CHAPTER 2

Market variation: implications for beneficiaries and policy reform

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In this chapter

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Most beneficiaries seek additional coverage to protect themselves from health care costs not covered by Medicare. Previous MedPAC work has concluded, however, that supplementing Medicare can be complicated and expensive, and often fails to shield beneficiaries from high expenses. These options, moreover, vary across the country and are changing.

Medicare insurance markets are complex. Rates of supplemental coverage across markets vary with beneficiary income, age, workforce unionization, and urban and rural location. State regulatory policies can also facilitate access to some insurance products. Our review of the structural and regulatory factors shaping Medicare markets identifies standardization versus flexibility in the design of benefits as critically important for beneficiaries, employers sponsoring retiree health benefits, and health plans and insurers.

The division of regulatory oversight of Medicare products among federal agencies and the states will continue to shape the evolution of Medigap, employer-sponsored, and Medicare+Choice options. Understanding the structure of Medicare supplementation and how federal and state law and regulations affect the ways that different products meet beneficiaries' changing needs will also be important in considering market-based reforms.

Previous MedPAC reports have documented the importance of supplementing traditional Medicare benefits. Our June 2002 Report to the Congress described how ongoing changes in medical technology and demographic characteristics of the beneficiary population have magnified limitations of Medicare's benefit design. Medicare does not cover most outpatient prescription drugs, certain preventive services, and other services such as routine and dental care. Together with high cost sharing for covered services such as outpatient care and mental health services and lack of protection against catastrophically high out-of-pocket liability, these limitations lead most beneficiaries to seek additional insurance coverage.

The patchwork of supplemental coverage that has evolved, however, only partly addresses the limits of Medicare's benefit package. As a result, many who have supplemental coverage still face large financial liabilities. They must pay out of pocket for health care products and services that Medicare does not cover. In addition, financial incentives may dissuade them from using the most clinically appropriate care. Current demographic trends and continuing advances in technology suggest that these problems will become more serious over time.

Additional analyses conducted by MedPAC have looked more closely at the options available to beneficiaries to supplement Medicare. In our March 2003 Report to the Congress, we described options for supplementing or enrolling in an alternative to the basic Medicare fee-for-service program:

- supplemental insurance purchased by individuals (Medigap);
- supplemental insurance available to retirees through employer- or union-sponsored plans;
- various alternative Medicare+Choice (M+C) plan models including HMOs, preferred provider organizations (PPOs), and private fee-for-service (FFS) plans;[1] and
- additional coverage through the Medicaid or other public programs for low-income beneficiaries.[2]

Some important options for supplementing Medicare coverage, however, are becoming less prevalent and less generous. Employment-related retiree health insurance is becoming less available and less comprehensive in the benefits it provides. The proportion of employers offering retiree health insurance has declined substantially over time. Retrenchment in benefits has generally affected new employees, rather than tenured employees or retirees (Fronstin 2001). Consequently, the Medicare Current Beneficiary Survey (MCBS) data from 1992 through 2000 show the proportion of Medicare beneficiaries with employer-sponsored insurance declining by only a small percentage. Over the next decade, many workers with coverage will retire, tending to stabilize the rate of employer-sponsored coverage in the Medicare population. The coverage they have will, however, most likely be less generous (with plans requiring higher beneficiary cost sharing); after this cohort retires, fewer workers will have these benefits, and these declines will coincide with the retirement of the baby boom generation (2011 and after).[3]

Overall, premiums for individual Medigap policies also increased rapidly throughout the 1990s (Atherly 2001), but increases in premiums varied across policy types and across states (American Academy of Actuaries 2003). Over the past several years, M+C plans have reduced their participation in Medicare markets, and, in those markets where they remain, increased premiums significantly to cover the costs of the benefits beyond those covered by Medicare. Reductions in M+C benefits and increasing premiums may be changing the way that beneficiaries view trade-offs among managed care, PPO options, and Medigap insurance in some market areas.

At the same time, other types of supplementation that can include new benefits such as prescription drug coverage or case management for serious medical conditions are now offered in conjunction with some individual Medigap policies, as well as PPO plans. These newer options may, moreover, serve as possible models for some reforms that would rely on private plans to provide more comprehensive coverage to Medicare beneficiaries.

Understanding these Medicare health insurance markets can inform policies in two ways:

(1) Understanding better how regulatory policies affect insurers and health plans (or other risk-bearing provider entities) could help inform future policies to reduce barriers to market entry; create incentives for participation in Medicare markets; or help beneficiaries to make more informed, appropriate insurance choices.

(2) Identifying the characteristics of active, competitive markets should help policymakers to predict more accurately what types of products might succeed, or would have little chance of succeeding, in different localities and for different beneficiary populations.

1 M+C also encompasses comprehensive health care plans designed to address special population needs including the Program of All-inclusive Care for the Elderly, Social Health Maintenance Organizations, and Evercare.

2 Chapter 5 of MedPAC's March 2003 Report to the Congress provides an overview of the health insurance options available to Medicare beneficiaries, including information on supplemental insurance, M+C options, and the distribution of coverage in the Medicare population.

3 An annual survey of employers with more than 500 workers shows that, between 1993 and 2001, the proportion reporting that they expect to continue offering health benefits to future retirees declined from 40 to 23 percent; the same survey showed that from 1997 to 2000, the percentage requiring Medicare-eligible retirees to pay the full costs of retiree benefits increased from 27 to 34 percent (Fronstin and Salisbury 2003).

This chapter first reviews the products available to Medicare beneficiaries and how these products affect beneficiaries' liability for health care costs, and describes the salient differences among the products and the markets where they are sold. In the second section, we review the current landscape of insurance options for Medicare beneficiaries across states and large metropolitan areas. We explore the characteristics associated with patterns of coverage in different markets. In the final section, we identify questions to examine in greater detail to better understand what policies might foster better beneficiary access to affordable supplemental benefits.

Insurance markets and supplemental benefits

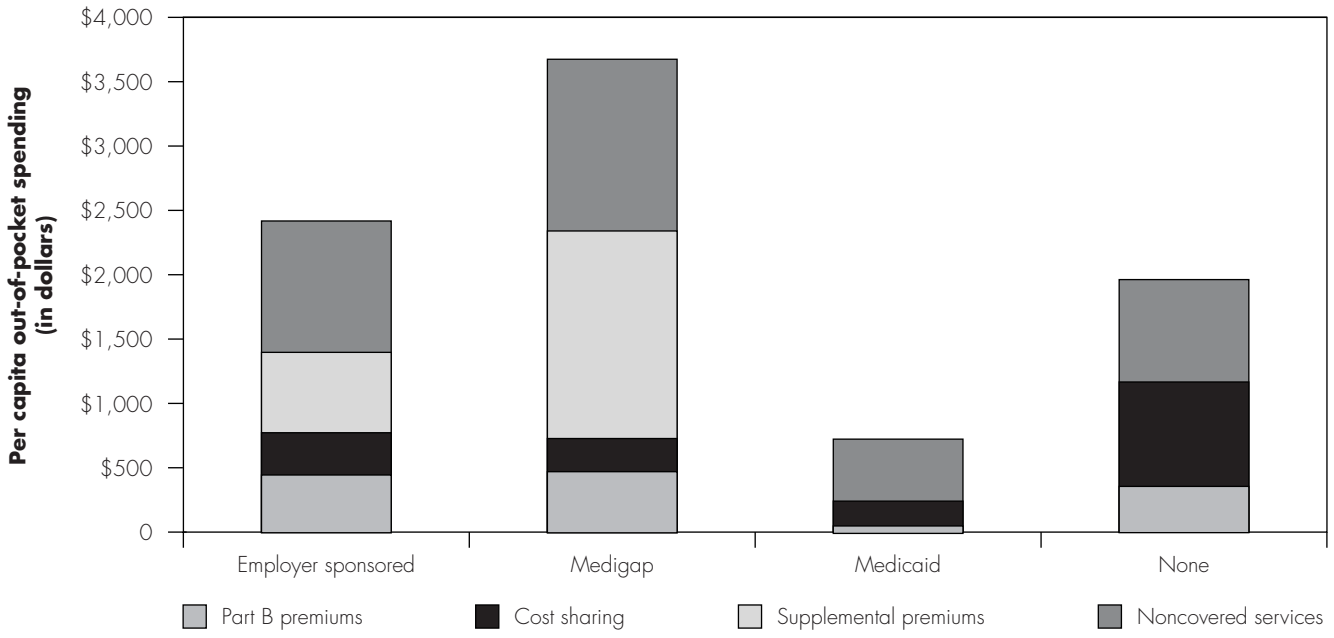
Currently, most beneficiaries are able to obtain additional coverage, primarily by supplementing traditional Medicare with employer-sponsored retiree health benefits (about one-third of beneficiaries)[4] or by purchasing Medigap policies (slightly under 30 percent). Beneficiaries may also choose to enroll in an M+C plan (currently about 13 percent). The M+C options—HMOs, PPOs, and private FFS plans—often provide more comprehensive coverage, which substitutes for other forms of supplementation.[5] Others obtain assistance from Medicaid or other public programs (around 15 percent).

