CHAPTER 2

Improving traditional Medicare's benefit design

CHAPTER 2

Improving traditional Medicare's benefit design

Chapter summary

Much of the Commission's work focuses on changing Medicare's payment systems to give providers incentives to maintain adequate access to care, improve quality, and use fewer resources. Complementary to this work is research on improving the design of Medicare's traditional fee-for-service (FFS) benefit, along with that of supplemental coverage. Reforming the FFS benefit offers an opportunity to align beneficiary incentives and program goals to obtain high-quality care for the best value. Of particular importance, reforms could improve financial protection for individuals who have the greatest need for services and who currently have very high cost sharing.

The current FFS benefit design includes a relatively high deductible for inpatient stays and a relatively low deductible for physician and outpatient care, and it requires beneficiaries to pay 20 percent of the Medicare-approved amount for most physician care and outpatient services. Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. If not supplemented with additional coverage, the FFS benefit design makes Medicare beneficiaries face substantial financial risk and may discourage the use of valuable care. One exception is certain preventive services, where Medicare has begun offering greater coverage and reduced cost sharing.

In this chapter

- Medicare's FFS benefit in a changing context
- Shorter term potential improvements to FFS Medicare
- Longer term potential improvements to Medicare

All but about 9 percent of Medicare beneficiaries have supplemental coverage through former employers or medigap policies, or they have additional coverage through Medicare Advantage plans, Medicaid, and other sources. The most widely used types of supplemental coverage such as standard medigap Plan C and Plan F policies fill in all or nearly all of Medicare's cost sharing in return for a monthly premium. Although popular, some forms of secondary insurance are expensive, with administrative costs of 20 percent or more. Supplemental coverage addresses beneficiaries' concerns about the uncertainty of what cost sharing they might owe in the FFS Medicare benefit, but it also dampens financial incentives beneficiaries would otherwise face to control spending.

Commission-sponsored work shows evidence that when elderly beneficiaries are insured against Medicare's cost-sharing requirements, they use more care and Medicare spends more on them. It is the flip side of an extensive body of literature showing that higher cost sharing leads to lower health care spending. Much of this literature also finds that cost sharing can have beneficial and detrimental effects on beneficiaries' health outcomes. Trying to encourage use of high-value care and discourage low-value care are the great challenges of benefit design.

For the near term, proposed incremental improvements to the FFS benefit and to supplemental coverage could begin changing beneficiaries' incentives. The aim of these improvements would be to reduce financial risk for beneficiaries with the highest levels of cost sharing, deter beneficiaries' use of lower value services, and avoid deterring beneficiaries from using higher value care—especially individuals with lower incomes. Potential improvements could include, for example, adding a cap to beneficiaries' out-of-pocket (OOP) costs in the FFS benefit and, at the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use. Such restrictions on supplemental coverage could lead to reductions in use of Medicare services sufficient to help finance the addition of an OOP cap. These strategies could be coupled with exceptions that waive cost sharing for services in certain circumstances—for example, if evidence identified them as leading to better health outcomes. The strategies could also include cost-sharing protections for low-income beneficiaries so that they would not forgo needed care. Providing beneficiaries with clear information to help them consider their treatment options with their providers could also be complementary to changes in benefit design.

For the longer term, the Medicare program will need to move toward more sophisticated benefit designs that give individuals incentives to use higher value care and avoid using lower value care. Part of this change will involve developing

the evidence base to better understand which treatments have higher and lower values. As currently practiced, value-based insurance design lowers cost sharing for services that have strong evidence of substantial clinical benefit. A primary goal of this approach is to improve quality of care. However, to achieve net savings, this approach requires careful targeting and willingness to lower cost sharing for services of high value and raise cost sharing for services of low value. ■

Much of the Commission's work focuses on changing Medicare's payment systems to give providers incentives to maintain adequate access to care and improve quality and efficiency. However, the design of fee-for-service (FFS) Medicare's benefits for Part A and Part B services also affects program spending and value through coverage policies and cost-sharing requirements. The treatment recommendations of medical providers strongly influence the amount of care beneficiaries receive. Still, for certain situations and conditions, Medicare's cost sharing can affect beneficiaries' decisions about whether to initiate care, the types of providers to see, and which treatments to use. Reforming the FFS benefit offers an opportunity to align beneficiary incentives and program goals to obtain high-quality care for the best value. Of particular importance, reforms could improve financial protection for individuals who have the greatest need for services and who currently have very high cost sharing.

Introduction

In today's traditional FFS Medicare, neither its payment system nor benefit design is built around incentives that reward delivery and use of high-quality, high-value care. The status quo encourages growth in the volume and intensity of services and has led to care that is often not coordinated, sometimes inappropriate, and occasionally risky to patients. It has also left beneficiaries with rising Part B premiums and out-of-pocket (OOP) costs and left taxpayers with an unsustainable burden for financing the program.

Given these problems, the program needs to be transformed to improve incentives for delivering and using high-value care (see Chapter 1 of the Commission's March 2010 report) (Medicare Payment Advisory Commission 2010). Changes for the long term could include a different benefit design for future cohorts of beneficiaries, the introduction of management tools into traditional Medicare, and incentives for beneficiaries to use high-value therapies based on clinical evidence about the effectiveness of alternative treatments—an approach called value-based insurance design. In the shorter term, other changes in Medicare policy could address some of the problems with beneficiary incentives as they are structured today.

Two key decision points for Medicare beneficiaries

Medicare beneficiaries make decisions about obtaining health care at two key points. First is the decision to choose between enrolling in FFS Medicare or a Medicare private plan. Each has advantages and drawbacks with respect to premiums, scope of benefit offerings, and rules about choice of providers. Second is the beneficiary's decision about whether to use a given health care service—which can be affected substantially by cost-sharing requirements.

Choosing between FFS Medicare and private Medicare plans

Today, about 75 percent of beneficiaries receive health benefits through traditional FFS Medicare. FFS Medicare's benefit design is uniform, with the same Part B premium nationwide despite large regional differences in average use of services and program expenditures.[1] Beneficiaries can use any provider willing to accept Medicare's terms and payment rates. To cover gaps in the FFS benefit, most beneficiaries have supplemental coverage through former employers or individually purchased medigap policies, or they have additional coverage through Medicaid or other sources. Despite Medicare's lower average payment rates to providers compared with private payers' rates, the FFS program has certain desirable characteristics for providers, including little or no utilization management (American Medical Association 2009).[2] Under this arrangement, there are few restrictions on the services providers and patients decide to use, and Medicare bears most of the insurance risk for beneficiaries' health spending.

At the other end of the spectrum are private Medicare plans that receive capitated payments for delivering Part A and Part B (and often Part D) benefits; they bear insurance risk for their enrollees' health spending. Private plans offer a wide variety of benefit packages, and some include a cap on OOP spending.[3] Medicare's private plans vary considerably in how well they manage delivery of care, enrollees' health outcomes, and spending (see Chapter 5 of the Commission's March 2010 report) (Medicare Payment Advisory Commission 2010). However, most private Medicare Advantage (MA) plans form networks of providers (some have an integrated delivery system), use cost sharing to steer enrollees toward contracted providers and preferred therapies, and apply utilization management tools such as prior authorization, concurrent review, and case management to manage care and constrain volume.[4] In exchange for greater constraints on service use, private plans typically offer beneficiaries additional benefits

beyond what is provided in FFS Medicare for low or no premiums, such as lower cost sharing for Part A and Part B services or vision and dental coverage.

For insured consumers outside the Medicare program, premiums act as a signal of the breadth of coverage and available providers. Premiums also reflect the relative health status and average use of services of the insured population. For example, plans with relatively tight networks of providers are expected to have lower premiums—the trade-off for less choice of providers is a lower price. In the Medicare program, however, the various premiums a beneficiary can face are not good signals of cost differences. Despite geographic differences in average use of services, FFS Medicare's Part B premium does not vary (except by income). In addition, many beneficiaries pay premiums for supplemental insurance that covers much of Medicare's cost sharing. While premiums for medigap policies vary widely, that variation reflects the health status of a particular pool of insured individuals and each insurer's ratings method more than breadth of coverage. Premiums for medigap policies can also be expensive because of high administrative costs, largely due to the need for medigap insurers to market directly to individuals (Moon 2006). For private plans that contract with Medicare through MA, premiums are a misleading signal; they are often zero or artificially low because, on average, Medicare pays private plans more for their enrollees' Part A and Part B care than the same beneficiaries would cost in the FFS program.[5] In the choice between FFS Medicare and enrolling in private Medicare plans, the premium signals that consumers typically use to help them make choices do not encourage beneficiaries to use efficiently delivered health care.

Beneficiary decisions about the use of care

Beneficiaries' use of care is strongly affected by the recommendations of medical providers. Still, the amount patients must pay for health care at the point of service can affect whether they seek care, the type of provider they see, and which treatment they use. A benefit design that encourages beneficiaries at the point of service to use care only when it is of high value is ideal but is a great challenge. A related challenge is how to provide beneficiaries with clear information about the potential risks and benefits of treatment options (see Chapter 7 of this report).

Medicare's FFS benefit structure has changed very little since 1965; it has considerable cost-sharing requirements and provides no OOP cap. For Part A services, it includes a relatively high deductible for inpatient stays ($1,100 in 2010) and daily copayments for long stays at hospitals and skilled nursing facilities.[6] Patients with more than one hospital stay can owe more than one hospital deductible for the year. For Part B services, the FFS benefit has a relatively low deductible ($155 in 2010) and requires beneficiaries to pay 20 percent of the Medicare-approved amount for most services. Increases in the deductibles and copayments under Part A and Part B are linked to average annual increases in Medicare spending for those services. There is no upper limit on how much cost sharing a beneficiary could owe under the FFS benefit. (Table 2-1 (p. 52) and Table 2-2 (p. 53) show Part A and Part B premiums and cost sharing.) Analyses suggest that the actuarial value—the percent of medical spending for a standard population paid by an insurer—of the traditional Medicare benefit is significantly lower than typical employer-sponsored health coverage (Peterson 2009, Yamamoto et al. 2008).

More recent changes to the FFS benefit design include greater coverage of and incentives for preventive care. The benefit now covers a "welcome to Medicare" physical within each beneficiary's first six months of enrollment in Part B, and it waives the Part B deductible for certain preventive services such as screening mammography and prostate-specific antigen blood tests. Under the Patient Protection and Affordable Care Act of 2010 (PPACA), beginning in 2011, Medicare's cost sharing will be eliminated for all Medicare-covered preventive services recommended with a grade of "A" or "B" by the U.S. Preventive Services Task Force.

Since the FFS benefit provides indemnity insurance and not managed care, cost sharing is one of the few means by which the Medicare program can provide incentives to affect beneficiaries' behavior. But more than 90 percent of FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost sharing, effectively nullifying the program's tool for influencing beneficiary incentives.

Effects of cost sharing on beneficiaries' use of services

There is an extensive literature about the effects of cost sharing on the use of health care services. The research shows that increases in cost sharing can lead to lower utilization and lower spending on health care. More controversial, however, is the effect increases in cost sharing have on health outcomes. Much of this literature is consistent with the notion that cost sharing can have both beneficial and detrimental effects on beneficiaries.

