CHAPTER 3

Options for changing the benefit package

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In this chapter

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

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

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

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

- broader Medicare coverage increased the likelihood that beneficiaries used services, or
- Medicare used its market power to reduce prices for newly covered services.

Options

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

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

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

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

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

Criteria

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

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

- **Financial protection.** Would the option improve the financial security of beneficiaries, on average or for specific subgroups? Would it protect beneficiaries from impoverishment or severe financial difficulty due to high cost-sharing expenses?

- **Access to care.** Would the option improve access to high-quality health care services in the most appropriate settings? Would it reduce disparities in access to care for beneficiaries with different health conditions?[1]

- **Efficiency.** Would the option promote the purchase of appropriate care at the lowest cost? Would it improve incentives for beneficiaries to use health care services (and, similarly, for providers to supply services) only when they are clinically necessary and worth their costs? In addition, would the option reduce administrative costs associated with health care spending on behalf of beneficiaries?

- **Feasibility.** Could the change be implemented without undue disruptions to beneficiaries, providers, and payers? For example, could a proposed change make use of Medicare's current administrative systems or would it require a different mechanism?

- **Cost implications.** Would the option require additional Medicare spending? If so, could it be implemented without increasing total spending on beneficiaries' health care? How would costs be distributed among Medicare, beneficiaries, and other payers?

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

Changing Medicare's cost-sharing structure

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

Problems with Medicare's cost-sharing structure

The goals of cost sharing in health insurance are to encourage appropriate use of services (and thus constrain the aggregate cost of the insurance) while providing enrollees with financial protection from high out-of-pocket costs. As discussed in Chapter 1, Medicare's cost-sharing system does not fully meet either of these goals. Cost sharing for random events over which beneficiaries exercise little control, such as hospitalizations, exposes them to high costs while having minimal effect on use of services. Cost sharing for more predictable, discretionary services, such as ambulatory care, is often too low to encourage prudent use of care. In addition, the lack of a cap on total cost-sharing liability subjects some beneficiaries to financial hardship. Finally, because Medicare has inconsistent cost-sharing rules for different kinds of treatment in different settings, beneficiaries' costs can depend on their condition. For example, people with mental illnesses who require outpatient treatment are subject to higher coinsurance than those who require most types of outpatient services for other conditions (50 percent versus 20 percent).[2] Some might argue that outpatient mental health services are more discretionary than other outpatient services and thus should be subject to higher coinsurance.

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

Options for cost-sharing changes

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

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

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

Change the deductible structure

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

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

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

Eliminate the blood deductibles Under both Parts A and B, beneficiaries must pay for the first three pints of blood they use (unless they donate replacement blood). This requirement does not encourage efficient use of blood or reduce Medicare's costs because very few beneficiaries who receive blood are charged the deductible.[3] Even if this deductible were charged more consistently, it would probably not encourage more prudent use of blood because beneficiaries do not initiate blood use. Removing the blood deductible would simplify the cost-sharing structure.

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

Change the coinsurance/ copayment structure

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

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

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

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

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

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

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

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

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

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

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

Eliminate cost sharing on currently covered preventive services Some covered preventive services, such as sigmoidoscopies and fecal occult blood tests, are underused (see Chapter 1). Excluding preventive services from coinsurance and the Part B deductible could encourage beneficiaries to use more preventive care.[11] However, this change would not guarantee increased use of additional preventive services. Providers' attitudes about encouraging preventive care and beneficiaries' lack of interest or knowledge about these services may be more significant barriers to obtaining needed care than cost sharing requirements. In addition, eliminating cost sharing on preventive care would increase the unevenness of the cost-sharing structure because most other covered services are subject to deductibles and coinsurance. This change would increase 2002 Medicare spending by about $750 million (less than 1 percent).

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

Require cost-sharing for home health services Requiring beneficiaries to share the cost of home health services would encourage them to use care more prudently and would treat home health care similarly to other services. However, cost sharing could discourage use of needed services, particularly for low-income and chronically ill beneficiaries, who tend to use these services most. In addition, cost sharing would increase administrative costs for home health agencies. Previously, MedPAC recommended the introduction of a modest home health copayment, subject to an annual limit (MedPAC 1999).

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

Cap annual cost sharing for covered services

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

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

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

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

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

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

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

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

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

Supplemental coverage

To address the inflationary effects of supplemental plans' coverage of Medicare cost sharing on Medicare spending, policymakers may want to consider options that would expose beneficiaries to modest cost-sharing amounts while still providing coverage for high health care costs. A first place to consider these changes is in the Medigap insurance market.[14] The Omnibus Budget Reconciliation Act of 1990 mandated the creation of 10 standardized Medigap plans, which were specified by the National Association of Insurance Commissioners (see Appendix B).[15] All of the standardized plans (those issued after 1992) cover the Part A deductible and Part B coinsurance, and three plans cover the Part B deductible (Table B-1, p. 77).