Beneficiary liability and supplementation

The extent to which different forms of supplementation shield beneficiaries from health care costs varies significantly. Previous research has demonstrated that supplemental insurance increases beneficiaries' access to health care (MedPAC 2002). It does not, however, effectively shield them from all out-of-pocket costs.

Figure 2-1 illustrates key differences in the coverage provided by the major forms of supplemental coverage. People with Medigap spend the most out of pocket for health care, followed by those with employer-sponsored supplemental coverage. This spending is both for insurance premiums and for health care services.

FIGURE 2-1 **Composition of out-of-pocket spending, by type of supplemental insurance, 2000**



Note: Sample of 9,601 consists of community-dwelling beneficiaries who participated in traditional Medicare in 2000. Out-of-pocket spending includes beneficiaries' direct spending in four categories: the Part B premium, cost sharing for covered services, supplemental premiums, and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2000.

4 The term "employer-sponsored supplemental insurance" or "employer-sponsored insurance" is often used to refer to coverage offered to retirees directly by employers as well as group coverage managed jointly by employers and unions. The Taft-Hartley Act (formally the Labor Management Relations Act of 1947) allowed for the creation of insurance funds formed by multiple employers, allowing unionized workers to retain coverage when they move among participating employers. Throughout this chapter, we use the term employer-sponsored insurance to refer to all employment-related plans, including Taft-Hartley plans.

5 In fact, federal law prohibits the sale of Medigap policies to individuals enrolled in M+C plans. When the M+C program was created, most plans did not require significant cost sharing and Medigap would therefore not have been of value to beneficiaries.

Medigap premiums are, on average, higher than employer-sponsored supplemental premiums. Further, most Medigap policies primarily cover Medicare cost sharing, and offer only limited coverage of non-Medicare services such as preventive services or home care. Those Medigap policies that do include prescription drug coverage require significant beneficiary cost sharing (Fox et al. 2003). Consequently, while those with Medigap spend less on Medicare cost sharing, they have higher total out-of-pocket costs, because they pay higher premiums, and have less coverage for non-Medicare services than beneficiaries with employer-sponsored supplemental insurance.

Beneficiaries with Medigap also use more Medicare services than those with other forms of supplementation and those with no supplementation (MedPAC 2002). While beneficiaries with Medigap are largely protected from out-of-pocket costs for Medicare-covered services, their use of related, uncovered items, such as prescription drugs, increase their out-of-pocket spending.

Low-income beneficiaries with Medicaid do not have to pay Medicare premiums, but some categories of Medicaid recipients (termed specified low-income Medicare beneficiaries) are liable for Medicare cost sharing. Medicaid covers both premiums and Medicare cost sharing for beneficiaries eligible for full Medicaid coverage or for those termed qualified Medicare beneficiaries (see MedPAC 2002). Medicaid pays for a variety of health care goods and services not covered by Medicare for those beneficiaries eligible for full Medicaid coverage, but beneficiaries still are liable for some minimal copayments, and for the costs of some health care services goods and services not covered by Medicaid.

Those with no supplemental coverage pay Medicare premiums, all Medicare cost sharing, and the full costs of noncovered services they use. Because those without supplemental coverage use fewer health care services, however, their out of pocket spending, on average, is lower than those with supplemental insurance.

Out-of-pocket spending for beneficiaries enrolled in M+C plans is not shown on Figure 2-1 (p. 21) because available data do not separate spending for cost sharing for Medicare-covered services from spending for other services provided by managed care plans. Data do show, however, that spending for premiums by M+C enrollees is on average lower than spending for premiums by beneficiaries who have Medigap or employer-sponsored supplements. In 2000, total premiums (Medicare Part B premiums plus M+C premiums) averaged $821 for those enrolled in M+C, compared to $2,037 for those with Medigap and $1,105 for those with employer-sponsored insurance. M+C enrollees also spend less out of pocket for health care services than beneficiaries with Medigap or employer-sponsored supplements. In 2000 for example, M+C enrollees spent, on average, about $910 out of pocket for health care services (including copayments and costs of uncovered services), while people with Medigap spent $1,602 out of pocket, and those with employer-sponsored supplemental coverage spent $1,236 out of pocket for services (including cost sharing and costs of uncovered services).

Out-of-pocket spending also varies by beneficiary health status. For every category of insurance coverage, beneficiaries reporting that they are in fair or poor health spend more out of pocket on health services than those in good-to-excellent health. Within the groups having each type of coverage, there were only small differences in the average premiums that healthy versus sicker beneficiaries paid for supplements. But beneficiaries in fair or poor health with Medigap spent close to $2,200 out of pocket for health services in 2000, compared with about $1,400 for those in good-to-excellent health. For beneficiaries in fair or poor health with no supplemental coverage, out-of-pocket costs for health services were close to $2,000, about twice as high as for those in good-to-excellent health. People in fair to poor health need more health care. But having supplemental coverage appears to be more effective in facilitating beneficiaries' access to care than it is in protecting beneficiaries from the costs of health care.

Overview of major options for supplementing Medicare

The available options for supplementing Medicare vary with local market circumstances and beneficiaries' resources and preferences. Options that supplement Medicare FFS or replace it have evolved very differently in local markets across the United States. Medigap premiums vary substantially across, and sometimes within, markets. Higher Medigap premiums may, for example, increase beneficiaries' interest in Medicare managed care options (McLaughlin et al. 2002). In some markets, beneficiaries choose particular Medigap policies much more frequently than in other areas; in some areas, employers provide more supplemental insurance; in some places most employment-based coverage is managed care, which could affect retirees' propensity to choose managed care options. In some markets, a relatively high proportion of beneficiaries have no supplemental insurance and low enrollment rates in Medicaid.

The variations in beneficiary liability and cost sharing associated with different types of supplementation reflect the very different structure of these forms of coverage. Table 2-1 compares the three most prevalent forms of Medicare supplementation. Each form of supplementation—Medigap insurance, employer-sponsored retiree health insurance, and supplementation of standard Medicare benefits currently available through M+C plans—has a distinct structure. Table 2-1 demonstrates that the participants in Medicare insurance markets do not play on a level field, but on different fields that may overlap. The actual market areas they serve are defined