The RAND health insurance experiment (HIE), conducted in the 1970s, is considered the gold standard because its

randomized design permitted analysts to measure the effects of insurance coverage while limiting selection bias—the tendency of sicker individuals to seek out coverage more than healthier persons. However, the HIE excluded elderly individuals. More recent literature, much of which focuses on prescription drugs, confirms that beneficiaries are sensitive to cost sharing, potentially affecting their use of clinically important medications as well as less important drugs. In Part D, private plans have used tiered cost sharing successfully to encourage enrollees to use generic drugs. Two recent studies suggest that higher cost sharing for outpatient visits is associated with increased hospital use. A recent Commission-sponsored study found that when elderly beneficiaries are insured against Medicare's cost sharing, they use more care and Medicare spends more on them.

Moderate sensitivity to price, reductions in effective and ineffective care

RAND HIE results suggest that individuals are moderately sensitive to price: A 10 percent increase in cost sharing led to about a 2 percent decline in patients' use of services (Newhouse and the Health Insurance Experiment Group 1993). This amount is lower than estimates of price sensitivity for gasoline and new car purchases that were evaluated at about the same time (Morrisey 1992). Participants were least sensitive to prices for inpatient services and most sensitive to prices for well care services, with other acute and chronic outpatient care falling in between.

The HIE found that reductions in use of services in response to cost sharing occurred by about the same amount in both effective and ineffective care (Newhouse and the Health Insurance Experiment Group 1993).[7] However, averaged across all participants, higher cost sharing did not affect health outcomes adversely. One exception was participants with both low incomes and poorer health—those individuals in free plans had a clinically significant reduction in blood pressure compared with individuals in plans with cost sharing (Manning et al. 1987).[8]

Most of the options evaluated in the HIE were within the context of indemnity insurance rather than in managed care plans. Among the benefit designs tested, the HIE found that both coinsurance and deductibles had "strong separate effects" (Keeler et al. 1988). The main effect of higher coinsurance was on whether participants initiated care for an episode of illness, but it also had slight effects on the costliness of care. Even small deductibles reduced participants' initiation of care, particularly outpatient care. Using HIE results, Newhouse and colleagues estimated that a well-designed indemnity policy would include (in 1983 dollars) an individual deductible of about $200 and 25 percent coinsurance up to a $1,500 OOP cap (Newhouse and the Health Insurance Experiment Group 1993). In 2006, Newhouse suggested that a deductible of about $1,000 for an individual policy in that year's dollars was roughly in line with prior HIE estimates (Newhouse 2006). However, he also noted there could be ways to improve such a policy, such as lowering cost sharing for services to treat chronic conditions if strong evidence existed that treatments were cost effective.

There are limits to generalizing from the HIE, particularly because it excluded elderly participants. Care that once was provided in the hospital is now delivered in outpatient settings, medical technology includes better diagnostic screening and minimally invasive treatments, and drugs are a more widespread mode of therapy. Policymakers also need to consider whether elderly and disabled beneficiaries, who have higher average health care spending and lower average incomes, might behave differently than the general population in reaction to cost sharing.

More recent literature shows sensitivity to cost sharing within managed care

Over the past several decades, many payers moved from indemnity coverage to managed care—with the notable exception of FFS Medicare. In the early days of managed care, plans lowered cost sharing relative to the indemnity coverage they replaced but established rules and limits on patients' use of providers and technologies. After the managed care backlash of the early 1990s, plans used a "belt and suspenders" approach, loosening managerial rules (the belt) and relying more heavily on differential cost sharing (the suspenders) to steer beneficiaries toward network providers and preferred drugs where they could obtain price discounts (Pauly and Ramsey 1999). Studies completed after the RAND HIE capture changes that have taken place in health care technology and delivery.

Effects of cost sharing on the Medicare population For the general population, there is little direct evidence that increased cost sharing results in worse health outcomes. However, there is reason to believe that the Medicare population's response to cost-sharing requirements may differ from the commercial population's reaction. Price sensitivity to goods and services without substitutes is generally low. Medicare beneficiaries, who tend to have a higher disease burden than other populations, may perceive few substitutes for medical care. Thus, as a group,

TABLE 2–1

Premiums and cost-sharing requirements for Part A services in 2010

Category	Amount
Premiums	$0 if entitled to Social Security retirement or survivor benefits, railroad retirement benefits, Social Security or railroad retirement disability benefits, or end-stage renal disease benefits. $461 per month for individuals who are 65 or older and not described above, in addition to the Part B premium (shown in Table 2-2).
Hospital stay	$1,100 deductible for days 1–60 each benefit period. $275 per day for days 61–90 each benefit period. $550 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over lifetime). All costs for each day after lifetime reserve days.
Skilled nursing facility stay	$0 for the first 20 days each benefit period. $137.50 per day for days 21–100 each benefit period. All costs for each day after day 100 in the benefit period.
Home health care	$0 for home health care services. May have Part B cost sharing if durable medical equipment is needed (shown in Table 2-2).
Hospice care	$0 for hospice visits. Up to a $5 copayment for outpatient prescription drugs for pain and symptom management. 5% of the Medicare-approved amount for inpatient respite care.
Blood	All costs for the first 3 pints (unless donated to replace what is used).

Note: A benefit period begins the day a beneficiary is admitted to a hospital or skilled nursing facility and ends when the beneficiary has not received hospital or skilled nursing care for 60 days in a row. If the beneficiary is admitted to the hospital after one benefit period has ended, a new benefit period begins and the beneficiary must again pay the inpatient hospital deductible. Part A cost sharing increases over time by the same percentage update applied to payments to inpatient hospitals and adjusted to reflect real change in case mix.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. *Medicare & You 2010*. Baltimore, MD: CMS. January. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Medicare beneficiaries may be less sensitive to cost-sharing requirements, although considerable variation in the health status of Medicare beneficiaries suggests that cost sharing could affect the health care decisions of some.

Studies that examine whether cost sharing affects health outcomes among the elderly are few and their findings are mixed.[9] A slightly larger number of studies examine the relationship between cost sharing and use of appropriate care.[10] A majority find evidence that higher cost sharing tends to reduce the use of appropriate services, with more evidence for prescription drugs than for other types of services.

Two recent studies raise concern that increases in cost sharing for outpatient care can cause some beneficiaries to forgo effective care and lead to more hospitalizations and potentially higher costs. One analysis involved retired California public employees who faced increased copayments for physician visits and prescription drugs (Chandra et al. 2010). The study found that increases in copayments for ambulatory care modestly increased hospital use for the average elderly person, but hospital spending increased significantly for chronically ill patients as physician and drug use decreased. A separate study observed enrollees in MA plans that increased ambulatory care copayments and matched them to control plans with no copayment increases (Trivedi et al. 2010). In the year after the copayment increases, researchers found a significant drop in outpatient visits and a significant rise in hospital admissions and inpatient days. Although questions remain about the degree to which their results can be generalized, the two studies suggest the need for attention to cost-sharing changes, as they can have both beneficial and detrimental effects.

Literature on effects of cost sharing for prescription drugs

Similarly, literature on cost sharing for prescription drug benefits shows the potential for good and bad effects. A large number of studies suggest that higher copayments and capped benefits for drugs are associated with lower medication adherence and spending (Hsu et al. 2006, Rice and Matsuoka 2004). An extensive review found moderate price sensitivity ranging from the average levels in the HIE to about three times as much (Gibson et al. 2005, Goldman

TABLE 2–2

Premiums and cost-sharing requirements for Part B services in 2010

Category	Amount	
Premiums	$96.40 per month:	Same premium as in 2009 applies if beneficiaries had the SSA withhold Part B premium payments from their Social Security check in 2009 and if income is below the following: Single beneficiaries with incomes of $85,000 or less Couples with incomes of $170,000 or less
	$110.50 per month:	All beneficiaries with incomes below the thresholds shown above and who are new to Part B for 2010 or have premiums paid by state Medicaid programs or Medicare Savings Programs.
	$154.70 per month:	Single beneficiaries with incomes between $85,001 and $107,000 Couples with incomes between $170,001 and $214,000
	$221.00 per month:	Single beneficiaries with incomes between $107,001 and $160,000 Couples with incomes between $214,001 and $320,000
	$287.30 per month:	Single beneficiaries with incomes between $160,001 and $214,000 Couples with incomes between $320,001 and $428,000
	$353.60 per month:	Single beneficiaries with incomes above $214,000 Couples with incomes above $428,000
Deductible	The first $155 of Part B–covered services or items	
Physician and other medical services	20% of the Medicare-approved amount for physician services (including most doctor services during inpatient stays), outpatient therapy (subject to limits), most preventive services, and durable medical equipment	
Outpatient hospital services	A coinsurance or copayment amount that varies by service, projected to average 24% in 2010. These rates are scheduled to phase down to 20% over time. No copayment for a single service can be more than the Part A hospital deductible ($1,100 in 2010).	
Mental health services	45% of the Medicare-approved amount for most outpatient mental health care*	
Clinical laboratory services	$0 for Medicare-approved services	
Home health care	$0 for home health care services	
Durable medical equipment	20% of the Medicare-approved amount	
Blood	All costs for the first 3 pints, then 20% of the Medicare-approved amount of additional pints (unless donated to replace what is used)	

Note: SSA (Social Security Administration). Under Part B's income-related premium, higher income individuals pay monthly premiums equal to 35 percent, 50 percent, 65 percent, or 80 percent of Medicare's average Part B costs for aged beneficiaries. Normally, all other individuals pay premiums equal to 25 percent of average costs for aged beneficiaries. In 2010, however, most beneficiaries pay the same premium as in 2009 because of a provision in law that does not permit the Part B premium to increase by a larger dollar amount than beneficiaries' Social Security checks. CMS estimates that about 5 percent of Medicare beneficiaries pay the higher premiums. The Part B deductible increases over time by the rate of growth in per capita spending for Part B services.
*This coinsurance rate is scheduled to phase down to 20 percent by 2014.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. *Medicare & You 2010*. Baltimore, MD: CMS. January. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

et al. 2007). More recent analysis of the effects of Part D on individuals who previously had no prescription drug coverage suggests that the program has increased use of some clinically important medications (Schneeweiss et al. 2009). At the same time, Part D plans have successfully encouraged enrollees to use generic alternatives when available (Office of Inspector General 2007). Plans' management tools, particularly their use of formularies that help to create competition among therapeutically similar drug treatments for which enrollees pay differential copayments, may also lower rates of growth in prices for drugs with patent protection (Duggan and Morton 2010).

TABLE 2–3

Medicare cost-sharing liability in 2008

Range of cost-sharing liability per person	Percent of FFS beneficiaries	Average amount of cost sharing per beneficiary
$1 to $499	42%	$250
$500 to $1,999	36	$1,071
$2,000 to $4,999	16	$3,036
$5,000 to $9,999	4	$6,879
$10,000 or more	2	$15,402

Note: FFS (fee-for-service). Amounts reflect cost sharing under FFS Medicare—not what beneficiaries paid out of pocket. Most beneficiaries have secondary insurance that covers some or all of their Medicare cost sharing.

Source: MedPAC based on data from CMS.

Evidence is mixed on whether lower cost sharing for prescription drugs has "cost offsets"—reduced spending for other medical services such as inpatient stays. Sokol and colleagues found evidence that high adherence among patients with diabetes or with high cholesterol was associated with a net economic benefit in disease-related medical costs (Sokol et al. 2005). For high blood pressure and congestive heart failure, the researchers did not find cost offsets. Another study looked at use of angiotensin-converting enzyme inhibitors among Medicare beneficiaries with diabetes and projected that first-dollar coverage could increase utilization of these medications and arguably lead to lower Medicare expenditures (Rosen et al. 2005). A recent study of the effects of Medicare coverage delivered within an MA prescription drug plan found that among beneficiaries who had no drug coverage before 2006, Part D coverage led to reductions in medical spending that roughly offset the increased spending on drugs (Zhang et al. 2009a). However, among enrollees who had drug coverage before 2006, Part D enrollment was associated with higher medical spending.