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

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

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

Illustrative combinations of cost-sharing changes

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

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

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

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

TABLE 3-1

Illustrative changes to Medicare's cost sharing

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

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

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

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

Package A

This package would replace the separate Part A and B deductibles with a combined annual Part A and B deductible of $400. It also would eliminate copayments on inpatient stays beyond 60 days and eliminate limits on the number of covered days. Taken together, these changes would have roughly no net impact on current Medicare spending.[17]

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

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

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

Package B

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

Package C

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

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

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

Package D

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

Package E

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

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

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

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

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

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

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

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

Expanding the Medicare benefit package

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

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

Prescription drugs

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

- Should the benefit be voluntary or mandatory? A voluntary benefit would avoid requiring beneficiaries to pay for a benefit they do not want or already have, but would invite adverse selection (beneficiaries with high expected drug spending would be more likely to enroll in the benefit, increasing its cost). High federal subsidies would increase participation and minimize adverse selection. A mandatory benefit would eliminate concerns about adverse selection, but could require many beneficiaries to purchase a benefit they already had (for example, through employer-sponsored supplemental coverage).
- Which entity or entities should manage the benefit? Policymakers would need to decide how a new drug benefit would be administered, who would bear the insurance risk, and how the prices for drugs would be determined. Many observers agree that, regardless of whether the government or private plans bear the insurance risk, the responsibility of negotiating prices and processing claims should be given to private-sector entities. However, they disagree on whether the Centers for Medicare & Medicaid Services (CMS) or private entities (such as insurance plans or pharmacy benefit management companies) should bear the risk, or whether risk should be shared.
- To what extent should the benefit be financed by Medicare versus beneficiaries? If Medicare were to subsidize most of the cost of a voluntary benefit, more beneficiaries would enroll and there would be less adverse selection. However, a generous subsidy would increase program costs (and thus require additional tax revenues) and displace existing spending on drug benefits by employers, state Medicaid plans, other government programs, and beneficiaries. To limit Medicare's costs, federal subsidies could be targeted to low-income beneficiaries. If beneficiaries help to finance a Medicare drug benefit through premiums, those who currently purchase Medigap plans to obtain drug coverage could redirect their spending on Medigap premiums to

Improving access to prescription drugs outside of a Medicare benefit

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

Expanding Medicaid drug coverage for low-income Medicare beneficiaries

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

Grants to states to fund drug assistance programs

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

Reforming Medigap coverage

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

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

Reducing drug prices faced by beneficiaries

Instead of or in addition to expanding insurance coverage of prescription drugs, policymakers could seek to reduce the prices beneficiaries pay for drugs. Prices could be reduced through changes in law and regulations governing when and how drugs come to market, the terms of market exclusivity, and how drugs may be sold. Currently, to allow a return on their investment, manufacturers of new drugs are given patents for a specified duration of time that prohibit other manufacturers from marketing the same product. Proposed legislation would make it easier for generic drugs to come to market, which could lead to lower prices for brand-name drugs. However, any reduction in drug prices would likely lower drug manufacturers' expected future profits, which might result in less research and development of new drugs.

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

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

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

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

- Should the benefit be targeted to beneficiaries with average drug costs or high costs? A key design decision is whether to cover spending by beneficiaries with average drug use, those with high use, or both groups. A benefit with no deductible and a limit on covered spending would favor beneficiaries with low or average spending. A benefit with a deductible and cap on out-of-pocket spending would target high-use beneficiaries, thus making adverse selection more likely.
- How should drug use and costs be managed? Employer-sponsored plans use cost-sharing rules, discount arrangements with pharmacies, promotion of generic substitution for brand-name drugs, formularies, rebates from drug manufacturers, and mail services to process prescriptions. Policymakers would need to decide which of these tools are appropriate for the Medicare population.
- Which drugs should be covered? A Medicare benefit could cover all drugs currently covered by Medicaid (which excludes only drugs used for fertility, hair growth, cosmetic effects, and a few other treatments). Alternatively, a Medicare benefit could cover only one drug in each therapeutic class, which would give the program leverage to negotiate lower prices with manufacturers but would reduce beneficiary choice and perhaps affect treatment outcomes. The program also could develop a list of preferred drugs subject to lower cost sharing.