TABLE 2-1

The playing field for Medicare supplementation

	Medigap	Employer-sponsored plans	Medicare+Choice Plans
What is covered?	All policy types cover Part A hospital coinsurance, 365 additional hospital days, Part B cost sharing, and cost of blood products. Most cover the Part A deductible and SNF copayments. Some add coverage for other services, including travel, home care, and preventive; three add a prescription drug benefit. Two policy types may be sold with a high deductible option.	Most provide coverage like that for active workers, including: Medicare coinsurance after a deductible, hospital stays exceeding Medicare limits, a cap on total enrollee spending, prescription drugs, and additional preventive services. Some plans include eye, hearing, or dental services, or expanded mental health services.	All plans must cover Medicare Parts A and B services, but may offer additional benefits. In 2003, about 50% of beneficiaries had access to plans that offer some prescription drug coverage, 30% to plans covering cost sharing for inpatient hospital services, and 10% to plans with no cost sharing for physician services. All plans offer some preventive and health promotion services.
How much risk does the insurer bear?	Each plan bears risk for the specific services it covers (see above). For most policy types, the hospital deductible and cost sharing for covered services (20%) represent the bulk of the insurers' risk.	Employers bear full risk for self-insured plans. Plans that are not self-insured assign risk to carriers with whom they contract.	Plans bear full risk under capitation with Medicare. Medicare cost plans do not bear risk, except for any cost sharing they cover for which they charge a premium. In the Medicare PPO demonstration, plans can negotiate risk-sharing arrangements with Medicare.
Can insurers underwrite or adjust premiums to limit their risk?	After a beneficiary's initial six-month open enrollment period, with certain exceptions related to losing other forms of coverage, insurers can rate policies by age; and medically underwrite policies (refuse to insure or charge higher premiums to people with preexisting conditions), unless state law places additional restrictions on rating or underwriting.	Self-insured plans cannot age rate or medically underwrite policies; they can adjust the benefits structure over time or adjust employee contributions, to the extent permitted under contractual obligations with employees. Plans that are not self-insured can experience-rate group coverage.	M+C plans accepting nongroup enrollees must enroll any beneficiary, regardless of age or health condition, except beneficiaries with ESRD. Plans may not adjust beneficiary premiums for health risk or use of services, but can reflect county residence. Medicare payments reflect age, sex, county residence, and Medicaid status. A new risk-adjustment system is phasing in over time.
Who regulates: • What plans can enter markets?	States regulate entry and exit of plans selling Medigap products based on state and federal standards. Federal standards apply to loss ratios, filing and approval of policies, claims payment, disclosure and reporting of information, marketing, and plan design (see below). States can impose more stringent standards than those in the federal-NAIC model if consistent with federal intent.	Federal law regulates self-insured plans. Standards address administrators' fiduciary responsibilities and plan requirements relating to the structure of benefits and reporting requirements. Generally, the same federal law regulates plans that are not self-insured, but state requirements may apply as well.	Risk-bearing entities participating in M+C must be licensed or certified under state law in each state where they offer coverage, and must meet all Medicare standards. Federal requirements preempt state requirements if there is a conflict.
• What restrictions are placed on marketing to beneficiaries?	Federal rules prohibit the sale of Medigap policies to individuals who already hold one, or who are enrolled in an M+C plan. Federal rules cover commission fees, compensation arrangements for issuers, and disclosure requirements, and require specific language in plan descriptions. States may add other requirements.	Federal law sets out standards for plan descriptions to give enrollees in private employer-sponsored plans.	Federal requirements apply to plan descriptions for enrollees. CMS reviews marketing materials for coordinated care and private FFS plans prior to use. Plans can market only in the service areas where they provide services. Materials for employer group plans need not be reviewed in advance.
• What data reporting requirements are placed on insurers?	Insurers must provide data to the states where they do business on plans they sell by policy type, and must submit data needed to certify their compliance with the established loss ratio standards for Medigap.	Federal law requires employer plans to submit data to the Department of Labor to establish compliance with fiduciary standards, nondiscrimination requirements, and basic plan requirements (guaranteed issue, renewability, and minimum benefit standards).	M+C coordinated care plans must submit administrative and patient data for many purposes, e.g., lists of network providers, financial incentives in provider contracts, patient diagnoses (for risk adjustment), quality review and improvement programs, enrollee satisfaction surveys, and marketing materials. Data reporting requirements on quality of care for PPOs and private FFS plans are more limited.

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TABLE 2-1

The playing field for Medicare supplementation

	Medigap	Employer-sponsored plans	Medicare+Choice Plans
How much risk is borne by the government?	Medicare bears most of the risk for most Part A services and about 80% of the risk for most Part B services covered by the program.	Medicare bears most of the risk for most Part A services and about 80% of the risk for most Part B services covered by the program.	Medicare pays a set amount per beneficiary per month based on enrollees' characteristics. Medicare is not at risk for any costs incurred by plans.
What is the beneficiary's liability?	Beneficiaries bear the costs of premiums. Average premiums ranged from $91 to $196 per month across the 10 plan types in 2001. Most Medigap policies do not cover prescription drugs or most preventive services. Beneficiaries are also liable for the costs of eye and dental care, hearing aids, and other assistive devices.	Most employer plans include some drug coverage; for other services not covered by Medicare, coverage varies substantially across employer plans. Beneficiary contributions to premiums vary from 0–100%; the average monthly premium for new retirees over age 65 was $79 in 2002. Liability is often limited by a catastrophic cap.	Beneficiary liability varies by plan. Premiums range from $0, plus a rebate of some of the Part B Medicare premium, to over $200 per month. Some plans shield beneficiaries from most or all liability for inpatient care; most limit cost sharing for physician services to a copayment; most cover some additional services such as prescription drugs.
What are beneficiary's rights to enrollment?	Federal statute requires guaranteed issue without preexisting condition exclusions for 6 months after beneficiaries enroll in Parts A and B at age 65. Additional guaranteed issue provisions apply to beneficiaries involuntarily disenrolled from terminated employer-sponsored plans, some M+C plans, and Medigap plans failing due to bankruptcy or insolvency. States can add protections for beneficiaries, including guaranteed issue for disabled under age 65, or if group benefits erode.	Employers specify enrollment options for retirees. Those offering choice among plans generally limit choice to an annual open enrollment season.	Under current law, Medicare beneficiaries are free to disenroll from M+C plans and enroll in a new plan accepting members, or return to FFS Medicare, at any time. M+C plans must accept new members during an annual open enrollment period (November 15–December 31). There is, however, an exception for plans that have reached their enrollment limit. Beginning in 2005, a lock-in provision will be instituted, allowing beneficiaries to leave plans only during an annual open enrollment period, or under certain other limited circumstances.
What are beneficiary's rights with respect to:			
• retaining coverage?	Federal law requires guaranteed renewal of Medigap policies. If a beneficiary drops a Medigap policy, however, insurers are not required to reissue the policy, except under certain conditions (e.g., involuntary disenrollment from an M+C plan).	Federal law requires guaranteed renewal under group policies but allows employers to reduce, eliminate, or discontinue all benefits, if employers reserve the right to do so and keep contractual agreements.	Federal statute and regulations restrict plans from disenrolling beneficiaries (with very limited exceptions). Plans can leave markets or service areas at the end of a year without penalty.
• retaining specific benefits over time?	Benefits are standardized. New benefits can be offered only under provisions subject to state and federal oversight.	See above.	Plans cannot reduce benefits or increase member liability during the course of a year. They can reduce premiums or cost sharing, or increase benefits.
• increasing premium rates?	States regulate increases and reflect federal maximum loss ratio requirements. Intensity of rate review activities varies by state.	See above.	CMS approves proposed premiums and benefit packages.
What are beneficiary's rights with respect to grievances or appeals for individual claims?	Federal rules require plans to inform beneficiaries about their rights, obtain information and assistance regarding Medigap problems, and coordinate Medigap issues about the appeal of Medicare claims. States address beneficiary grievances and complaints. State resources for investigating insurance complaints and providing consumer assistance vary.	States' involvement in adjudicating appeals of coverage or claims depends on the precise wording of the state laws and interpretations of federal law for ERISA as well as self-insured plans. Federal resources for investigating individual appeals and claims are limited.	Federal law sets out detailed requirements for beneficiary grievances and appeals. State law pertains when it is not clearly preempted by federal law.

Note: ERISA (Employee Retirement Income Security Act of 1974), ESRD (end-stage renal disease), FFS (fee-for-service), M+C (Medicare+Choice), NAIC (National Association of Insurance Commissioners), PPO (preferred provider organization), SNF (skilled nursng facility). For more detailed information, see MedPAC's Report to the Congress: Medicare payment policy, March 2003.

by different laws and regulations, as well as by demographics and economics. Further, because different rules govern when and under what circumstances people can enroll and disenroll, insurance options do not compete against each other directly.

Changes occurring in private markets that serve current Medicare beneficiaries suggest a need to understand how the factors contributing to variations in local markets for Medicare insurance products interact. These different insurance products are broadly defined by the ways products and entities take on insurance risk. However, markets for Medicare insurance products reflect complicated interactions between federal and state regulation and oversight, not just of insurance products that supplement Medicare, but of all insurance products. Markets are, moreover, shaped by many other factors, including population characteristics (density, age structure, economic resources, health status, propensity to use health care), the concentration and ownership of providers (hospitals, physician groups, managed care plans, health insurers), economic structure (employment and industry structure, unionization, cost of living), and the health care environment (safety net programs, Medicaid policy).

As supplemental coverage options have evolved, policymakers have employed different ways of fostering these markets and protecting consumers who rely on them. Looking across these markets allows us to identify some of the basic issues underlying meaningful choice among insurance options for the beneficiary population. Some of these issues relate to how supplemental benefits are structured, and some relate to how they are regulated.

The structure of supplemental benefits

Medicare supplements—Medigap, or employer-sponsored supplemental insurance—can be either individual insurance or group insurance products. These forms of insurance work differently.

Medigap structure

The individual insurance market has provided supplemental insurance to millions of Medicare beneficiaries since Medicare began in 1966. Reforms enacted in the Omnibus Budget Reconciliation Act of 1990 (OBRA–90) restructured the market for supplemental insurance by creating a set of 10 standardized policies (policies A through J), called Medigap policies, that could be marketed by private insurance companies. These standard plans generally provide coverage of Medicare's cost-sharing requirements but offer few additional benefits beyond the basic Medicare benefit package.