Other research has begun analyzing the effect on medication adherence of Part D's coverage gap (the portion of spending between the program's initial coverage limit and the annual out-of-pocket threshold, in which the Part D plan enrollee pays the full discounted price for the drug). Several studies have compared enrollees in MA–prescription drug plans that had a gap in coverage with enrollees in similar plans with no gap or generic-only benefits in the coverage gap (Fung et al. 2009, Zhang et al. 2009b). Drug spending among enrollees with no gap coverage was significantly lower than for those with gap coverage, and the former group had significantly lower medication adherence.[11]

Effects of supplemental coverage on Medicare spending

Researchers agree that Medicare beneficiaries with medigap or retiree health coverage tend to have higher use of services and spending than those with no supplemental coverage. However, they disagree on what proportion of this difference is due to a pure insurance effect (i.e., higher use of care because the patient does not face Medicare's full cost-sharing amount) versus selection bias (i.e., the greater tendency of individuals with higher health care needs to purchase insurance).

Many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements regardless of whether there is evidence that the service is ineffective or, conversely, whether it might prevent a hospitalization. Thus, some portion of the higher spending of these beneficiaries is arguably due to an insurance effect. Studies that attribute at least a portion of higher spending to an insurance effect find a spending increase of about 25 percent, with estimates ranging from 6 percent to 44 percent (Atherly 2001).[12] Estimates for the effects of medigap policies are generally higher than for employer-sponsored retiree coverage, and they tend to show larger effects for outpatient than for inpatient services.

Another set of studies finds small or statistically insignificant induced demand for care resulting from supplemental insurance after controlling for selection bias (Long 1994, Wolfe and Goddeeris 1991). Differences in the methodologies used to control for selection bias have contributed to the wide range of expenditure differences found in the literature. Some researchers believe that previously reported differences in spending might be overstated because supplemental coverage encourages beneficiaries to adhere to medical therapies that prevent hospitalizations or the use of other services (Chandra et al. 2010). Another line of research suggests that the responsiveness of beneficiaries to cost sharing is varied and the effects of supplemental coverage are more modest for individuals in poorer health (Remler and Atherly 2003).

Last year's Commission-sponsored study

Commission-sponsored work showed evidence that when elderly beneficiaries are insured against Medicare's cost sharing, they use more care and Medicare spends more on them (Hogan 2009). That analysis found some notable patterns where supplemental coverage seemed to have

more or less of an effect. For example, having secondary insurance was not associated with higher spending for emergency hospitalizations, but it was associated with higher Part B spending that ranged from 30 percent to over 50 percent more. Overall, beneficiaries with private supplemental insurance spent more on elective hospital admissions, preventive care, office-based physician care, medical specialists, and services such as minor procedures, imaging, and endoscopy.

When looking at beneficiaries within a given category of supplemental insurance—for example, comparing individuals with retiree coverage or comparing medigap policyholders—paying little OOP seemed to be an influential factor associated with higher Medicare spending. The analysis suggests that if supplemental coverage did not fill as much of Medicare's cost sharing, cost sharing could be structured in ways to encourage beneficiaries to choose high-value care. For example, differential copayments between primary and specialty care could be used to encourage more of the former. This approach is used commonly within MA plans and commercial insurance for non-Medicare populations.

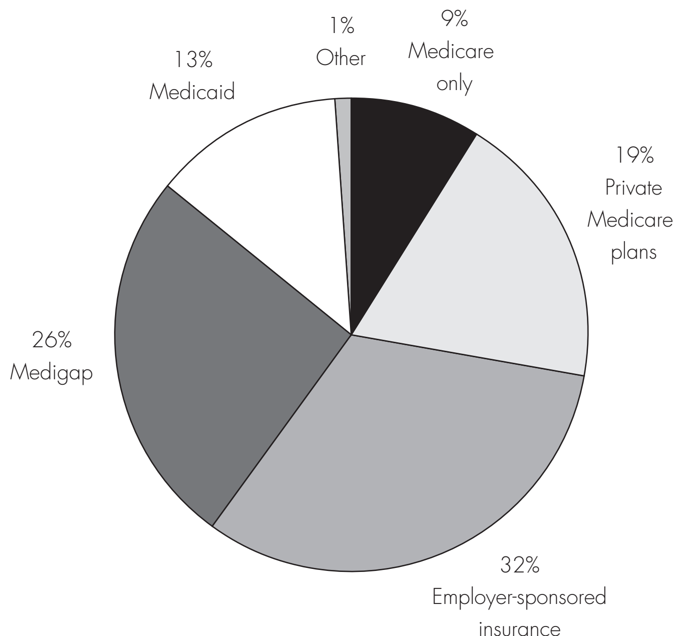
The Commission's analysis also found that lower income beneficiaries were moderately more sensitive to cost sharing than higher income individuals. In general, when either lower income or higher income beneficiaries had supplemental insurance, their Medicare spending was higher than that of individuals without supplemental coverage but with a similar income. However, the presence of secondary insurance had a moderately stronger effect on spending for lower income beneficiaries. This finding is consistent with other research that suggests that differences in price sensitivity to rising copayments for prescription drugs may account for some of the observed disparities in health across socioeconomic groups (Chernew et al. 2008).

Medicare's FFS benefit in a changing context

Medicare's FFS benefit needs to change to discourage use of lower value services, moderate rapid growth in Part B premiums and OOP costs, and rein in unsustainable rates of program spending. These changes must take into account the role of supplemental coverage that currently, for each health care service delivered, shields beneficiaries from the true cost of care. However, when considering potential changes to the FFS benefit, it is also important to bear in mind ways in which beneficiaries' future options for supplemental insurance will differ.

FIGURE 2–1

Most Medicare beneficiaries had supplemental coverage in 2006



Note: Excludes long-term institutionalized beneficiaries.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost & Use files.

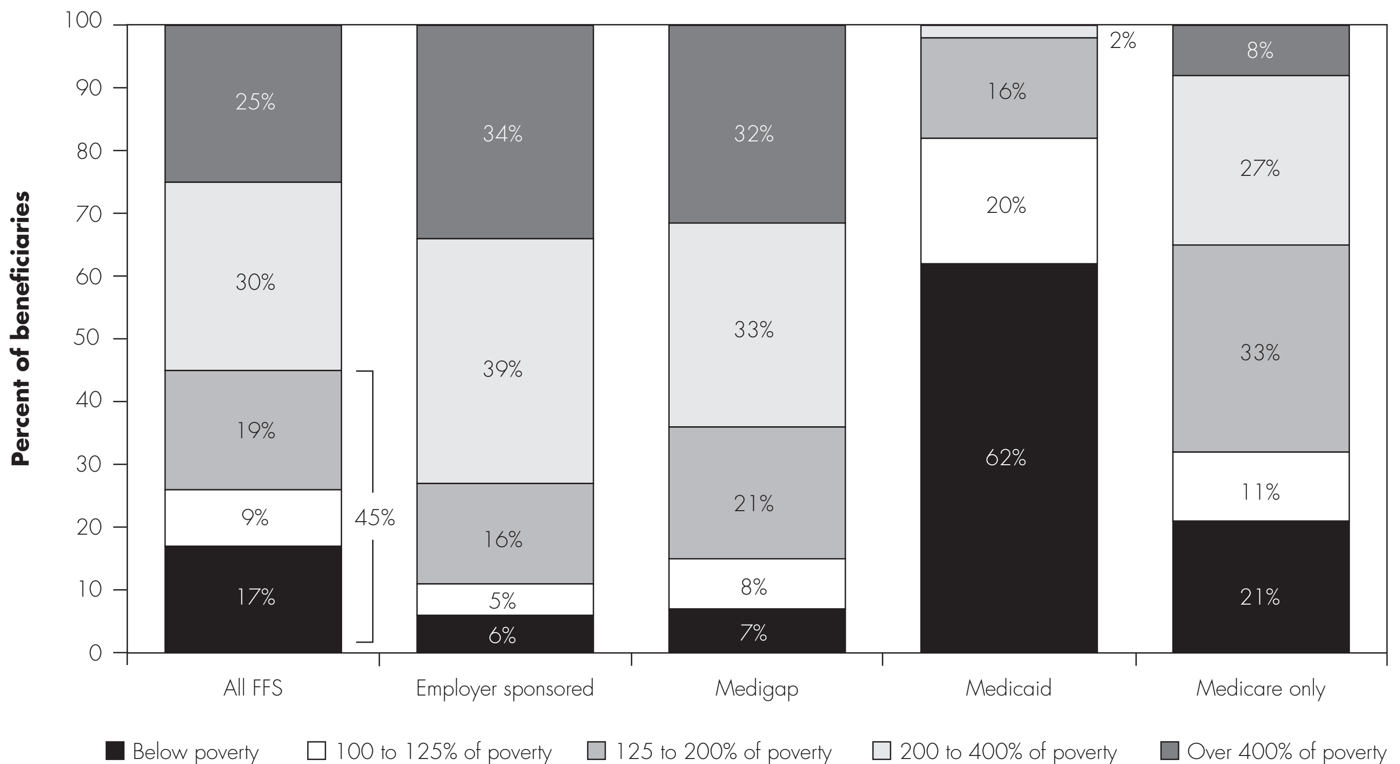
Shortcomings of the FFS benefit and the role of supplemental plans

The Commission and its predecessor commissions have explored problems with traditional Medicare's benefit design for many years (Medicare Payment Advisory Commission 2009, Physician Payment Review Commission 1997). The FFS benefit alone does not provide true insurance—financial protection against very high levels of OOP spending. Compared with other types of coverage, Medicare's benefit has a high inpatient deductible and a low outpatient deductible. These features lead to a small percentage of Medicare beneficiaries incurring the highest levels of cost sharing (Table 2-3).

Shortcomings in the FFS benefit design lead more than 90 percent of beneficiaries to take up supplemental coverage (Figure 2-1). In 2006, employer-sponsored retiree policies that wrap around the Medicare FFS benefit covered the

FIGURE 2–2

Distribution of FFS beneficiaries' income by type of supplemental coverage in 2006



Note: FFS (fee-for-service). Excludes long-term institutionalized beneficiaries. In 2006, the federal poverty threshold was $9,996 for people living alone and $12,186 for married couples. Sums may not total to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost & Use files.

most beneficiaries, followed by individually purchased medigap policies, private Medicare plans, and Medicaid.[13] Nine percent of beneficiaries relied solely on Medicare's benefit.

The economic circumstances of beneficiaries differ significantly across categories of supplemental insurance. Among all FFS beneficiaries, in 2006, about 45 percent had incomes of 200 percent of the poverty threshold or less (Figure 2-2).[14] On average, beneficiaries with employer-sponsored retiree coverage or medigap policies had higher incomes than individuals with no supplemental insurance or with both Medicare and Medicaid benefits.

