

Medicare cost-sharing and
supplemental insurance

May 1, 2003

Statement of
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Chairman
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
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Chairman Johnson, Congressman Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss cost-sharing in the Medicare program and supplemental insurance.

Thank you for the opportunity to participate in this important discussion. MedPAC has considered the design of Medicare's benefit package and beneficiary cost-sharing over the past several years. We also have examined the different ways that beneficiaries supplement Medicare benefits, including Medigap; how various forms of supplementation affect access to care; and the costs of the health care services beneficiaries use. In my remarks today, I would like to draw on that work, and highlight several key points:

- The limitations of the Medicare benefit package and the characteristics of its cost sharing cause beneficiaries to enroll in a variety of supplemental insurance programs. These include employer-sponsored retiree insurance, Medigap, and Medicaid.
- Beneficiaries' access to different forms of supplemental coverage vary by their characteristics (such as where they worked, their financial resources, and their health care preferences) and where they live.
- Supplemental coverage improves beneficiaries' access to care, their use of necessary services and reduces their cost sharing on covered services. It also increases Medicare spending and total administrative costs.
- Medigap in particular may still leave beneficiaries with a significant degree of liability and its premium represents a major proportion of beneficiary out-of-pocket expense.

Limitations of the benefit package

As we discussed in our June 2002 Report to the Congress: Assessing Medicare Benefits, Medicare has provided tens of millions of older and disabled Americans with access to acute medical care—extending lives, improving health and functional status, and protecting families from impoverishment (MedPAC 2002). Changes in medical technology, as well as demographic changes, however, have drawn attention to the limitations of the basic Medicare benefit package.

By law, the Medicare benefit package is generally limited to acute care services needed for the

diagnosis or treatment of illness or injury.¹ Medicare's covered services have been revised over its lifetime. These revisions have substantially expanded coverage, adding new technologies and procedures, more post-acute care, and other benefits such as selected preventive services and hospice care for those at the end of life. However, the basic structure of the benefit design has remained essentially unchanged since Medicare's inception.

Medicare beneficiaries may receive covered services in the traditional program or they may enroll in a private health insurance plan under the Medicare+Choice (M+C) program. Traditional Medicare covers health care services—furnished on a fee-for-service basis—through its two parts, the Hospital Insurance and Supplementary Medical Insurance programs, known as Parts A and B, respectively. My discussion today will focus on the benefit design and cost-sharing structure of the traditional program.

There are three serious limitations of the Medicare benefit package:

- It does not cover some important health care products and services. For example, the program does not cover outpatient prescription drugs (with limited exceptions), many preventive services (such as annual physical exams), and routine eye and dental care.
- It has high cost sharing on some covered services such as outpatient care and none on others.
- It has no limit on total cost sharing (catastrophic cap).

Cost sharing structure Medicare's cost-sharing structure has several weaknesses (see Table 1). Insurance theory suggests that random, non-discretionary events should be covered more fully than events that are within the insured person's discretion. In Medicare, however, the Part A hospital inpatient deductible is large (\$840 in 2003), while that for physician services or other ambulatory care under Part B is small (\$100) even though inpatient care is generally believed to be less discretionary and more difficult to predict than ambulatory care. Further, the low Part B deductible provides little incentive to use covered services judiciously, while the high hospital inpatient deductible may contribute to beneficiaries' perceived need for supplemental insurance.²

Medicare's cost-sharing provisions vary considerably among covered services and these variations may lead to inefficient choices by beneficiaries and providers. For instance, the coinsurance liability for hospital outpatient services (20-55 percent) is often substantially higher than the coinsurance that applies for ambulatory surgery centers or physicians' offices (20 percent). These discrepancies could inappropriately affect patients' or providers' decisions about the setting for care. The high (50 percent) copayment for outpatient mental health services and high coinsurance for many outpatient hospital services may create barriers to the use of these services. On the other hand, no cost sharing on home health and lab services may increase use of

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

² At \$100, the Part B deductible is unchanged since it was raised in 1991 and only about one-half as high as ambulatory care deductibles commonly required by PPOs for services furnished by favored (in-network) providers (Gold 2002).

those services, either because beneficiaries are more likely to demand them or providers are more likely to order them.

Limited financial protection Medicare's benefit design and cost-sharing structure taken together determine how well beneficiaries are protected from the cost of acute illness. Medicare seeks to ensure access to clinically appropriate care and to insulate beneficiaries and their families from the risk of impoverishment associated with serious illness.