The most popular Medigap policy is Plan F (37 percent of Medigap policies), which covers most of Medicare's cost sharing, followed by Plan C (23 percent of policies), which is similar, but does not cover the excess amount beneficiaries may be required to pay to doctors who do not accept Medicare-approved amounts as payment in full. Three of the standard plans (H, I, and J) do offer limited coverage of outpatient prescription drugs, but all come with a $250 annual deductible, 50 percent coinsurance, and a cap on benefits of $1,250 per year (Plans H and I) or $3,000 per year (Plan J); only about 8 percent of beneficiaries hold these policies (MedPAC 2002, 2003). A significant number of beneficiaries (almost one-fourth) still hold prestandard plans. In three states, Wisconsin, Massachusetts, and Minnesota, the standardized Medigap plans available differ from the federal plans. These states developed their supplemental insurance reforms, including standardization of plan offerings, prior to the enactment of OBRA–90; because the state reforms achieved the same goals as the OBRA–90 reforms, the states obtained waivers from the federal requirements.

Most Medigap enrollees buy policies that are marketed to individuals. The rest buy policies which are only marketed to individuals who belong to particular membership groups.[6] Group Medigap policies, like other Medigap policies, are subject to rating and other underwriting provisions set out in state or federal law.

The extent of meaningful choice in the Medigap market after beneficiaries have made their initial choice when turning age 65 is debatable (Chollet and Kirk 2001).[7] Age rating in many states (see p. 28) means that new plans for older beneficiaries can be expensive. Moreover, in some states, or areas within states, the number of plans actively marketed is quite small. National Association of Insurance Commissioners (NAIC) data show that in 2001, nine states had only one insurer, or no insurer at all, offering each of the Medigap plans that include drug coverage (H, I, or J).[8]

In the individual insurance market, beneficiaries have to make decisions for themselves after sorting through available product options. CMS provides assistance to consumers through its publications, internet information services and a national hot line, and through the State

6 In some states, large association plans marketing to membership groups such as AARP are identified as group plans in NAIC data, while in other states similar plans may not be identified as group plans. The proportion of beneficiaries enrolled in group plans varies substantially from state to state. In many states, more than 90 percent of Medigap policyholders are in individual plans, but in some, including California and New Jersey, more than half are in group plans (Chollet and Kirk 2001).

7 Two pieces of evidence support the view that many beneficiaries tend to stay with the same Medigap policy. First, as noted above, close to one-fourth are still in the prestandard plan they purchased prior to the OBRA–90 reforms. Second, according to an analysis conducted for the Department of Health and Human Services (HHS), almost one-third of Medigap policy holders in 1999 were enrolled in closed policy forms (where no new policies are being sold), and in some states, more than half of all policyholders were in closed plans; fewer than half of all Medigap insurers offered open products and were active (actively selling new policies) in 1999. Insurers may close products to new enrollees because the costs, and therefore premiums, are increasing rapidly. Insurers fearing an adverse selection spiral, where only the most expensive enrollees stay with the plan, may limit their losses by closing the plan (Chollet and Kirk 2001).

8 MedPAC's analysis excluded plans that had not sold at least 10 policies during the last 3 years from the data.

Health Insurance Assistance Programs (SHIPs).[9] States provide varying forms of information about Medigap policies over the internet. OBRA–90 standardization of policies simplified this task, but the job of sorting through policies, prices, and rating provisions can still be difficult, particularly for older beneficiaries who leave or lose access to M+C plans.

Employer-sponsored supplemental insurance structure

About one-third of Medicare beneficiaries are covered by employer-sponsored retiree health insurance; it is currently the most common form of supplementation. Employer-sponsored retiree health insurance includes both supplemental benefits provided by plans (almost entirely through the group market) and enrollment in M+C plans.

Most supplemental insurance provided through the group market is structured to wrap around or coordinate with Medicare benefits. Some retiree coverage (more common among very large employer or union-negotiated plans) provides full, or close to full, coordination of benefits. In these arrangements, benefits cover Medicare cost sharing (deductibles and coinsurance) for covered services as well as some services Medicare does not cover, including (in most cases) prescription drugs. The dominant method of supplementing benefits, however, is the carve-out. Generally, this means that the benefit package is designed so that, after Medicare benefits are factored in, the beneficiary has the same level of out-of-pocket liability for covered plan services that he or she would have had with the working employee plan.

Employers can offer retiree coverage through M+C plans. Coordinating the benefits that employers seek to offer to retirees with the benefits included in managed care packages can be difficult. For example, employers may want to include vision or dental benefits that managed care plans do not offer, or prefer to include different copayment or deductibles structures than those incorporated into M+C plans. To address these problems, CMS used authority granted to it in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to modify contracting rules to better accommodate group-based coverage (see text box, opposite).

Although the employer-sponsored group market offers fairly comprehensive supplemental coverage, beneficiaries' choices are limited. The benefit offerings are not standardized and generally reflect, or may be formally linked to, the benefits provided to those still working in any particular organization.[10] Group coverage, including employer group coverage through M+C plans, is shaped by employers' decisions about both corporate and local issues as they negotiate health benefits with insurers, health plans, and employee or union representatives. Large employers may contract with a variety of insurers and health plans, but many smaller ones contract with only one or two (often one is a PPO or other sort of managed care plan). Thus, only retirees of large public or private sector employers generally have any choice among supplemental plans, and not all options offered by their employers may be available where retirees live. Whether beneficiaries have any employer-sponsored supplemental plan available to them, whether their plan continues to be available over time, and, if they retain coverage over time, how much of the premium is paid by the employer, depend on where they or their spouses worked.

Policy directions

The structure of Medicare supplemental products raises two policy issues: standardization of benefits, and beneficiaries' ability to enroll in and move between different supplemental products.

The issue of standardization of benefits is fundamental for all forms of supplementation. Flexibility in benefits design increases both beneficiaries' and employers' ability to obtain the coverage that best meets their needs. However, specialized benefit options could increase the probability of biased selection, leading to increased premiums for beneficiaries enrolled in the plans offering the best coverage for people with greater health care needs. The standardization of benefits, or, at least, greater standardization of descriptions of supplemental benefits in marketing materials, could help beneficiaries to make more informed choices among plan alternatives (Dallek and Edwards 2001).

A second set of issues involves the rules governing enrollment, guaranteed issue, and guaranteed renewal across the different product markets. A coordinated open enrollment period for M+C and Medigap, for example, might provide an opportunity for beneficiaries to compare and choose among available options more systematically. Depending on other policy changes affecting guaranteed issue, rating, or underwriting, an open enrollment period could also decrease favorable selection of health plans (Rice 1999). Significant changes to Medigap rules could, however, also disrupt markets providing products that many beneficiaries value (MedPAC 2003). Any of these proposals could, moreover, entail changes in the laws and regulations governing labor employment and labor relations, as discussed in the next section.

9 SHIPs receive funding from CMS, but they are operated jointly with the states. In addition to small state and regional staffs, they rely heavily on volunteer counselors, often recruited and trained by, or in cooperation with, area agencies on aging. In some states the agencies are administered by the Department of Insurance; in others, by the Department of Aging.

10 M+C employer group plans are employee benefits, so explanations and descriptions are generally the responsibility of the employer. Marketing materials for M+C plans for employer groups are exempt from CMS preapproval of marketing materials, but CMS reviews them to ensure that they are accurate and provide required information, for example, on beneficiary rights.

Employer group coverage in the Medicare+Choice program

CMS established three categories of plans, waiving certain requirements to encourage participation in Medicare+Choice (M+C):

1. **Employer-only plans.** Under certain circumstances, M+C organizations are allowed to offer employer-only plans (not available to beneficiaries in the individual market). M+C organizations can establish unique service areas for these plans.

2. **Actuarial swaps.** M+C organizations can swap additional benefits (above the basic benefits) of approximately equal value when an employer prefers a different benefit package from that offered to the individual market. The M+C plans must, however, cover all Parts A and B benefits. For example, an employer may prefer a vision rather than the dental benefit an M+C plan offers in its individual market product. The benefits can be swapped if they are of equivalent value. Or, a union may prefer a dental and a vision benefit rather than a prescription drug benefit of the same value. The M+C plan can replace its drug benefit with the dental plus vision benefit in the plan it offers to the union.