At the median, Medicare beneficiaries spent about 16 percent of their income on premiums and other OOP health spending in 2005 (Neuman et al. 2009). However, that figure masks considerable variation across individuals. Generally, beneficiaries with higher Medicare spending pay a larger proportion of their income than those with lower Medicare spending, but the relative burden of financial liability depends on the beneficiary's type of supplemental coverage. Two groups tend to pay comparatively more than others: (1) beneficiaries with medigap policies, and (2) those with no supplemental coverage and high use of Medicare services (Medicare Payment Advisory Commission 2009).

Like the FFS benefit, supplemental coverage has some notable problems. The one form of supplemental insurance available to all elderly Medicare beneficiaries—medigap coverage—is popular among beneficiaries but can have high premiums. A 2009 survey found that 88 percent of medigap policyholders are satisfied with their secondary coverage, and 77 percent believe these policies are a good value (America's Health Insurance Plans/Blue Cross Blue Shield 2009). Yet medigap policies can be expensive because they tend to cover individuals with higher health spending and have administrative costs of 20 percent or more (Scanlon 2002).[15] The most popular types of

TABLE 2–4

Benefits offered under standard medigap policies in 2010

	Plan type										
Category	**A**	**B**	**C**	**D**	**F**	**F (high deductible)***	**G**	**K**	**L**	**M**	**N**
Part A hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B cost sharing for other than preventive services	✓	✓	✓	✓	✓	✓	✓	✓** (50%)	✓** (75%)	✓	✓** ($20/$50)
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	✓** (50%)	✓** (75%)	✓	✓
Hospice care cost sharing	✓	✓	✓	✓	✓	✓	✓	✓ (50%)	✓ (75%)	✓	✓
SNF coinsurance			✓	✓	✓	✓	✓	✓ (50%)	✓ (75%)	✓	✓
Part A deductible		✓	✓	✓	✓	✓	✓	✓ (50%)	✓ (75%)	✓ (50%)	✓
Part B deductible			✓		✓	✓					
Part B excess charges					✓	✓	✓				
Foreign travel emergency (up to plan limits)			✓	✓	✓	✓	✓			✓	✓
Medicare preventive care Part B coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: SNF (skilled nursing facility). Plan E, Plan H, Plan I, and Plan J will close to further enrollment in 2010. Insurers may begin offering standard Plan M and Plan N in June 2010.
*High-deductible Plan F pays the same benefits as Plan F after one has paid a calendar year deductible of $2,000 in 2010. Applicable expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B but do not include the plan's separate foreign travel emergency deductible.
**Plan K and Plan L require the insured to pay 50 percent and 75 percent, respectively, of Part B coinsurance payments unrelated to hospitalizations and preventive services. After meeting the Part B deductible and an out-of-pocket limit of $4,620 in Plan K or $2,310 in Plan L, the plan pays 100 percent of Medicare cost sharing for covered services for the rest of the calendar year. Plan N has set dollar amounts that beneficiaries pay in lieu of certain Part B coinsurance payments ($20 for office visits and $50 for emergency room visits).

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. *Choosing a medigap policy: A guide to health insurance for people with Medicare*. Additional information from the National Association of Insurance Commissioners.

medigap policies, standard Plan C and Plan F, nearly fill in all of Medicare's cost-sharing requirements, including both the Part A and Part B deductibles (Table 2-4 and Table 2-5 (p. 58)). By effectively masking FFS Medicare's price signals at the point of service, supplemental coverage can influence beneficiaries' choices about whether to seek care and which types of providers and therapies to use.

Premiums for medigap policies can also vary widely, even in the same market. This variation is due in part to different approaches that states allow insurers to use for setting premium rates.[16] But considerable variation in medigap premiums also exists in states that allow only community rating—that is, premiums cannot vary by an individual's age, gender, or health status. For example, in 2009 in Albany, New York, premiums for a medigap Plan F policy (the most popular plan type) varied between $1,940 and $4,130 (Table 2-5). Much of this variation likely reflects the average health status and utilization trends of each medigap insurer's covered population.[17]

TABLE 2–5

Distribution of medigap policies and average premiums

Plan type	2008 Number of policyholders (in thousands)	Percent of policyholders	Average annual premium	Range of premiums in Albany, New York, February 2009*
All	9,492	100%	$2,000	N/A
A	265	3	1,500	$1,230–$2,420
B	516	5	1,800	$1,670–$3,240
C	1,523	16	1,900	$1,830–$3,750
D	399	4	2,000	$1,800–$2,920
E, H, I, J	1,114	12	2,000	$1,810–$2,720
F	3,703	39	2,000	$1,940–$4,130
F (high deductible)	32	0	500	$850–$1,190
G	336	4	1,900	$1,810–$2,720
K	13	0	800	$890–$1,340
L	23	0	1,300	$1,240–$1,900
Waiver-state policies	624	7	2,200	N/A
Pre-1991 policies	842	9	2,600	N/A

Note: N/A (not applicable). Plan E, Plan H, Plan I, and Plan J will close to further enrollment in 2010. Insurers may begin offering standard Plan M and Plan N in June 2010. Waiver states include Massachusetts, Minnesota, and Wisconsin.
*New York state uses community rating, meaning that premiums cannot vary by age, gender, or health status of the insured individual.

Source: MedPAC analysis of 2008 data from the National Association of Insurance Commissioners. Data for premiums from Albany, New York, from New York State Insurance Department website.

Policymakers, insurers, and regulators have taken several steps to develop more affordable types of medigap policies, but so far those products have not attracted much enrollment. Medicare SELECT® plans have the same standard designs as other medigap policies but require beneficiaries to use a provider network in return for lower premiums.[18] A 1997 evaluation found that SELECT plans provide a weak form of managed care in that they recruit hospitals willing to provide a discount for their networks but generally do not form physician networks (Lee et al. 1997). In 2006, insurers had 1.1 million Medicare SELECT plans in force—11 percent of all medigap policies (America's Health Insurance Plans 2008). After 1997, insurers were allowed to sell high-deductible versions of Plan F and Plan J in return for lower premiums.[19]

The Medicare Prescription Drug, Modernization, and Improvement Act of 2003 created two other types of standard products—Plan K and Plan L—that fill in less of Medicare's cost sharing in return for lower premiums. Plan K and Plan L require policyholders to pay 50 percent and 75 percent, respectively, of Part B coinsurance amounts unrelated to hospitalizations and preventive services. Although they have lower premiums than other types of medigap policies, as of 2008, Plan K and Plan L combined made up less than 0.5 percent of all medigap policies.

Effective June 2010, medigap insurers may introduce two new types of policies—Plan M and Plan N. Plan M will cover 50 percent of the Part A deductible but none of the Part B deductible. Plan N will cover all of the Part A deductible but none of the Part B deductible, and it will require copayments of up to $20 for office visits and up to $50 for emergency room visits (National Association of Insurance Commissioners 2010).[20] Both Plan M and Plan N are expected to have lower premiums than other medigap policies.

Further research on why beneficiaries have not taken up lower premium options in greater numbers could help to evaluate potential changes to supplemental coverage. One potential reason may be that newer types of policies such as Plan K and Plan L use percentage coinsurance rather than fixed-dollar copayments, which leaves beneficiaries with uncertainty about the amount of cost

sharing they might owe at the point of service. Because the dollar amounts of cost sharing in Plan N are known to policyholders in advance (i.e., the policies include copayments rather than coinsurance), Plan N may have broader market appeal than Plan K and Plan L. It would also be useful to understand whether the relative size of commissions to insurance agents on the various types of medigap policies affect how those alternatives are marketed to beneficiaries.

Employer-sponsored insurance typically provides beneficiaries with broader coverage for lower premiums than medigap policies. However, employer-sponsored coverage may not fill in all cost sharing and is not available to everyone. Retiree policies through large employers typically include a lower deductible for hospitalizations than Medicare's; a cap on OOP spending; and sometimes benefits that FFS Medicare does not cover, such as dental care (Yamamoto et al. 2008). Employers who offer retiree plans often pay for much of the premium for supplemental coverage. One 2007 survey found that, on average, large employers subsidized 60 percent of the total premium for single coverage; retirees paid 40 percent (Gabel et al. 2008).

Many employer plans require retirees enrolled in Medicare to pay deductibles and cost sharing just as active workers and younger retirees do. But it is unclear whether these cost-sharing arrangements apply to all retirees or primarily those who are in younger cohorts. In 2007, Actuarial Research Corporation analyzed 2005 data from the Medical Expenditure Panel Survey for the Commission. At that time, about 20 percent of Medicare beneficiaries with supplemental coverage through an employer had no OOP spending other than their premiums—their retiree plans paid for their Medicare cost sharing. Last year, Direct Research used 2005 data from the Medicare Current Beneficiary Survey to estimate that 50 percent of FFS beneficiaries with employer-sponsored coverage paid 5 percent or less of their Part B spending OOP. These estimates suggest that today a sizable portion of beneficiaries with employer-sponsored coverage have most of their Medicare cost sharing filled in by secondary insurance.

Expected changes over time

In 2007, the Commission looked at ways in which the profile of Medicare beneficiaries will change over time (Medicare Payment Advisory Commission 2007). We expect that a greater proportion of the Medicare population will be treated for multiple chronic conditions. At the same time, the rate of disability among beneficiaries as measured by limitations in activities of daily living has been declining, although it is not clear that this trend will continue after more of the baby-boom generation joins Medicare. Individuals of Hispanic and Asian ethnicity will make up growing shares of beneficiaries, and changes to the typical family structure will leave fewer adult children available to provide long-term care for their parents.

Similarly, changes in the structure of the economy and continued rapid growth in health care spending will also affect the availability and price of supplemental coverage. Although the percentage of Medicare beneficiaries with employer-sponsored retiree coverage has remained fairly constant since the early 1990s (Merlis 2006), the number of large employers offering such coverage to new retirees has been declining, which will affect future cohorts of Medicare beneficiaries (Employee Benefit Research Institute 2008). Beneficiaries who have aged into Medicare more recently are less likely to have retiree coverage (Stuart et al. 2003). As those cohorts replace older ones in Medicare, employer-sponsored supplemental coverage will play less of a role than it does today.

With less retiree coverage available, more Medicare beneficiaries are likely to turn to MA plans or medigap policies or to remain in traditional Medicare without supplemental coverage. All three alternatives have features that make them generally less attractive to beneficiaries than most forms of retiree coverage that wrap around Medicare's FFS benefit. In the past, beneficiaries in MA plans generally had small or no premiums and additional coverage beyond standard Part A and Part B benefits in exchange for a more restricted choice of providers and managed use of care. Under the PPACA, MA payments will change in ways that could reduce the availability of extra benefits or lead to higher MA premiums. Medigap premiums, which typically cost more than beneficiaries pay for retiree coverage, will rise increasingly with the growth in health care costs. It remains to be seen whether higher premiums will encourage beneficiaries to move into new types of medigap policies that have lower premiums. Finally, beneficiaries without supplemental coverage pay no additional premiums beyond those for Medicare but are exposed to full FFS cost sharing, which increases their risk of becoming impoverished because of a costly illness. To the extent that more beneficiaries become impoverished, more will incur enough medical expenses to "spend down" their income so that they qualify for Medicaid, further straining state and federal budgets.

Employer coverage among the working population is also becoming less comprehensive and includes more cost sharing and higher premiums. In the future, some beneficiaries may be more willing to accept a reformed FFS benefit because they may view a restructured Medicare program as better coverage than what they had during their working years.