Medicare provides considerable financial protection to its enrollees; most would be much worse off without its benefits. On average, beneficiaries consumed \$7,500 in health care services in 1999, of which Medicare covered 58 percent (Table 2). Moreover, Medicare covered a substantially larger share of the total for beneficiaries with the highest spending (Figure 1). For instance, on average, Medicare covered about 73 percent of the total for the 10 percent of beneficiaries with the highest total spending.

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

Supplemental coverage options

About 90 percent of Medicare beneficiaries obtain some type of additional coverage. Supplements have been available from Medicare's beginning in 1966, when it looked quite similar to the private sector insurance packages offered to the general population. Beneficiaries may obtain supplemental coverage for a variety of reasons. Many—particularly those with relatively low incomes—may prefer the known cost of a premium to the unknown costs that may be associated with an unexpected illness, and even to the predictable costs of routine medical services. Also, large employers in certain industries historically have provided retiree coverage that provides supplemental insurance at low cost to some beneficiaries. Moreover, as noncovered services, such as prescription drugs, have accounted for a growing share of beneficiaries' health care, obtaining additional coverage has become more important as one means of limiting financial risk.

Sources of additional coverage include supplements sponsored by former or current employers, individually purchased Medigap plans, and Medicaid coverage provided for low-income individuals. Also, for purposes of this discussion, additional benefits offered by some M+C or other Medicare managed care plans are also considered.

About one-third of all Medicare beneficiaries have **employer-sponsored** supplemental insurance

(Figure 2).³ Currently, benefits provided by employer-sponsored plans tend to be comprehensive. For example, almost all retiree plans provide some coverage of prescription drugs, and the average retiree has an out-of-pocket cap of \$1,500 per year for all covered services.

Medigap—private health insurance specifically designed to wrap around Medicare’s benefit design—is the second most common form of additional coverage. Twenty-seven percent of beneficiaries held Medigap policies in 2000. All policies issued since 1992, except those sold in three waiver states, have been limited to 10 standard benefit packages. The plans beneficiaries most commonly choose cover Medicare deductibles and coinsurance, but not prescription drugs.

State **Medicaid** programs provide additional coverage for certain low-income, sick, and disabled Medicare beneficiaries—about 12 percent of community-dwelling beneficiaries in 2000. People with full dual eligibility receive Medicare benefits, coverage of Medicare cost-sharing, and full Medicaid benefits, including some health care products and services—notably prescription drugs and long-term care—not covered by Medicare. Other Medicaid programs pay for Medicare premiums and/or cost sharing, but not for Medicare’s noncovered benefits.

Medicare managed care plans may offer reduced cost sharing requirements or other benefits beyond those covered in the traditional program, such as some coverage for outpatient prescription drugs. Medicare’s managed care options consist primarily of private managed care plans that participate in the M+C program, but also include plans paid on a cost basis, and those participating in various demonstration projects. About 18 percent of Medicare beneficiaries were enrolled in some form of Medicare managed care in 2000—although this share has declined to about 15 percent in 2002. Using enrollment data from M+C managed care plans as a proportion of all beneficiaries (not just community-dwelling as in Figure 2) enrollment peaked in 2000 at 15.8 percent.

Other sources of additional coverage, held by about 2 percent of beneficiaries, include benefits obtained through the Department of Veterans Affairs (VA) or the TRICARE program for military retirees.

Availability of options vary

The options for supplementing Medicare actually available to beneficiaries vary considerably because of significant differences in local market circumstances, as well as differences in beneficiaries’ resources and preferences. MedPAC has investigated the factors accounting for relatively low rates of supplementation in some states. We find some states have about twice the national average of Medicare beneficiaries who lack any supplemental coverage, and this was generally true in both urban and rural areas in the state. Beneficiaries living in rural areas are more likely to be in the traditional Medicare FFS program without any supplemental coverage or to be enrolled in Medigap than those in urban areas.

We also find, however, that coverage patterns can vary among metropolitan areas—even in the

³The distributional numbers presented here come from MedPAC analyses of the 2000 Medicare Current Beneficiary Survey (MCBS) Cost and Use file and include only community-dwelling individuals.

same state. Tampa and Miami, for example, look very different in regard to each type of coverage. An explanation for some of the difference lies in the respective proportion of people on Medicaid, the availability of Medicare managed care, and the employment structure. Because 21 percent of Miami's senior population is living under the poverty level and Tampa's rate is 11 percent, more people in Miami may have supplementation through Medicaid.

