiaries with different treatment needs, and strengthen incentives to control the use of services that provide only marginal clinical value. In light of budget constraints, policymakers might want to use savings achieved from one or more changes to offset costs associated with other changes. Accordingly, a combination of changes could be made to improve incentives for care use and financial protection without significantly increasing costs. In this section, we identify problems with Medicare's cost-sharing structure, discuss options for changing it, and evaluate illustrative combinations of these options (Medicare's current cost-sharing rules are shown in Chapter 1, Table 1-1, p. 5).

### Problems with Medicare's cost-sharing structure

The goals of cost sharing in health insurance are to encourage appropriate use of services (and thus constrain the aggregate cost of the insurance) while providing enrollees with financial protection from high out-of-pocket costs. As discussed in Chapter 1, Medicare's cost-sharing system does not fully meet either of these goals. Cost sharing for random events over which beneficiaries exercise little control, such as hospitalizations, exposes them to high costs while having minimal effect on use of services. Cost sharing for more

predictable, discretionary services, such as ambulatory care, is often too low to encourage prudent use of care. In addition, the lack of a cap on total cost-sharing liability subjects some beneficiaries to financial hardship. Finally, because Medicare has inconsistent cost-sharing rules for different kinds of treatment in different settings, beneficiaries' costs can depend on their condition. For example, people with mental illnesses who require outpatient treatment are subject to higher coinsurance than those who require most types of outpatient services for other conditions (50 percent versus 20 percent).<sup>2</sup> Some might argue that outpatient mental health services are more discretionary than other outpatient services and thus should be subject to higher coinsurance.

The ability of Medicare's cost-sharing design to encourage appropriate use of care is affected by the widespread demand for supplemental insurance. As discussed in Chapter 2, most beneficiaries have supplemental coverage, much of which fully covers Medicare's cost sharing. This coverage thus reduces beneficiaries' price sensitivity and leads to higher use of services, which in turn increases Medicare spending. Because beneficiaries and providers have imperfect information about patients' health and the effectiveness of various treatments, this higher use probably represents a mix of necessary and unnecessary care.

### Options for cost-sharing changes

The following discussion presents options for adjusting three features of cost-sharing design—deductibles, coinsurance or copayments, and caps on cost sharing expenses—to balance the goals of providing protection for high medical costs and encouraging appropriate use of services. We also present ways to modify the impact of supplemental coverage.

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1 Although we focus on financial barriers to care, such as the high cost of individual services or high liabilities from the use of many services, non-financial barriers, such as provider availability, may also be important.

2 Although coinsurance for physician services for non-mental health problems is 20 percent, services received in outpatient hospital departments are subject to average coinsurance in the range of 45 to 50 percent.

## Change the deductible structure

The Part B deductible has remained at \$100 since 1991, but beneficiaries are subject to a relatively high inpatient hospital deductible of \$812. Options to change these deductibles include:

**Increase the Part B deductible and index it to annual growth in per capita Part B spending** This change would encourage more efficient use of Part B services, which are relatively price sensitive. As the deductible increased along with growth in spending, it would cause the Part B premium to decline (compared with current law) but could eventually hinder access for poor and near-poor beneficiaries who lack supplemental coverage.

**Reduce the inpatient hospital deductible** This change would lower beneficiaries' financial exposure to the cost of hospitalizations. Because hospital stays are relatively non-discretionary events, they should be subject to low cost sharing.

**Eliminate the blood deductibles** Under both Parts A and B, beneficiaries must pay for the first three pints of blood they use (unless they donate replacement blood). This requirement does not encourage efficient use of blood or reduce Medicare's costs because very few beneficiaries who receive blood are charged the deductible.<sup>3</sup> Even if this deductible were charged more

consistently, it would probably not encourage more prudent use of blood because beneficiaries do not initiate blood use. Removing the blood deductible would simplify the cost-sharing structure.

**Combine the inpatient hospital deductible and Part B deductible into a single annual deductible indexed to growth in per capita Medicare costs** A combined deductible set at a budget-neutral level would be about \$380 in 2002.<sup>4</sup> This would lower cost sharing for the approximately 20 percent of beneficiaries who have hospital stays but increase it for the 70 percent who use only Part B services and spend over \$100 on them. A single deductible would be less confusing to beneficiaries than the current system of separate deductibles and would be more consistent with private sector benefit design.<sup>5</sup>

## Change the coinsurance/copayment structure

Current coinsurance rates are uneven among various types of services and settings, which distorts decisions about which treatments to pursue. For example, beneficiaries face different coinsurance rates depending on whether they undergo a procedure in a hospital outpatient department, ambulatory surgical center, or physician office. Options for changing coinsurance/copayment rules include:

## Reduce outpatient hospital

**coinsurance** Because of an historical anomaly, beneficiaries are responsible for a much higher share of the costs of outpatient hospital services (45 to 50 percent) than for other Part B services (20 percent).<sup>6</sup> Beneficiaries who require repeat visits may incur particularly high liabilities as a result. For example, we estimate that beneficiaries undergoing radiation therapy were responsible for an average of \$2,880 in coinsurance in 2001 (MedPAC 2001).<sup>7</sup> Setting the outpatient hospital coinsurance consistent with other Part B services would improve beneficiaries' financial protection from high medical costs, especially for those with chronic conditions.<sup>8</sup> In addition, equalizing coinsurance rates between sites of care (such as hospital outpatient departments, physician offices, and ambulatory surgical centers) would minimize financial incentives to choose one site over another. Independent of other cost-sharing changes, reducing this coinsurance to 20 percent would require additional program spending of about \$5.5 billion in 2002.

**Require 20 percent coinsurance for clinical laboratory services** Clinical laboratory services is one of only two Medicare benefits not subject to any cost-sharing requirements (the other is home health care). Requiring beneficiaries to pay 20 percent coinsurance for these services would equalize cost sharing between clinical laboratory and other Part

3 Using data from the 1999 Medicare Provider Analysis and Review 20 percent file, we estimate that fewer than 10 percent of inpatient cases that use blood were charged the blood deductible. These charges were less than \$20 million.

4 Unless otherwise noted, cost estimates of cost-sharing changes are based on an Actuarial Research Corporation model using data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

5 This change would have implications for Medicare's financing structure because Part A and Part B services are financed by separate trust funds with distinct revenue sources—Part A is financed by payroll taxes and Part B is financed by beneficiary premiums and general government revenues. Without other changes, decreasing beneficiary cost sharing for Part A services and increasing it for Part B services would shift program spending from Part B to Part A. This would reduce the Part A trust fund balance and decrease Part B premiums and general revenue contributions.

6 Under the prior payment system for care in hospital outpatient departments, beneficiaries' coinsurance was 20 percent of the hospital's charges while Medicare's payment was the lesser of costs or charges (or a blend of the two). Because charges for services were generally higher than costs, the coinsurance represented a higher share of the payment than 20 percent.

7 This analysis is based on 1999 outpatient hospital use rates and 2001 payments and coinsurance.

8 The Balanced Budget Act of 1997 established the outpatient hospital prospective payment system and began a gradual reduction in beneficiary coinsurance—the so-called buy-down—until it reaches 20 percent. However, this process would have taken an estimated 30-40 years (MedPAC 2001). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 phased in a reduction of coinsurance to 40 percent of payment by 2006. MedPAC has recommended that the reduction be accelerated so that coinsurance reaches 20 percent of Medicare's payment for all procedures by 2010 (MedPAC 2001).



B services and would reduce Medicare spending by about \$1.5 billion in 2002. However, because beneficiaries do not initiate their use of laboratory services (they usually are ordered by physicians), adding coinsurance probably would not encourage more prudent use of care. Coinsurance also may pose a financial barrier to low-income beneficiaries who lack supplemental coverage. In addition, laboratories would have incentives not to collect the coinsurance because the cost to the lab of billing and collecting the coinsurance would often exceed the coinsurance amount.<sup>9</sup>

**Reduce mental health outpatient coinsurance** Beneficiaries face a 50 percent coinsurance for most outpatient mental health services, compared with 20 percent for most other outpatient services.<sup>10</sup> Equalizing cost sharing for outpatient mental health and other outpatient care would reduce a financial barrier to mental health care and provide parity to beneficiaries with mental disorders and those with other illnesses, with a small increase in Medicare spending (approximately \$500 million in 2002). This change also would simplify Medicare's cost-sharing structure.

**Eliminate cost sharing on currently covered preventive services** Some covered preventive services, such as sigmoidoscopies and fecal occult blood tests, are underused (see Chapter 1). Excluding preventive services from coinsurance and the Part B deductible could encourage beneficiaries to use more preventive care.<sup>11</sup> However, this change would not guarantee increased use of additional preventive services. Providers' attitudes about encouraging preventive

care and beneficiaries' lack of interest or knowledge about these services may be more significant barriers to obtaining needed care than cost sharing requirements. In addition, eliminating cost sharing on preventive care would increase the unevenness of the cost-sharing structure because most other covered services are subject to deductibles and coinsurance. This change would increase 2002 Medicare spending by about \$750 million (less than 1 percent).

**Eliminate hospital copayments for days 61-150 and cover an unlimited number of hospital days** This change would improve financial protection for beneficiaries with long hospital stays, for whom the current hospital copayment structure imposes high liabilities.<sup>12</sup> For example, an individual with a 90-day stay in 2002 would be charged \$6,090 of coinsurance in addition to the \$812 deductible. Although only 1 percent of inpatient discharges incurred coinsurance in 1998, the average liability for such discharges was \$3,000 (Health Care Financing Administration 2001). This risk of high liability may increase demand for supplemental coverage. This change would increase 2002 Medicare spending by about \$750 million (less than 1 percent).

**Require cost-sharing for home health services** Requiring beneficiaries to share the cost of home health services would encourage them to use care more prudently and would treat home health care similarly to other services. However, cost sharing could discourage use of needed services, particularly for low-income and chronically ill beneficiaries, who tend to use these services most. In

addition, cost sharing would increase administrative costs for home health agencies. Previously, MedPAC recommended the introduction of a modest home health copayment, subject to an annual limit (MedPAC 1999).

**Modify skilled nursing facility copayments** Currently, no copayment is required for days 1 to 20 of a stay in a skilled nursing facility (SNF); days 21 to 100 are subject to a daily copayment of \$101.50. (Coverage is not provided beyond 100 days.) Requiring copayments for the first 20 days of a stay and reducing copayments for the last 80 days would improve the equity of the system (all SNF users would share in the cost, not only long-stay residents) and could reduce financial burdens on long-stay residents. However, shifting cost sharing from the last 80 days of a stay—which are the most discretionary days—to the first 20 days—which are the least discretionary—would reduce incentives to use SNF services efficiently. Although SNF services and home health services cannot in most cases be substituted for one another, their cost sharing policies should be somewhat parallel so that treatment decisions are not inappropriately influenced. That is, if home health services were to require cost sharing, SNF cost sharing should be modified to be consistent with it.

### **Cap annual cost sharing for covered services**

Medicare does not currently limit beneficiaries' annual cost-sharing liability for covered services—a feature of many private-sector health plans—and a small percentage of beneficiaries incur high cost-sharing liabilities.<sup>13</sup> We estimate that,

9 An Institute of Medicine (IOM) report found that a copayment of 20 percent would be less than \$2.30 on average for the 100 highest dollar volume lab tests, compared with \$5.00 to produce and send a bill (IOM 2000a).

10 The Medicare payment for most outpatient mental health services is calculated as follows: The allowed charge is first reduced by 37.5 percent. Medicare then pays 80 percent of the remaining amount, which is 50 percent of the total ( $0.625 \times 0.80 = 0.50$ ). The beneficiary is responsible for the remaining 50 percent.

11 Although some preventive services are not subject to the Part B coinsurance or deductible, most are, such as osteoporosis screenings, diabetes self-management training, and some cancer screenings.

12 In addition to the Part A deductible, beneficiaries are responsible for a copayment of \$203 per day for inpatient hospital days between 61 and 90 and \$406 for days between 91 and 150. After the 90<sup>th</sup> day of a hospitalization, beneficiaries may draw upon a nonrenewable reserve of 60 additional days of coverage (lifetime reserve days).

13 Cost-sharing liability refers to the deductibles, copayments, and coinsurance that beneficiaries are required to pay for Medicare services. A substantial portion of these liabilities is covered by supplemental insurance. Thus, the numbers in this section do not represent direct spending by beneficiaries.

in 2002, 3 percent of beneficiaries will have liabilities of more than \$5,000, the catastrophic limit in the 2001 Blue Cross/Blue Shield standard option in the Federal Employee Health Benefit Plan. We estimate that about 8 percent will have liabilities of more than \$3,000 in 2002.

Because most beneficiaries have supplemental coverage that covers cost sharing on Medicare-covered services, a cap would improve financial protection and access to care primarily for people who lack supplemental insurance. Depending on its level, a cap also could induce some beneficiaries to forgo supplemental insurance and could lower supplemental insurance premiums.

Capping cost-sharing liability would be costly. Although only 3 percent of beneficiaries are projected to exceed \$5,000 in total cost sharing for covered services in 2002, they will incur more than \$13,000 in liability, on average. Beneficiaries who are projected to exceed \$3,000 in cost sharing in 2002 will incur over \$10,000 in liability, on average. Holding other cost-sharing parameters constant, we estimate that a \$5,000 limit would increase program spending by about 3 percent in 2002 (\$7 billion) and a \$3,000 limit would increase program spending by about 5 percent in 2002 (\$12 billion).

### Supplemental coverage

To address the inflationary effects of supplemental plans' coverage of Medicare cost sharing on Medicare spending, policymakers may want to consider options that would expose beneficiaries to

modest cost-sharing amounts while still providing coverage for high health care costs. A first place to consider these changes is in the Medigap insurance market.<sup>14</sup> The Omnibus Budget Reconciliation Act of 1990 mandated the creation of 10 standardized Medigap plans, which were specified by the National Association of Insurance Commissioners (see Appendix B).<sup>15</sup> All of the standardized plans (those issued after 1992) cover the Part A deductible and Part B coinsurance, and three plans cover the Part B deductible (Table B-1, p. 77).

Standardized Medigap plans could be prohibited from covering the Part B deductible or allowed to cover only half of the Part B coinsurance. Making beneficiaries responsible for some of the marginal costs of services would increase their price sensitivity and encourage them to be more judicious in their use of care. This, in turn, would reduce Medicare spending. Changes of this sort also would likely result in lower Medigap premiums or, at a minimum, slower premium increases, making Medigap a more affordable option.

Such changes would have several disadvantages, however. For some beneficiaries, greater financial exposure at the time of using the service could hinder access to needed care. Those who would incur high cost-sharing expenses might forgo needed care. In addition, beneficiaries who purchase supplemental plans to make their health care spending predictable and eliminate the hassle of dealing with medical bills would face unpredictable expenses and a paperwork burden. Finally, making more

beneficiaries directly responsible for the costs of services could lead to an increased number of unpaid medical bills and therefore bad debt for providers.

These concerns could be mitigated by requiring that beneficiaries make a fixed copayment (for example, \$5 or \$10) at the time of service rather than pay a percentage of the provider's charge. Such a copayment would help sensitize beneficiaries to the cost of the service but also would be affordable, predictable, and convenient. Another option would be to combine reduced coverage of Part B coinsurance with an annual cap on cost sharing; this would limit beneficiaries' liabilities but still expose them to modest costs when they use care.

### Illustrative combinations of cost-sharing changes

To get a sense of how many of these cost-sharing options could achieve different objectives, we present five packages that illustrate different combinations of potential changes (Table 3-1). The illustrations do not represent recommendations by the Commission. The packages build on each other, incorporating progressively more changes to the current cost-sharing structure. However, the items that make up the packages may also be considered separately. The packages would not change the design of standardized Medigap plans. We present the approximate impact each package would have on current (2002) Medicare spending to give readers a sense of the magnitude of the changes.<sup>16</sup> The long-term costs of these changes would likely be different

14 Both employer-sponsored supplemental plans' and Medicaid's coverage of Medicare's cost sharing lead to higher use of Medicare services. The Congress has few mechanisms available to influence the design of employer-sponsored coverage, however. In addition, it would be inadvisable to increase cost-sharing exposure for Medicaid beneficiaries because they would have difficulty affording care.

15 The Balanced Budget Act of 1997 authorized high-deductible options for plans F and J, which are not sold or purchased by many people. The Bush administration has proposed two new plans, K and L, that would cover less of Medicare's cost sharing but include a cap on total cost sharing and drug coverage similar to that in plans J and H, respectively.

16 The cost estimates are based on an Actuarial Research Corporation (ARC) model that estimated spending by Medicare, supplemental payers, and beneficiaries on Medicare-covered services under current law using data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds. Changes in cost sharing under each package were assumed to affect beneficiaries' use of services and, thus, total spending on services (if cost sharing went up for a particular service we assumed that beneficiaries used less of that service, and if cost sharing declined we assumed that beneficiaries used more). Thus, ARC adjusted the spending estimate for each package based on assumed price elasticities (the percentage change in demand associated with a percentage change in price) for each service. The price elasticities were consistent with results from the RAND Health Insurance Experiment, and from similar cost-sharing analyses by the Centers for Medicare & Medicaid Services and the Congressional Budget Office.