3. **Actuarial equivalence.** M+C plans can raise copayments for certain benefits but provide a higher benefit level. The waiver for actuarial equivalence applies to both Medicare benefits and uncovered benefits. For example, a plan offering a $500 drug benefit with a $5 copayment in its individual market plan could offer a different benefit (such as unlimited drugs with a $10 copayment), designed to mirror other employee coverage, in its group plans. Or, an M+C plan that required individuals to pay a $10 copayment for all physician visits could offer employers or unions plans with copayments for physician visits of $5 for primary care and $20 for specialists. To obtain a waiver for this type of adjustment, the plan must indicate to CMS how the cost sharing amounts would tend to affect beneficiary cost sharing, whether the benefit would change, and whether the modifications will be tied to any changes in premiums charged (CMS 2002b). ■

Issues in state and federal regulation

State and federal entities regulate health plans and insurers. The rules for entering markets (including licensing and solvency requirements), exiting markets, premium setting, underwriting, guaranteed issue and renewal, and marketing practices of both insurers and risk-bearing health plans vary for different supplemental products. In the next section, we examine each of the supplemental insurance types' regulatory framework. States are responsible for regulating the individual insurance market. In the case of Medigap, however, federal statute establishes a basic framework and requirements. Technically, responsibility for enforcing Medigap rules is voluntary for states—they could cede these responsibilities to CMS—but all states have chosen to accept this responsibility, and some have chosen to expand regulation of Medigap beyond the federal standards.

Medigap regulation

As required by OBRA–90, the basic Medigap protections are set out in the National Association of Insurance Commissioners (NAIC) model regulation (NAIC Model), which most states have incorporated into their own insurance regulations. Medigap premiums are regulated by states. Federal standards set limits for Medigap loss ratios, but states must review and, where necessary, require adjustments to rates.[11] CMS has a formal role in interpreting the statutory provisions and reviewing state policies governing all aspects of Medigap insurance.

Enrollment rules The NAIC Model dictates what products insurers can sell and beneficiary enrollment rules. Issuers can sell up to four types of any standard Medigap plan: individual, group, individual Select,[12] or group Select. Within the Model regulations, however, Medigap insurers may (unless otherwise constrained by state law) deny coverage to applicants enrolled in Medicare for more than 6 months; deny current policyholders from moving (within carrier) to other policy forms 12 months after initial enrollment; deny beneficiaries leaving M+C or retiree plans coverage in many of the standard forms, including those that include prescription drug coverage; or restart a 6-month waiting period for coverage of preexisting conditions when a beneficiary changes Medigap policies (Chollet and Kirk 2001).

11 Some states require insurers to submit proposed rate increases for formal review prior to implementing premium changes; the rest review premiums after they have been filed, requiring changes or imposing penalties retroactively if necessary. The majority of states require prior approval of rate increases for Medigap policies. NAIC data from a survey of states indicates that 15 states use a file and use procedure (not requiring prior approval) for Medigap as well as other individual insurance products; some of these, however, employ a rigorous postfiling review process. Conversely, some states that require prior approval employ less rigorous or pro forma reviews, making it difficult to categorize state oversight procedures in an accurate way (Kirk and Chollet 2002).

12 Medicare Select policies are Medigap policies that cover more of the cost sharing when beneficiaries use network providers; they are a form of PPO, but, until recently, were allowed to contract with networks only for hospital services (MedPAC 2003).

Some states, however, have expanded guaranteed-issue requirements for some or all Medigap policies. Connecticut, for example, required carriers to offer Plans A through G on a guaranteed-issue basis to all Medicare enrollees at all times throughout the year; Michigan extends guaranteed issue to Medicare enrollees who have lost group coverage; and Maryland requires continuous open enrollment for Plans C and I (NAIC 2000).

The NAIC Model places some limits on rating practices, but states can go beyond these. Medigap insurers may, unless prevented by state law, price policies on an issue- or attained-age basis,[13] and they may underwrite policies, that is, charge higher premiums based on beneficiary health status or health history. A minority of states restrict Medicare age-rating practices. Other states have enacted community rating provisions that prohibit any rating or medical underwriting on Medigap, and some states have enacted legislation requiring guaranteed issue to beneficiaries under age 65 (disabled), who are not covered under federal open enrollment provisions.

States have also enacted laws to address problems caused by the withdrawal of M+C plans since 1998. Some states expanded on the protections for beneficiaries moving from M+C plans back to FFS that were introduced in the Balanced Budget Act of 1997, and other states implemented broader provisions designed to increase access to Medigap. For example, in Colorado, a beneficiary now does not have to wait until an M+C plan terminates to qualify for guaranteed-issue protections. Maine requires that if an eligible beneficiary disenrolled from M+C seeks to return to a Medigap policy no longer being sold in the state, the carrier must reinstate the plan. States have also enacted changes to Medigap requirements to provide additional guaranteed issue or open enrollment provisions (above federal standards) for retirees who lose retiree supplemental coverage, or experience significant reductions in benefits (NAIC 2000). In 2004, California will require a special one-time open enrollment period for disabled beneficiaries under age 65 for policies A, B, C, F, H, I, or J, during which insurers cannot charge different rates than offered to those age 65 or older.

Innovative benefits Introducing new or restructured benefits is of particular interest for Medigap. The OBRA–90 reforms established standardized plans so that beneficiaries could navigate the supplemental market safely. Over time, as the population and medical technology have changed, a tension has emerged between the commitment to the OBRA–90 principles and a perception that, granted more flexibility, the insurance market could adapt products to meet the changing needs of the beneficiary population.

CMS has used its statutory authority to help clarify federal laws' intent to expand innovative benefits offered by Medigap. These innovative benefits can include benefits not otherwise available or that are cost effective, as long as they do not compromise the goal of standardization (that is, simplification designed to promote comparability across plans). The statute also specifically states that Medigap insurers may incorporate vendor discounts for products or services not covered by Medicare along with standardized benefit packages. This could be important, for example, for designing a prescription drug benefit that uses the services of a pharmacy benefits management company.

While some insurers have pursued this option, it is does not appear to be common across states. NAIC's state surveys show only a handful of filings submitted to states for innovative benefits.[14] Filings approved include:

- a vision care benefit approved for a subset of policy types by one Medigap insurer;
- a case management benefit approved for policies offered by one insurer; and
- several prescription drug benefit provisions under Plan F, including an unlimited generic drug benefit (under the high-deductible plan option); a drug benefit with a formulary (also high deductible); and a prescription drug benefit under a standard policy.

States have not approved other filings for innovative benefits, including increased deductibles, mental health, smoking cessation and weight management benefits, and several other filings for prescription drug benefits. Some filings for a prescription drug benefit turned down by state insurance commissioners appear identical to those approved in other states (NAIC 2000, 2003). One state reported to NAIC that to maintain the integrity of the standardized plans, the innovative benefit should be made available as a rider rather than as a part of the standard package.

While few states have received requests from insurers to market packages with innovative benefits, CMS believes that this provision could become a significant tool for expanding choice in the Medicare insurance market. More specifically, CMS believes that the HHS Office of Inspector General's recent statements describing arrangements permissible for insurers under safe harbor provisions of antikickback rules allow Medicare Select policies to incorporate benefits such as prescription drug coverage, case management services, nurse advice lines, or the use of management techniques, including drug formularies.

Medicare Select CMS believes that Medigap can accommodate other

13 Under issue-age rating, enrollees pay premiums based on their age when their policy was first issued to them; under attained-age rating, enrollees pay premiums based on their current age.

14 NAIC had not completed its most recent survey at the time this report was being finalized; information on some innovative benefit plans may not be captured in the data NAIC made available to us.

managed care features involving provider networks under Medicare Select policies (Scully 2002).[15] Individual state insurance law and regulation could impede the expansion of benefits under Medicare Select. Some states do not allow indemnity insurers to offer closed panel benefits, and any willing provider laws could deter provider networks for Medicare Select. State laws regulating hospitals could also make Select contracting more difficult.[16] In 2000, four states (including one waiver state) reported to NAIC that they did not permit the sale of Select policies. Two of these states now allow these sales, although one has not yet enacted the regulations needed before insurers can market the plans (Smolka 2003). In some states, insurers' low level of interest in Select plans may be the problem—if insurers do not ask to market the plans, states have little reason to allow them to do so.

Employer-sponsored supplemental plans

The Employee Retirement Income Security Act of 1974 (ERISA) generally covers self-insured plans, including employer-managed and Taft-Hartley plans. ERISA's standards for employer-sponsored health plans usually preempt state law or regulations.[17] ERISA governs all self-insured plans, and most employer-sponsored plans providing supplemental coverage are self-insured. When employers are not self-insured, states regulate coverage or benefits issues pertaining to employer-sponsored insurance that are not specifically preempted by ERISA.[18]

M+C plans and other organizations of providers

Federal oversight of health care markets involves broad legal issues related to business and trade. The Department of Justice and the Federal Trade Commission (FTC) are examining an increasingly difficult set of legal and regulatory questions surrounding contracting; delegation of financial risk; the effect of mergers, monopsony purchasing power, antitrust violations, and price collusion; and complex consumer information and consumer protection issues (Hellinger 1998, Muris 2002, Noble and Brennan 1999, Pauly 1998). In one recent case, the FTC found that collective negotiation of fees by a physician group was reasonable for fostering clinical integration of care and led to more effective, higher-quality care. In another case, the FTC found that physician collaboration resulting in a substantial degree of market concentration was acceptable because the collaboration substantially improved the quality of care. In another case, however, the FTC found that a group of 1,200 physicians had colluded, leading to increased costs to consumers (Muris 2002).