In summary, we find that Federal and state oversight of Medicare products influence the availability and design of Medigap, employer-sponsored, and M+C options (as well as supplementation available through Medicaid). For example, some of the variation among states in Medigap enrollment may be a result of differing State regulation of those products. Nonetheless, even though state characteristics have an important influence over health insurance markets, local factors such as income and employment history are also important. All of these factors will need to be considered in the design of reforms.

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:

- the number of beneficiaries enrolled in Medicare managed care has fallen, as have the number of plans participating and, in many areas, the value of the benefits offered;
- employers have scaled back on coverage for future retirees and increased premium contributions and cost sharing for current retirees, and state that they will continue to do so in the future;
- Medigap premiums have continued to increase, raising questions about the affordability of this form of supplemental coverage; and
- fiscal pressures at the state level may cause reductions in Medicaid coverage.

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.

Effects of supplemental coverage

Access and use Beneficiaries with additional coverage have consistently reported better access to health care than those without (MedPAC 2000). In 2000, beneficiaries with only fee-for-service Medicare compared to those with employer-sponsored or Medigap insurance were more than four times as likely to report trouble getting care; nearly five times as likely to have delayed care due to cost; and about three times as likely to lack a usual source of care. 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 any supplemental coverage, but more likely to report problems than those with private supplemental coverage (MedPAC 2002).

Other research has shown that people with supplemental drug coverage also have higher use of medically appropriate therapies for conditions such as hypertension and coronary heart disease. These studies have focused particularly on use of prescription drugs (Blustein 2000, Federman 2001, Seddon 2001, Adams 2001). Our research has shown that beneficiaries without a supplemental source of coverage use fewer services deemed clinically necessary than those with a supplement (MedPAC 2002). On the other hand, some increased use may not be appropriate, as is discussed in a later section.

Out-of-pocket costs Although the vast majority of beneficiaries obtain some type of additional insurance, they still face potentially large out-of-pocket spending (Figure 3). Beneficiaries' out-of-pocket spending includes their direct spending on services—or the associated cost sharing—and their payments for insurance premiums, including those for Medicare Part B and any amounts for additional insurance.

Per capita out-of-pocket spending varies widely among groups with different types of supplemental coverage (Figure 4). These spending differences primarily reflect differences in premium payments for supplemental coverage and direct payments for noncovered services as opposed to cost sharing for covered services. As might be expected, the roughly 4 million people who qualify for Medicaid benefits have relatively low out-of-pocket spending and most of what they spend goes toward services not covered by Medicare or Medicaid. About 10 million people buy Medigap policies. On average, these beneficiaries annually spend about \$1,400 for noncovered services and cost sharing, and about \$1,700 for Medigap premiums. Even those who have employer-sponsored supplemental insurance, which usually provides generous benefits, still have relatively high spending for noncovered services. Beneficiaries who report being in fair or poor health spend more out-of-pocket for health coverage and for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare. These findings suggest that supplemental coverage does not fully address the limitations of Medicare's benefits.

High out-of-pocket spending may push some Medicare beneficiaries into poverty. Our analysis shows that about 11 percent with total incomes above poverty have out-of-pocket spending large enough to push them into poverty. Those with incomes just above the poverty line (100 to 110 percent) clearly have a much greater likelihood of falling into poverty than those with higher incomes.

Implications of first-dollar coverage All of the Medigap plans, Medicaid, and some employer-sponsored plans provide generous coverage of Medicare's cost-sharing requirements. This so-called first-dollar coverage often protects beneficiaries from financial liability from the first dollar of expenditure beyond their premium.

First-dollar coverage may respond to beneficiaries' desire for convenience and 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, coinsurance or deductibles may not affect use as expected or desired. 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, along with insurers' administrative markup.

Medicare beneficiaries with supplemental insurance use more services and thus generate higher program expenditures than those without such coverage. This in turn increases beneficiaries' Part B premiums and the burden on tax payers. A MedPAC analysis of the 1998 MCBS found that Medicaid dual-eligible beneficiaries have the highest Medicare program expenditures, followed by beneficiaries with Medigap coverage, and then by those with employer-sponsored

coverage. Medicare beneficiaries without any supplemental coverage have the lowest Medicare program expenditures. 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 (Atherly 2001).

Increased administrative costs Multiple sources of coverage also increase administrative costs for providers and insurers. Administrative costs for insurers may include marketing, claims processing, reserves, and profit. 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—although the administrative costs for the Medicare program are thought to be both understated and insufficient. For example, the administrative budget for CMS does not include the costs of collecting payroll taxes for the Part A trust fund or of withholding Part B premiums from Social Security checks. The National Academy of Social Insurance recommended more resources for CMS to better manage the program (King 2002).