**TABLE  
3-1**

**Illustrative changes to Medicare's cost sharing**

	<b>Current law (2002)</b>	<b>Package A</b>	<b>Package B</b>	<b>Package C</b>	<b>Package D</b>	<b>Package E</b>
Combined deductible	Inpatient: \$812/benefit period Part B: \$100/year	\$400/year	\$400/year	\$400/year	\$400/year	\$400/year
Annual cost-sharing cap	None	N/C	\$5,000	\$5,000	\$3,000	\$5,000
Inpatient hospital copayment	1–60 days: none 61–90 days: \$203/day 91–150 days: \$406/day	\$0	\$0	\$0	\$0	\$0
Covered days for inpatient care	90 days per benefit period plus 60 lifetime reserve days	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Home health copayment	None	N/C	N/C	\$10/visit, capped at \$200 per episode		
Skilled nursing facility copayment	1–20 days: none 21–100 days: \$101.50/day	N/C	N/C	1–84 days: \$55/day (or until cost-sharing cap is reached)		
Cost sharing on covered preventive services	Most services subject to deductible and 20% coinsurance	N/C	N/C	N/C	\$0	\$0
Coinsurance for outpatient mental health services	50% of allowed charge	N/C	N/C	N/C	20%	20%
Coinsurance for outpatient hospital services	45–50% of total payment	N/C	N/C	N/C	N/C	20%
Approximate additional 2002 Medicare spending in billions (percent change from current law)		\$0 (0%)	\$6 (2%)	\$4 (2%)	\$10 (4%)	\$9 (3%)

Note: N/C (no change from current law). Cost sharing for services not listed (such as physician services) would not change. A benefit period begins when a beneficiary is admitted for inpatient care and ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days. A home health episode is a 60-day period of care.

Source: Current law information from Centers for Medicare & Medicaid Services, Medicare & You, 2002. Current law coinsurance for outpatient hospital services based on MedPAC estimate. Approximate 2002 cost of illustrative packages from Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

than the single-year costs because of changes in the health status of beneficiaries, health care technology, medical practice, supplemental coverage patterns, and other factors. Because these trends are difficult to predict, we have not attempted to estimate cost changes for years beyond 2002.

**Package A**

This package would replace the separate Part A and B deductibles with a combined annual Part A and B deductible of \$400. It also would eliminate copayments on inpatient stays beyond 60 days and eliminate limits on the number of covered

days. Taken together, these changes would have roughly no net impact on current Medicare spending.<sup>17</sup>

These changes would improve financial protection for the 20 percent of beneficiaries who have inpatient hospital stays, especially those with long stays. It

<sup>17</sup> These changes would have implications for Medicare's financing structure because Part A and Part B services are financed by separate trust funds with distinct revenue sources. See footnote 5 for more detail.

therefore would provide more help to beneficiaries with serious health care problems. Because this improvement in inpatient coverage would be paid for by a higher deductible on Part B services, about 70 percent of beneficiaries would face higher liabilities. (The 10 percent of beneficiaries who currently spend less than \$100 on Part B services and have no hospital stays would have no change in liability.) This option would improve incentives to use Part B services prudently.<sup>18</sup> The effect of this option on the demand for supplemental coverage is unclear. On the one hand, to the extent demand for supplemental coverage is motivated by the currently high Part A deductible, this change could reduce demand for supplemental coverage. On the other hand, a higher deductible for Part B services could increase demand for supplemental insurance.

### Package B

In addition to the features of Package A, this package would add a \$5,000 annual cap on cost sharing for Medicare covered services. This cap would increase current Medicare spending by an estimated \$6 billion, or 2 percent.<sup>19</sup> About 3 percent of beneficiaries (one million people) would exceed this cap and save about \$8,000 on average. Compared with Package A, this package would provide additional financial protection to beneficiaries with high spending on covered services. It also could reduce demand for supplemental coverage. However, more generous Medicare coverage could reduce premiums for supplemental plans, which could increase demand for them.

### Package C

This option would add to Package B a home health copayment of \$10 per visit, capped at \$200 per home health episode.<sup>20</sup> It also would replace the current SNF copayment of \$101.50 for days 21 to 100 with a copayment of \$55 for each day of the stay. Because of the home health copayment, Package C would cost about \$4 billion, or \$2 billion less than Package B.

The introduction of cost sharing for home health services would encourage beneficiaries to use them more prudently. The copayment we modeled would save the program almost \$2 billion by reducing home health use and Medicare's share of home health spending, thus offsetting part of the cost of the cost-sharing cap.

Setting the copayment for SNF services at \$55 for each day of the stay, independent of an annual cap on cost sharing, would neither increase nor decrease Medicare spending on these services. When this copayment is combined with a \$5,000 cap and a \$400 deductible, no copayment would be required after the 84<sup>th</sup> day of the stay unless the cap was exceeded earlier. Requiring SNF copayments for the first 20 days of a stay and reducing copayments for the remaining days would reduce financial burdens on long-stay residents and would increase incentives to lengthen SNF stays (because the marginal cost of an additional day beyond the 20<sup>th</sup> day would decline compared with current law).<sup>21</sup> Although SNF and home health services cannot in most cases be substituted for one another, adding copayments to the first 20 days of a SNF stay in conjunction with a home health

copayment would reduce incentives for beneficiaries to choose SNF care over home health care to avoid the home health copayment.

### Package D

In addition to the changes in Package C, this option would set the cost-sharing cap at \$3,000, eliminate cost sharing for currently covered preventive services, and reduce coinsurance for outpatient mental health services from 50 percent to 20 percent. This package would cost \$10 billion, or about 4 percent above current spending (more than twice as much as Package C), primarily because of the more generous cost-sharing cap. The lower cap would further improve financial protection from high liabilities for beneficiaries and could further decrease demand for supplemental coverage. About 8 percent of beneficiaries (three million people) would reach the \$3,000 cap; their coinsurance liability would decline by about \$7,000 on average. Eliminating cost sharing on preventive services would encourage greater use of preventive care. Reducing cost sharing on outpatient mental health services would ensure parity between beneficiaries with mental disorders and those with other illnesses.

### Package E

This option builds on Package D by reducing the outpatient hospital coinsurance to 20 percent of the payment amount. To keep the cost of these packages about the same, the cost-sharing cap would be set at \$5,000 (as in Packages B and C). Package E would cost about \$9 billion, or 3 percent above current spending. As discussed above, reducing

18 If beneficiaries obtained supplemental insurance to cover the entire combined deductible, however, this change would have only a minor effect on the use of Part B services.

19 If the standardized Medigap plans were prohibited from covering the combined deductible, greater beneficiary exposure to the cost of services would lead to less use of services. The decline in use of services would reduce Medicare spending by an estimated \$3 billion (1 percent) and could be used to offset, at least in part, the cost of the cap.

20 A home health episode is a 60-day period of care. Data limitations required us to model a per visit copayment. With the introduction of episode-based payments, a per episode copayment would make more sense.

21 Under the current system, beneficiaries who incurred any SNF copayments in 1998—those with SNF stays of over 20 days—had 53-day stays on average and incurred average cost sharing of \$3,166 (Health Care Financing Administration 2001). If the copayment were set at \$55 per day, a 53-day stay would cost \$2,915 in cost sharing—a savings of about \$250.

the outpatient hospital coinsurance would strengthen financial protection for beneficiaries who use many outpatient hospital services, improve access to outpatient hospital care, and reduce financial incentives to choose one site of care over another. Although the cost-sharing cap is higher than in Package D, the lower outpatient hospital coinsurance would limit the number of beneficiaries with catastrophic liabilities.

### **Impact of cost-sharing changes on beneficiaries with different health care needs**

The illustrative cost-sharing changes presented in this section would have different effects on three groups of beneficiaries with different health care needs: the generally healthy, chronically ill, and terminally ill (see Chapter 1). The combined deductible would reduce cost sharing for beneficiaries who are hospitalized (more likely to be chronically or terminally ill) and increase cost sharing for those who use only Part B services (more likely to be healthy). Because chronically and terminally ill beneficiaries use many covered services, we also would expect them to benefit from a cap on cost sharing and a reduction in coinsurance for outpatient hospital and outpatient mental health services. However, this group would bear most of the burden of home health cost sharing. Although beneficiaries who are healthy except for episodes of acute illness would likely pay higher cost sharing for Part B services, they also would receive better protection from the cost of unpredictable, expensive hospitalizations. Reduced cost sharing for preventive services would help both healthy and chronically ill beneficiaries, depending on the type of service. Healthy individuals are more likely to benefit from no cost sharing for cancer screenings and those with chronic illnesses are more likely to benefit from no cost sharing for services aimed at reducing the burden of disease, such as diabetes self-management training.

## **Expanding the Medicare benefit package**

Adding new benefits to Medicare would conform the benefit package to changes in the practice of medicine, reduce disparities in coverage for beneficiaries with different treatment needs, and improve financial protection for beneficiaries. Expanding Medicare benefits must be undertaken with careful attention to many implementation issues that influence which beneficiaries receive the greatest benefit, who bears the costs, and the respective roles of the federal government, state governments, and the private market.

The following section discusses options for expanding or adding coverage of six services: prescription drugs, case and disease management services, preventive services, mental health care, vision and hearing services, and dental care. (Long-term care services raise similar issues but the topic is beyond the scope of this report.) Adding a drug benefit would significantly increase Medicare spending. Expanding coverage for the other services could be done in a way that would have a relatively small impact on Medicare and systemwide costs.

### **Prescription drugs**

Advocates of creating a Medicare drug benefit note that prescription drugs have become essential to combat disease and improve quality of life, and as such should be included in the Medicare package (see text box on page 52 for a discussion of other options for expanding access to prescription drugs). In pursuing drug coverage under Medicare, policymakers would need to address the key design issues discussed below.

- Should the benefit be voluntary or mandatory? A voluntary benefit would avoid requiring beneficiaries to pay for a benefit they do not want or already have, but would invite adverse selection (beneficiaries with high expected drug spending would

be more likely to enroll in the benefit, increasing its cost). High federal subsidies would increase participation and minimize adverse selection. A mandatory benefit would eliminate concerns about adverse selection, but could require many beneficiaries to purchase a benefit they already had (for example, through employer-sponsored supplemental coverage).

- Which entity or entities should manage the benefit? Policymakers would need to decide how a new drug benefit would be administered, who would bear the insurance risk, and how the prices for drugs would be determined. Many observers agree that, regardless of whether the government or private plans bear the insurance risk, the responsibility of negotiating prices and processing claims should be given to private-sector entities. However, they disagree on whether the Centers for Medicare & Medicaid Services (CMS) or private entities (such as insurance plans or pharmacy benefit management companies) should bear the risk, or whether risk should be shared.
- To what extent should the benefit be financed by Medicare versus beneficiaries? If Medicare were to subsidize most of the cost of a voluntary benefit, more beneficiaries would enroll and there would be less adverse selection. However, a generous subsidy would increase program costs (and thus require additional tax revenues) and displace existing spending on drug benefits by employers, state Medicaid plans, other government programs, and beneficiaries. To limit Medicare's costs, federal subsidies could be targeted to low-income beneficiaries. If beneficiaries help to finance a Medicare drug benefit through premiums, those who currently purchase Medigap plans to obtain drug coverage could redirect their spending on Medigap premiums to

## Improving access to prescription drugs outside of a Medicare benefit

Policymakers are currently considering options to expand beneficiaries' access to drug coverage outside of Medicare. Some proposals would target assistance to low-income or high-cost beneficiaries by helping states provide coverage. Other proposals would try to change the Medigap market to make drug coverage more available. Among the proposals are:

### **Expanding Medicaid drug coverage for low-income Medicare beneficiaries**

Several states have received Medicaid demonstration waivers from the Department of Health and Human Services that permit them to cover prescription drugs for low-income Medicare beneficiaries who are not eligible for full Medicaid benefits. Expanding Medicaid waiver programs would target beneficiaries who may be in greatest need of drug coverage, but would increase Medicaid spending by the federal government and states. Evidence that many beneficiaries who are eligible for Medicaid programs do not enroll in them suggests that participation in Medicaid drug programs might be low.<sup>22</sup>

### **Grants to states to fund drug assistance programs**

Thus far, 32 states have created programs that provide drug coverage for low-income elderly and disabled people (National Conference of State Legislatures 2002). Providing federal funds to such programs would give states more flexibility to offer drug coverage than under Medicaid, but would take longer to implement in states that do not currently have such programs. Further, the federal government would need to establish a minimum level of coverage that

qualified for federal funds and standards for beneficiary eligibility to limit federal costs.

### **Reforming Medigap coverage**

Only 3 of the 10 standardized Medigap plans offer drug coverage; this leads to adverse selection, whereby beneficiaries with high expected spending on prescription drugs and Medicare-covered services are more likely to purchase these policies. Adverse selection raises premiums and makes these plans unaffordable for some beneficiaries.

Requiring that the same drug benefit be offered under each of the 10 standardized plans would reduce adverse selection across plans because beneficiaries' knowledge of their expected use of prescription drugs would not influence their choice of plan. (Such knowledge would instead influence whether to buy Medigap insurance at all.) Because drug coverage is expensive, Medigap premiums would rise substantially under this approach, which could make them unaffordable for most beneficiaries. To keep policies that cover prescription drugs affordable, other benefits—such as coverage of Medicare's deductibles and coinsurance—could be reduced.

### **Reducing drug prices faced by beneficiaries**

Instead of or in addition to expanding insurance coverage of prescription drugs, policymakers could seek to reduce the prices beneficiaries pay for drugs. Prices could be reduced through changes in law and regulations governing when and how drugs come to market, the terms of market exclusivity, and how drugs may be sold. Currently, to allow a return on

their investment, manufacturers of new drugs are given patents for a specified duration of time that prohibit other manufacturers from marketing the same product. Proposed legislation would make it easier for generic drugs to come to market, which could lead to lower prices for brand-name drugs. However, any reduction in drug prices would likely lower drug manufacturers' expected future profits, which might result in less research and development of new drugs.

A second approach to reducing prices would be to encourage Medicare beneficiaries to participate in drug discount card programs and take advantage of their market power. The potential for such a program to produce substantial savings depends critically on its design. Previous experience with discount cards offered by private-sector organizations has yielded mixed results. A recent General Accounting Office (GAO) report suggested that the cards generate prices that are lower than typical retail prices but that the discounts vary by program, drug, and retail outlet. In fact, on-line pharmacies had lower prices for some drugs (GAO 2001).

The potential of drug discount cards might be better achieved if beneficiaries were to enroll in a single plan. Card companies would be in an improved position to negotiate discounts because they could guarantee manufacturers greater volume. Such a program may give both plan administrators and Medicare administrators experience in managing a program of this magnitude for the Medicare population, which would be valuable if a drug benefit is included in Medicare. ■

22 Fewer than half of Medicare beneficiaries who are eligible to receive Medicaid assistance actually do (Laschober and Topoleski 1999).

Medicare drug benefit premiums. Similarly, employers and Medicaid programs that provide drug coverage to beneficiaries could use the money they currently spend on drug benefits to subsidize premiums for a Medicare drug benefit.

- Should the benefit be targeted to beneficiaries with average drug costs or high costs? A key design decision is whether to cover spending by beneficiaries with average drug use, those with high use, or both groups. A benefit with no deductible and a limit on covered spending would favor beneficiaries with low or average spending. A benefit with a deductible and cap on out-of-pocket spending would target high-use beneficiaries, thus making adverse selection more likely.

- How should drug use and costs be managed? Employer-sponsored plans use cost-sharing rules, discount arrangements with pharmacies, promotion of generic substitution for brand-name drugs, formularies, rebates from drug manufacturers, and mail services to process prescriptions. Policymakers would need to decide which of these tools are appropriate for the Medicare population.
- Which drugs should be covered? A Medicare benefit could cover all drugs currently covered by Medicaid (which excludes only drugs used for fertility, hair growth, cosmetic effects, and a few other treatments). Alternatively, a Medicare benefit could cover only one drug in each therapeutic class, which would give the program leverage to negotiate lower prices with manufacturers but

would reduce beneficiary choice and perhaps affect treatment outcomes. The program also could develop a list of preferred drugs subject to lower cost sharing.

To provide a sense of how different cost sharing designs would influence the cost of a drug benefit and which beneficiaries would be most helped by a benefit, we modeled the impact of three illustrative approaches with different deductibles, coinsurance levels, limits on covered spending, and caps on out-of-pocket spending. These illustrations do not represent recommendations by the Commission.

