CHAPTER 2

Coverage beyond the basic benefit package

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In this chapter

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

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

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

Although additional coverage helps to ensure access, the patchwork of multiple sources creates some inefficiencies. The various supplements provide different degrees of coverage, but most are quite generous at filling in Medicare's cost-sharing requirements.[2] The generosity of these provisions may undermine incentives to be judicious in the use of services that are inherent in cost-sharing structures.

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

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

Scope of additional coverage by source

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

Employer-sponsored insurance

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

Medigap insurance

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

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

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

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

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

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

Medicaid

Medicaid generally offers the most complete supplemental coverage. People dually eligible for both Medicare and Medicaid are the only Medicare beneficiaries who have supplemental coverage for the full range of health services. They are not liable for Medicare's cost sharing.[6] In addition, they receive a comprehensive prescription drug benefit, are protected against long-term care costs, and are generally eligible for some preventive, dental, vision, and hearing services. These benefits are important because the population that Medicaid serves—the poor elderly, poor people with disabilities, and people who are impoverished by health care costs—have health care needs that would pose a significant financial burden for them. Medicaid also offers partial benefits to cover Medicare cost sharing for certain low-income groups.

Medicare managed care

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

Table 2-1 (p. 30) provides a comparison of the benefits offered by each type of supplemental coverage, as well as eligibility criteria and average premiums. People dually eligible for Medicare and Medicaid receive the most comprehensive benefits, with coverage of Medicare's cost sharing and many important uncovered benefits, such as prescription drugs and long-term care. Employer-sponsored coverage for Medicare-eligible retirees is also fairly comprehensive, although it is becoming less so. The benefit structure resembles that of active workers, covering prescription drugs and some additional services and buying down Medicare's cost sharing to low levels. Medigap insurance, except for plans with prescription drugs or preventive benefits, focuses on eliminating Medicare's cost sharing rather than expanding its benefits. Medicare managed care provides some extra benefits—which have been diminishing in recent years—and reduces cost sharing.

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

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

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

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

TABLE 2-1

Eligibility, premiums, and benefits by source of additional coverage

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

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

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

The majority of Medicare beneficiaries pay premiums for supplemental coverage. The average monthly premium for M+C enrollees was $31 in 2001.[7] For Medicare-eligible retirees with employer-sponsored coverage, the average monthly premium was $50 in 2001, or 26 percent of the total premium paid. The remainder was paid by former employers (Henry J. Kaiser Family Foundation et al. 2002).[8] For Medigap plans, the average premium was about $115 per month in 2000. Medigap insurance is the most expensive option for beneficiaries, in part because it is unsubsidized, but also because it is generally marketed to individuals, raising administrative costs. In contrast, retirees often receive a subsidy from their former employer and benefit from the savings generated from coverage in the group market. Beneficiaries who are dually eligible for Medicaid and Medicare receive a direct federal or state subsidy, and therefore pay no premium for their Medicaid benefits.

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

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

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

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

TABLE 2-2

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

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

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

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

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

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

To assess the relationship between supplemental coverage and use of necessary clinical services, MedPAC analyzed differences in the use of services selected to measure access to care for people age 65 or older. Developed by a team of physicians and health services researchers under the Access to Care for the Elderly Project, these indicators represent the views of clinical experts on what care is deemed necessary. They include use of preventive services, such as an annual physical exam; use of services considered necessary for a given condition, such as an electrocardiogram during a visit to the emergency department for unstable angina; and avoidable outcomes, such as nonelective admission for congestive heart failure (Asch et al. 2000).[10] The indicators represent a "floor" of care and can be used to measure underuse.