Shorter term potential improvements to FFS Medicare

For the near term, incremental steps can be taken to begin changing beneficiaries' incentives. The aims of these nearer term measures include:

- reducing financial risk for beneficiaries who currently have very high cost sharing,
- avoiding cost sharing that may deter beneficiaries—especially those with lower incomes—from using higher value care, and
- redefining the role of supplemental coverage to avoid encouraging beneficiaries' use of lower value services.

Providing beneficiaries with clear information about the potential risks and benefits of their treatment options through shared decision making with their medical providers could also be complementary to changes in benefit design (see Chapter 7 in this report).

Reducing financial risk for beneficiaries with high spending

While most individuals have at least one outpatient physician visit in a year, only about one in five has a hospital stay. The result is that beneficiaries who have a hospitalization during a year can accumulate considerably more cost-sharing expenses than those who are not hospitalized. (Over several years, the odds of having one or more hospital stays go up considerably. For example, among beneficiaries who were in Medicare in 2004 and were alive in 2008, about half had a hospital stay at some point over that five-year period.) Beneficiaries with multiple hospitalizations may need to pay the inpatient deductible repeatedly, and those who require longer stays in hospitals or skilled nursing facilities pay sizable daily copayments. In addition, patients who are hospitalized have little control over care associated with their stay—for example, the professional services of physicians and physical therapists—and pay 20 percent coinsurance for those services. Although much of Medicare beneficiaries' cost sharing is triggered by a hospitalization, ultimately most of the cost sharing they incur stems from coinsurance on their use of Part B services (Medicare Payment Advisory Commission 2009).

If the FFS benefit were redesigned to include an OOP cap, the effects would be mixed—generally lower spending for beneficiaries and higher program spending for the government. Such a policy would benefit individuals who currently pay very high Medicare cost sharing, particularly those with no supplemental coverage, and would tend to lower supplemental premiums for many other beneficiaries. However, Medicare would begin paying for some of the costs now covered by secondary insurers. Because beneficiaries who have medigap policies pay the full premium for the supplemental benefits of everyone in their insurance pool (including some beneficiaries with high Medicare cost sharing), all beneficiaries who had medigap policies would see lower premiums but Medicare spending would grow. An OOP cap would also lead to somewhat higher Part B premiums since they are set as a percentage of Medicare's spending for Part B services.

To illustrate, using conservative assumptions about beneficiary responses to cost sharing: If in 2011 the FFS benefit capped each beneficiary's cost sharing at $4,000, Medicare program spending would increase by nearly $18 billion, or 4 percent, and the monthly Part B premium would increase by about $7, which is $88 per year, or 6 percent (Table 2-6).[21] At the same time, however, the policy would lead to an average $404 annual reduction in medigap premiums (24 percent). (This estimate is a crude approximation of medigap effects based on overall average spending across all beneficiaries with medigap policies. Effects on specific medigap plans would depend on each pool of individuals covered.) It is less straightforward to quantify what would happen with other forms of supplemental coverage such as employer-sponsored insurance. Average costs of those supplemental premiums (including both employer and retiree shares) would decline by an estimated $414 yearly (28 percent). However, some employers might choose to apply those savings toward reducing their contributions to retiree premiums rather than passing along the reduction in retirees' share of the premium.

Having no more cost sharing above an OOP cap would likely lead to higher utilization. One way to counter this tendency would be to follow Part D's example. It has an OOP cap, but above that cap beneficiaries still

TABLE 2–6

Projected effects of adding an OOP cap to the FFS benefit in 2011

Category	Baseline	Percentage change associated with adding the following out-of-pocket maximum:		
		$4,000	$5,000	$7,000
Medicare program spending	$431.7 billion	4%	3%	2%
Part B premium	$123	6	5	3
Average medigap "premium"*	$1,693	–24	–19	–12
Average "premium" for employer-sponsored insurance*	$1,486	–28	–23	–17

Note: OOP (out of pocket), FFS (fee-for-service). This analysis excludes Part D.
*These values are simple estimates of the overall change in supplemental benefit spending under the policy change plus a loading factor, divided by the applicable number of beneficiaries with medigap or employer-sponsored policies. Note that the average for employer-sponsored insurance is the whole premium—the share paid for by both employers and beneficiaries. Employers may or may not choose to pass on reductions in spending for supplemental benefits to their retirees.

pay nominal cost sharing to deter the use of lower value services.

One way to reduce Medicare's program costs under an OOP cap would be to combine the FFS deductibles for Part A and Part B services. To remain budget neutral, a combined deductible would need to be high. For example, if today's separate deductibles were replaced in 2011 with a combined deductible under a policy that capped OOP expenses at $4,000, all enrollees in FFS Medicare would need to pay for the first $1,328 of Part A or Part B services. Again using conservative assumptions about beneficiaries' behavioral responses, at this amount, Medicare spending would break even and the new benefit would not worsen the program's financial sustainability. If supplemental policies were permitted to fill in this combined deductible, most beneficiaries would likely see little change or a net lowering of their combined OOP spending, Part B premiums, and premiums for supplemental coverage.

Avoiding cost sharing that deters use of high-value care

Even though most beneficiaries would benefit or see little change under a revised benefit with an OOP cap and a combined deductible, there are legitimate concerns with that approach for beneficiaries without supplemental coverage. In 2009, research conducted for the Commission found that individuals without supplemental coverage, who tended to have lower incomes than others with medigap policies or employer-sponsored coverage, used less care (Medicare Payment Advisory Commission 2009). To the extent that these beneficiaries would forgo necessary care because of a high combined deductible, they could experience poorer health outcomes and higher use of other medical services.

One approach to address this policy challenge would be to refine programs that help beneficiaries with limited incomes pay for Medicare premiums and cost sharing. Three such programs include Medicaid support for individuals dually eligible for Medicare and Medicaid, the Medicare Savings Programs, and Part D's low-income subsidy.[22] Providing assistance with premiums and cost sharing addresses the concern that individuals with low incomes may obtain less necessary care because of the financial burden of OOP costs. At the same time, filling in all cost sharing for low-income enrollees would mean that Medicare would have fewer tools to encourage the use of necessary care and deter the use of ineffective care. For this reason, Part D and many state Medicaid programs ask low-income enrollees to pay smaller cost-sharing amounts.

A related idea is to set cost-sharing obligations relative to each individual's income (Gruber 2006). However, there are significant administrative issues with carrying out this approach, and policymakers would need to come to a consensus on what share of income would be equitable. The PPACA may have set a precedent for such an approach. In new state-based health insurance exchanges, the law calls for reduced cost-sharing amounts and OOP spending limits for individuals younger than 65 with lower incomes (Kaiser Family Foundation 2010).

Another way to discourage unnecessary care would be to set lower copayments for higher value services and higher copayments for lower value services (Chernew et al. 2007). Copayments could be difficult to set at levels that would be budget neutral to current law cost sharing

without being too high for a substantial number of beneficiaries. For this approach to have its intended effect, supplemental coverage could not be permitted to fill in these copayments. An alternative approach that would redefine the role of supplemental coverage is described below. The PPACA uses such an approach (see text box).

Redefining the role of supplemental coverage

Instead of replacing the current Part A and Part B deductibles with a combined deductible, policymakers could focus on redefining the amount of Medicare cost sharing that supplemental insurance could fill in. For example, the Congressional Budget Office (CBO) estimates that if medigap insurers were barred from paying any of the first $525 of a policyholder's cost sharing and if medigap coverage were limited to 50 percent of the next $4,725 in Medicare cost sharing with all further cost sharing covered by the policy, the option would lower federal spending by about $4 billion per year beginning in 2012 (Congressional Budget Office 2008).[23] As estimated by CBO, this option would apply only to medigap policies—it would not affect beneficiaries with employer-sponsored retiree coverage. Given that beneficiaries with retiree coverage outnumber medigap policyholders, including that group in the option might more than double the $4 billion estimate. Our preliminary estimates for 2011 suggest that the magnitude of reduced spending would be approximately enough to add an $8,000 OOP cap to the FFS benefit and keep program spending budget neutral.

Another approach might keep medigap policies and employer-sponsored insurance from filling in fixed-dollar copayment amounts for services such as office visits and use of hospital emergency rooms. Copayments could be set to steer beneficiaries toward certain types of care—by setting copayments for office visits, for example, that were lower for seeing primary care providers according to specialty. This approach is used commonly within MA plans and in commercial insurance.

The methods for carrying out such a change vary by type of supplemental coverage because of the way private insurance is regulated. For example, medigap policies are subject to both state and federal regulation; to ensure that medigap changes were made nationwide, the Congress would need to direct the National Association of Insurance Commissioners (NAIC) to redefine medigap standards.

It is less clear how to carry out restrictions on supplemental coverage obtained through employers. Most individuals who receive retiree health benefits worked for large employers subject to the Employee Retirement Income Security Act (ERISA). ERISA exempts self-insured employers from state laws and regulations but does not set standards for what benefits employers provide to retirees. Therefore, to limit retiree coverage from filling in some of Medicare's cost sharing, policymakers might need to make changes to ERISA or to other laws that are broader than Medicare (e.g., tax treatment of health benefits). Alternatively, one could make such restrictions a condition for employers to receive Part D's retiree drug subsidy, but such an approach deserves careful consideration of the potential effects on continued provision of retiree health benefits.[24]

Estimates of the effects of such copayments can vary substantially depending on the groups of services to which copayments apply. For example, MA plans often apply copayments to face-to-face visits with providers for evaluation and management services as well as other types of services such as X-rays and other imaging, chiropractic care, and physical therapy. By comparison, recent guidance developed by the NAIC in conjunction with CMS suggests that insurers offering the new medigap Plan N will use a narrower interpretation of office visits. The guidance states that Plan N will apply copayments of up to $20 only for services that can be billed under CPT–4 codes 99201–99205 (evaluation and management of new patients), 99211–99215 (evaluation and management of established patients), as well as 92002, 92004, 92012, and 92014 (ophthalmology), and 90805 (psychotherapy) (National Association of Insurance Commissioners 2010). Such an interpretation may not achieve the degree of reduction in use of Part B services that was envisioned with changes to medigap Plan C and Plan F called for in the PPACA (see text box). Other details would need to be evaluated carefully, such as the level of copayment that would apply when a beneficiary receives primary care from a medical specialist.

To illustrate this copayment approach, we assume all medigap and employer-sponsored policies that currently provide first-dollar coverage could no longer fill in $10 copayments for primary care office visits, $25 copayments for visits for specialty care (including certain nonphysician providers such as chiropractors and physical therapists), and $50 copayments for visits to emergency rooms. Our preliminary estimates suggest that this approach would reduce Medicare program spending by about $7 billion

Changes in the Patient Protection and Affordable Care Act of 2010 relevant to benefit design

The recently enacted Patient Protection and Affordable Care Act of 2010 (PPACA) puts in place certain changes that will affect future medigap options and reduce cost-sharing requirements for certain preventive services within Medicare. First, the law directs the National Association of Insurance Commissioners (NAIC) to revise standards for medigap policies classified as Plan C and Plan F. These standard types, which are the only ones that cover all Part B cost sharing, are the most popular plan types, accounting for about 55 percent of all medigap policies in 2008.

The new law requests the NAIC to revise Plan C and Plan F standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under Part B. New standards are to be based on evidence published in peer-reviewed journals or current examples used in integrated delivery systems. NAIC's revised standards are, to the extent practicable, to be in place as of January 1, 2015.