Table 3-2 outlines the design of the three options and presents Medicare's approximate 2002 costs (assuming the benefit had been implemented for 2002) and monthly beneficiary premiums (assuming beneficiary premiums finance

**TABLE 3-2**

**Illustrative prescription drug benefit options**

	Option A	Option B	Option C
Annual deductible	None	\$500	\$250
Beneficiary coinsurance and annual cap on out-of-pocket spending	50% cost sharing up to \$3,000 in total spending (\$1,500 out of pocket)	50% cost sharing up to \$6,000 in total spending after deductible (\$3,000 out of pocket)	50% cost sharing up to \$3,000 in total spending after deductible (\$1,500 out of pocket)
	100% cost sharing after \$3,000 in total spending	25% cost sharing between \$6,000 and \$10,000 in total spending after deductible (up to an additional \$1,000 out of pocket)	100% cost sharing between \$3,000 and \$7,500 in total spending after deductible (up to an additional \$4,500 out of pocket)
	No out-of-pocket cap	0% cost sharing after \$10,000 in total spending after deductible (\$4,500 total out of pocket)	0% cost sharing after \$7,500 in total spending after deductible (\$6,250 total out of pocket)
2002 monthly beneficiary premium (50% of cost of benefit)	\$30	\$52	\$42
2002 estimated Medicare cost (50% of cost of benefit)	\$14 billion	\$25 billion	\$20 billion

Note: Assumptions include 1) only one option is made available to beneficiaries (no choice of options); 2) the use of modest techniques to manage drug costs would reduce current prices paid by beneficiaries by 10 percent; and 3) 100 percent of beneficiaries would participate in a drug benefit.

Source: Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

half of the cost of the benefit).<sup>23</sup> The long-term costs of a prescription drug benefit would likely be higher than the single-year costs because of expected increases in prescription drug prices and use. Because the nature of this growth is difficult to predict, we have not attempted to estimate costs beyond 2002. Figure 3-1 compares the shares of drug spending that would be paid by Medicare and beneficiaries at different spending levels under each option.

### Option A

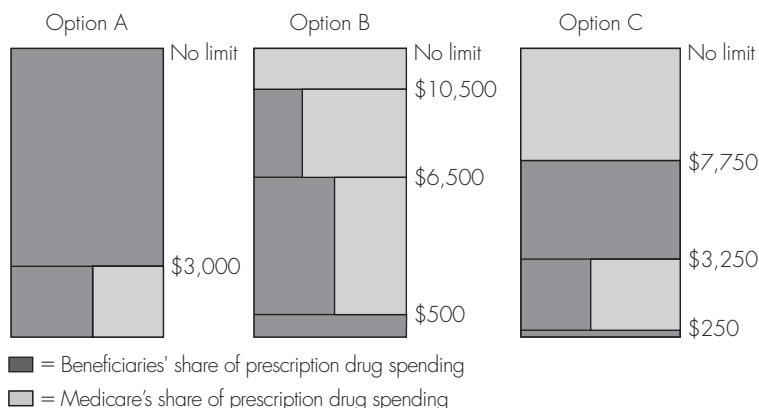
This option would not impose a deductible and would require 50 percent cost sharing for the first \$3,000 spent on drugs. Although it would help all beneficiaries with prescription drug expenses, it would not provide protection against very high drug spending. This design would likely increase access to prescription drugs for beneficiaries who currently lack comparable coverage through supplemental plans. Assuming that Medicare and beneficiaries each pay half the cost of the benefit, the initial annual Medicare cost of this option would be about \$14 billion, and beneficiary premiums would be about \$30 per month.<sup>24</sup>

### Option B

This option features a \$500 deductible, decreased cost sharing as spending increases, and a cap on out-of-pocket spending beyond \$4,500. Compared with Option A, this option would provide greater protection for beneficiaries with high drug costs and less for those with low costs. Although it would improve protection for those with high out-of-pocket spending, half of beneficiaries—those who spend less than \$500 per year on drugs—would not receive any help with their drug costs. This design is the most costly of the three approaches

**FIGURE 3-1**

**Medicare and beneficiary shares of prescription drug spending under illustrative drug benefit options**



Source: Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

presented here, with an estimated initial annual cost to Medicare of \$25 billion and beneficiary premiums of about \$50 per month.

### Option C

This option features a deductible of \$250 and a cap on out-of-pocket spending beyond \$6,250. It would cover 50 percent of drug spending up to \$3,000 (after the deductible), but once beneficiaries have spent \$1,500 out of pocket it would not cover any spending until out-of-pocket expenses exceeded \$6,250. Although this design would provide at least some help to the majority of beneficiaries who purchase drugs, it would expose beneficiaries with out-of-pocket spending above \$1,500 and below \$6,250 to high liabilities. It would cost Medicare about \$20 billion—\$5 billion less than Option B—and beneficiary premiums would be about \$40 per month.

### Case management and disease management services

To better meet the health care needs of beneficiaries with chronic conditions and potentially reduce total health care spending, policymakers may want to consider covering case and disease management services as part of fee-for-service Medicare. Case and disease management programs have been successfully employed by the private sector, including M+C plans, to improve the treatment of chronic conditions and in some cases to reduce costs.

Both case management and disease management programs seek to coordinate care for people who are at risk of needing costly medical services. The goal is to improve the quality of care and save money by encouraging practitioners to adopt evidence-based practices, educating

23 We also assumed that enrollment in the drug benefit would be mandatory and that there would be no choice of plans. We also made no specific assumption about whether the benefit would be administered by CMS or by private entities; for the purpose of this exercise, we assumed that the cost would be the same under either approach. Finally, we assumed that cost management techniques such as volume discounts and pharmacy management programs would result in a 10 percent decrease in the prices currently paid for drugs by or on behalf of beneficiaries.

24 Approximate costs of each of the prescription drug benefit options are from an Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and projections of 2002 drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.



patients about managing their care, and improving access to support services. The two programs differ in their emphasis and target populations. Case management tends to focus on medically or socially vulnerable “high-risk” patients, while disease management programs focus on a single disease, such as diabetes, end-stage renal disease, or congestive heart failure. Patients served by case management often have disparate needs; those served by disease management tend to have similar needs.

Case and disease management services include identifying at-risk patients, using case managers to conduct outreach and education programs, promoting communication among providers, and encouraging adoption of evidence-based guidelines. These programs sometimes involve the development of management information systems to track patient care and extra payments to physicians to devote additional time to patients in the program.

Although Medicare pays physicians for coordinating care and providing patient education as evaluation and management services, the program may not compensate physicians adequately for providing a broader array of coordination services. Moreover, Medicare does not cover care coordination services provided by case managers, such as registered nurses, who are not eligible for separate payment.

Medicare’s experience to date with case management raises questions about how to adopt case and disease management techniques. A CMS demonstration of case management services for the Medicare program in the 1990s showed neither improved outcomes nor reduced costs. The demonstration’s evaluation attributed this failure to several design features: the clients’ physicians were not involved in the interventions, the projects did not have sufficiently focused interventions and goals, the staff was not sufficiently experienced or knowledgeable, and the participants had no financial incentive to reduce Medicare spending (Schore et al. 1997).

CMS is conducting a new case and disease management demonstration at 15 different sites over the next few years to test ways of paying for these services and conditions for service delivery. This demonstration may shed more light on effective approaches for integrating coordinated care benefits into Medicare. Key issues to address in the design of such benefits include:

- What services should Medicare pay for and who should deliver them? Coordinated care programs may include a broad array of services, such as interdisciplinary team meetings to discuss patient care and progress, phone calls to remind patients of appointments or to take medications, training to educate patients about self-care, and coordination of community social services. Policymakers would need to decide which of these services Medicare should cover and for which patients. Policymakers also may decide to subsidize information support systems for providers to identify and track patients enrolled in coordinated care programs.
- How could financial incentives be used to encourage providers to offer cost-effective, clinically appropriate services to the beneficiaries who would benefit most? If physicians and other providers were paid on a fee-for-service basis for delivering coordinated care, they would have no financial incentive to produce savings for Medicare. Putting providers at financial risk by paying for services on a capitated basis or paying for a larger bundle of services would provide incentives to reduce costs, but also could encourage providers to stint on needed care. CMS’s current case and disease management demonstration, which requires participating providers to offset fully the costs of case and disease management services with savings from improved coordination of care, may offer insight on this question.

- How could benefits be managed cost effectively? To reduce costs, case or disease management programs must be targeted at patients who would benefit most. Thus, Medicare would need to devise ways to identify and enroll such beneficiaries. Medicare also would need to set uniform rules for local or national organizations that wished to provide coordinated care services to beneficiaries. Determining which coordinated care programs could participate and whether savings were achieved would be labor and data intensive for both CMS and the care management programs.

## Preventive services

Use of clinical preventive services can help avoid, and reduce the burden of, illness among the elderly and disabled. Although some beneficiaries avail themselves of preventive services regardless of coverage, others find bearing the full or even part of the cost of the services a barrier to use. Accordingly, the Congress has expanded coverage for preventive services and has waived all or part of normal cost-sharing requirements for some of these services.

Two factors limit the effectiveness of current coverage of preventive services. First, policymakers have not always heeded the evidence-based recommendations of expert panels in selecting which preventive services to cover; some of the more effective services are not covered and some non-recommended services are covered (see Chapter 1 and Appendix A). Second, the cost sharing required for some preventive services may discourage beneficiaries who receive no immediate benefit from a service from obtaining it.

In considering any additional preventive services that Medicare may cover, policymakers should take advantage of available scientific evidence. For example, policymakers could base coverage decisions on recommendations by the United States Preventive Services Task Force (USPSTF). Those

recommendations include services that many beneficiaries currently use even though they are not covered by Medicare, such as periodic physical exams, as well as other services that are not often obtained, such as counseling for smoking cessation.

Instead of specifying covered preventive services in law, CMS could make coverage decisions by considering clinical effectiveness and taking into account recommendations from the USPSTF and other organizations.

Because cost of care is a factor in deciding whether to obtain services, existing cost-sharing requirements on preventive services could be eliminated to encourage greater use of preventive care. Reducing cost sharing would not guarantee, however, that beneficiaries would use services. Providers' attitudes about encouraging preventive care and beneficiaries' lack of interest in, or knowledge about, these services may be greater barriers to receiving needed care than cost-sharing requirements.

Improved access to preventive care could have a significant impact on beneficiaries' health with a relatively modest financial impact. Coverage of preventive services that reduce the use of curative services in the future (such as immunizations) could reduce both beneficiary financial liability and overall program costs. Coverage of some preventive services, such as periodic physical exams, should not pose administrative difficulties because providers of these services already receive Medicare payment. Other services, such as counseling for smoking cessation, may require the program to set rules for participation and payment for new providers.

## **Mental health services**

Treatment for many types of mental illness includes outpatient services—such as psychotherapy, prescription drugs, and

case management—that either are not covered or are inadequately covered by Medicare. Reducing the coinsurance for outpatient mental health services from 50 to 20 percent would improve access to psychotherapy for beneficiaries with mental disorders. Because this option would reduce coinsurance on currently covered services, it should not pose implementation problems. Adding a prescription drug benefit to Medicare also would facilitate access to drug therapies used to treat mental conditions, but would raise the implementation issues discussed earlier. Finally, case management services could steer beneficiaries with chronic mental conditions to appropriate therapies and help them better manage their care. Expanded coverage of mental health services should improve access to care by reducing beneficiaries' costs but also should require some cost sharing to encourage prudent use of care.

## **Vision and hearing**

Medicare currently covers walkers, canes, and wheelchairs for beneficiaries with musculoskeletal illnesses, but not devices associated with sensory impairments, such as eyeglasses or hearing aids.<sup>25</sup> Loss of vision and hearing can lead to dependency, isolation, depression, and reduced functioning and productivity among the elderly (Cassel, Besdine, and Siegel 1999).

The vast majority of people age 70 and older (93 percent) wore glasses in 1995 (Desai et al. 2001). Seventy percent of individuals age 65 and older who purchased glasses in 1998 spent between \$100 and \$400, but less than 10 percent spent over \$400.<sup>26</sup> If Medicare covered eyeglasses for all beneficiaries who needed them, such coverage would improve access to prescription lenses. Given the high percentage of the elderly who wear glasses, such coverage could be costly but would at least partially replace current spending by beneficiaries, Medicare+Choice plans, and

supplemental coverage. Alternatively, Medicare could target coverage to beneficiaries who require expensive eyeglasses by requiring a high deductible.

In 1995, one-third of people age 70 and older had a hearing impairment. This problem can lead to social isolation, cognitive decline, and decreased mobility (Desai et al. 2001). Hearing aids, telephone amplifiers, and medical evaluations can improve quality of life for people with hearing problems. These devices and services are not covered by Medicare, and many of the elderly with hearing impairments do not use them. Only about one-third of older persons with hearing problems in 1995 reported using a hearing aid, perhaps because these aids can be expensive. Medicare coverage of hearing devices and services could improve access to them by reducing the financial liability of beneficiaries who use them. Because Medicare already covers certain assistive devices, it may be able to use existing administrative structures to manage a hearing care benefit. However, given the large number of elderly people who have hearing problems, the cost of covering hearing services could be high. To control Medicare's costs, encourage the prudent use of care, and target coverage to beneficiaries who require expensive hearing devices and services, Medicare could require high cost sharing with a hearing care benefit.

## **Dental Services**

Currently, Medicare covers very few dental services and only those that are integral to treatment of certain medical conditions (for example, tooth extraction before radiation treatment). Medicare explicitly does not cover dental care to treat, remove, fill, or replace teeth or to treat the gums and other structures supporting the teeth (CCH Inc. 2002). By comparison, about half of under-65 workers receive dental coverage from their employers (Gold 2002).

25 Some Medicare beneficiaries obtain coverage for eyeglasses from M+C plans or employer-sponsored insurance.

26 Data from the 1998 Medical Expenditure Panel Survey.

Given this limited coverage, some beneficiaries spend a considerable amount out of pocket for dental services: beneficiaries with the highest 10 percent of spending on dental services spent about \$1,500 out of pocket, on average, for dental care in 1998.<sup>27</sup> These potentially high liabilities may lead some beneficiaries to forgo needed treatment, which may cause a decline in their oral health that requires costly medical care in the future. Poor dental health can lead to a decline in beneficiaries' quality of life and even to malnutrition. Indeed, public health experts consider oral health to be an essential component of a person's overall health and have established a goal of reducing toothlessness among the elderly (Department of Health and Human Services 2000). For these reasons, policymakers may want to consider having Medicare cover both preventive and acute dental care. However, such coverage would be costly.

Alternatively, policymakers could limit coverage to services associated with specific acute conditions. An Institute of Medicine panel recently examined the advisability of covering "medically necessary" dental services associated with five underlying conditions—head and neck cancer, leukemia, lymphoma, organ transplant, and valvular heart disease. The panel recommended coverage of certain services related to the first two conditions, but found that existing evidence did not warrant coverage of the last three (IOM 2000b). The panel also recommended that the Congress direct CMS to develop recommendations for coverage of dental services needed in conjunction with surgery, chemotherapy, radiation, or pharmacologic treatment for life-threatening medical conditions.

### **Impact of benefit expansions on beneficiaries with different health care needs**

As was the case with the illustrative cost-sharing changes presented earlier, expansions to the benefit package would

have varying effects on healthy, chronically ill, and terminally ill beneficiaries. Generally healthy and chronically ill beneficiaries would benefit from different kinds of preventive services—healthy individuals could benefit from cholesterol measurement while chronically ill people could benefit from injury prevention. Coverage of vision, hearing, and dental care also would help both groups. However, chronically ill beneficiaries would derive greater benefit than healthy individuals from improved coverage of prescription drugs, case and disease management services, and mental health care. Terminally ill individuals would benefit primarily from prescription drug coverage.

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### **Creating a comprehensive benefit package by reallocating resources**

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Policymakers may want to consider creating a comprehensive benefit package that would include modified cost sharing as well as additional benefits such as prescription drug coverage. A comprehensive benefit package could encourage more efficient use of services and could help ensure that all beneficiaries—not only those with supplemental coverage—have adequate access to care and greater protection from high health care costs. A comprehensive package could be provided directly by Medicare or through private entities under a premium support approach or an expanded M+C program. An efficient benefit design is critical either to sustain the current fee-for-service program or to provide a viable basis for market competition.

In theory, additional costs under a comprehensive plan could be offset at least partially by savings from a reduced need for supplemental coverage, which is associated with higher administrative costs and additional use of services. If the introduction of a comprehensive package led to lower rates of supplemental

coverage, total spending on beneficiaries' health care could stay about the same as under current law.

Creating a comprehensive package would have significant implications. First, a comprehensive package would substantially redistribute spending on beneficiaries' health care. If Medicare directly provided a comprehensive package, spending would shift from private payers to Medicare, thereby increasing the program's role in the health care system. Expanding Medicare's role could lead to market distortions and more limited beneficiary choices. Second, establishing a comprehensive package would create an entitlement to additional benefits, just as the program begins to experience financial pressure from accelerating growth in health costs and demographic changes. Thus, a key question is how an expanded Medicare benefit would be financed. Currently, private supplemental coverage is financed by beneficiaries and employers. However, if Medicare expanded to cover additional benefits with no change in the ratio of payroll taxes, general revenues, and premiums used to finance today's benefits, significant costs would be shifted from beneficiaries and employers to the working population.