States also regulate managed care plans. Some states, for example, have been more aggressive than others in responding to perceived problems in the managed care marketplace. "Any willing provider" laws, for example, prevent plans from excluding providers from their networks. Other state regulations mandate access to specialists and require plans to give providers access to information about standards for acceptance into a network, reasons for termination, and economic profiles of physician practice patterns developed by plans (Cornell 2000, Noble and Brennan 1999). Limiting provider organizations' ability to select the participants in their networks, for example, could increase beneficiaries' access to providers, but limit the networks' ability to control costs. Such policies could, therefore, affect organizations' decisions about where to locate and ultimately deter national participation in Medicare.

A state's policies not only influence managed care, but also reflect its local evolution. Depending on how state laws define risk-bearing entities, for example, organizations such as PPOs or provider sponsored organizations (PSOs)[19] may or may not be licensed in the same way as HMOs, and may or may not be subject to the same state oversight of quality of care or consumer protection. The responsibility for oversight of managed care organizations may reside with the insurance department, health department, or some specialized unit, or may be shared among several state agencies. Some states recognize PPOs as separate risk-bearing entities that must be licensed by the department of insurance; others do not. Some states treat PSOs like PPOs, but apply different solvency requirements; having to meet these requirements could discourage providers from incorporating in groups. In other states, PPOs and PSOs may not be structured as risk-bearing entities, but as contractors or subcontractors that affiliate themselves with licensed health plans or insurers. The administrative burdens associated with state regulation, the need to meet solvency standards, and other requirements could deter provider organizations from forming in some states.

15 The March 2003 MedPAC Report to the Congress notes that Medicare beneficiaries currently hold about 1 million Select policies. Many are concentrated in a small number of states.

16 The Maryland hospital payment system, for example, prevents hospitals from discounting charges.

17 Legal experts do not always agree on the interpretation of some aspects of ERISA preemption provisions, including the regulation of nontraditional insurers such as provider sponsored organizations that accept risk (Butler 2000).

18 Generally, states can regulate multiple employer welfare arrangements (when two or more employers jointly sponsor health coverage) for salaried or nonunion employees and regulate hospital rates charged to insurers and others who pay health care bills (Butler 2000).

19 A PSO is a plan offered by a private provider sponsored organization that is not organized as a PPO, but can be licensed by states. Or, until November 2002, upon meeting federal requirements, it could obtain a waiver from CMS allowing it participate in the M+C program until it obtained a license from the state in which it operates.

Under current law, states license and regulate the risk-bearing entities that participate in M+C, while CMS ensures that participating organizations meet national Medicare standards set out in statute, regulation, and agency operational policy. Federal law requires that all M+C organizations (except federally waived physician-sponsored organizations) be licensed under state law as risk-bearing entities eligible to offer health insurance coverage in the states where they offer M+C benefits. An organization already licensed to offer indemnity insurance may have to obtain an HMO license to participate in M+C, and an HMO may need to obtain an additional license to provide a point-of-service option (paid on an indemnity basis).

Federal law specifically preempts state law governing M+C plans on most aspects of benefits and coverage determinations (including appeals and grievances). States may not require an organization to offer a particular state-mandated benefit to Medicare enrollees under an M+C contract.[20] However, except for these areas of preemption (see text box at right), M+C organizations must comply with all state laws and regulations applicable to insurers or health plans, unless these laws are incompatible with federal law and standards (CMS 2002a). And, to the extent that health plans and provider organizations do not exclusively serve Medicare patients, state regulations may affect business decisions to enter markets in a given state.

Federal preemption of state requirements for licensed Medicare+Choice organizations

Since Medicare+Choice (M+C) organizations must first be state licensed or certified, the states play a key role in the M+C program. However, not all state laws governing health plans and insurers apply to the M+C products of a health plan or insurer.

Specifically preempted

State standards on:

- Direct access to provider requirements, whether in-plan or out-of-plan
- Benefit mandates, other than cost sharing
- Appeals and grievances with respect to coverage determinations
- Inclusion of providers (such as "any willing provider" laws; requirement of inclusion of specific types of providers as network providers)

Subject to general preemption only in case of a conflict between federal and state standards

- Market conduct examinations
- Timely payment of claims standards
- Enforcement actions
- Unfair claim settlement standards governing the process for determination of benefits as opposed to the benefits themselves
- Investigation of consumer complaints
- Filing and review of advertising and marketing materials
- Utilization review programs and standards
- Quality assurance programs
- Adequacy of provider network
- Filing and review of policy forms and rate filings
- Credentialing procedures (other than those affected by specific preemption on provider participation)
- Agent licensing
- Filing and review of provider contracts
- Enforcement of loss-ratio standards
- Standards and enforcement of commission limitations ■

Source: Reprinted from: CMS, 2002a.

Policy directions

Employers, beneficiaries, health plans, and insurers providing supplemental insurance to Medicare beneficiaries function in a heavily regulated environment. The various regulators, however, may have differing perspectives. Federal regulators are concerned both about competition and how to regulate the organizations contracting with the Medicare program in particular. Self-insured employers and employers contracting as groups with M+C plans are largely exempt from state regulation, but are important players in local markets. Any significant change to the existing mix of supplemental insurance products will have to address the role of the employer-sponsored market and the rules of play among competing insurers and health plans.

The broader issues surrounding states' regulatory responsibilities in health care and insurance, and federal preemption of those responsibilities, are complex. These regulatory interactions would need to be weighed as part of any broad market-based Medicare reforms. The NAIC Model for Medigap establishes a

20 This provision does not apply to non-Medicare lines of business offered to Medicare beneficiaries, including employer- or union-sponsored health benefit programs for retirees.

comprehensive set of requirements and consumer protections for insurance products that, in the view of most analysts, substantially alleviates problems that undermined the individual market for supplemental insurance. Whether the regulations and standardized benefit packages set out in the model enable insurers to adapt benefits to meet current market needs, however, is a topic of debate. So, too, is the issue of whether individual states should have a significant role in developing active insurance markets that meet beneficiary needs, in terms of affordable products, adequate consumer information, and protection from fraud and abuse.

In the next section, we examine variations among Medicare markets, focusing on both demographic and regulatory factors affecting beneficiaries' access to and choices of supplemental products.

Overview of Medicare insurance markets in states and metropolitan areas

This section shows the diversity of Medicare insurance markets across the country, illustrates some coverage patterns, suggests some hypotheses that might help explain some of the patterns, and begins identifying interesting local markets for us to investigate in greater depth. Because the relationships between coverage, state and federal regulatory policies, market characteristics, and beneficiary characteristics are so complicated and intertwined, and because the data are so limiting, we do not attempt to reach conclusions about how federal policy choices could, or should, structure insurance markets for Medicare beneficiaries.

Most of the data used in this section come from the March Supplement of the 2002 Current Population Survey (CPS), which measures coverage during 2001. The survey contains insurance coverage data for over 23,000 noninstitutionalized Medicare beneficiaries, with a minimum of about 200 beneficiaries from every state. We have used the CPS data for three reasons: It is the only national survey that can provide state-level population estimates (as well as estimates for larger metropolitan statistical areas); the 2001 data reported in the Supplement are more recent than data available from other major national surveys, including the Medicare Current Beneficiary Survey (MCBS); and the national results are consistent with other national survey results. We note, however, that relatively small sample sizes in some less-populous states may lead to imprecise estimates for those states, so that they may not support sophisticated multivariate analysis. Nonetheless, the data are sufficient to illustrate levels of variation and to begin to identify possible patterns of coverage for further investigation.

State patterns

Although most states contain several distinct insurance markets, some important features of markets are determined at the state level, such as Medicaid policy and insurance regulation. Our analysis shows great variation among states in the insurance choices made by beneficiaries.

In the series of tables that follow, states are grouped if they are especially high or especially low in the prevalence of a given type of insurance. In establishing these groups, we ranked all states along the prevalence measures and looked for natural breaks at the high and low ends of the distributions; we did not aim for any particular number in a group. The tables report the values for the groups as well as the national average for the relevant insurance type. Because imprecision can occur at the state level, we do not rank the states within the groups; rather, they are listed alphabetically.