Because the revised standards would apply only to newly issued medigap policies, the law will not affect current policyholders who already have Plan C or Plan F. Nor does the health reform law place any new minimum cost-sharing requirements on retiree policies offered by employers. Over time, however, the use of copayments in medigap plans could change incentives for Medicare beneficiaries as they consider their use of care, particularly as the availability of employer-sponsored insurance declines.

Second, the PPACA allows for an annual wellness exam in which providers create a personalized prevention plan for beneficiaries—a schedule for receiving preventive services tailored to each person's clinical situation. Beginning in 2011, beneficiaries will not owe cost sharing for Medicare-covered preventive services recommended with a grade of "A" or "B" by the U.S. Preventive Services Task Force (USPSTF). The law also gives the Secretary authority to modify Medicare coverage of certain preventive services based on recommendations of the USPSTF. ■

in 2011. This amount of savings could approximately pay for a $9,000 OOP cap added to the FFS benefit. These estimates assume an insurance effect—in this case, a decrease in the use of services as beneficiaries pay more cost sharing—similar in magnitude to assumptions used by CBO in its budget options. For most beneficiaries with medigap policies, the cost of new copayments would be more than offset by the lower premiums for their supplemental coverage.

The copayment approach could be coupled with other changes to the FFS benefit to encourage appropriate use of services and allow a lower OOP cap. Cost sharing could be made more uniform across services and could be applied to services for which no cost sharing is required today, such as laboratory tests and home health care.

A separate approach involves an excise tax on insurers that offer the most complete coverage—supplemental policies that fill in most of Medicare's cost sharing. This approach uses a different philosophy in that it would not forbid supplemental policies from filling in all of Medicare's cost sharing but instead would charge the insurer for at least some of the added costs imposed on Medicare of having such comprehensive coverage. Applying a tax only to supplemental policies that fill in nearly all of Medicare's cost sharing could serve several purposes. First, it would help to recoup some of the additional Medicare spending associated with that more complete coverage.[25] Taxes would be paid by medigap insurers directly to the Medicare trust funds through the same Medicare administrative contractors who already process claims.[26] Presumably, insurers would pass the excise tax along by raising premiums for those more complete plans. In turn, beneficiaries in those plans would have an incentive to voluntarily consider newer types of medigap plans that require paying more of Medicare's cost sharing.

One potential consequence of higher premiums is that rather than switch to a different supplemental plan, some beneficiaries may choose to drop coverage altogether. If dropping all supplemental coverage led beneficiaries to forgo necessary care, it could worsen their health

outcomes and potentially result in higher Medicare spending. To encourage individuals to move into newer types of medigap policies or other sources of additional benefits, policymakers may want to consider reducing hurdles that prevent switching. For example, an option to move into medigap plans without first-dollar coverage that are not subject to the excise tax on a guaranteed-issue basis might limit the numbers of beneficiaries who choose to drop supplemental coverage.

As an example, if an excise tax were applied only to those medigap policies that cover both the Part A and Part B deductibles, a 10 percent excise tax might raise on the order of $1 billion per year. The tax would, in all likelihood, need to be significantly greater than 10 percent to recoup the induced demand attributable to medigap coverage. However, because of the difficulty in disentangling the effects of a pure insurance effect from selection bias (described earlier), the exact percentage is uncertain. If the excise tax encouraged beneficiaries to move into the newer types of medigap policies that require paying more of Medicare's cost sharing at the point of service, that behavior could lead to slower growth in Medicare spending and in premiums for Part B and medigap policies.

Other ideas to explore

The Commission will continue to explore other options. Pilot or demonstration programs may provide a way to try new approaches with supplemental coverage. For example, Medicare might want to encourage new types of Medicare SELECT plans that include physician networks in addition to hospital networks. Insurers might be more interested in establishing physician networks for SELECT products or using more managed approaches in administering medigap benefits if they shared some of the savings from doing so. In addition, the NAIC is beginning to catalog states' approval of "new or innovative benefits" offered by medigap insurers. State insurance regulators have had authority to approve the addition of such benefits to standard medigap policies for some time, but so far relatively little information has been shared. Doing so would allow states and insurance companies to look for best practices.

Another potential subject of a pilot or demonstration could be a value-based insurance design that tailored Part D cost-sharing requirements to individuals' clinical needs (Murphy et al. 2009). It would be an opportunity to test whether value-based insurance design could help achieve lower Part A and Part B spending.

Longer term potential improvements to Medicare

For the longer term, the Medicare program will need to move toward benefit designs that give individuals incentives to use higher value care and discourage using lower value care. Part of this change will involve developing the evidence base to better understand which treatments are of higher and lower value. Several years ago the Commission recommended that policymakers establish an independent, public–private entity that would produce information to compare the clinical effectiveness of a health service with its alternatives (Medicare Payment Advisory Commission 2008). Along the same lines, the PPACA establishes the Patient-Centered Outcomes Research Institute to identify national priorities for comparative clinical effectiveness research and sponsor comparative-effectiveness research efforts. In addition, Medicare may want to begin examining how the incentives of beneficiaries can best be used to help transform the structure of health care delivery.

Moving toward value-based insurance design

In recent years, policymakers have become more aware that not all health care services are of the same value, but identifying which services are of higher or lower value can be difficult. The term "value based" is applied to strategies for reimbursing providers (value-based purchasing) and cost-sharing options designed to encourage beneficiaries to undertake certain high-value behaviors or use high-value treatment options (value-based insurance design). Testing these approaches would help policymakers decide which ones could encourage beneficiaries more effectively to use high-value health care services.

Incentives for selecting among treatment options

Some insurers have begun setting different levels of cost sharing for the same medical intervention based on the clinical benefit a given patient is likely to derive (Chernew et al. 2007, Fendrick et al. 2001). For example, patients with diabetes have lower cost sharing for medical interventions shown to prevent or reduce the long-term complications of the disease, such as drugs that control blood pressure. When there is evidence that specific therapies are comparatively more effective and appropriate for certain patients, lowering their cost sharing to help increase their adherence to the therapy could improve

health outcomes. If higher adherence leads to fewer exacerbations of the patient's condition, this approach could also lower spending. At the same time, where evidence suggests that medical therapies are less effective, increasing beneficiaries' cost sharing could deter use of those services. The extent to which value-based insurance design could reduce Medicare program spending depends on beneficiaries' underlying health risk, the cost of adverse outcomes, beneficiaries' responsiveness to copayments, and the effectiveness of medical therapies at reducing risk (Chernew et al. 2010).

A primary objective of value-based insurance design is to improve beneficiaries' quality of care and encourage high-value care. For some, a separate goal may be to achieve net savings. However, achieving savings requires careful targeting and willingness to lower cost sharing for high-value services and raise cost sharing for low-value services. Many services do not save money even though they are cost effective. Value-based insurance design would lead to overall lower spending only if it helped to reduce medical interventions when the costs outweigh the clinical benefits.

Insurers, large employers, and researchers have tested key elements of value-based insurance design with some success. The University of Michigan, Pitney Bowes, and the municipality of Asheville, North Carolina, have implemented programs that lower copayments for diabetes patients for certain high-value interventions related to their condition, while maintaining lower cost sharing for generic drugs (Chernew et al. 2007). Other employers such as Marriott, Alcoa, Procter & Gamble, and IBM are investigating their own approaches to value-based insurance design, as are major insurers such as Aetna (Fuhrmans 2007, Wojcik 2009). In a study of the nonelderly, researchers found that varying copayments for cholesterol-lowering drugs based on expected therapeutic benefit increased adherence and reduced use of hospital and emergency services (Goldman et al. 2006). Similarly, one program implemented by a large employer increased use of high-value services and arguably broke even from a combined perspective of employer and employees (Chernew et al. 2008, Chernew et al. 2010).

Aiming differential copayments at those patients most likely to benefit clinically would, in principle, achieve better value more effectively than a blunt, across-the-board approach to raising and lowering copayments. However, the targeted approach requires solid evidence about the comparative effectiveness of alternative therapies as well as the ability to accurately identify patients' conditions and their severity. Therapies for some diseases have a more thorough body of evidence than others on comparative effectiveness. To make the value-based insurance approach effective, policymakers and payers would need significantly more investment in comparative-effectiveness research and alternative methods of identifying relevant patient characteristics (such as information typically found in an electronic medical record). There are also administrative hurdles such as higher administrative costs, near-term cost increases associated with lower copayments, legal issues, and the potential for fraud. Beneficiaries might be concerned about the complexity and equity of the benefit design as well as the need to protect the privacy of patient data (Chernew et al. 2007).

Incentives for selecting among providers

As Medicare further develops methods for measuring providers' quality of care and resource use, it could take steps beyond confidentially informing providers of their relative rankings. (These rankings are made through analyses comparing providers' practice patterns with those of their peers after risk adjustment—that is, controlling for differences in patients' health status.) For example, Medicare could use the information to charge higher cost sharing for beneficiaries who use providers identified consistently as resource use "outliers" compared with their peers. Over time, with the accumulation of data, provider payments could be tied to beneficiaries' long-term health outcomes rather than to delivery of individual services. At the same time, however, Medicare would need to ensure that beneficiaries had sufficient access to providers at lower cost sharing. The effectiveness of this approach would depend on the supply of providers in specific markets and their bargaining leverage.

The Commission has been exploring different payment approaches designed to counter the financial incentives under the FFS payment system for providers to increase volume and consequently spending. Accountable care organizations (ACOs) involve an approach in which Medicare would give providers the opportunity to earn bonuses funded by shared savings, withholds, or both, if they met quality and resource use targets (Medicare Payment Advisory Commission 2009). Under some approaches, providers would bear more financial risk for health care spending that the Medicare program now bears, and ACOs would leave decisions about managing care to its group of providers. To foster the development of ACOs, Medicare could encourage beneficiaries to use

ACO providers by offering lower cost sharing or more generous financial protection against high OOP spending.

Similarly, beneficiary incentives could help promote the use of medical homes. In Medicare, a medical home program would encourage beneficiaries to seek or remain with a physician who can manage their overall care. Under such a program, Medicare would direct monthly payments to medical homes to promote the important role that personal physicians and their health care team play in coordinating care delivery, particularly for patients with multiple conditions (Medicare Payment Advisory Commission 2008). Incentives for beneficiaries to use medical homes could include reduced cost sharing or a cap on OOP spending. Such incentives might help to encourage providers to organize themselves in a way that could deliver the combination of primary care and related care management, information technology, and quality improvement services that would better coordinate care.

Future options for newly enrolling Medicare beneficiaries

Today, as individuals become eligible for Medicare, they may either enroll in a private Medicare plan or use FFS Medicare. If the latter, beneficiaries also usually take up supplemental coverage.

For the future, entering cohorts of Medicare beneficiaries could face a somewhat different set of choices. That future could continue to include both the FFS benefit and MA plans, but it would help beneficiaries make clearer choices by presenting them with better price signals through the premiums and cost sharing of those options. MA plan premiums and cost sharing would function better as price signals if benchmarks that CMS uses to evaluate MA plan bids were set at 100 percent of FFS costs, thereby reducing the additional MA subsidies that distort the comparison to FFS Medicare (Medicare Payment Advisory Commission 2010). The PPACA will likely bring MA payments much closer to 100 percent of FFS costs. Redefining the role of supplemental coverage in ways described earlier would also help to send better price signals through cost sharing in the FFS benefit.