If, instead, an expanded benefit were financed through beneficiary premiums, redistribution would be among beneficiaries, employers, and government programs providing supplemental coverage, and would not increase the burden on younger generations. The impact of a redistribution on beneficiaries' out-of-pocket spending would depend on their existing source of supplemental coverage (if any) and who pays for it, and on their current direct spending on prescription drugs and other health care services. For example, under a more comprehensive Medicare benefit, healthy beneficiaries with no supplemental coverage would have to spend more, on average, than they would otherwise on premiums and direct spending on health care. Retirees with generous employer-

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27 Data from 1998 Medicare Current Beneficiary Survey, Cost and Use file.

sponsored insurance could spend more if they were required to pay a premium to Medicare for coverage they had previously received for little cost. Beneficiaries who have high direct spending would likely spend less than they do now.

## Design issues

A comprehensive benefit package could be designed in any number of ways. In addition to decisions about how to finance expanded coverage, key issues include whether a comprehensive package would be offered as a substitute to the current package or as an alternative, whether the plan would be offered directly by Medicare or through private plans, how generous the package should be, and the impact of the package on supplemental coverage. Design choices would affect total resources spent on beneficiaries' health care, who pays for the care, and who benefits from a comprehensive plan.

### Should a comprehensive plan be offered along with or in place of the current benefit package?

Policymakers would need to decide whether to offer a comprehensive plan either as an alternative to the current benefit package or as a substitute. Replacing the current package with a comprehensive plan would require that all beneficiaries participate in the new plan and could require them to pay higher premiums. For some, the opportunity to buy expanded coverage (that may otherwise be unavailable to them in the private market) would be well worth the investment. For others, this requirement might be perceived as burdensome because it could increase their premiums or provide coverage they had received elsewhere for less.

Offering a comprehensive plan as an alternative to the current package (perhaps for a higher premium) would allow beneficiaries to remain in the current program if they do not value the additional coverage or currently receive it

from another source for less money. However, allowing this choice would raise concern about risk segmentation: beneficiaries who believe they are less likely to need additional services would be more likely to remain in the current program, while those who believe they will have greater need for coverage would be more likely to choose the comprehensive benefit package. This pattern of enrollment would increase costs for the comprehensive plan and lower costs for the current plan, strengthening incentives for people who use fewer services to stay in the current plan. Policymakers could minimize risk segmentation by providing higher premium subsidies for beneficiaries who enroll in the comprehensive package or by limiting the opportunity to enroll in the comprehensive plan to initial eligibility for Medicare.

### Who would deliver a comprehensive benefit package?

Medicare could provide a comprehensive package directly, with CMS (or another government entity) determining prices and coverage rules for the expanded set of benefits. Although Medicare could use its scale to limit administrative costs and its market power to negotiate lower prices for services in some areas, such concentrated power could distort the marketplace. For example, a centralized purchaser might hamper innovation by the way it determined the prices and conditions under which it paid for services. In addition, Medicare may be less responsive to changes in beneficiary preferences and market conditions than private plans, which could lead to excessive or inadequate payments to providers.

Alternatively, private insurance plans could replace or compete with Medicare's fee-for-service plan to offer a comprehensive benefit package. A marketplace with more purchasers would be less subject to distortion and might spur more innovative and efficient care delivery. However, because each plan

would have its own claims processing, marketing, and other overhead costs, a competitive approach would have higher administrative costs. A competitive approach also raises other issues. For example, how many plans should be allowed to compete? Would they be national, regional, or both? Would plans be available for rural beneficiaries? On what basis would plans compete for enrollees: price, additional benefits, and/or quality? If there were multiple private plans, should they offer the same benefit package or have more flexibility? If the benefit package varied, risk segmentation would be more likely; if it did not, innovation in benefit design would be constrained.

### How comprehensive should the package be?

In designing a comprehensive package, policymakers should balance the need to address the major limitations of the current program with the goal of keeping the package affordable for the beneficiaries and taxpayers who would finance it. The level of coverage also would affect beneficiaries' demand for supplemental coverage. If coverage was sufficiently generous to reduce enrollment in supplemental plans, there would likely be system-wide administrative savings and less coverage of Medicare cost sharing, which would encourage more prudent use of services. Therefore, it would be important to determine the level of coverage that would be sufficiently comprehensive to reduce beneficiaries' demand for supplemental insurance. Although the distribution of Medigap insurance purchases suggests that beneficiaries are interested in generous coverage that makes their out-of-pocket costs more predictable, the limited supplemental options currently available make it difficult to assess precisely what benefit combinations beneficiaries prefer. Most Medigap policies are standardized and retirees with employer-sponsored coverage often do not have a choice of coverage design.<sup>28</sup>

28 The most popular Medigap plans (F and C) cover both the Part A and B deductibles and all cost sharing. Federal retirees, one of the few categories of retirees given a choice of employer health coverage, tend to select the most comprehensive coverage options.

## What would be the impact of a comprehensive package on supplemental coverage?

Even without an expansion of Medicare benefits, the availability and comprehensiveness of private supplemental coverage appears to be diminishing (see Chapter 2). Medigap premiums have increased over the past 10 years and many plans are not available in all areas. Further, employers report that to control costs they are increasing beneficiary cost-sharing requirements, including the portion of premiums that beneficiaries pay (Robinson 2002). Some employers are eliminating coverage for future retirees.

An expansion of the Medicare benefit package would accelerate this trend. Depending upon the nature of the expansion, insurers would need to determine whether they could profitably market a product that covers a reduced scope of services. On the one hand, premiums would still have to cover administrative costs, which could make them too high to be attractive. On the other hand, premiums for more limited plans would likely be lower than those for current plans, which could increase demand for supplemental coverage.

Employers could decide to continue offering supplemental coverage around the expanded Medicare package or use the policy change as an opportunity to stop offering and managing retiree health insurance. Employers might opt to pay retirees' higher Medicare premiums associated with a comprehensive plan or continue to offer supplemental benefits to retain their competitive advantage in attracting employees.

Medicaid and other government programs that pay for health care services received by Medicare beneficiaries also would be affected by a comprehensive benefit package.<sup>29</sup> Medicaid covers Medicare's

premiums and cost sharing and non-covered services such as prescription drugs and long-term care for Medicare beneficiaries who are dually eligible for Medicaid. A comprehensive package that reduced Medicare's cost sharing and added prescription drug coverage would offset money currently spent by Medicaid on dual eligibles. Medicaid savings would be reduced if states covered the higher Medicare premium for dually eligible beneficiaries.

## Illustrative model

To examine how current spending on Medicare-covered services and prescription drugs could be reallocated to protect beneficiaries better from high medical costs, we modeled an illustrative comprehensive Medicare benefit package and its effects on spending for different groups of beneficiaries. This model assumed an outpatient prescription drug benefit but did not include changes for vision, hearing, dental, or other uncovered services. The analysis is illustrative only, and does not represent a recommendation by the Commission.

The illustrative package would modify the cost-sharing structure for currently covered services and add prescription drug coverage (Table 3-3, p. 60). Compared with current law, it would increase cost sharing on fairly predictable, discretionary services (such as home health care) to encourage more prudent use of care. It also would reduce cost sharing on less predictable services, such as inpatient care, and treatments that currently are subject to disproportionately high coinsurance (such as outpatient hospital and outpatient mental health services). The package would eliminate cost sharing on preventive services to encourage greater use of preventive care, and limit total annual cost sharing liability to \$3,000. The prescription drug benefit would be the same as Option B, described in Table 3-2 (p. 53).

## Key assumptions used in illustrative model

We assumed that enrollment in the new package would be mandatory. We made no specific assumption about whether it would be administered by CMS or by private entities; for the purpose of this exercise, we assumed that costs would be the same under either approach. We also assumed that cost management techniques such as volume discounts and pharmacy management programs would decrease the prices currently paid for drugs by or on behalf of beneficiaries by 10 percent. Although we made no assumptions about how additional Medicare spending would be financed, we discuss the effects of requiring beneficiaries to finance additional costs.

A major assumption in our modeling relates to the degree to which beneficiaries would continue to purchase or be provided supplemental coverage under this new Medicare benefit package. Supplemental insurance has an important impact on the use of services and administrative costs in the system. We assume that lower rates of supplementation lead to higher out-of-pocket costs and, in turn, lower use of services. Similarly, we assume that higher rates of supplementation increase use of services.<sup>30</sup> Because supplemental insurance has higher administrative costs than Medicare, transferring benefits from supplemental payers to Medicare would lower system-wide administrative costs.

Given uncertainty about whether beneficiaries would continue to obtain supplemental insurance if offered this new comprehensive package, we illustrated two of the possible responses. Under scenario one, we assumed that beneficiaries who currently have supplemental insurance would retain it and that the same fraction of out-of-pocket spending would be covered by

29 The Department of Defense's TRICARE For Life program provides supplemental coverage for military personnel and retirees enrolled in Medicare. In addition, the Department of Veterans Affairs provides health care services, including prescription drugs, for a growing number of elderly and disabled veterans (see Appendix B). Because a comprehensive benefit package would cover some services and cost sharing these programs currently cover, these programs would have reduced spending under a comprehensive package.

30 The specific assumptions used in the modeling imply price elasticities consistent with results from the RAND Health Insurance Experiment and from similar cost sharing analyses by CMS and the Congressional Budget Office.

supplemental coverage under the new package as under current law. Because average out-of-pocket spending would fall under the new package, spending by supplemental policies would decline.

Under scenario two, we assumed that only 25 percent of beneficiaries with Medigap and employer-sponsored insurance would retain their coverage, but that all beneficiaries with other types of supplemental coverage (such as Medicaid) would retain their coverage. Under an expanded Medicare benefit package, beneficiaries with Medigap policies might decide that they no longer need supplemental insurance to cover their reduced health care liabilities. Medigap insurers also might determine that they could no longer profitably offer plans that spread relatively fixed administrative costs across a reduced scope of benefits. In addition, employers might choose to discontinue supplemental coverage. Instead, they could decide to subsidize the higher Medicare premiums that beneficiaries might be required to pay for the new package. Although it is difficult to predict how state Medicaid programs would respond to a more comprehensive package, they would likely continue to cover out-of-pocket spending for Medicaid beneficiaries.

In addition to the assumption about changes in supplemental coverage, we made several other assumptions regarding administrative costs, the distribution of supplemental coverage, and changes in demand for health care services as a result of cost sharing changes. Accordingly, the model's results are highly uncertain. Because of this uncertainty, we limit our assessment of the aggregate and distributional effects of comprehensive coverage under Medicare to a single year (2002). Nevertheless, we expect that the long-term effects would differ from single-year impacts because of changes in spending for specific services (for example, spending for prescription drugs is projected to increase faster than spending for most other services), changing trends in supplemental coverage, and other factors.

**TABLE  
3-3**

**Current law compared with illustrative comprehensive benefit package**

	<b>Current law (2002)</b>	<b>Illustrative package</b>
Combined deductible	Inpatient: \$812/benefit period Part B: \$100/year	\$400/year
Annual cost-sharing cap	None	\$3,000 (excluding spending on prescription drugs)
Inpatient hospital copayment	1–60 days: none 61–90 days: \$203/day 91–150 days: \$406/day	\$0
Covered days for inpatient care	90 days per benefit period plus 60 lifetime reserve days	Unlimited
Home health copayment	None	\$10/visit, capped at \$200 per episode
Skilled nursing facility copayment	1–20 days: none 21–100 days: \$101.50/day	1–55 days: \$55/day (or until cost-sharing cap is reached)
Cost sharing on covered preventive services	Most services subject to deductible and 20% coinsurance	\$0
Coinsurance for outpatient mental health services	50% of allowed charge	20%
Coinsurance for outpatient hospital services	45–50% of total payment	20%
Outpatient prescription drug coverage	Limited	Covers full range of drugs with: \$500 deductible 50% cost-sharing up to \$6,000 in total spending (after deductible) 25% cost-sharing between \$6,000 and \$10,000 in total spending 0% cost-sharing after \$10,000 in total spending (\$4,500 out of pocket)

Note: Cost sharing for services not listed (such as physician services) would not change. A benefit period begins when a beneficiary is admitted for inpatient care and ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days. A home health episode is a 60-day period of care.

Source: Current law information from Centers for Medicare & Medicaid Services, *Medicare & You*, 2002. Current law coinsurance for outpatient hospital services based on MedPAC estimate.

**Scenario one: beneficiaries retain supplemental coverage**

Under this scenario, our model implies significant shifts in sources of spending and a slight increase in total spending on

behalf of beneficiaries. Table 3-4 illustrates these changes by comparing projected 2002 spending on beneficiaries' health care under current law and under the illustrative comprehensive benefit

**TABLE  
3-4**

**Changes in 2002 spending under a comprehensive benefit package, scenario 1**

**Health care outlays (billions)**

	<b>Beneficiary direct spending (excluding premiums)</b>	<b>Supplemental coverage payments</b>	<b>Medicare payments</b>	<b>Total</b>	<b>Administrative costs (billions)</b>	<b>Total spending (billions)</b>
Current law	\$58	\$75	\$251	\$384	\$18	\$402
Comprehensive package: scenario 1	38	46	314	398	16	413
Change	-20	-29	63	14	-2	12

Note: Scenario 1 assumes that all beneficiaries with supplemental coverage retain their coverage. Health care outlays include approximate spending for Medicare-covered services (excluding hospice services) and prescription drugs, but not other non-covered services. Total spending under current law is lower in this table than in Table 2-5 (\$402 billion versus \$446 billion) because this table excludes spending for other non-covered services—such as vision, dental, equipment, and supplies—and for Medicare-covered hospice services.

Beneficiary direct spending includes beneficiary spending on deductibles, copayments, and coinsurance for currently covered services and spending on prescription drugs. Premiums for Medicare and supplemental coverage are not included to avoid double counting. Supplemental coverage payments include spending by Medigap plans, employer-sponsored insurance, Medicaid, other federal and state government programs, and some Medicare+Choice spending. Administrative costs include the administrative costs of insurance, such as marketing and claims processing. Numbers may not add to totals due to rounding.

Source: Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

package. The table divides spending into health care outlays (direct spending on goods and services by beneficiaries, Medicare, and supplemental payers) and administrative costs incurred by Medicare and supplemental payers. Medicare spending would rise by about \$63 billion (about \$1,560 per beneficiary).<sup>31</sup> Most of this increase—\$50 billion—would be spent on prescription drug coverage. The rest of the spending increase reflects changes in cost sharing for currently covered services. Because Medicare would cover more spending and beneficiaries with supplemental coverage would retain their coverage under this scenario, direct spending by beneficiaries on Medicare cost sharing and prescription drugs would decline by about \$20 billion in aggregate (almost \$500 per beneficiary). Payments by supplemental insurers would decline by about \$30

billion in aggregate (about \$700 per beneficiary) because Medicare would cover a larger share of total spending. This decline in spending would probably cause supplemental premiums to fall.

Under scenario one, broader Medicare coverage and continued supplemental coverage would induce beneficiaries to use more health care services. Thus, net health care outlays would increase by about \$14 billion (\$350 per beneficiary). Because beneficiaries would maintain their supplemental coverage in this scenario, administrative savings would be minimal. As a result, total spending (health care outlays plus administrative costs) would increase by about 3 percent, or \$12 billion (\$300 per beneficiary).

Beneficiaries would have improved financial protection from high medical costs and better access to prescription

drugs under scenario one. However, individual beneficiaries could end up spending more out of pocket on cost sharing, prescription drugs, and premiums than they currently do, depending upon the increase in Medicare premiums, their current form of supplemental insurance, and their current spending on health services. Policymakers would need to decide the shares of higher Medicare spending that should be financed by beneficiaries through higher premiums, by general revenues, or by payroll taxes. If the increase in Medicare spending was financed entirely by higher beneficiary premiums, premiums would be higher by about \$130 per month (\$1,560 per year), more than double the current Part B premium of \$54 per month (\$648 per year). Because supplemental spending would decline under this scenario, supplemental premiums also would

31 Spending estimates are based on an Actuarial Research Corporation model that estimated spending by Medicare, supplemental payers, and beneficiaries on health care services under current law and under the illustrative comprehensive benefit package using data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), the 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

probably fall and some beneficiaries could use savings from Medigap premiums to help cover higher Medicare premiums. However, beneficiaries with employer-sponsored coverage could not control whether their employers would use savings on supplemental coverage to subsidize their Medicare premiums. Medicaid and other government programs that cover health care services for beneficiaries also could decide to use their savings from more generous Medicare coverage to subsidize higher Medicare premiums for the individuals they cover.

Under scenario one, direct spending by beneficiaries on Medicare's cost sharing and prescription drugs would decline by about 35 percent on average (Table 3-5). However, beneficiaries who would otherwise have low direct spending (the lowest four deciles of direct spending) would spend about the same or slightly more than they do now, primarily because the comprehensive package would impose a higher deductible on Part B services. Beneficiaries with higher direct spending (the highest six deciles) would spend less, primarily because the comprehensive benefit package would cap cost sharing and prescription drug spending. Assuming that Medicare premiums would increase, beneficiaries with reduced direct spending could use their savings to help cover higher premiums. Savings for beneficiaries with the highest direct spending would be more than enough to cover a higher Medicare premium.