Confusion among beneficiaries The multiple sources of supplemental coverage create a maze of options for beneficiaries. 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 half knew that they have health plan choices available (Stevens 2000). Beneficiaries are frequently unclear about the differences 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. Confusion about Medigap was one of the reasons for the standardization of Medigap policies. Before standardization, some beneficiaries bought multiple policies, not understanding that the coverage was duplicative.

Some research suggests that many Medicare beneficiaries are not highly motivated to make choices about their insurance coverage. A recent survey found that most beneficiaries (in both FFS and M+C plans) did not give serious thought to options for insurance coverage. Only 14 percent thought seriously about options or actually changed plans, and, of those, more than one-third were either new beneficiaries (who had to make a choice) or beneficiaries who switched from one M+C plan to another (Gold 2001).

Conclusion

Uneven cost-sharing, lack of a catastrophic cap, and omission of certain services—most notably prescription drugs—have called into question the health security promised by the Medicare program. To fill the gaps in the benefit package, most beneficiaries obtain supplemental coverage, but this coverage is often costly and, for Medigap in particular, only partly effective in addressing the limitation of the Medicare benefits package. It also may contribute to inefficiency in providing health care for Medicare beneficiaries because of first-dollar coverage. The

availability and affordability of supplemental coverage is, moreover, uneven across different markets, and increasingly unstable.

Although beneficiaries value their Medicare and supplemental coverage, the problems with the current Medicare benefit package and the resultant supplemental coverage system leave policymakers with difficult choices. It might be possible to improve beneficiary financial protection through adjustments to the supplemental market, however, it would be more fruitful to first directly address the limitations in the Medicare benefit package and its cost sharing provisions.

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Table 1. Medicare benefits and cost-sharing requirements, 2003*

Services	Beneficiary cost sharing
Part A	
Inpatient hospital (up to 90 days per benefit period plus 60 lifetime reserve days)**	\$840 for the first stay in a benefit period Days 1–60; fully covered Days 61–90; \$210 per day coinsurance 60 lifetime reserve days: \$420 per day
Skilled nursing facility (up to 100 days per benefit period)	Days 1–20; no coinsurance Days 21–100: \$105 per day
Hospice care: for terminally ill beneficiaries	Nominal coinsurance for drugs and respite care
Part B	
Premium	\$58.70 per month
Deductible	\$100 annually
Physician and other medical services (including supplies, durable medical equipment, and physical and speech therapy)	20 percent of Medicare-approved amount
Outpatient hospital care	20 percent of 1996 national median charge updated to 2000
Ambulatory surgical services	20 percent of Medicare-approved amount
Laboratory services	None
Outpatient mental health services	50 percent of Medicare-approved amount
Preventive services	20 percent of approved amount (none for Pap smear, pneumococcal vaccine, flu shot, prostate specific antigen (PSA) test)
Both Part A and Part B	
Home health care for homebound beneficiaries needing skilled care	None

* These benefits and cost-sharing requirements apply to traditional Medicare. Medicare+Choice plans can deviate from these requirements, but they must cover the same services, cost sharing cannot be higher on average, and CMS must approve each plan's cost-sharing and benefit package.

** A benefit period begins when a patient is admitted to the hospital for inpatient care and ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days.

Source: Centers for Medicare & Medicaid Services.