The desirability of current Medicare options may differ in the future from what it is today. For example, fewer beneficiaries will have employer-sponsored supplemental coverage available to them. Insurers will continue to offer medigap policies, but premiums for that coverage (as well as for Medicare Part B) will likely take up a larger share of household income. The attractiveness of MA plans to beneficiaries may depend on how well plans are able to manage their benefits and deliver services with fewer resources relative to the cost of providing care to beneficiaries in FFS Medicare. The availability of additional coverage through Medicaid will depend in part on other constraints on state and federal spending.

The future could hold other adaptations to the FFS model. A separate, more managed benefit could be offered to beneficiaries on a voluntary basis (referred to hereafter as a Medicare preferred provider organization (PPO)). In exchange for some form of lower OOP costs, enhanced benefits, or both, a Medicare PPO would set limits on the amount of Medicare's cost sharing that could be filled in by supplemental coverage and would employ management tools to curb the use of inappropriate services.

Among the utilization management tools a Medicare PPO could adopt are prior authorization, concurrent review, and case management. Medicare would incorporate these tools to promote appropriate use of services and to protect patient safety. Pharmacy benefit managers use similar tools routinely to evaluate whether enrollees' prescriptions are covered when they present them at the pharmacy, and some private payers use such measures to manage radiology services and other types of benefits. To adopt such measures, Medicare would need strong evidence behind the treatment guidelines it used as well as a transparent process for setting criteria about when utilization tools would be used. Medicare's administrative costs would grow accordingly.

Medicare would need to give beneficiaries incentives to enroll voluntarily in such a program. Several strategies could be used to encourage enrollment:

- Set a cap on OOP spending and offer easy-to-understand cost sharing in the form of copayments.
- Set premiums for the reformed benefit in a risk pool separate from the traditional FFS program's risk pool. In other words, premiums for the reformed benefit would reflect average costs for enrollees in the reformed package, and premiums for the FFS benefit would reflect average costs for FFS enrollees. To the extent that the reformed Medicare benefit led to lower average costs, premiums under the reformed benefit would be lower than those for traditional FFS Medicare.
- Provide federal subsidies to low-income individuals to help them with premiums and most of their cost

sharing if they enroll in the reformed Medicare option. States might encourage individuals to enroll in the reformed benefit rather than in the current FFS benefit if the revised Medicare option tended, on average, to reduce state Medicaid benefit spending.

Initially, these features might tend to attract sicker and costlier enrollees first into the reformed Medicare option, which could make its premiums high. For example, the opportunity to enroll in a reformed Medicare benefit with an OOP cap might be especially attractive to disabled beneficiaries younger than age 65 who live in states where they are now unable to purchase medigap policies. At a time when Medicaid costs are growing rapidly, states would likely look to a reformed Medicare option as an opportunity to have the federal government pay for 100 percent of assistance with premiums and cost sharing for dual-eligible beneficiaries. These factors suggest that, based on health status alone, average costs of benefits could be high and, at least initially, premiums for a risk pool of enrollees in a reformed Medicare benefit might not be as attractive as intended relative to FFS premiums.

To counter the problem of adverse selection in a new Medicare option, it would be important to enroll as broad a group of beneficiaries as possible from the beginning. This strategy was used when Part D was introduced. Beneficiaries were given a one-time option to enroll during an initial enrollment period. After that period, individuals who chose to wait and enroll later faced a monthly penalty in addition to their Part D premium. ■

Endnotes

1 Higher income beneficiaries pay a higher income-related Part B premium, but a high-income beneficiary in, for example, California pays the same Part B premium as a beneficiary in Maine with the same income.

2 For example, the American Medical Association's 2009 National Health Insurer Report Card shows that Medicare performed similar to or better than private insurers on several claims-processing measures, such as indicators for timeliness, transparency, and accuracy of claims processing (American Medical Association 2009). The report card noted that, although Medicare had higher rates of denied claims (4 percent) than several of the private insurers, Medicare does not require preauthorization for services, as do many private insurers.

3 Beginning in 2011, all Medicare Advantage plans will be required to include an OOP cap ($6,700 for that year). Some Medicare Advantage plans include an OOP cap lower than that required of all plans.

4 An exception is private FFS plans, which use a model that generally does not involve managing care.

5 The Commission estimates that under the Part C payment system, MA plans are currently paid substantially above what the same beneficiaries would cost in FFS Medicare (Medicare Payment Advisory Commission 2010). The health reform law will likely bring MA payments much closer to 100 percent of FFS costs. For more about the Part C payment system, see http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_MA.pdf.

6 In 2007, the Part A deductible was $992 and the Part B deductible was an additional $131. By comparison, in 2007, a typical large employer used a combined deductible for inpatient and outpatient care of $500 per individual ($1,000 per family) for in-network care (Yamamoto et al. 2008). (For out-of-network providers, it was $1,000 per individual ($2,000 per family).) For people younger than 65 who are not enrolled in Medicare, deductibles can be much higher than Medicare's if they purchase insurance in the individual market—that is, without the benefit of a large risk pool like major employers and Medicare have. In a 2009 survey, the median respondent who purchased a single, individual policy with a preferred provider organization or an HMO with a point-of-service option faced a deductible of between $2,000 and $2,500 (America's Health Insurance Plans 2009).

7 Physicians on the RAND HIE team grouped conditions into categories based on their judgment of whether medical treatments tend to be effective (Newhouse and the Health Insurance Experiment Group 1993). For example, treatment for certain acute conditions such as infections (e.g., strep throat or pneumonia) and for traumas (e.g., fractures or lacerations) was categorized as highly effective. Examples of medical care for chronic conditions that was categorized as highly effective include treatment of thyroid disease, diabetes, hypertension, and congestive heart failure. Other conditions were categorized as "medical care rarely effective" or "self-care effective" such as obesity, influenza, and constipation.

8 The sample size was too small to test whether this result was associated with statistically significant differences in mortality.

9 For example, among seven studies reviewed by Rice and Matsuoka, four support the idea that increased cost sharing is correlated with worsened health status, as measured by mortality rates (two studies) or health status (two studies) (Rice and Matsuoka 2004). Two of the remaining three studies that showed no effect on health outcomes focused on myocardial infarction (Magid et al. 1997, Pilote et al. 2002). Individuals' perceptions about being in a life-threatening emergency may have made them less responsive to price changes (Rice and Matsuoka 2004).

10 Among the nine studies examined by Rice and Matsuoka, six found evidence that higher cost sharing tends to reduce the appropriate use of services (Rice and Matsuoka 2004). Evidence was strongest for prescription drugs and less definitive for other services.

11 Cost sharing is one of many factors that can affect medication adherence. For example, beneficiaries who receive Part D's low-income subsidy (LIS) face no coverage gap. A recent CMS-sponsored study found relatively low rates of use of commonly recommended drugs among diabetic patients enrolled in Part D, with lower drug prevalence rates among LIS enrollees (Stuart and Simoni-Wastila 2009).

12 One often-cited estimate based on data from the mid-1990s suggests that use of services ranged from 17 percent higher for those with employer coverage to 28 percent higher for those with medigap policies (Christensen and Shinogle 1997).

13 Some employers offer retiree coverage through MA plans. As of April 2010, about 18 percent of enrollment in MA plans was through employer groups.

14 In 2006, the poverty threshold was $9,669 for single people and about $12,186 for married couples.

15 By comparison, a 2006 survey of Blue Cross Blue Shield plans that covered their own insured business as well as plans run for self-insured employer groups found that administrative costs were typically about 12 percent of premiums (Merlis 2009).

16 Wide ranges in premiums suggest that the market for supplemental coverage is not very efficient. Different ratings methods are one reason for the wide range, and they include the following:

- Community rating—all beneficiaries are charged the same rate for a given plan.
- Issue age rating—all beneficiaries in a plan are charged a set rate based on how old they are when they first purchase the plan.
- Attained age rating—all beneficiaries of a given age are charged the same within a plan.
- Individual medical underwriting—the process that an insurance company uses to decide, based on the applicant's medical history, whether to accept the application for insurance. Except in guaranteed-issue situations, beneficiaries in poorer health may be refused coverage entirely, may have fewer choices of plans available to them (sometimes only higher priced options), and preexisting condition exclusions may apply.

17 While beneficiaries may be confused by the bewildering array of premium choices and lose confidence that they can select the plan that is best for them, there is a safeguard against plans providing poor value. Medigap plans must return a minimum level of benefits relative to their premiums, with a medical loss ratio of not less than 65 percent; that is, each medigap plan must pay out in medical benefits at least 65 percent of the premiums collected from the policyholders. Group policies, which are sold through employers, unions, and other groups and tend to have lower administrative costs, must have a minimum loss ratio of 75 percent. The National Association of Insurance Commissioners reports that for 2008, the average medigap loss ratio was 80 percent (81 percent for group policies and 79 percent for individual policies).

18 Medicare SELECT provider networks are usually just for inpatient care but in some cases include specific physicians. When a policyholder does not use a network provider for nonemergency care, she must pay some or all of Medicare's cost sharing.

19 Under the terms of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, insurers cannot issue new Plan J policies because they would compete with Part D by including prescription drugs in their covered benefits. In 2010, enrollees pay the first $2,000 in Medicare cost sharing under the high deductible of Plan F.

20 After the policyholder meets the Part B deductible, Plan N's cost sharing is the lesser of a $20 copayment or Medicare's coinsurance amount for Part B evaluation and management services for either specialist or nonspecialist office visits. The lesser of a $50 copayment or Part B coinsurance applies for each covered emergency room visit. However, that cost sharing is waived if the beneficiary is admitted and the emergency visit is covered subsequently by Part A (National Association of Insurance Commissioners 2010).

21 The PPACA will create state-based health insurance exchanges that use four benefit categories available to individuals who are not Medicare beneficiaries. Compared with those benefit categories, the $4,000 cap described here is lower than limits on OOP spending for higher income individuals under the new law, but it is significantly higher than limits prescribed for individuals with incomes less than 200 percent of the federal poverty level (Kaiser Family Foundation 2010). Benefits in the health insurance exchanges generally are to follow the OOP limit in current law for health savings accounts ($5,950 for individuals in 2010). However, the PPACA reduces the OOP limits for lower income individuals: $1,983 for individuals with incomes between 100 percent and 200 percent of the federal poverty level, $2,975 for individuals between 200 percent and 300 percent, and $3,987 for individuals between 300 percent and 400 percent.

22 Within the Medicare Savings Programs (MSPs), only qualified Medicare beneficiaries (who have incomes less than 100 percent of the federal poverty level) receive assistance with both Medicare's cost sharing and premiums. Beneficiaries with other designations under MSP—specified low-income Medicare beneficiaries and qualifying individuals—receive assistance with Medicare premiums but not cost sharing.

23 CBO prepared estimates for this option beginning in 2011, with the amounts of restrictions on medigap policies indexed each year to the average annual growth in Medicare costs. Because CBO assumes some ramp up of the policy in 2011, we present their steady-state estimates for 2012.

24 In return for providing primary prescription drug coverage to their former employees, employers receive a tax-free subsidy from Medicare for some of their drug costs. Under the PPACA, employers may still receive this subsidy. However, effective in 2013, they can no longer deduct from income prescription drug expenses for which they receive the subsidy.

25 It is similar in nature to the approach used in Part D, in which beneficiaries who enroll in plans with enhanced benefits must pay premiums that incorporate an assumption about their higher use of services stemming from having supplemental benefits. However, some Part D plans have a relatively healthy mix of enrollees, and the additional premium associated with their enhanced benefits may not cost very much.