### Scenario two: reduced supplemental coverage

Under scenario two, total spending on behalf of beneficiaries would decline slightly but spending by source would shift significantly. Table 3-6 illustrates these changes by comparing projected 2002 spending on health care received by beneficiaries under current law and under the illustrative comprehensive benefit package. Medicare would cover more spending under scenario two than under current law, but Medigap and employer-sponsored insurance would cover less, leaving total beneficiary direct spending on cost sharing and prescription drugs

**TABLE 3-5**

## Changes in beneficiaries' direct spending under a comprehensive benefit package, scenario 1, by spending decile

Direct spending decile	2002 direct spending per beneficiary		Dollar change	Percent change
	Current law	Scenario 1		
1st	\$ 0	\$ 0	\$ 0	0%
2nd	30	30	0	0
3rd	140	160	20	14
4th	290	300	10	3
5th	520	480	-40	-8
6th	810	700	-110	-14
7th	1,180	970	-210	-18
8th	1,810	1,350	-460	-25
9th	2,840	2,010	-830	-29
10th	6,840	3,530	-3,310	-48
All beneficiaries	1,440	950	-490	-34

Note: Direct spending excludes Medicare and supplemental premiums. Direct spending includes beneficiary spending on deductibles, copayments, and coinsurance for currently covered services and spending on prescription drugs. Scenario 1 assumes that all beneficiaries with supplemental coverage retain their coverage.

Source: Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

unchanged. Because only 25 percent of beneficiaries with Medigap and employer-sponsored coverage would retain their coverage under this scenario, supplemental coverage payments would decline by an additional \$20 billion compared with scenario one, and by \$50 billion compared with current law. This additional decline in spending by supplemental insurers would probably cause a more significant reduction in supplemental premiums than under scenario one. Medicare spending would increase by about \$50 billion (about \$1,250 per beneficiary) from current law. This increase is smaller than under scenario one because beneficiaries would have reduced supplemental coverage for Medicare's cost sharing, which would cause them to use fewer currently covered services. Most of the increase in Medicare spending—\$45 billion—is attributable to

prescription drug coverage. The remaining \$5 billion increase results from changes in the cost sharing structure for currently covered services, partially offset by reduced use of services.

Beneficiaries would use fewer currently covered services than under current law because the assumed reduction in supplemental coverage would expose them to more cost sharing. However, Medicare coverage of prescription drugs would lead beneficiaries to spend more on drugs. These offsetting effects would leave total health care outlays roughly unchanged, compared with a slight increase in outlays under scenario one. Because many beneficiaries are assumed to drop their supplemental coverage in scenario two, and because supplemental coverage is assumed to have higher administrative costs than Medicare, total



**TABLE  
3-6**

**Changes in 2002 spending under a comprehensive benefit package, scenario 2**

**Health care outlays (billions)**

	<b>Beneficiary direct spending (excluding premiums)</b>	<b>Supplemental coverage payments</b>	<b>Medicare payments</b>	<b>Total</b>	<b>Administrative costs (billions)</b>	<b>Total spending (billions)</b>
Current law	\$58	\$75	\$251	\$384	\$18	\$402
Comprehensive package: scenario 2	57	24	301	382	11	392
Change	-1	-51	50	-2	-7	-9

Note: Scenario 2 assumes that 25 percent of beneficiaries with Medigap plans and employer-sponsored insurance retain their coverage, while all beneficiaries with other types of supplemental coverage retain their coverage. Health care outlays include approximate spending for Medicare-covered services (excluding hospice services) and prescription drugs, but not other non-covered services. Total spending under current law is lower in this table than in Table 2-5 (\$402 billion versus \$446 billion) because this table excludes spending for other non-covered services—such as vision, dental, equipment, and supplies—and for Medicare-covered hospice services.

Beneficiary direct spending includes beneficiary spending on deductibles, copayments, and coinsurance for currently covered services and spending on prescription drugs. Premiums for Medicare and supplemental coverage are not included to avoid double counting. Supplemental coverage payments include spending by Medigap plans, employer-sponsored insurance, Medicaid, other federal and state government programs, and some M+C spending. Administrative costs include the administrative costs of insurance, such as marketing and claims processing. Numbers may not add to totals due to rounding.

Source: Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

administrative costs would decline by about \$7 billion. Total system spending would decline by about 2 percent, or \$9 billion (\$230 per beneficiary).

As with scenario one, beneficiaries under scenario two would have improved insurance protection against high medical costs and better access to prescription drugs. However, whether individual beneficiaries spend more or less out of pocket on cost sharing, prescription drugs, and premiums than they currently do would depend upon the increase in Medicare premiums, beneficiaries' current form and cost of supplemental insurance, and their current spending on health services.

If the increase in Medicare spending was financed entirely by higher beneficiary premiums, such premiums would be about \$104 per month higher (\$1,250 per year), compared with the \$130 monthly

premium increase under scenario one. Beneficiaries who retained scaled-down Medigap plans or dropped their plans could use their Medigap premium savings to help cover higher Medicare premiums. For example, beneficiaries who currently have Medigap Plan H—which has an average monthly premium of \$110 and covers the inpatient deductible, Part B coinsurance, and limited prescription drug spending (Table B-1, p. 77)—could drop this plan and use the savings to cover the \$104 increase in monthly Medicare premiums.<sup>32</sup> Such beneficiaries would obtain more complete coverage for drugs under the comprehensive Medicare package but give up some coverage of cost sharing for other services under Medigap Plan H. Beneficiaries with employer-sponsored coverage could not control whether employers used savings on supplemental coverage to subsidize their retirees' Medicare premiums.

Although direct spending by beneficiaries for Medicare's cost sharing and prescription drugs would be about the same on average under scenario two as current law, direct spending would change for individual beneficiaries depending on their current supplemental coverage and direct spending level. Beneficiaries with employer-sponsored or Medigap coverage would have higher direct spending than currently because of the assumed reduction in these forms of supplemental coverage, but beneficiaries with other types of supplemental coverage and those who lack supplemental coverage would have lower direct spending. Beneficiaries in the highest 10 percent of direct spending would spend less under scenario two, while beneficiaries with lower direct spending would spend more than they currently do (Table 3-7, p. 64). The distribution of direct spending would become flatter because the comprehensive

32 MedPAC estimate of Medigap premiums based on analysis of 2000 data from the National Association of Insurance Commissioners.

**TABLE  
3-7**

**Changes in beneficiaries' direct spending under a comprehensive benefit package, scenario 2, by spending decile**

Direct spending decile	2002 direct spending per beneficiary		Dollar change	Percent change
	Current law	Scenario 2		
1st	\$ 0	\$ 0	\$ 0	0%
2nd	30	70	40	133
3rd	140	300	160	114
4th	290	590	300	103
5th	520	880	360	69
6th	810	1,190	380	47
7th	1,180	1,590	410	35
8th	1,810	2,170	360	20
9th	2,840	2,910	70	2
10th	6,840	4,430	-2,410	-35
All beneficiaries	1,440	1,410	-30	-2

Note: Direct spending excludes Medicare and supplemental premiums. Direct spending includes beneficiary spending on deductibles, copayments, and coinsurance for currently covered services and spending on prescription drugs. Scenario 2 assumes that 25 percent of beneficiaries with Medigap and employer-sponsored insurance retain their coverage, while all beneficiaries with other types of supplemental coverage retain their coverage.

Source: Actuarial Research Corporation model based on data from the 1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), 2002 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Finance Committee, March 7, 2002.

benefit package would increase the deductible on Part B services and cap cost sharing and prescription drug spending.

**Summary of modeling results**

Our modeling shows that a more comprehensive Medicare benefit package could be substituted for the current one without increasing total health spending on beneficiaries, if supplemental coverage declined. Higher spending by Medicare

could be offset at least partially by reducing the higher administrative costs and additional use of services associated with supplemental insurance. A restructured cost-sharing system also could encourage more prudent use of services by beneficiaries. Some beneficiaries, such as those who have high direct spending on health services, would spend less out of pocket, and others, such as retirees with generous employer-

sponsored insurance, could end up spending more. Regardless of changes in out-of-pocket spending, all beneficiaries would have improved insurance protection from high medical costs and better access to prescription drugs than under the current benefit package.

**Conclusion**

Many alternatives exist for addressing limitations in Medicare's benefit package, each of which involves tradeoffs among the goals of financial protection, access to care, efficient use of services, feasibility, and affordability. We discuss only a few of the options here. Modifying Medicare's cost-sharing structure could improve financial protection, access to care, and efficiency with little increase in spending, but would not remedy lack of coverage for important services. Expanding the benefit package to cover prescription drugs and other services would enhance financial protection and access to care. Although expanding coverage would require substantial new Medicare resources, spending by other payers would fall. Finally, creating a more comprehensive benefit package that includes a prescription drug benefit and a cap on cost sharing could improve financial protection, access to care, and efficiency. A comprehensive package could be provided directly by the government or through private sector entities. Although this change could be accomplished without increasing total spending on beneficiaries' health care, it would substantially redistribute existing resources. ■

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A P P E N D I X

A

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**Preventive services  
and Medicare**

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## Preventive services and Medicare

The original Medicare benefit package limited coverage to acute care services. Adding preventive services requires a change in the Medicare statute (unlike adding coverage for new technologies for the diagnosis or treatment of disease, which can be evaluated either by local carriers or through the national Medicare coverage determination process). In 1980, the pneumococcal pneumonia vaccine became the first preventive service added to Medicare's benefit package. The Balanced Budget Act of 1997 enacted the largest expansion of preventive benefits, adding or expanding coverage for diabetes management as well as screening for osteoporosis and for prostate, colorectal, cervical, and breast cancer. For some preventive services, Congress has chosen to waive the deductible and coinsurance requirements normally applicable to benefits; for others it has not.

Although the hearings and deliberations that have led to the introduction of new preventive benefits drew upon expert scientific advice, the process has been essentially *ad hoc*, and the resulting set of benefits does not reflect the current consensus of experts in the field of prevention and health promotion. The differences are illustrated by comparing the preventive services Medicare covers with the recommendations of the U.S. Preventive Services Task Force (USPSTF).

The task force is an independent panel of private-sector experts in primary care and prevention convened by the U.S. Public Health Service to systematically review evidence regarding the effectiveness of clinical preventive services. The group has issued recommendations on preventive interventions, many of which

are being updated. Some of the group's recommendations concur with Medicare coverage, while others diverge. Influenza vaccine and pneumococcal pneumonia vaccine are both recommended by the USPSTF and covered by Medicare. However, prostate-specific antigen tests, which screen for markers related to prostate cancer, and bone density tests, which can indicate osteoporosis, are not recommended by the group, although both are covered by Medicare. Further, the task force recommends other preventive services that Medicare does not cover, such as counseling regarding diet and exercise.

Table A-1 (next page) provides information comparing the preventive services recommended by the USPSTF to those covered by Medicare and to coverage offered in employer-sponsored health plans.

**TABLE  
A-1**

**Recommended coverage and Medicare coverage of clinical preventive services**

<b>Service</b>	<b>USPSTF recommendation for the 65+ population</b>	<b>Medicare coverage and date implemented</b>	<b>Percent of employers providing coverage, 1997</b>
<b>Screening</b>			
Cervical cancer screening by Pap smear and pelvic exam	Pap smear	Pap smear–1990 Pelvic exam–1998	89% (Pap smear)
Breast cancer screening by mammography	Yes	1991	91
Colorectal cancer screening by fecal occult blood test, sigmoidoscopy, screening barium enema, colonoscopy	Fecal occult blood test and/or sigmoidoscopy	Fecal occult blood test, sigmoidoscopy, screening barium enema, colonoscopy–1998	72
Osteoporosis screening by bone densitometry	Not recommended	1998	Data unavailable
Prostate cancer screening by prostate-specific antigen (PSA) and digital rectal exam	Not recommended	2000	76 (PSA only)
Glaucoma screening	No recommendation	2002	Data unavailable
Skin cancer screening	No recommendation	No	64
Cholesterol measurement	Yes	No	60
Periodic physical exams	Blood pressure, height and weight	No	89
Periodic gynecological exams	No recommendation	No	92
Assess for hearing impairment	Yes	No	Data unavailable
Mantoux test for tuberculosis	For high-risk populations, including those in long-term care facilities	No	Data unavailable
<b>Counseling</b>			
Substance use, diet and exercise, injury prevention, dental health	Yes	No	22 to 35 (varies by type of counseling)
Diabetes self-management training	No recommendation	1998	35
Nutritional therapy services for beneficiaries with diabetes or end-stage renal disease	No recommendation	2002	Data unavailable

continued on next page



**TABLE  
A-1**

**Recommended coverage and Medicare coverage of clinical preventive services**

<b>Service</b>	<b>USPSTF recommendation for the 65+ population</b>	<b>Medicare coverage and date implemented</b>	<b>Percent of employers providing coverage, 1997</b>
<b>Immunizations</b>			
Pneumococcal pneumonia vaccine	Yes	1981	41%
Hepatitis B vaccine	No recommendation	1984	Data unavailable
Influenza vaccine	Yes	1993	57
Tetanus-diphtheria boosters	Yes	No	Data unavailable
<b>Chemoprophylaxis</b>			
Discuss hormone prophylaxis (women)	Yes	No	Data unavailable
Discuss use of aspirin to prevent coronary heart disease with patients at increased risk	Yes	No	Data unavailable

Note: USPSTF (United States Preventive Services Task Force).

Sources: Medicare coverage: Institute of Medicine 2000, CCH Inc. 2001.  
 USPSTF recommendations: USPSTF 1996, USPSTF 2002.  
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A P P E N D I X

# B

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**Sources of additional coverage  
for Medicare beneficiaries**

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## Sources of additional coverage for Medicare beneficiaries

This section provides a detailed description of the major sources of additional coverage for Medicare beneficiaries, including employer-sponsored insurance, Medigap insurance, Medicaid, Medicare managed care, and the TRICARE program for military personnel.<sup>1</sup> (A brief description of health benefits provided to military veterans through the Department of Veterans Affairs [VA] is provided at the end of this appendix, although VA health benefits do not generally coordinate with Medicare coverage in the same way). Each of the sources of additional insurance provides, in varying degrees, coverage of Medicare’s cost-sharing requirements, and many provide additional benefits such as outpatient prescription drugs or coverage for other services not covered by Medicare. Some of these insurance options require the beneficiaries to pay a premium, while others are available at no cost to beneficiaries. Most require that beneficiaries pay the Medicare Part B premium. All of these sources of additional coverage either have explicit eligibility restrictions, limited open enrollment periods, or are only available in certain areas of the country.

### Employer-sponsored insurance

The most common form of supplemental coverage is employer-sponsored insurance, which covers 33 percent of non-institutionalized Medicare beneficiaries. Some of these beneficiaries have access to employer-sponsored coverage in their current jobs or through a spouse’s employer, but the majority receive coverage as part of their retiree benefit packages. Employers have traditionally offered health insurance, including retiree coverage, as a way to recruit and retain workers. Offering retiree health benefits also makes it easier for employers to offer older workers early retirement options.

Employer-sponsored insurance typically provides some coverage for Medicare’s cost-sharing requirements, as well as additional benefits such as outpatient prescription drug, dental, hearing, or vision coverage. Because the employer sometimes pays all or part of the premium, employer-sponsored insurance

can be an inexpensive source of supplemental coverage for beneficiaries. However, the amount of coverage and the employees’ share of the cost vary by firm.

Large firms are much more likely than smaller firms to offer employer-sponsored insurance and retiree benefits and generally offer more generous benefits at lower cost to the enrollee. One prominent employer survey found that about 23 percent of large firms nationwide offered health coverage to Medicare-eligible retirees in 2001.<sup>2</sup> The probability that a firm offered coverage increased with firm size; about 54 percent of firms with 20,000 or more employees offered retiree coverage to Medicare-eligible retirees, compared with 17 percent of firms with 500 to 999 employees (Mercer 2002).

In addition to size, firm location and industry type also influence the extent of coverage. Firms in the Northeast were more likely to offer retiree coverage in 2001 than those in the Midwest (26 percent versus 19 percent). Similarly, government jobs were more likely to offer coverage to Medicare-eligible retirees (57 percent) than financial services jobs (36

<sup>1</sup> TRICARE is not an acronym; we present the name in all capital letters because it appears this way in statute.

<sup>2</sup> Another survey of major employers in 2001 found that 61 percent of firms offered retiree health care coverage to Medicare-eligible retirees (Hewitt Associates 2001). The survey we cite in the text contains a more nationally representative sample of firms, while the Hewitt Associates survey consists primarily of larger employers that are more likely to offer coverage.

percent), transportation, communication, and utility jobs (29 percent), or wholesale/retail jobs (6 percent) (Mercer 2002).