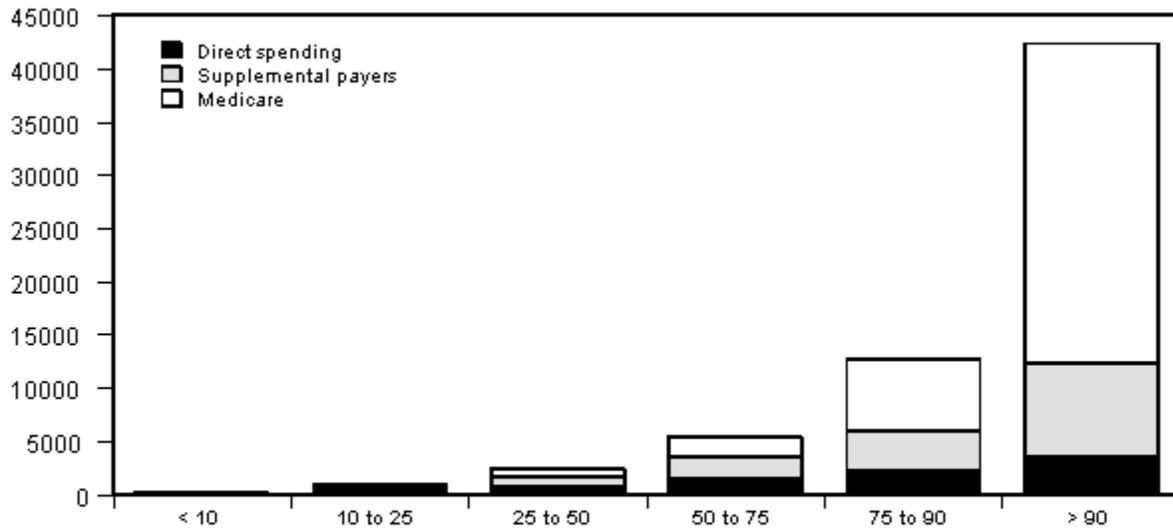
Table 2. Total spending on health services for Medicare beneficiaries, by source of payment, 1999

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

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

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

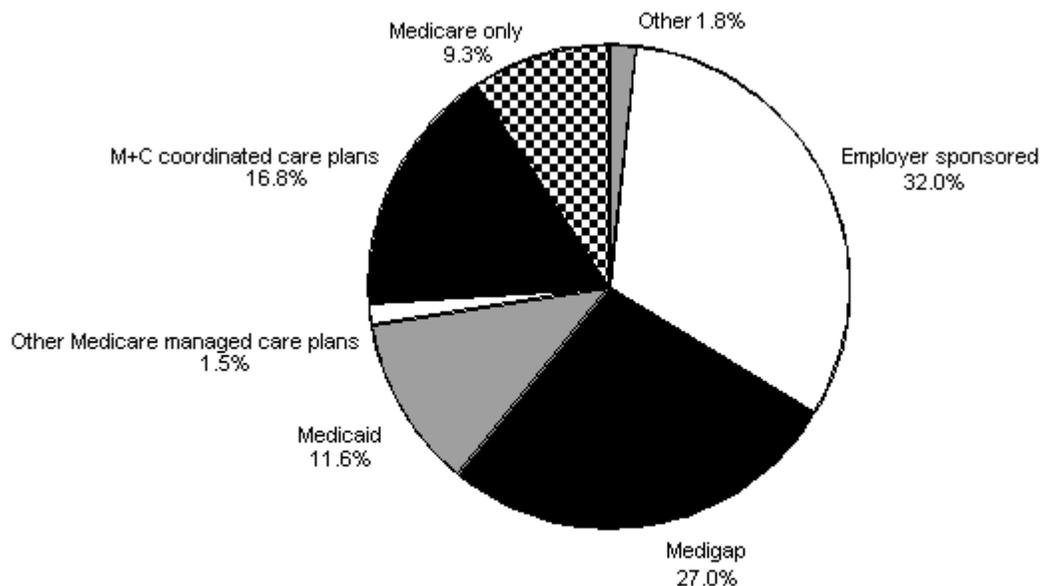
Figure 1. Per capita spending on health services, by source of payment, 2000



Note: Analysis includes fee-for-services beneficiaries living in the community.