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

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

TABLE 3-2

Illustrative prescription drug benefit options

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

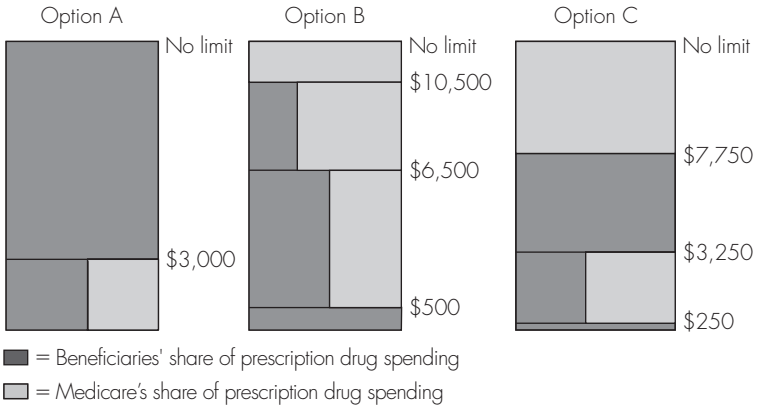
Note: Assumptions include 1) only one option is made available to beneficiaries (no choice of options); 2) the use of modest techniques to manage drug costs would reduce current prices paid by beneficiaries by 10 percent; and 3) 100 percent of beneficiaries would participate in a drug benefit.

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

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

FIGURE 3-1

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



Source: Actuarial Research Corporation model based on data from the1998 Medical Expenditure Panel Survey, 1998 Medicare Current Beneficiary Survey (Cost and Use file), and projections of 2002 prescription drug spending by beneficiaries from testimony by Dan L. Crippen, Director, Congressional Budget Office, before the U.S. Senate Committee on Finance, March 7, 2002.

Option A

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

Option B

This option features a $500 deductible, decreased cost sharing as spending increases, and a cap on out-of-pocket spending beyond $4,500. Compared with Option A, this option would provide greater protection for beneficiaries with high drug costs and less for those with low costs. Although it would improve protection for those with high out-of-pocket spending, half of beneficiaries—those who spend less than $500 per year on drugs—would not receive any help with their drug costs. This design is the most costly of the three approaches presented here, with an estimated initial annual cost to Medicare of $25 billion and beneficiary premiums of about $50 per month.

Option C

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

Case management and disease management services

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

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

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

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

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

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

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

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

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

- What services should Medicare pay for and who should deliver them? Coordinated care programs may include a broad array of services, such as interdisciplinary team meetings to discuss patient care and progress, phone calls to remind patients of appointments or to take medications, training to educate patients about self-care, and coordination of community social services. Policymakers would need to decide which of these services Medicare should cover and for which patients. Policymakers also may decide to subsidize information support systems for providers to identify and track patients enrolled in coordinated care programs.

- How could financial incentives be used to encourage providers to offer cost-effective, clinically appropriate services to the beneficiaries who would benefit most? If physicians and other providers were paid on a fee-for-service basis for delivering coordinated care, they would have no financial incentive to produce savings for Medicare. Putting providers at financial risk by paying for services on a capitated basis or paying for a larger bundle of services would provide incentives to reduce costs, but also could encourage providers to stint on needed care. CMS's current case and disease management demonstration, which requires participating providers to offset fully the costs of case and disease management services with savings from improved coordination of care, may offer insight on this question.

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

Preventive services

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

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

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

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

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

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

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

Mental health services

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

Vision and hearing

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

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

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

Dental Services

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

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

26 Data from the 1998 Medical Expenditure Panel Survey.

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

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

Impact of benefit expansions on beneficiaries with different health care needs

As was the case with the illustrative cost-sharing changes presented earlier, expansions to the benefit package would have varying effects on healthy, chronically ill, and terminally ill beneficiaries. Generally healthy and chronically ill beneficiaries would benefit from different kinds of preventive services— healthy individuals could benefit from cholesterol measurement while chronically ill people could benefit from injury prevention. Coverage of vision, hearing, and dental care also would help both groups. However, chronically ill beneficiaries would derive greater benefit than healthy individuals from improved coverage of prescription drugs, case and disease management services, and mental health care. Terminally ill individuals would benefit primarily from prescription drug coverage.

Creating a comprehensive benefit package by reallocating resources

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

In theory, additional costs under a comprehensive plan could be offset at least partially by savings from a reduced need for supplemental coverage, which is associated with higher administrative costs and additional use of services. If the introduction of a comprehensive package led to lower rates of supplemental coverage, total spending on beneficiaries' health care could stay about the same as under current law.