Depending on the firm, employers use three main approaches to coordinate their health benefits with those of Medicare: traditional coordination of benefits, the “carve-out” method, and the exclusion method (sometimes called maintenance of benefits). Under traditional coordination of benefits, the employer-sponsored plan essentially pays whatever Medicare does not, up to the total dollar amount that the plan would have spent in the absence of Medicare. This method generally leaves beneficiaries with little or no out-of-pocket liability. With the carve-out method, the employer-sponsored plan computes what it would have paid in the absence of Medicare, deducts the Medicare payment, and then pays only the difference (if any) between the Medicare payment and the amount the plan would have paid. The beneficiary could be responsible for up to 100 percent of the remaining cost after Medicare pays. Finally, under the exclusion method, the employer-sponsored plan computes the total amount that remains after Medicare has paid and then covers whatever percentage of that amount the plan typically pays (for example, if the plan typically pays 80 percent of the cost of services, it would pay 80 percent of the amount that remains after Medicare pays, leaving the beneficiary responsible for the rest). Traditional coordination of benefits is the most generous, leaving retirees with the lowest out-of-pocket expenditures. Despite the generosity of this method, it continues to be commonly used.

Firms vary by the amount of the premium they pay versus the amount they require employees to pay. The majority of firms contribute part of the premium and require the employees to pay the remainder. However, some employers pay the full premium, while others offer coverage options but contribute nothing to the premium. The average premium in 2001 for a single retiree was \$50 per month, 26 percent of the full premium. This premium is two-thirds higher than

the premium that active workers pay in the same firms that offer retiree coverage (Henry J. Kaiser Family Foundation et al. 2002). About 40 percent of employers adjust the amount of their premium contribution according to the employees’ age at retirement or number of years of service (Mercer 2002). The employers’ contribution to the insurance premium is tax deductible, providing a tax subsidy to the firm. Indirectly, this also provides a tax benefit to the employee, who would otherwise receive the amount of the employer’s premium contribution in the form of taxable wages.

Not all employees in firms that offer retiree coverage are eligible for it, but it is assumed that most eligible people choose to take it. On average, a retiree must have at least 10 years of service to be eligible for retiree health benefits (Henry J. Kaiser Family Foundation et al. 2002). One study found that employee participation tends to increase with income (Shea and Stewart 1995).

In 2001, the option most commonly chosen by retirees in firms that offered retiree coverage was the indemnity plan option (56 percent of retirees with an option) (Henry J. Kaiser Family Foundation et al. 2002). A number of employers have tried to encourage the use of managed care for retirees, but given the decreasing availability of Medicare managed care and the dissatisfaction of retirees with limited choices, employers have had difficulty promoting this option.

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## **Private Medigap insurance**

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Medigap insurance is private coverage designed specifically to wrap around the Medicare benefit package; it is the second most common form of supplemental coverage. Most Medigap insurance is marketed directly to individual Medicare beneficiaries (75 percent of Medigap policyholders had individual policies in 1999), with the remainder sold as group policies (most likely association plans)

(Chollet and Kirk 2001). Individual Medigap insurance premiums are not tax deductible.

Private supplemental insurance, similar to what we now call Medigap insurance, has existed since the beginning of Medicare, but changes have occurred over the years due to federal and state insurance regulations and the evolution of the market. The most important change occurred with passage of the Omnibus Budget Reconciliation Act of 1990, which standardized the benefits of most Medigap plans sold after 1992 (the 10 standard plans are commonly labeled A through J). These standard plans generally provide coverage of Medicare’s cost-sharing requirements but offer few additional benefits beyond the basic Medicare benefit package (Table B-1). Three of the standard plans (H, I, and J) do offer limited coverage of outpatient prescription drugs, but all come with a \$250 annual deductible, 50 percent coinsurance, and a cap on benefits of \$1,250 per year (plans H and I) or \$3,000 per year (plan J). Relatively few beneficiaries enroll in the three plans that offer prescription drug coverage.

Insurers issuing policies in Massachusetts, Minnesota, and Wisconsin are exempt from the standard plan requirements because, prior to 1992, these states had laws in effect mandating standard benefit packages. Massachusetts has three standard Medigap plans—a core plan that covers some of the basic Medicare cost-sharing requirements and some additional state-mandated benefits and two plans that add coverage of the Medicare Part A and Part B deductibles, skilled nursing facility coinsurance, and foreign travel coverage. One of these three plans includes outpatient prescription drug coverage that provides generic drugs at no cost and requires a \$35 deductible per quarter and 20 percent coinsurance for brand-name drugs. Minnesota has two standardized plans that allow beneficiaries to add optional riders. Both plans add extra benefits beyond Medicare’s benefit package. The more basic plan does not include prescription drug coverage (unless beneficiaries choose to add this as an

**TABLE  
B-1**

**Benefits, enrollment, and average premiums in standardized Medigap plans, 2000**

Benefits, enrollment, and premiums	Standardized Medigap plan									
	A	B	C	D	E	F	G	H	I	J
<b>Cost sharing</b>										
Part A hospital coinsurance	•	•	•	•	•	•	•	•	•	•
365 additional hospital days	•	•	•	•	•	•	•	•	•	•
Part B coinsurance	•	•	•	•	•	•	•	•	•	•
Blood products	•	•	•	•	•	•	•	•	•	•
Part A deductible		•	•	•	•	•	•	•	•	•
Part B deductible			•			•				•
Skilled nursing facility copayments			•	•	•	•	•	•	•	•
Part B balance billing						•	•		•	•
<b>Additional benefits</b>										
Foreign travel			•	•	•	•	•	•	•	•
Home health care				•			•		•	•
Preventive medical care					•					•
Prescription drugs								•	•	•
Enrollment	10%	10%	26%	6%	2%	35%	3%	2%	3%	4%
Average monthly premium	\$87	\$88	\$106	\$98	\$95	\$110	\$87	\$109	\$159	\$176

Note: Percentages do not sum to 100 because of rounding.

Source: Medicare Payment Advisory Commission analysis of 2000 Medicare Supplemental Exhibits from the National Association of Insurance Commissioners.

optional rider), while the extended basic plan covers 80 percent of the cost of outpatient prescription drugs. Wisconsin has one basic plan plus optional riders. The basic plan offers prescription drug coverage that only insures beneficiaries against extremely high prescription drug costs; beneficiaries must spend \$6,250 before receiving the benefit and pay 20 percent coinsurance for expenditures over this amount. In 2000, an estimated 4 percent of all Medigap enrollees were in plans issued in one of these three states.<sup>3</sup>

Beneficiaries who purchased Medigap policies prior to 1992 are generally allowed to retain these policies. About 31 percent of Medigap enrollees in 2000

were in these so-called pre-standard plans. Because insurers are prohibited from issuing new policies for pre-standard plans, the estimated minimum age of policyholders in these plans today is about 75 and the number of beneficiaries enrolled in these plans has been declining, from 3.7 million in 1998 to 3.3 million in 2000. While it is thought that many pre-standard Medigap policies include coverage for outpatient prescription drugs, the covered benefit may be less generous than that offered in the standard policies. For example, AARP's pre-standard Medigap policy, which enrolls about 20 percent of all beneficiaries in pre-standard plans, offers prescription drug coverage

with a \$50 deductible, 50 percent coinsurance, and a \$500 cap on benefits (Chollet and Kirk 2001, Smolka 2002).

Medigap premiums vary substantially among beneficiaries because insurers factor in the costs of benefits offered by the 10 standardized plans, federal and state access and consumer protection regulations, geographic differences in health care costs, and characteristics of individual applicants and enrollees. In addition, Medigap insurers in most states can, under certain conditions, medically underwrite—meaning that they can consider a beneficiary's health and medical history in deciding whether to offer a policy and how much to charge.<sup>4</sup>

3 Unless otherwise noted, all of the data on premiums for Medigap plans and the distribution of enrollees across plan types come from MedPAC analysis of National Association of Insurance Commissioners' data.

4 Insurers are prohibited from medically underwriting for the first 6 months after a beneficiary over the age of 65 first enrolls in Medicare Part B (the open enrollment period).

This practice is common, particularly for Medigap plans that include prescription drug coverage.

A Medicare beneficiary's current age or age at the time of enrollment also plays an important role in determining the Medigap premium. Under community rating, all enrollees in a product are charged the same premium regardless of their current age or their age at the time of enrollment. Under issue-age rating, insurers set premiums based on beneficiaries' age at the time of enrollment. Finally, under attained-age rating, insurers base annual premiums on the current age of the enrollees.

Each rating approach creates issues for insurers and beneficiaries. Because community rating requires insurers to average the premiums across all age groups, insurers argue that it tends to produce much higher premiums for people age 65 than other rating systems. Because most beneficiaries purchase Medigap policies at age 65, this may discourage early enrollment. Issue-age rating may discourage beneficiaries from changing Medigap plans because the beneficiaries will generally be older and consequently will face a higher premium when they purchase the new product. Insurers that use attained-age rating increase the premiums as beneficiaries age, charging the highest premiums to the oldest beneficiaries, who are often those least able to afford it. One study found that the annual claim cost per insured beneficiary was lowest for those in attained-age rated plans, probably because beneficiaries whose premiums were growing faster than their income—likely older beneficiaries with more health problems—dropped such coverage (American Academy of Actuaries 2000). Recognizing these issues, 10 states have prohibited attained-age rating, 6 have prohibited entry-age rating, and 8 have required community rating as of 1999 (Chollet and Kirk 2001).

The average premium for individual Medigap insurance across all plan types—standardized and non-standardized—was \$115 per month in 2000. The average premium for plan F, the most common standardized plan option, was \$110 per month; premiums for standardized plans that include outpatient prescription drug coverage ranged from \$109 for plan H (cap of \$1,250) to \$176 for plan J (cap of \$3,000). Medigap premiums vary considerably by state. For example, premiums in California, Indiana, and Florida tend to be much higher (more than twice as much for all plans and more than four times as much for standardized plans) than premiums in New Hampshire, Pennsylvania, Utah, and Montana. Some, but not all, of this variance can be explained by regional differences in beneficiaries' preference for different plans, regional variation in health care costs, regional availability of different plans, and characteristics of enrollees (Chollet and Kirk 2001). Premiums also vary substantially according to the age of the beneficiary and the rating methodology used. For example, policies for older beneficiaries in attained-age rated policies may cost considerably more than policies that use other approaches to rating. In 1999, for example, a Pennsylvania insurer that offered both attained-age and issue-age policies for the same plan would have charged an 80 year-old male \$112 per month for an issue-age policy that he purchased at age 65 and \$132 for an attained-age policy (General Accounting Office 2001).

Beneficiaries in all parts of the country are guaranteed to be able to purchase a Medigap policy under certain conditions. Within 6 months of enrolling in Medicare's Part B, any beneficiary over the age of 65, regardless of health status, is guaranteed access to a Medigap policy.<sup>5</sup> In addition, federal law guarantees elderly beneficiaries the right to purchase Medigap plan A, B, C, or F if they enroll in a Medicare managed care plan and the plan stops serving their area, if they lose employer-sponsored insurance, if they are

enrolled in a Medigap policy provided by an insurer that goes bankrupt, or if they are forced to disenroll from a Medicare managed care plan (either because the plan goes out of business, commits fraud, or the beneficiary moves out of the plan's service area). Similarly, beneficiaries who join a Medicare managed care plan when they are first eligible for Medicare and disenroll within one year have the right to purchase any plan sold in their state, and beneficiaries who join a managed care plan for the first time and want to leave within one year have the right to return to their original Medigap coverage (if the same plan is available) or to purchase plan A, B, C, or F (if the same plan is not available). These guaranteed issue rights do not extend to plans that include outpatient prescription drug coverage. For this reason, Medicare managed care plans that include such coverage provide an attractive alternative to Medigap insurance in areas where managed care plans are offered. Medicare beneficiaries under the age of 65 do not have the same federal protections as elderly beneficiaries; they are only guaranteed access to a Medigap policy in certain states (Centers for Medicare & Medicaid Services 2002a).

Once an individual purchases a Medigap policy, the policy cannot be cancelled (except for failure to pay the premiums) and the beneficiary can continue to hold the policy even after moving to another state. Because most Medigap insurance protections are for entry into the system, beneficiaries have limited protections if they decide to change policies.

Beneficiaries in all areas of the country have access to Medigap policies, although they may not necessarily have access to all 10 standard policies. All insurers who issue Medigap policies are required to offer at least plan A, the most basic policy, but not all of the plans. The three plans that include prescription drug coverage are often the most difficult to find (Chollet and Cook 2001). In addition, the fact that plans are offered in a

5 Medigap insurers may limit coverage for pre-existing medical conditions for a certain amount of time after issuing a policy, but the law generally requires insurers to reduce the length of time by the amount of previous health insurance coverage.



particular area does not necessarily mean that they are affordable or that they will accept new enrollees. Insurers may, in fact, raise the price of their less profitable plans to discourage enrollment.<sup>6</sup> Fewer than half of all Medigap enrollees (48 percent), and 68 percent of those in standard policy options, are enrolled in plans that are still accepting new enrollees. This fraction varies by plan type; almost 80 percent of beneficiaries in plan F are in plans that are still accepting new enrollees, compared with 21 percent of beneficiaries in plan H (one of the plans with prescription drug coverage) (Chollet and Kirk 2001).

It is difficult to assess the participation rates in Medigap plans, given the complexity of their availability and the variation in their premiums. A review of studies on supplemental coverage found that beneficiaries who were most likely to purchase individual Medigap policies tended to be older, female, white, more educated, and wealthier than beneficiaries who did not purchase Medigap policies. The studies generally did not agree on whether Medigap enrollees differ significantly by health status from other beneficiaries, although most studies found that Medigap enrollees in plans with prescription drug coverage tended to have more health problems than those who did not enroll in these plans (Atherly 2001). Medigap participation rates appear to be higher among Medicare beneficiaries with fewer alternatives. Beneficiaries in rural areas, for example, are much less likely to have access to either retiree coverage or Medicare managed care and are more likely to have purchased a Medigap policy than beneficiaries in urban areas: 39

percent of beneficiaries in rural areas had a Medigap policy in 1999 compared with 23 percent of beneficiaries in urban areas.<sup>7</sup>

Among beneficiaries enrolled in standard plans, enrollment is highest in the four “guaranteed issue” plans—A, B, C, and F. The most popular plans are plan F, which covers most of Medicare’s cost-sharing requirements but offers little in the way of extra benefits (35 percent) and plan C, which is similar to F but does not cover the excess amount beneficiaries may be required to pay for doctors who do not accept payment of the Medicare-approved amount as payment in full (26 percent) (Table B-1).<sup>8</sup> Plans H, I, and J together amount to about 9 percent of Medigap enrollees in standard plans.

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## Medicaid and other state programs

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Medicaid provides supplemental insurance coverage for certain low-income, sick, and disabled beneficiaries. It was created in 1965 as a companion program to Medicare to provide health assistance to people qualifying for welfare and to pay for nursing home care for the elderly. Over the years, it has evolved to cover community-based long-term care services and Medicare’s cost-sharing requirements. Dual eligibles—Medicare beneficiaries who are also entitled to Medicaid benefits—are among the most costly Medicare beneficiaries. In 1997, they represented just 17 percent of the Medicare beneficiary population yet accounted for 28 percent of total Medicare spending. Similarly, dual-

eligible beneficiaries accounted for 19 percent of the total Medicaid population but accounted for 35 percent of total Medicaid costs (Clark and Hulbert 1998).

States reported that in the first quarter of fiscal year 1999 there were approximately 5.5 million dual-eligible beneficiaries.<sup>9</sup> Of these, 58 percent were eligible for the full package of Medicare and Medicaid benefits, 11 percent were eligible to receive coverage for some part of Medicare’s cost-sharing requirements, and the remaining 31 percent were classified as “other” or “unknown.” In 1999, the proportion of Medicare beneficiaries classified as dual eligible varied by state, ranging from a high of almost 28 percent in Mississippi and Tennessee to less than 8 percent in Arizona, Idaho, and Utah (Ellwood and Quinn 2002). Dual-eligible beneficiaries, compared with the rest of the eligible Medicare population, tend to be disproportionately female (63 percent versus 55 percent), over age 85 (18 percent versus 10 percent), and members of racial or ethnic minority groups (38 percent versus 14 percent) (Centers for Medicare & Medicaid Services 2002b).

Dual-eligible beneficiaries can be categorized into three main types. The first category includes Medicare beneficiaries who, because of low income and assets or because of a disability, qualify for the Supplemental Security Income (SSI) program, which automatically triggers Medicaid eligibility in most states.<sup>10</sup> SSI is a nationwide income-support program for people age 65 and older and people who are blind or disabled who have limited resources and incomes below about 75 percent of the

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6 Insurers that want to continue offering a particular plan type in a given market may keep a product “open”—meaning that the plan continues to accept new enrollees—but may charge a high premium for it. They have an incentive to do so because if they stop marketing that product state insurance regulators may prohibit them from reentering the market with products for that plan type for five years. However, the extent to which insurers can charge excessive premiums is also limited by regulation (General Accounting Office 2001).