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

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

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

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

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

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

TABLE 2-3

Use of clinically necessary services by supplemental coverage status

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

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

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

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

Access to sources of additional coverage

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

Each source of supplemental coverage has some restrictions on eligibility. Employer-sponsored insurance is limited to beneficiaries (and their spouses) who worked for employers who offered such coverage. Medicaid is limited to beneficiaries who meet income and asset requirements. Enrollment in Medicare managed care products is limited to beneficiaries who reside in counties where plans participate. For example, 76 percent of beneficiaries living in predominantly urban areas have the option of joining an M+C plan, compared with only 13 percent of beneficiaries living in rural areas. Medigap insurance appears to be a more important option in areas that lack Medicare managed care options and is available to all elderly beneficiaries. During the first 6 months of enrollment in Medicare Part B, all beneficiaries aged 65 and older have the right to purchase a Medigap policy of their choice, subject to plan availability in their area. Outside of this open-enrollment period and certain other limited periods, however, access is not guaranteed.[14] Insurers may refuse to sell a policy or charge a higher premium based on a person's health status.

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

- **Age.** In 1999, beneficiaries under age 65 were least likely to have supplemental coverage, especially Medigap insurance. Those over age 80 were most likely to have Medigap coverage.
- **Income.** Among low-income beneficiaries, Medicaid was most common, covering 45 percent of those who are poor and 21 percent of the near poor (those with incomes between 100 and 125 percent of poverty). At the other end of the income distribution, 48 percent of those with high incomes (greater than 400 percent of poverty) had employer-sponsored insurance. One study found that low-income beneficiaries were more likely to be in Medicare managed care than to have Medigap insurance, most likely because of its lower premiums (Pourat et al. 2000).
- **Residence.** Rural Medicare beneficiaries were more likely than their urban counterparts to have Medigap coverage (39 versus 23 percent), less likely to be in Medicare managed care (4 versus 23 percent), and more likely to lack any type of supplemental coverage (14 versus 7 percent).
- **Health status**. Compared with those reporting excellent or very good health, beneficiaries in poor health were less likely to have employer-sponsored insurance (28 versus 35 percent), less likely to have Medigap coverage (19 versus 30 percent), more likely to have Medicaid (24 versus 6 percent), and more likely to lack any type of supplemental coverage (14 versus 7 percent).

Impact of supplemental coverage on program and system efficiency

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

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

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

TABLE 2-4

Sources of additional coverage by selected beneficiary characteristics, 1999

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

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

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

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

First-dollar coverage may respond to beneficiaries' desire to limit financial risk to the maximum extent possible, but it may not be the most efficient policy. For the Medicare program, extensive coverage of deductibles and coinsurance diminishes many of the incentives embedded in the cost-sharing structures that are meant to encourage people to be judicious in their use of services. Therefore, both current coinsurance or deductibles, and any revised cost-sharing structures, may not affect use as expected or desired. Because fee-for-service Medicare has no care management tools, program spending may be excessive as a result. For beneficiaries and those that sponsor their coverage, first-dollar coverage also raises the premiums for supplemental coverage. In addition, the costs of predictable expenditures such as the Part B deductible are automatically included in the premium, with insurers incurring costs to administer these benefits, which also must be incorporated into the premiums. More efficient supplemental products might expand offered benefits while limiting coverage of deductibles and other cost-sharing requirements.

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

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

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

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

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

The future of additional coverage

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

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

Medicare managed care

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

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

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

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

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

Medigap

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

Employer-sponsored insurance

Employer-sponsored insurance, the largest source of supplemental coverage, has also been declining. Over the past decade, the proportion of employers offering retiree health coverage has declined, even during the strong economy of the late 1990s. A nationally representative survey of public and private employers with 500 or more employees found that 23 percent offered health coverage to Medicare-eligible retirees in 2001, down from 40 percent in 1994 (Mercer 2002). The declines have accelerated in recent years: The percentage of firms with 200 or more workers offering coverage to retirees over age 65 declined by 10 points between 1999 and 2001. The same survey found that the percentage of small firms (those employing 3-199 workers) offering retiree health coverage fell from 9 percent in 2000 to 3 percent in 2001 (Henry K. Kaiser Family Foundation et al. 2002). Few, if any, employers have added health coverage for Medicare-eligible retirees (Mercer 2001). In fact, the declining proportion of firms offering health insurance may have occurred because fewer new firms offer such coverage, not because established firms are dropping it. These declines generally affect future, rather than current, retirees. In 2001, five percent of large employers had plans that covered only current retirees, or those hired before a certain year (Mercer 2002). Employers also have increased the number of years of service required to qualify for retiree health benefits (Watson Wyatt Worldwide, in press).