Overall, the CPS data show that almost a third (32 percent) of Medicare beneficiaries are covered by employer-sponsored private supplemental health insurance. The percentage ranges among states from a low of 16 percent to a high of 47 percent. Table 2-2 shows those states with the highest and lowest percentages of Medicare beneficiaries with employer-sponsored coverage. The average rate for the four lowest states is 19 percent, and 46 percent for the four highest states.

The CPS data show that nationally, 14 percent of Medicare beneficiaries also receive Medicaid benefits. At a state level, Medicaid covered between 5 and 28 percent of Medicare beneficiaries. Table 2-3 (p. 32) shows the states with the highest and lowest proportion of Medicare beneficiaries who also receive benefits through Medicaid. The highest group of states has an average of 22 percent of beneficiaries receiving Medicaid benefits, while the lowest group averages 7 percent.

The CPS data show that 28 percent of Medicare beneficiaries across the country have Medigap supplemental coverage, a figure corroborated by data from the NAIC. At the state level, however, the two data sources sometimes show large differences. Both sources show large variation at the state level, with coverage percentages ranging from the single digits to over 60 percent. Table 2-4 (p. 32) shows states with relatively high and low percentages of beneficiaries covered by

TABLE 2-2

Medicare beneficiaries with employer-sponsored coverage, by state

Highest percentage	Lowest percentage
Delaware	Arkansas
Hawaii	North Dakota
Michigan	South Dakota
Ohio	Wyoming

Note: National average 32 percent; range for highest group 43 to 47 percent; range for lowest group 16 to 20 percent.

Source: MedPAC analysis of 2001 data from the March 2002 Supplement of the Current Population Survey.

TABLE 2-3

Medicare beneficiaries with Medicaid coverage, by state

Highest percentage	Lowest percentage
Alaska	Arizona
California	Indiana
Kentucky	Minnesota
Mississippi	Nebraska
South Carolina	New Hampshire
Tennessee	
Vermont	

Note: National average 14 percent; range for highest group 20 to 28 percent; range for lowest group 5 to 7 percent.

Source: MedPAC analysis of 2001 data from the March 2002 Supplement of the Current Population Survey.

TABLE 2-4

Medicare beneficiaries with Medigap coverage, by state

Highest percentage	Lowest percentage
Iowa	Alaska
Kansas	California
Montana	District of Columbia
Nebraska	Georgia
North Dakota	Hawaii
South Dakota	Nevada
	New Mexico*
	New York
	Vermont*
	West Virginia

Note: National average 28 percent; range on highest group 44 to 60 percent; range on lowest group 9 to 19 percent.
*State Current Population Survey estimate differs substantially from National Association of Insurance Commissioners reports.

Source: MedPAC analysis of 2001 data from the March 2002 Supplement of the Current Population Survey.

TABLE 2-5

Percent of Medigap policies that include a prescription drug benefit (H, I, or J), by state

Highest percentage	Lowest percentage
Alaska	Alabama
District of Columbia	Idaho
North Carolina	Kansas
Utah	Louisiana
Virginia	Michigan
Washington	North Dakota
	Rhode Island
	South Carolina
	South Dakota

Note: National average 8 percent; range on highest group 18 to 27 percent; range on lowest group 1 to 3 percent.

Source: MedPAC analysis of 2001 MedSup data from the National Association of Insurance Commissioners.

Medigap plans. The table uses CPS data; asterisks mark those states for which the NAIC data differ considerably.[21] Overall, 52 percent of Medicare beneficiaries in the highest group have Medigap coverage while the lowest group averages 18 percent.

Medigap policies that include a prescription drug benefit (forms H, I, and J) constitute about 8 percent of all Medigap policies sold across the country. NAIC data show (Table 2-5), however, that there is considerable state variation in the percentage of policies including a drug benefit, with policies H, I, and J accounting for as much as 27 percent of all standard Medigap policies (in Alaska) and less than 1 percent in several states.

Many beneficiaries may also choose a Medicare managed care plan that offers supplemental benefits. Because CPS did not ask beneficiaries whether they were enrolled in a Medicare managed care plan, we used CMS administrative data to determine the percentage of each state's beneficiaries enrolled in managed care plans. To be consistent with the CPS data we examine 2001 data: 15 percent of Medicare beneficiaries were enrolled in either M+C plans or Medicare cost-based HMOs. Medicare managed care penetration ranged from 0 to over 40 percent among states. The nine states listed on Table 2-6 as the low group had less than 1 percent of their Medicare beneficiaries enrolled in Medicare managed care plans. Some of those states did not have an M+C plan offered to their residents in 2001. The states in the high group all had at least 25 percent of their beneficiaries enrolled in Medicare managed care plans, and averaged 31 percent enrollment.

After incorporating all currently available data, we applied several methods using different data from the available sources to identify which states have a disproportionately high share of beneficiaries with no coverage other than traditional Medicare. We found Arkansas, the District of Columbia, Georgia, Maine, North Carolina, West Virginia, and possibly Vermont (depending on which source is correct for Medigap coverage) to

TABLE 2-6

Medicare beneficiaries in Medicare managed care plans, by state

Highest percentage	Lowest percentage
Arizona	Alaska
California	Maine
Colorado	Mississippi
Massachusetts	Montana
Oregon	New Hampshire
Pennsylvania	South Carolina
Rhode Island	Utah
	Vermont
	Wyoming

Source: Monthly summary report on Medicare managed care plans, CMS, July 2001.

21 NAIC data include information on policies, not individuals' coverage; people with multiple Medigap policies are counted in the data multiple times. The NAIC analytical file is compiled from the information that insurers provide to states. Errors and omissions in reporting can and do occur. MedPAC staff are obtaining additional information to help explain anomalies in the data.

be the most likely to have the highest percentages of beneficiaries without any supplemental coverage. In these states, about twice the national average of Medicare beneficiaries are in FFS Medicare and have no supplemental coverage. We intend to investigate these states further.

Urban and rural patterns

While state differences are clearly apparent, many states include multiple markets. One way to look at markets below the state level is to divide state markets into urban and rural areas. All of our data, except for the NAIC Medigap data, can be split into urban and rural components. Unfortunately, the CPS sample sizes are not large enough to evaluate urban and rural differences for many states. Therefore, we reexamine the above state findings by grouping the states in order to get adequate sample sizes.

Table 2-7 shows that urban-dwelling beneficiaries are more likely to have employer-sponsored supplemental coverage, and be enrolled in Medicare managed care plans, but less likely to purchase Medigap than their rural counterparts. From these data, we estimate that beneficiaries living in rural areas are more likely to be in the traditional Medicare FFS program without any supplemental coverage.

But do the national-level differences between urban and rural insurance patterns hold at the state level? If insurance markets are influenced by state characteristics, both urban and rural markets within a state should be affected by state policies. To test this hypothesis we examined states that were high or low in market penetration by the previously mentioned insurance types to see if they were high or low in both their urban and rural areas. To get adequate sample sizes for this analysis we grouped together states particularly high or low for the share of a given product. For example, we grouped those states listed as high on Table 2-2 (p. 31) for employer-sponsored supplemental coverage. We found that, in general, if a state's beneficiaries were more likely to hold a particular type of insurance than the national average, that propensity held in both urban and rural areas. For each of the four insurance types (Medicaid, employer sponsored, Medigap, and managed care), the penetration rate for the high groups are at least twice as high as the low groups, for both urban and rural areas. These findings strongly suggest that state market characteristics transcend urban and rural market differences.

Metropolitan area patterns

Another way to look at some substate markets is to examine insurance coverage at the metropolitan area level. Table 2-8 (p. 34) shows insurance coverage for the 12 metropolitan areas with the largest sample size in the CPS. Coverage patterns vary. Medicare managed care shows the greatest range. Medigap enrollment rates usually do not get above the national average and stay well below some of the higher rates found in rural states.

Even though state characteristics have an important influence over health insurance markets, local factors may also be important. The one example of two metropolitan areas within a state, Tampa and Miami, shows very different types of coverage. In this case, an explanation lies partly in the fact that 21 percent of Miami's senior population is living under the poverty level; Tampa's rate is 11 percent.

Trade-offs and hypotheses

Comparing the markets for Medicare insurance products and health plans is difficult. The market areas for specific products are not the same from product to product. Many demographic and structural characteristics are interconnected, and the intricacies of state policies and regulation are often difficult to measure accurately. It is possible, however, to identify some potentially important relationships among the factors shaping Medicare insurance markets, and patterns that warrant closer examination.