7 Estimates from MedPAC analysis of National Association of Insurance Commissioners’ data.

8 Federal law allows doctors who refuse to accept Medicare’s approved payment amount as payment in full to charge beneficiaries up to 15 percent more than the approved payment amount. This is sometimes referred to as “balance billing.”

9 Estimates from the Medicaid Statistical Information System, which are state-reported data, tend to be lower than estimates obtained from the Medicare Current Beneficiary Survey, which are based on beneficiaries’ self-reported data.

10 In 1998, 11 states obtained waivers allowing them to impose more restrictive Medicaid eligibility restrictions than those for SSI.

federal poverty level.<sup>11</sup> The second category includes beneficiaries who qualify through optional “medically needy” or “300 percent of SSI” programs. Most states allow certain individuals to deduct medical expenses from income to qualify for Medicaid or allow institutionalized individuals to qualify for Medicaid if their incomes are at or below 300 percent of the SSI income standard, as long as they meet SSI’s resource eligibility standards (Bruen et al. 1999). Most nursing home residents and many individuals with high prescription drug or medical equipment costs qualify for Medicaid this way. Third, states have options to extend Medicaid eligibility to non-institutionalized elderly or disabled individuals through home and community-based services waiver programs or through options that allow states to set more liberal income and asset eligibility standards than SSI (Schwalberg et al. 2001).

Medicaid offers several levels of coverage to dual-eligible beneficiaries. First, many dual-eligible beneficiaries are eligible to receive coverage for health services beyond those covered by Medicare. Medicaid law requires that all participating states cover a core set of services—hospital, physician, and nursing facility care—and that they offer the same services to all eligible beneficiaries (except those in waiver programs, described later). Many states go beyond this requirement and take advantage of options that allow them to provide a more comprehensive set of Medicaid benefits—including outpatient prescription drugs—to dual-eligible beneficiaries. Otherwise, states would likely have to pay the costs of uncompensated care for these same

beneficiaries, and the federal government does not pay the states matching funds for the costs of uncompensated care.

Most dual-eligible beneficiaries and some low-income beneficiaries who do not entirely meet the requirements for dual eligibility receive Medicaid coverage for part or all of their Medicare premiums or cost-sharing requirements.<sup>12</sup> As such, Medicaid resembles a Medigap plan C or F (covering most of Medicare’s cost-sharing requirements without providing additional benefits). Several mandatory Medicaid programs pay beneficiaries’ Medicare premiums or cost-sharing requirements. The qualified Medicare beneficiary (QMB) program pays Medicare’s premiums, deductibles, and coinsurance for all beneficiaries whose income is at or below 100 percent of the federal poverty level and whose assets are at or below twice the SSI limit. The specified low-income Medicare beneficiary (SLMB) program pays the Medicare Part B premium for beneficiaries with incomes between 100 percent and 120 percent of poverty. The qualifying individual-1 (QI-1) program pays the Part B premium for beneficiaries with incomes between 120 and 135 percent of poverty, and the Qualifying Individual-2 (QI-2) program subsidizes a portion of the Part B premium for beneficiaries with incomes between 135 percent and 175 percent of poverty.<sup>13</sup> Because the QI program’s federal funding is limited, assistance is available on a first-come, first-serve basis (General Accounting Office 1999). Although Medicaid’s QMB, SLMB, and QI programs are defined by federal law, states have discretion in how they implement these programs (Nemore 1999).

Lastly, states can use waivers to extend comprehensive or limited Medicaid benefits to other dual-eligible beneficiaries. The most common type of waiver is known as a home and community-based services (1915(c)) waiver. States can, with federal approval, provide a state-designed set of health and long-term care services to individuals living in the community who do not qualify for Medicaid only because they are not institutionalized. All states used some form of home and community-based services waiver program to provide benefits to an estimated 622,000 beneficiaries in 1998 (Smith et al. 2000). In addition, some states have applied for Section 1115 Research and Demonstration waivers to extend prescription drug coverage to dual-eligible beneficiaries. States have found these waivers difficult to use, however, because they must demonstrate that their Medicaid programs will cost no more with the implementation of the prescription drug program than they would have cost had the program not been implemented. The Bush Administration has proposed legislation to expand the use of waivers for increasing outpatient prescription drug coverage.<sup>14</sup> In addition, the National Governors’ Association reports that about 30 states have implemented non-Medicaid state pharmaceutical assistance programs to, at a minimum, provide greater discounts on prescription drugs and in some cases provide beneficiaries assistance in purchasing comprehensive prescription drug benefits (National Governors’ Association 2002).

The benefits package for dual-eligible beneficiaries who are fully eligible to receive Medicaid is one of the most

11 Specifically, the SSI monthly income standard is \$545 for an individual and \$817 for a couple in 2002 (disregarding the first \$20 per month). The SSI resource limit is \$2,000 for an individual and \$3,000 for a couple and generally excludes the home, a car (depending on use and value), burial plots, and the first \$1,500 in burial funds and life insurance (Social Security Administration 2002).

12 The Balanced Budget Act of 1997 (PL 105-33) allowed states to pay providers the lower of Medicare’s cost-sharing requirements or the states’ Medicaid rates, although providers are not permitted to charge beneficiaries the difference. In 1999, only 16 states reimbursed providers for the full amount of Medicare’s cost-sharing requirements (Nemore 1999).

13 Income and resource standards and methodologies cannot be more restrictive in the QMB, SLMB and QI programs than they are for SSI; however, they can be more generous (Schneider et al. 1999).

14 The President’s fiscal year 2003 budget includes a proposal to allow states to expand prescription drug coverage to beneficiaries with incomes up to 100 percent of poverty through the regular Medicaid program and to access a federal matching rate of 90 percent for prescription drug coverage for Medicare beneficiaries with incomes between 100 percent and 150 percent of the federal poverty level (Department of Health and Human Services 2002).

comprehensive of all Medicare supplemental options. The vast majority of dual-eligible beneficiaries do not pay premiums for Medicare or Medicaid, and any cost-sharing requirements are nominal. Medicaid is also one of the few programs, public or private, that pays for long-term care; in 2000, Medicaid paid for 48 percent of all nursing home care (Levit et al. 2002). In addition, dual-eligible beneficiaries generally receive a comprehensive prescription drug benefit through Medicaid.

Despite the generosity of benefits available to dual-eligible beneficiaries, participation in Medicaid by eligible Medicare beneficiaries is low in most states. Given the characteristics of the Medicare population, an estimated 24 percent of all non-institutionalized beneficiaries are eligible for or enrolled in one of the Medicaid programs. However, fewer than half of those eligible to receive Medicaid assistance actually do (Laschober and Topoleski 1999). Common explanations for the low participation rate include lack of knowledge of the programs, the stigma associated with Medicaid, and barriers to enrollment (such as a complex application process). Beneficiaries commonly believe that Medicaid is only for “poor people” and that applying could put their estates at risk (General Accounting Office 1999). The way a state implements its Medicaid programs also affects participation rates. For example, in 1999, more than half of states did not use a simplified enrollment application, more than three-quarters of states did not provide outreach materials in other languages, and about two-thirds of states did not make eligibility screening tools available to outside agencies, clinics, or senior centers (Nemore 1999). Medicare beneficiaries who are eligible but not enrolled in Medicaid are more likely to be 80 years old or older, married, and otherwise insured (through Medicare managed care or private supplemental insurance) than enrolled beneficiaries (Laschober and Topoleski 1999).

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## Medicare managed care

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The Medicare managed care program allows beneficiaries the option of joining a private health plan, which then receives payment from Medicare for providing Medicare-covered services. These private plans are allowed to charge beneficiaries an additional premium and provide additional benefits. However, if plans’ reported costs are lower than their Medicare payments, they are required by law either to return the difference to enrollees in the form of additional benefits or contribute the money to a reserve fund for future use (few plans choose this option).

Thus, although Medicare managed care is technically an alternative method of delivering Medicare benefits through private plans instead of through traditional Medicare, beneficiaries in certain areas of the country have joined managed care plans to take advantage of the supplemental benefits they offer. Recent surveys have found that obtaining outpatient prescription drug coverage, keeping premiums down, and lowering out-of-pocket costs topped the list of reasons beneficiaries cited for choosing a health plan or for switching among health plans. In fact, about half the time, beneficiaries switching from one health plan to another cited reasons involving issues of benefits, premiums, or related matters, including reaching a benefit limit (19 percent), high out-of-pocket costs (11 percent), premiums that are too high (7 percent), or the desire for a prescription drug benefit (5 percent). Individuals moving into a Medicare health maintenance organization (HMO) for the first time or into a new HMO also typically gave reasons connected with benefits and premiums (Gold et al. 2001).

Private managed care plans have participated in Medicare since the program first began in 1965. However, two major changes have occurred during the course of the program. In the mid-1980s, the Tax Equity and Fiscal

Responsibility Act of 1982 (TEFRA) authorized Medicare to begin paying HMOs a fixed amount each month, called a capitation rate, to provide care to Medicare enrollees (other types of plans, such as cost plans and health care prepayment plans, continued to be paid on a cost basis). By law, TEFRA plans were paid a county-level payment rate equal to 95 percent of the estimated cost of providing Medicare services to an average beneficiary, adjusted for some basic demographic characteristics of enrolled beneficiaries.

Later, the Balanced Budget Act of 1997 created the Medicare+Choice (M+C) program, which revised and expanded the rules governing private health plan participation in Medicare. Under M+C, new types of private health plans were allowed to provide Medicare benefits in exchange for capitated payments, and the formula for calculating plan payments was changed. The types of plans allowed to participate now include the HMOs formerly authorized to participate under TEFRA, point-of-service plans, preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. Few of these new plan types have entered the program; M+C plans continue to be mostly HMOs.

Medicare managed care plans are not available to beneficiaries in all parts of the country. Throughout the history of the program, plans have tended to locate mainly in certain parts of Florida, the West Coast, and New England. However, plan participation in Medicare has been cyclical, with plans expanding to more areas of the country during peak periods and cutting back on their service areas during periods of increasing costs and lower Medicare plan payments. Plans tend to operate primarily in areas with greater concentrations of health care providers and beneficiaries, and with higher-than-average Medicare payment rates.

By the mid-1990s, Medicare's plan payments exceeded plans' costs in some areas. At the same time, managed care plans were gaining prominence in the overall health care market. Taking advantage of increasing profits and popularity, HMOs boosted their benefit offerings and expanded service to more areas of the country. As a result, total enrollment in these plans grew rapidly (nearly 1 million new enrollees per year), peaking at 6.35 million enrollees in 1999. In 1998, 74 percent of all Medicare beneficiaries were living in areas where they could choose to join a Medicare HMO.<sup>15</sup>

Medicare managed care plans generally offer reduced Medicare cost-sharing requirements, some preventive services, more predictability in out-of-pocket expenditures, and additional benefits, such as coverage for dental services, eyeglasses, and outpatient prescription drugs. In recent years, coverage for outpatient prescription drugs has been one of the most popular features of Medicare managed care plans. In 1999, 84 percent of plans offered prescription drug coverage, often unlimited or with relatively high limits (Gold and Achman 2001). Prescription drug coverage through a Medicare managed care plan was an option for about 65 percent of beneficiaries.

Relatively low premiums have made the Medicare managed care option even more attractive to beneficiaries. The average monthly premium for an M+C plan in 1999 was \$6, while 80 percent of plans charged no premium, and the average monthly premium among beneficiaries paying a premium was \$32 (Gold and Achman 2001). A managed care plan without a monthly premium was an option for a full 61 percent of beneficiaries. In fact, more than half (54 percent) of all beneficiaries could enroll in a plan that offered prescription drug coverage and charged no monthly premium.

Where beneficiaries live influences how much they have to pay to join plans and how generous the benefits are. In areas in which plans have an easier time providing Medicare services at costs that are below the Medicare plan payment amounts, beneficiaries typically pay lower premiums and receive more generous coverage than do beneficiaries in other areas.

Unlike most other sources of additional insurance, Medicare HMOs often restrict beneficiaries' freedom to see any provider. Many HMOs only cover services provided by specific health care providers (those that participate in the plans' designated networks); others provide incentives for beneficiaries to use network providers.

The past four years have seen a reversal in the expansion of Medicare HMO enrollment that took place during the early and mid-1990s. This reduction in the number of plans and the number of enrollees has coincided, in part, with the implementation of a new plan payment methodology that has constrained growth in payment rates in many high-payment areas. Also, HMOs generally began experiencing rising costs and lower enrollments during this period, with health care consumers in all segments of the market—not just Medicare beneficiaries—rejecting many of the methods HMOs had used successfully to contain costs. Finally, health care providers are increasingly reluctant to offer HMOs the deep discounts on services they had before. As a consequence, Medicare HMO premiums have risen and the benefits offered have generally declined (see Chapter 2).

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## TRICARE For Life/ Department of Defense

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TRICARE For Life is a new program that provides supplemental coverage for military personnel and retirees enrolled in Medicare. The National Defense Authorization Act for Fiscal Year 2001 created the program (effective October 1, 2001) to wrap around the Medicare benefits. The Act also created a new prescription drug benefit (effective April 1, 2001), which provides eligible Medicare beneficiaries with the same pharmacy benefit enjoyed by military personnel not eligible for Medicare.

TRICARE covers virtually all of Medicare's cost-sharing requirements, including deductibles and coinsurance for inpatient and outpatient services. It provides unlimited coverage for inpatient hospitalizations and skilled nursing facility stays, with beneficiaries responsible for 20-25 percent coinsurance for stays beyond the normal Medicare-covered allowance. The program also offers a comprehensive prescription drug benefit that gives beneficiaries the option to obtain prescription drugs at no cost from military treatment facilities or with only nominal copays from any pharmacy. In general, for most Medicare-covered services, Medicare will pay first and TRICARE will pay the beneficiaries' remaining out-of-pocket expenses. If beneficiaries have other sources of coverage, TRICARE pays after the other sources have paid. The program includes a \$3,000 annual out-of-pocket limit (Politi 2002).

To be eligible for the program, all beneficiaries must pay the Medicare Part B premium, but are not required to pay any additional premium to join. Eligible beneficiaries include uniformed service

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15 Unless otherwise noted, all Medicare managed care estimates are from MedPAC analyses of the Medicare Compare database and the Medicare managed care market penetration files, from the Centers for Medicare & Medicaid Services.

retirees (including retired guard and reservists) who served at least 20 years in the military, family members of uniformed service retirees (including widows/widowers), and certain former spouses of uniformed service retirees if they were eligible for TRICARE before age 65.

Medicare beneficiaries who meet the eligibility criteria are automatically enrolled in TRICARE and in the pharmacy benefit program with no application process. Approximately 1.5 million people are eligible for this benefit.

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## **Department of Veterans Affairs**

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Another coverage option for beneficiaries who are military veterans is to receive health care services through the Department of Veterans Affairs (VA). This option is unlike the others described here in that Medicare is prohibited by law from paying for any part of the services provided in VA facilities, and the VA does not generally pay for services rendered outside of VA facilities (so it does not function as a source of coverage

for Medicare cost-sharing requirements, for example). Still, for those who qualify, the VA program provides generous benefits—including broad coverage of most inpatient and outpatient services at little or no charge to the beneficiaries, preventive care, and outpatient prescription drug coverage—and has become increasingly popular in recent years, with more than 1 million new enrollees in the past 5 years. The growth has largely been fueled by elderly veterans seeking prescription drug coverage (Simmons 2002).

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A P P E N D I X

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**Review of CMS's estimate of  
the payment update for  
physician services**

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## Review of CMS's estimate of the payment update for physician services

The Balanced Budget Refinement Act of 1999 (BBRA) requires the Centers for Medicare & Medicaid Services (CMS) to use the sustainable growth rate (SGR) system to prepare, by March 1 of each year, a preliminary estimate of the next year's payment update for physician services. The BBRA also requires MedPAC to include a review of that estimate in our June report.

In MedPAC's March 2002 report to the Congress, the Commission recommended that the Congress repeal the SGR system and replace it with an update method based on the estimated change in the cost of providing physician services for the

coming year. Nonetheless, to meet our statutory obligation, we have reviewed the CMS estimate.

CMS projects an update for 2003 of  $-5.7$  percent. This estimate is the product of a change in input prices of  $1.6$  percent, an update adjustment factor of  $-7.0$  percent, and a legislative adjustment of  $-0.2$  percent. The update adjustment factor of  $-7.0$  percent is the maximum negative adjustment permitted under current law.

This year, MedPAC has no reason to doubt the preliminary estimate of the update. In the past, the Commission has

raised questions about CMS's estimates of the update adjustment factor because two of its components—growth in the national economy and changes in enrollment in traditional Medicare—have been volatile and difficult to estimate. For 2003, however, CMS estimates that the update adjustment factor would be  $-13.1$  percent if it were not held to a maximum reduction of  $-7.0$  percent. Even if components of the update adjustment factor change during the coming months, the update under the SGR system is unlikely to change.