26 Insurers are also facing new taxes under the health reform law. Specifically, the law calls for a general fee on health insurance providers and places an excise tax on high-cost employer-sponsored health coverage.

References

American Medical Association. 2009. *2009 national health insurer report card*. Washington, DC: AMA.

America's Health Insurance Plans. 2008. *Medigap: What you need to know.* Washington, DC: AHIP.

America's Health Insurance Plans. 2009. *Individual health insurance 2009: A comprehensive survey of premiums, availability, and benefits*. Washington, DC: AHIP. October.

America's Health Insurance Plans/Blue Cross Blue Shield. 2009. Medigap policyholder survey. Prepared by Gary A. Ferguson, Senior Vice President, American Viewpoint. May.

Atherly, A. 2001. Supplemental insurance: Medicare's accidental stepchild. *Medical Care Research and Review* 58, no. 2 (June): 131–161.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010a. *Medicare & You 2010*. Baltimore, MD: CMS. January. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010b. *Choosing a medigap policy: A guide to health insurance for people with Medicare.* Baltimore, MD: CMS. March. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Chandra, A., J. Gruber, and R. McKnight. 2010. Patient cost-sharing and hospitalization offsets in the elderly. *American Economic Review* 100, no. 1 (March): 193–213.

Chernew, M. E., A. B. Rosen, and A. M. Fendrick. 2007. Value-based insurance design: By abandoning the archaic principle that all services must cost the same for all patients, we can move to a high-value health system. *Health Affairs* 26, no. 2 (January): w195–w203.

Chernew, M., T. Gibson, K. Yu-Isenberg, et al. 2008. Effects of increased patient cost sharing on socioeconomic disparities in health care. *Journal of General Internal Medicine* 23, no. 8 (August): 1131–1136.

Chernew, M., I. Juster, M. Shah, et al. 2010. Evidence that value-based insurance can be effective. *Health Affairs* 29, no. 3 (February): 1–7.

Christensen, S., and J. Shinogle. 1997. Effects of supplemental coverage on use of services by Medicare enrollees. *Health Care Financing Review* 19, no. 1 (Fall): 5–17.

Congressional Budget Office. 2008. *Budget options, volume I: Health care.* Washington, DC: CBO.

Duggan, M., and F. Scott Morton. 2010. The effect of Medicare Part D on pharmaceutical prices and utilization. *American Economic Review* 100, no. 1 (March): 590–607.

Employee Benefit Research Institute. 2008. *The future of employer-based health benefits: Have employers reached a tipping point?* EBRI notes 29, no. 2. Washington, DC: EBRI.

Fendrick, A. M., D. G. Smith, M. E. Chernew, et al. 2001. A benefit-based copay for prescription drugs: Patient contribution based on total benefits, not drug acquisition cost. *American Journal of Managed Care* 7, no. 9 (September): 861–867.

Fuhrmans, V. 2007. New tack on copays: Cutting them. *Wall Street Journal* (May 8): D1.

Fung, V., C. M. Mangione, J. Huang, et al. 2009. Falling into the coverage gap: Part D drug costs and adherence for Medicare Advantage prescription drug plan beneficiaries with diabetes. *Health Services Research* 45, no. 2 (December 30): 1–21.

Gabel, J., H. Whitmore, and J. Pickreign. 2008. *Survey of retiree health benefits, 2007: A chartbook.* Commonwealth Fund/NORC. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/Sep/Retiree%20Health%20Benefits%20After%20Medicare%20Part%20D%20%20A%20Snapshot%20of%20Prescription%20Drug%20Coverage/Gabel_surveyretireehltbenef2007_1171_chartbook%20ppt.ppt.

Gibson T., R. Ozminkowski, and R. Goetzel. 2005. The effects of prescription drug cost sharing: A review of the evidence. *American Journal of Managed Care* 11, no. 11: 730–740.

Goldman, D. P., G. F. Joyce, and P. Karaca-Mandic. 2006. Varying pharmacy benefits with clinical status: The case of cholesterol-lowering therapy. *American Journal of Managed Care* 12, no. 1: 21–28.

Goldman, D. P., G. F. Joyce, and Y. Zheng. 2007. Prescription drug cost sharing: Associations with medication and medical utilization and spending and health. *Journal of the American Medical Association* 298, no. 1 (July 4): 61–67.

Gruber, J. 2006. *The role of consumer copayments for health care: Lessons from the RAND Health Insurance Experiment and beyond*. Menlo Park, CA: Kaiser Family Foundation. October.

Hogan, C. 2009. Exploring the effects of secondary coverage on Medicare spending for the elderly. Washington, DC: Contractor report for MedPAC.

Hsu, J., M. Price, and J. Huang. 2006. Unintended consequences of caps on Medicare drug benefits. *New England Journal of Medicine* 354, no. 22 (June 1): 2349–2359.

Kaiser Family Foundation. 2010. *Focus on health reform: Summary of new health reform law*. Washington, DC: KFF. April.

Keeler, E. B., J. L. Buchanan, J. E. Rolph, et al. 1988. *The demand for episodes of treatment in the health insurance experiment.* Report R–3454–HHS. Santa Monica, CA: RAND. March.

Lee, A. J., S. A. Garfinkel, R. K. Khandker, et al. 1997. Impact of Medicare SELECT on cost and utilization in 11 states: Innovations in fee-for-service financing and delivery. *Health Care Financing Review* 19, no. 1 (Fall): 19–40.

Long, S. H. 1994. Prescription drugs and the elderly: Issues and options. *Health Affairs*, no. II (Spring): 157–174.

Magid, D. J., T. D. Koepsell, N. R. Every, et al. 1997. Absence of association between insurance copayments and delays in seeking emergency care among patients with myocardial infarction. *New England Journal of Medicine* 336 (June): 1722–1729.

Manning, W. G., J. P. Newhouse, N. Duan, et al. 1987. Health insurance and the demand for medical care: Evidence from a randomized experiment. *American Economic Review* 77, no. 3 (June): 251–277.

Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2008. *Report to the Congress: Reforming the delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2009. *Report to the Congress: Improving incentives in the Medicare program*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Merlis, Mark. 2006. *Health benefits in retirement: Set for extinction?* National Health Policy Forum background paper (February 8). Washington, DC: NHPF.

Merlis, M. 2009. Simplifying administration of health insurance. Washington, DC: National Academy of Social Insurance. January.

Moon, M. 2006. *Medicare: A policy primer.* Washington, DC: Urban Institute Press.

Morrisey, M. A. 1992. *Price sensitivity in health care: Implications for health care policy.* Washington, DC: The National Federation of Independent Business Foundation.

Murphy, L., J. Carloss, R. Brown, et al. 2009. *Value-based insurance design in the Medicare prescription drug benefit: An analysis of policy options.* Washington, DC: Avalere Health.

National Association of Insurance Commissioners. 2010. Memo from commissioner Kevin McCarty, Chair, Senior Issues (B) Task Force. Revised questions and answers regarding implementation of Medicare supplement plan N copayment, deductible and coinsurance. Washington, DC: NAIC. April 22.

Neuman, T., J. Cubanski, and A. Damico. 2009. *Revisiting 'Skin in the game' among Medicare beneficiaries: An updated analysis of the increasing financial burden of health care spending from 1997 to 2005.* Washington, DC: KFF. February.

Newhouse, J. P. 2006. Reconsidering the moral hazard—risk avoidance tradeoff. *Journal of Health Economics* 25, no. 5 (September): 1005–1014.

Newhouse, J. P., and the Health Insurance Experiment Group. 1993. *Free for all? Lessons from the RAND health insurance experiment.* Cambridge, MA: Harvard University Press.

Office of Inspector General, Department of Health and Human Services. 2007. *Generic drug utilization in the Medicare Part D program*. Washington, DC: OIG.

Pauly, M. V., and S. D. Ramsey. 1999. Would you like suspenders to go with that belt? An analysis of optimal combinations of cost sharing and managed care. *Journal of Health Economics* 18: 443–458.

Peterson, C. L. 2009. *Setting and valuing health insurance benefits*. Report R40491. Washington, DC: Congressional Research Service.

Physician Payment Review Commission. 1997. *Annual report to Congress*. Washington, DC: PPRC.

Pilote, L., C. Beck, H. Richard, et al. 2002. The effects of cost sharing on essential drug prescriptions, utilization of medical care and outcomes after acute myocardial infarction in elderly patients. *Canadian Medical Association Journal* 167 (August): 246–252.

Remler, D. K., and A. J. Atherly. 2003. Health status heterogeneity of cost-sharing responsiveness: How do sick people respond to cost-sharing? *Health Economics* 12: 269–280.

Rice, T., and K. Y. Matsuoka. 2004. The impact of cost sharing on appropriate utilization and health status: A review of the literature on seniors. *Medical Care Research and Review* 61, no. 4 (December): 415–452.

Rosen, A. B., M. B. Hamel, M. C. Weinstein, et al. 2005. Cost-effectiveness of full Medicare coverage of angiotensin-converting enzyme inhibitors for beneficiaries with diabetes. *Annals of Internal Medicine* 143, no. 2 (July): 89–99.

Scanlon, W. J. 2002. *Medigap: Current policies contain coverage gaps, undermine cost control incentives.* Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO–02–533T. Washington, DC: GAO. March 14.

Schneeweiss, S., A. R. Patrick, A. Pedan, et al. 2009. The effects of Medicare Part D coverage on drug use and cost sharing among seniors without prior drug benefits. *Health Affairs Web Exclusive* (February 3): w305–w316.

Sokol, M. C., K. A. McGuigan, R. R. Verbrugge, et al. 2005. Impact of medication adherence on hospitalization risk and healthcare cost. *Medical Care* 43, no. 6 (June): 521–530.

Stuart, B., and L. Simoni-Wastila. 2009. *Medication use and adherence among Medicare beneficiaries with diabetes and selected comorbidities enrolled in stand-alone Part D prescription drug plans*. Baltimore, MD: CMS. November 25.

Stuart, B., P. K. Singhal, C. Fahlman, et al. 2003. Employer-sponsored health insurance and prescription drug coverage for new retirees: Dramatic declines in five years. *Health Affairs Web Exclusive* (July 23): w3-334–w3-341.

Trivedi, A. N., H. Moloo, and V. Mor. 2010. Increased ambulatory care copayments and hospitalizations among the elderly. *New England Journal of Medicine* 362, no. 4: 320–328.

Wojcik, J. 2009. IBM to pick up the tab for workers' primary care. *BusinessInsurance.com* (November 8).

Wolfe, J. R., and J. H. Goddeeris. 1991. Adverse selection, moral hazard, and wealth effects in the Medigap insurance market. *Journal of Health Economics* 10: 433–459.

Yamamoto, D., T. Neuman, and M. Kitchman Strollo. 2008. *How does the benefit value of Medicare compare to the benefit value of typical large employer plans?* Washington, DC: Kaiser Family Foundation.

Zhang, Y., J. M. Donohue, J. R. Lave, et al. 2009a. The effect of Medicare Part D on drug and medical spending. *New England Journal of Medicine* 361, no. 1 (July 2): 52–61.

Zhang, Y., J. M. Donohue, J. P. Newhouse, et al. 2009b. The effects of the coverage gap on drug spending: A closer look at Medicare Part D. *Health Affairs Web Exclusive* (February 3): w317–w325.