While overall supplemental coverage varies by state, simple bivariate regressions suggest some substitution between products. First, there appears to be substitution between employer-sponsored coverage and Medigap coverage. Second, we found some evidence of state-level substitution between Medicaid and Medigap coverage. We did not, however, find a significant trade-off between Medigap and Medicare managed care at the state level. We are aware of research that has found relationships between Medigap and M+C below the state level that warrant further investigation (McLaughlin et al. 2002).

Increased overall Medigap prevalence is associated with decreased prevalence of Medigap with drug coverage. We have not yet found any statistical evidence that rating policies affect that relationship. Perhaps, because high Medigap states tend to be rural, and rural beneficiaries tend to have lower income, beneficiaries in high Medigap states cannot easily afford to buy the plans that offer drug coverage. We plan to examine this issue further.

TABLE 2-7 **Medicare beneficiaries' supplementation, by urban and rural areas**

Areas	Medicaid	Employer	Medigap	Managed care
Total	14%	32%	28%	15%
Urban	14	33	25	19
Rural	14	29	33	2

Source: MedPAC analysis of Current Population Survey, 2001 and Medicare Compare data from CMS.

TABLE 2-8

Medicare beneficiaries' supplementation, selected metropolitan areas

Metro area	Medicaid	Employer	Medigap	Managed care
New York	26%	26%	11%	19%
Los Angeles	31	29	11	35
Chicago	10	31	28	12
Washington	8	45	23	4
Providence	15	22	34	33
Philadelphia	14	31	33	34
Honolulu	14	44	21	33
Detroit	7	47	19	9
Las Vegas	12	32	17	31
Miami	26	10	5	45
Tampa	8	36	21	30
Boston	13	33	23	21

Note: Areas are listed in order of Medicare sample size in the Current Population Survey. Each beneficiary may have more than one type of coverage.

Source: MedPAC analysis of Current Population Survey, 2001, and Medicare Compare data from CMS.

The level of union membership may help explain the prevalence of employer-based supplemental coverage. Three of the four states that rank high on employer supplemental coverage (Hawaii,[22] Michigan, and Ohio) have substantially higher than average shares of union representation, while the four states in the low group all have lower than average representation. Another hypothesis is that states with a high percentage of workers in large firms also have a high percentage of Medicare beneficiaries with employer-sponsored supplemental coverage. We found that only one of our four high-percentage states (Delaware) had a noticeably high number of its workers employed by large firms; however, it was the state whose high percentage of employer coverage was not explained by unionization.

The income level of the beneficiaries in a state seems to influence the markets. All six of the states in the high Medigap group have lower than average poverty ratios for seniors.[23] Meanwhile, most of the states in the low Medigap group have higher than average percentages of seniors in poverty. The percentage of seniors in poverty is also related to the percentage of beneficiaries receiving Medicaid benefits, although the relationship may not be as strong as one might expect from a means-tested program like Medicaid, because states have discretion in determining Medicaid eligibility.

We also examined some state regulatory policies in relation to the age group data. Supplemental insurance coverage varies by age. We looked at three age groups: under 65 (the disabled), 65 to 76, and over 76,[24] and found that those under 65 are much more likely to receive benefits from Medicaid (Table 2-9). Those in the 65-to-76 age group are the most likely to be covered by employer-sponsored supplemental insurance, while those over 76 are the most likely to have Medigap coverage. The disabled are the most likely not to have any FFS supplemental coverage.[25] Those in the 65-to-76 age group are the most likely to have some coverage.

Table 2-10 lists state mandates affecting Medigap issue and rating. First we grouped the 14 states that mandated, prior to 1998, guaranteed issue for Medigap policies for the under-65 population. We find that overall, these states had slightly higher Medigap participation rates among the disabled, but the significant difference in participation rates between the aged and the disabled remains. When looking at the state level, we find that some of the guaranteed-issue states had high rates of participation among the disabled, and others did not. However, of the seven states that have disabled Medigap participation rates of at least 15 percent, five had mandates prior to 1998, and another one recently enacted a mandate. (The state that reached 15 percent without a mandate has very high overall Medigap participation and still has a large difference in participation between the elderly and disabled.) The conclusion we draw is that mandated guaranteed issue for the disabled is not sufficient to ensure higher participation, but it may facilitate access to Medigap (White et al. 1998).

22 Hawaii also has an employer mandate for health insurance coverage for active workers that could affect retiree benefits as well.

23 The poverty threshold is determined nationally and does not vary by state. It does not reflect the cost of living in particular states.

24 At the time the CPS data were collected, those beneficiaries over age 76 were old enough to have purchased prestandard policies.

25 We did not have managed care data by age group available for this analysis.

TABLE 2-9

Medicare beneficiaries' supplementation, by age and state Medigap mandates

Age	Medicaid	Employer	Medigap	Any FFS supplement
United States total				
<65	37%	22%	8%	63%
65–76	10	38	29	73
>76	10	27	34	68
States with under 65 mandates prior to 1998				
<65	40	21	9	65
65–76	9	38	31	74
>76	10	28	35	69
States with community rating				
<65	39	23	10	64
65–76	11	39	25	72
>76	12	29	31	68

Note: FFS (fee-for-service).

Source: MedPAC analysis of Current Population Survey, 2001.

Community rating requires younger beneficiaries to pay more, given their average spending, than older beneficiaries. To test the hypothesis that community rating would increase Medigap participation for those over 76 and decrease it for those in the younger-aged group, we also examined states that required community rating for Medigap. We do not find any relationship for the eight states that required community rating, although as a group, the overall Medigap participation is slightly lower in those states than in the nation as a whole.

TABLE 2-10

State Medigap mandates

States requiring community rating

Arkansas	Minnesota
Connecticut	New York
Maine	Vermont
Massachusetts	Washington

States prohibiting age rating

Florida (entry age)
Georgia (entry age and attained age)
Idaho (entry age and attained age)
Missouri (entry age and attained age)

States mandating coverage of Medicare beneficiaries under age 65

Mandates implemented prior to 1998

Connecticut	New York
Kansas	Oklahoma
Maine	Oregon
Massachusetts	Pennsylvania
Minnesota	Texas
New Hampshire	Washington
New Jersey	Wisconsin

Mandates implemented 1998 and after

California
Louisiana
Maryland
Missouri
Mississippi
North Carolina
South Dakota

Source: American Academy of Actuaries, 2003.

Conclusions and key policy questions for future work

In our June 2002 Report to the Congress we concluded that, on an individual level, beneficiaries who were disabled, poor, living in rural areas, and in poor health were more likely to be covered only by Medicare FFS. Additional analysis shows that in particular areas of the country—states and metropolitan areas—a substantial portion of the Medicare population has no supplemental coverage. Our findings here also show that local market factors and regulatory policies make a difference.

Differences in the structure of supplemental coverage affect beneficiaries' access to coverage and their ability to make meaningful choices among insurance options. We also found evidence that distinct markets are shaped by substantively different regulatory policies. The way that regulatory oversight of Medicare products is divided among federal government and the states will continue to shape and perhaps frustrate the evolution of Medigap, employer-sponsored, and M+C options (as well as supplementation available through Medicaid), and will be critical in the design of any future market-based reforms. In particular, the interplay between standardization and flexibility in the design of benefits is important for beneficiaries, employers sponsoring retiree health benefits, and health plans and insurers in deciding how, or whether, to participate in Medicare markets.

It is difficult, if not impossible, however, to sort out the multiple, interconnected factors that shape specific markets from available data. More in-depth analysis is needed to tease out how these pieces fit together, and whether there are particular policies related to the design of supplemental products, or regulatory policies that would promote efficient markets that meet beneficiaries' needs. To

really understand what is happening within these markets, we plan to undertake case studies to examine a set of specific markets in greater depth.

These specific markets will include one or more markets characterized by a high concentration of employer-sponsored supplemental insurance, Medigap insurance, Medigap policies including drug coverage, and M+C enrollment, and markets with low levels of one or more of the other forms of supplementation, including a market with a low level of any supplementation. We will analyze markets in a state with a waiver from federal Medigap requirements, and markets that differ with respect to state requirements regarding guaranteed issue and community rating of Medigap products.

We will examine:

- whether, from the perspective of consumer advocates and beneficiaries, public program administrators, or insurers, there are problems (availability, cost, consumer confusion) with products (private or public) that supplement traditional Medicare coverage, and how this may vary across different groups of beneficiaries (disabled, low-income, oldest);
- how the economic and demographic structure of the market is viewed by Medigap insurers, health plans and risk-bearing provider groups, large public and private employers offering supplemental retiree health insurance, and state Medicaid administrators; and
- how the state regulatory environment is perceived by Medigap insurers, health plans, and risk-bearing provider groups and whether there are policy reforms they believe would affect their decisions about marketing to Medicare beneficiaries in the future. ■

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