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# **Acronyms**

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## Acronyms

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<b>ADL</b>	activity of daily living
<b>ARC</b>	Actuarial Research Corporation
<b>BBRA</b>	Balanced Budget Refinement Act of 1999
<b>CABG</b>	coronary artery bypass graft
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CT</b>	computed tomography
<b>DoD</b>	Department of Defense
<b>ESRD</b>	end-stage renal disease
<b>GAO</b>	General Accounting Office
<b>HCFA</b>	Health Care Financing Administration
<b>HHS</b>	U.S. Department of Health and Human Services
<b>HMO</b>	health maintenance organization
<b>IADL</b>	instrumental activity of daily living
<b>IOM</b>	Institute of Medicine
<b>M+C</b>	Medicare+Choice
<b>MCBS</b>	Medicare Current Beneficiary Survey
<b>MedPAC</b>	Medicare Payment Advisory Commission
<b>MRI</b>	magnetic resonance imaging
<b>MSA</b>	metropolitan statistical area
<b>PPO</b>	preferred provider organization
<b>PSA</b>	prostate-specific antigen
<b>QI</b>	qualifying individual
<b>QMB</b>	qualified Medicare beneficiary
<b>SGR</b>	sustainable growth rate
<b>SLMB</b>	specified low-income Medicare beneficiary
<b>SNF</b>	skilled nursing facility
<b>SSA</b>	Social Security Administration
<b>SSI</b>	Supplemental Security Income
<b>TEFRA</b>	Tax Equity and Fiscal Responsibility Act of 1982
<b>USPSTF</b>	U.S. Preventive Services Task Force
<b>VA</b>	Department of Veterans Affairs





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## **More about MedPAC**

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New York, NY

**Mary K. Wakefield, Ph.D.,  
R.N., F.A.A.N.**

*Center for Rural Health*  
*University of North Dakota*  
Grand Forks, ND

*Term expires April 2003*

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**Autry O.V. "Pete" DeBusk**

*DeRoyal*  
Powell, TN

**Glenn M. Hackbarth, J.D.**

**Alan R. Nelson, M.D.**  
*American College of Physicians-  
American Society of Internal Medicine*  
Washington, DC

**Robert D. Reischauer, Ph.D.**

**David A. Smith**  
*AFL-CIO*  
Washington, DC

**Ray E. Stowers, D.O.**

*Oklahoma State University College  
of Osteopathic Medicine*  
Tulsa, OK

*Term expires April 2004*

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**Sheila P. Burke, M.P.A.,  
R.N., F.A.A.N.**

*Smithsonian Institution*  
Washington, DC

**Allen D. Feezor**

*California Public Employees'  
Retirement System*  
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**Ralph W. Muller**

*University of Chicago Hospitals  
and Health Systems*  
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**Joseph P. Newhouse, Ph.D.**

*Harvard University*  
Boston, MA

**Alice Rosenblatt, F.S.A.,  
M.A.A.A.**

*WellPoint Health Networks*  
Thousand Oaks, CA

**John W. Rowe, M.D.**

*Aetna Inc.*  
Hartford, CT



## Commissioners' biographies

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**Beatrice S. Braun, M.D.**, is a member of the Board of Directors of AARP. She is also a member of the State Advisory Council for the Florida Department of Elder Affairs and serves on the Board of Directors for the Mid-Florida Area Agency on Aging. Dr. Braun founded and, until her retirement in 1989, directed a day treatment program at St. Vincent's Hospital in Harrison, N.Y. for people with severe and persistent mental illness. She is a past president of the American Association for Partial Hospitalization. She also had a private practice in psychiatry for 16 years and was named a fellow of the American Psychiatric Association. Before her psychiatric specialization, Dr. Braun served for 17 years as a family physician and missionary in South Korea.

**Sheila P. Burke, M.P.A., R.N., F.A.A.N.**, is the Smithsonian Institution's undersecretary for American Museums and National Programs. Before joining the Smithsonian, she was executive dean and lecturer in public policy at the John F. Kennedy School of Government, Harvard University, Boston. From 1986 to 1996, Ms. Burke was chief of staff for former Senate Majority Leader Bob Dole and was elected secretary of the Senate in 1995. She currently serves as a board member of the Kaiser Family Foundation, the Kaiser Commission on Medicaid and the Uninsured, the Center for Health Care Strategies, Inc., the American Board of Internal Medicine Foundation, Wellpoint Health Networks, Chubb Insurance, and Community Health Systems. She also sits on the national advisory council at the Center for State Health Policy and has chaired the National Academy of Social Insurance's study panel on Restructuring Medicare for the Long-Term. Ms. Burke holds a B.S. in nursing from the University of San Francisco and an M.P.A. from Harvard University.

**Autry O.V. "Pete" DeBusk** is chairman, chief executive officer, and founder of DeRoyal, a global supplier of medical products and services in the acute care, patient care, wound care, and OEM (original equipment manufacturing) markets. Mr. DeBusk formed his first company in 1970 with a patent he received on an orthopedic product. In 1976 he consolidated his many product lines into one company, DeRoyal Industries. A member of several community organizations, Mr. DeBusk is also chairman of the Board of Trustees at Lincoln Memorial University in Harrogate, Tenn., as well as a founder and board member of the Autry O.V. DeBusk Boys and Girls Club in Hall, Tenn. As an innovative leader in the medical industry, he received a prestigious award from Duke University in 2000 recognizing his original contributions to orthopedic surgery. He received his B.S. degree from Lincoln Memorial University and attended graduate school at the University of Georgia.

**Allen D. Feezor** is assistant executive officer, Health Benefit Services, California Public Employees' Retirement System (CalPERS). Previously, Mr. Feezor was vice president for planning, marketing, and managed care for University Health Systems of East Carolina in Greenville, N.C. From 1985 to 1995, he was chief deputy commissioner for the North Carolina Department of Insurance, where he chaired two national task forces that pioneered state health insurance and small group reform. He has headed the 430,000-member North Carolina Teachers', State Employees' and Retirees' Health Plan and has served as Senior Representative in Washington, D.C. for the Blue Cross/Blue Shield Association. He was a founding faculty member of the National Academy for State Health Policy and a contributor to two Institute of Medicine studies—one on the future of health benefits and another on improving Medicare. He currently serves on the boards of Pacific Business Group on Health and the Integrated Health Association. Mr. Feezor earned his B.A. and M.A. degrees in political science from Duke University.

**Glenn M. Hackbarth, J.D.**, is chairman of the Commission and an independent consultant living in Bend, Ore. He has experience as a healthcare executive, government official, and policy analyst. He was chief executive officer and one of the founders of Harvard Vanguard Medical Associates, a multispecialty group practice in Boston that serves as a major teaching affiliate of Harvard Medical School. Harvard Vanguard was created from the staff-model delivery system that was the original core of Harvard Community Health Plan. Mr. Hackbarth previously served as senior vice president of Harvard Community Health Plan. From 1981 to 1988, Mr. Hackbarth held positions at the U.S. Department of Health and Human Services, including deputy administrator of the Health Care Financing Administration. Mr. Hackbarth received his B.A. from Penn State University and his M.A. and J.D. from Duke University.

**Floyd D. Loop, M.D.**, has served since 1989 as chief executive officer and chairman of the Board of Governors of The Cleveland Clinic Foundation. In the past 10 years, the Cleveland Clinic has developed a regional health care delivery system of clinics and acquired hospitals. Dr. Loop has practiced thoracic and cardiovascular surgery for 30 years and from 1975 to 1989 served as chairman of this department at the Cleveland Clinic. As a practicing surgeon, Dr. Loop and his colleagues have made numerous contributions to cardiac surgery, including extensive writings on internal thoracic artery grafting, reoperations, myocardial protection, and long-term results. He is a former editor of *Seminars in Thoracic and Cardiovascular Surgery* and has served on the editorial boards of 15 specialty journals in surgery and cardiology. Dr. Loop is the author of more than 300 articles on surgery. He has served on the American Board of Thoracic Surgery, chaired the Residency Review Committee, and has been president of the American Association for Thoracic Surgery. He received a medical degree from The George Washington University and completed surgical residencies at The George Washington University and the Cleveland Clinic.

**Ralph W. Muller** is currently on sabbatical at the King's Fund in London. Until July 2001, he was president and chief executive officer of the University of Chicago Hospitals and Health Systems (UCHHS), a position he has held since 1985. As deputy dean of the University of Chicago's Pritzker School of Medicine, he guided the creation of the UCHHS as a corporation separate from the university, where he had been budget director. Before joining the university, he held senior positions with the Commonwealth of Massachusetts, including deputy commissioner of the Department of Public Welfare. Mr. Muller is immediate past chairman of the Association of American Medical Colleges, past chairman of the Council of Teaching Hospitals and Health Systems, and past vice-chairman of the University Health System Consortium. He is chairman of the National Opinion Research Center, a social service research organization. Mr. Muller received his B.A. in economics from Syracuse University and his M.A. in government from Harvard University.

**Alan R. Nelson, M.D.**, is an internist-endocrinologist who was in private practice in Salt Lake City until becoming chief executive officer of the American Society of Internal Medicine (ASIM) in 1992. Following the merger of ASIM with the American College of Physicians (ACP) in 1998, Dr. Nelson headed the Washington Office of ACP-ASIM until his semi-retirement in January 2000 and now serves as special advisor to the executive vice president and chief executive officer. Dr. Nelson also serves on the Board of Trustees of Intermountain HealthCare, a large integrated health system headquartered in Salt Lake City. A member of the prestigious Institute of Medicine of the National Academy of Sciences (IOM), he serves on the IOM Roundtable on Environmental Health Sciences Research and Medicine and is chair of the study committee on Rural and Ethnic Disparities in Health Care. Dr. Nelson, who grew up in Logan, Utah and attended Utah State University, received his M.D. from Northwestern University.

**Joseph P. Newhouse, Ph.D.**, is the John D. MacArthur Professor of Health Policy and Management at Harvard University and director of Harvard's Division of Health Policy Research and Education. At Harvard since 1988, Dr. Newhouse was previously a senior corporate fellow and head of the economics department at RAND Corp. He has conducted research in health care financing, economics, and policy, and was the principal investigator for the RAND Health Insurance Experiment. Recipient of several professional awards, he is a member of the Institute of Medicine, a former chair of the Prospective Payment Assessment Commission, and a former member of the Physician Payment Review Commission. He is also a past president of the Association for Health Services Research and the International Health Economics Association and has been elected to the American Academy of Arts and Sciences. Dr. Newhouse is editor of the *Journal of Health Economics*. He received a B.A. from Harvard College and a Ph.D. in economics from Harvard University.

**Janet G. Newport** is corporate vice president of public policy for PacifiCare Health Systems (PHS), Inc. The Corporate Public Policy Department is responsible for PHS's policy development and strategic response on health care issues, support of the entity's Ethics and Legal Operations Program, and acts as the company liaison with key government agencies and the Congress. Ms. Newport serves on several American Association of Health Plans technical and advisory committees and is an industry representative on the Centers for Medicare & Medicaid Services (CMS) Medicare Council. She has also served as an industry representative on internal CMS technical committees. She has more than 25 years of public affairs experience, including over 10 years directing the Washington, D.C. office of another major Medicare risk contractor. Ms. Newport received a political science degree from American University.

**Carol Raphael** is president and chief executive officer of the Visiting Nurse Service (VNS) of New York, the largest voluntary home health care organization in the United States. Her responsibilities include managing its post-acute, long-term care, maternal and child health, high-tech, rehabilitation, hospice, mental health and public health programs and its Centers of Excellence in cardiopulmonary, diabetes, asthma, and cancer care. Under Ms. Raphael's leadership, VNS created VNS Choice, a Medicaid long-term care health plan, the Medicare Community Nursing Organization, and multicultural programs to ensure access for the Hispanic and Asian populations. Ms. Raphael also developed the VNS Center for Home Care Policy and Research, which conducts policy-relevant research focusing on the management, cost, quality, and outcomes of home- and community-based services. Previously, Ms. Raphael served as the executive deputy commissioner of the New York City Human Resources Administration in charge of the Income and Medical Assistance Administration. Ms. Raphael has served on several Robert Wood Johnson Foundation advisory committees and New York State panels, including the New York State Hospital Review and Planning Council, for which she chairs the Fiscal Policy Committee. She has an M.P.A. from Harvard University's Kennedy School of Government.

**Robert D. Reischauer, Ph.D.**, is vice chairman of the Commission and president of The Urban Institute. Previously, he was a senior fellow with the Brookings Institution and from 1989 to 1995 was the director of the Congressional Budget Office. Dr. Reischauer currently serves on the boards of the Academy of Political Sciences, the Center on Budget and Policy Priorities, and the Committee for a Responsible Federal Budget. He also serves on the editorial board of *Health Affairs*, chairs the National Academy of Social Insurance's project on Restructuring Medicare for the Long-Term, and is a member of the Institute of Medicine and the Medicare Competitive Pricing Advisory Commission. Dr. Reischauer received his A.B. degree from Harvard College and his M.I.A. and Ph.D. from Columbia University.

**Alice Rosenblatt, F.S.A., M.A.A.A.,** is chief actuary and senior vice president of Integration Planning and Implementation at WellPoint Health Networks. Before joining WellPoint in 1996, she was a principal at Coopers & Lybrand LLP, where she consulted with insurers, health plans, providers, and employers. She is a former senior vice president and chief actuary of Blue Cross Blue Shield of Massachusetts and Blue Cross of California. Other positions include work for The New England and William M. Mercer, Inc. Ms. Rosenblatt has served on the Board of Governors of the Society of Actuaries and the American Academy of Actuaries. She previously chaired the Academy's federal health committee and work group on risk adjustment. Ms. Rosenblatt has testified on risk adjustment before subcommittees of the Committee on Ways and Means and the Committee on Commerce of the U.S. House of Representatives. She has a B.S. and an M.A. in mathematics from City College of New York and the City University of New York, respectively.

**John W. Rowe, M.D.,** is chairman, president, and chief executive officer of Aetna Inc., the nation's largest healthcare insurer. Prior to joining Aetna, Dr. Rowe served as president and chief executive officer of Mount Sinai NYU Health. Prior to the Mount Sinai NYU Health merger, Dr. Rowe was president of The Mount Sinai Hospital and the Mount Sinai School of Medicine in New York City, where he currently is a professor of medicine. Before joining Mount Sinai in 1988, Dr. Rowe was a professor of medicine and the founding director of the Division on Aging at Harvard Medical School and chief of gerontology at Boston's Beth Israel Hospital. He has authored over 200 scientific publications, mostly on the physiology of the aging process, as well as a leading textbook of geriatric medicine. Dr. Rowe was director of the MacArthur Foundation Research Network on Successful Aging and is co-author, with Robert Kahn, Ph.D., of *Successful Aging* (Pantheon, 1998). He served on the Board of Governors of the American Board of Internal Medicine and as president of the Gerontological Society of America, and is a member of the Institute of Medicine of the National Academy of Sciences.

**David A. Smith** is senior policy advisor to the president of the AFL-CIO, where he previously served as director of the Public Policy Department. Prior to joining the AFL-CIO, he served as senior deputy budget director and as Commissioner of Economic Development for the City of New York. Mr. Smith spent most of the 1980s in Washington as an aide to Senator Edward M. Kennedy and as a senior economist at the Joint Economic Committee. Mr. Smith has taught economics and public policy at the University of Massachusetts and the New School for Social Research, and is a senior fellow at the Century Foundation. He is a member of the Board of Directors of Public Campaign and of the National Bureau of Economic Research, a fellow of the National Academy of Social Insurance, and a member of the Advisory Committee to the Export-Import Bank. Mr. Smith attended Tufts University and received a M.Ed. from Harvard University.

**Ray E. Stowers, D.O.,** is the director of the Oklahoma Rural Health Policy and Research Center as well as director of rural health in the Department of Family Medicine at Oklahoma State University College of Osteopathic Medicine. He was in private rural practice for 25 years at Family Medicine Clinics, Inc. in Medford, Okla. and is a member of the National Rural Health Association. Dr. Stowers is first vice president of the American Osteopathic Association and has served that organization in many capacities, including several related to physician coding and reimbursement issues. He has been on the Physician Payment Review Commission and was a founding member of the American Medical Association's Relative Value Update Committee. Dr. Stowers received his B.S. and B.A. from Phillips University in Okla. and his D.O. from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Mo.



**Mary K. Wakefield, Ph.D., R.N., F.A.A.N.,** is director, Center for Rural Health at the University of North Dakota. Previously, she was professor and director of the Center for Health Policy, Research, and Ethics at George Mason University, working on policy analysis, research, and educational initiatives. Dr. Wakefield has held administrative and legislative staff positions in the U.S. Senate and served on many public and private health-related advisory boards. From 1997 through 1998, she was on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Dr. Wakefield is a member of the Institute of Medicine's Committee on Quality Health Care in America and a fellow of the American Academy of Nursing. In 2000, she was appointed to the National Advisory Committee on Rural Health, Office of Rural Health Policy, Health Resources and Services Administration. Dr. Wakefield received her B.S. in nursing from the University of Mary, Bismarck, N.D., and her M.S. and Ph.D. from the University of Texas at Austin.



## Commission staff

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