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

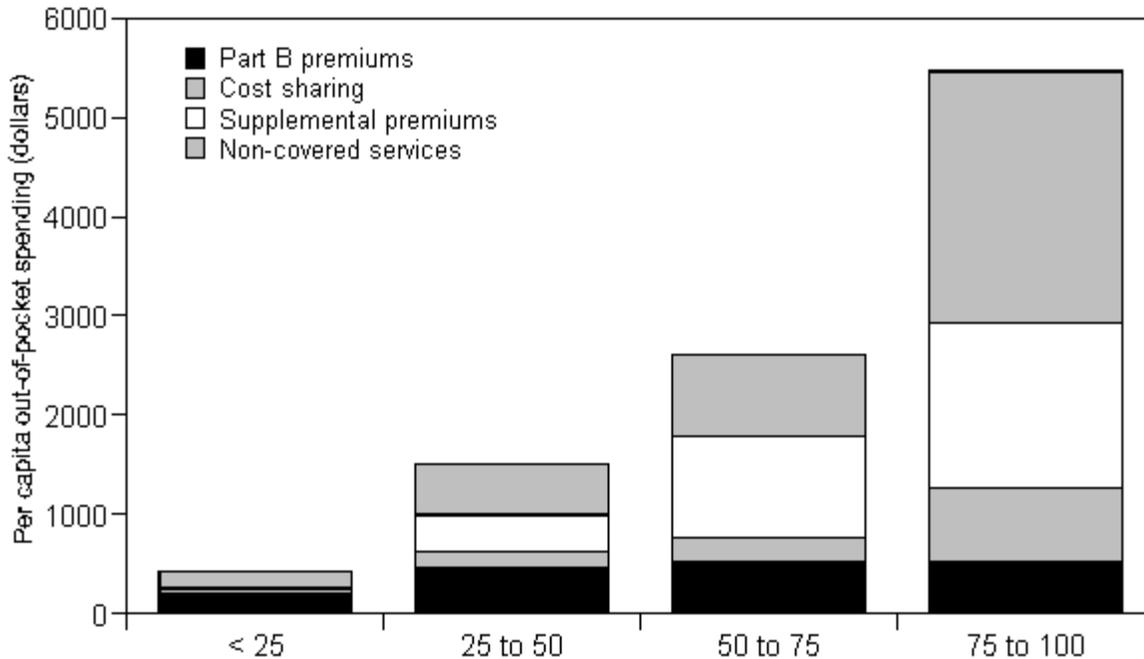
Figure 2. Sources of supplemental coverage among beneficiaries living in the community, 2000



Note: M+C (Medicare+Choice). Other includes federal and state programs not included in other categories. Analysis includes beneficiaries living in the community. The share of all beneficiaries (community-dwelling and institutionalized) in M+C coordinated care plans was 15.8% in 2000.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2000; Medicare managed care plans monthly summary report, CMS, December 2000.

Figure 3. Composition of out-of-pocket spending, by out-of-pocket spending level, 2000

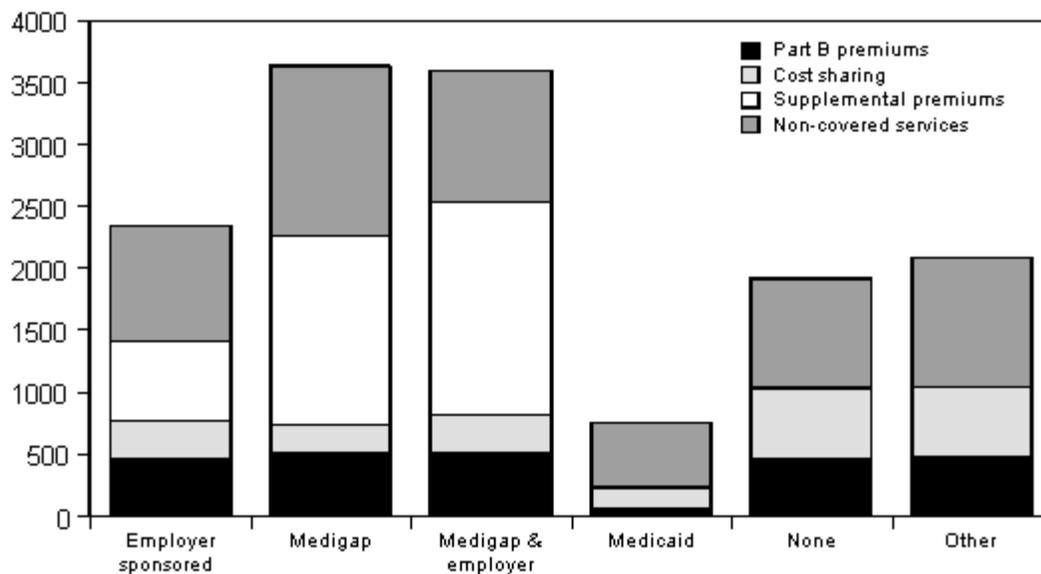


Groups of people ranked by out-of-pocket spending (percentile ranges)

Note: Sample of 9,577 includes 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 non-covered services. The vertical bars represent per capita out-of-pocket spending, divided into the four categories, for each group. For example the < 25 group illustrates per capita out-of-pocket spending for beneficiaries with the 25 percent smallest values (the lowest quartile). Likewise, the 75 to 100 group illustrates per capita out-of-pocket spending for beneficiaries with the 25 percent largest values (the highest quartile).

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

Figure 4. Variation and composition of out-of-pocket spending, by type of supplemental insurance, 2000



Note: Analysis includes fee-for-services beneficiaries living in the community.

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