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

In addition to the recent declines in firms offering coverage to their retirees, those that offer coverage have been scaling back on drug benefits and increasing retirees' premium contributions. Among firms that offer retiree health benefits, 32 percent increased cost sharing for prescription drugs and 53 percent increased retirees' share of the premium between 1999 and 2001. About 36 percent of large employers have capped their contribution towards retiree coverage either for current or future retirees (Hewitt Associates 2001).

Medicaid

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

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

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

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

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

Total spending and sources of payment for beneficiaries' health care

The additional coverage purchased by or on behalf of Medicare beneficiaries contributes a substantial share of the total spending for beneficiaries' health care. In this section, we look at spending by all sources—Medicare, beneficiaries, private supplemental plans, and public programs—to gain a more complete picture of the total amount being spent on beneficiaries' health care. According to estimates produced for MedPAC, total projected spending in 2002 (excluding long-term care) is $446 billion, including administrative costs (Table 2-5).[19] Of that, Medicare is projected to account for about $262 billion, or 59 percent of total spending. Other payers are projected to account for about $184 billion, or 41 percent of the total (Figure 2-1, p. 38).

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

The administrative costs of insurance—marketing, claims processing, reinsurance, profits, and so forth—vary by source. Private supplemental insurers incur the highest administrative costs; of the $69 billion they are projected to spend in 2002, 15 percent will go toward administration. Administrative costs are projected to be 2 to 3 percent for both public supplemental insurance and for Medicare.

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

TABLE 2-5 **Estimated spending on medical services for Medicare beneficiaries, by source, 2002**

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

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

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

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

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

Conclusion

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

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

FIGURE 2-1

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

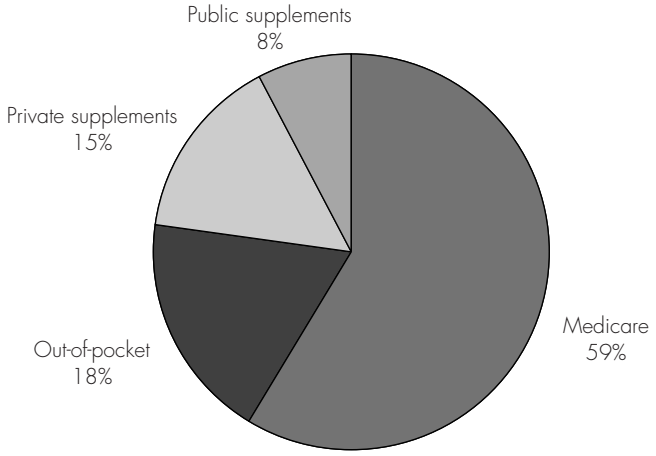
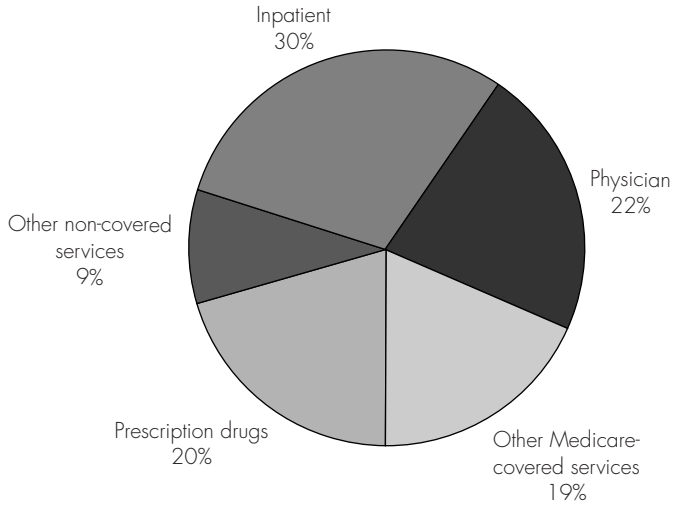


FIGURE 2-2

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



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

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

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

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