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

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

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

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

Design issues

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

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

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

Offering a comprehensive plan as an alternative to the current package (perhaps for a higher premium) would allow beneficiaries to remain in the current program if they do not value the additional coverage or currently receive it from another source for less money. However, allowing this choice would raise concern about risk segmentation: beneficiaries who believe they are less likely to need additional services would be more likely to remain in the current program, while those who believe they will have greater need for coverage would be more likely to choose the comprehensive benefit package. This pattern of enrollment would increase costs for the comprehensive plan and lower costs for the current plan, strengthening incentives for people who use fewer services to stay in the current plan. Policymakers could minimize risk segmentation by providing higher premium subsidies for beneficiaries who enroll in the comprehensive package or by limiting the opportunity to enroll in the comprehensive plan to initial eligibility for Medicare.

Who would deliver a comprehensive benefit package?

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

Alternatively, private insurance plans could replace or compete with Medicare's fee-for-service plan to offer a comprehensive benefit package. A marketplace with more purchasers would be less subject to distortion and might spur more innovative and efficient care delivery. However, because each plan would have its own claims processing, marketing, and other overhead costs, a competitive approach would have higher administrative costs. A competitive approach also raises other issues. For example, how many plans should be allowed to compete? Would they be national, regional, or both? Would plans be available for rural beneficiaries? On what basis would plans compete for enrollees: price, additional benefits, and/or quality? If there were multiple private plans, should they offer the same benefit package or have more flexibility? If the benefit package varied, risk segmentation would be more likely; if it did not, innovation in benefit design would be constrained.

How comprehensive should the package be?

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

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

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

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

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

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

Medicaid and other government programs that pay for health care services received by Medicare beneficiaries also would be affected by a comprehensive benefit package.[29] Medicaid covers Medicare's premiums and cost sharing and non-covered services such as prescription drugs and long-term care for Medicare beneficiaries who are dually eligible for Medicaid. A comprehensive package that reduced Medicare's cost sharing and added prescription drug coverage would offset money currently spent by Medicaid on dual eligibles. Medicaid savings would be reduced if states covered the higher Medicare premium for dually eligible beneficiaries.

Illustrative model

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

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

Key assumptions used in illustrative model

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

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

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

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

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

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

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

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

TABLE 3-3

Current law compared with illustrative comprehensive benefit package

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

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

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

Scenario one: beneficiaries retain supplemental coverage

Under this scenario, our model implies significant shifts in sources of spending and a slight increase in total spending on behalf of beneficiaries. Table 3-4 illustrates these changes by comparing projected 2002 spending on beneficiaries' health care under current law and under the illustrative comprehensive benefit

TABLE 3-4

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

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

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

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

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

package. The table divides spending into health care outlays (direct spending on goods and services by beneficiaries, Medicare, and supplemental payers) and administrative costs incurred by Medicare and supplemental payers. Medicare spending would rise by about $63 billion (about $1,560 per beneficiary).[31] Most of this increase—$50 billion—would be spent on prescription drug coverage. The rest of the spending increase reflects changes in cost sharing for currently covered services. Because Medicare would cover more spending and beneficiaries with supplemental coverage would retain their coverage under this scenario, direct spending by beneficiaries on Medicare cost sharing and prescription drugs would decline by about $20 billion in aggregate (almost $500 per beneficiary). Payments by supplemental insurers would decline by about $30 billion in aggregate (about $700 per beneficiary) because Medicare would cover a larger share of total spending. This decline in spending would probably cause supplemental premiums to fall.

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

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

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

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

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

TABLE 3-5

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

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

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

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

Scenario two: reduced supplemental coverage

Under scenario two, total spending on behalf of beneficiaries would decline slightly but spending by source would shift significantly. Table 3-6 illustrates these changes by comparing projected 2002 spending on health care received by beneficiaries under current law and under the illustrative comprehensive benefit package. Medicare would cover more spending under scenario two than under current law, but Medigap and employer-sponsored insurance would cover less, leaving total beneficiary direct spending on cost sharing and prescription drugs unchanged. Because only 25 percent of beneficiaries with Medigap and employer-sponsored coverage would retain their coverage under this scenario, supplemental coverage payments would decline by an additional $20 billion compared with scenario one, and by $50 billion compared with current law. This additional decline in spending by supplemental insurers would probably cause a more significant reduction in supplemental premiums than under scenario one. Medicare spending would increase by about $50 billion (about $1,250 per beneficiary) from current law. This increase is smaller than under scenario one because beneficiaries would have reduced supplemental coverage for Medicare's cost sharing, which would cause them to use fewer currently covered services. Most of the increase in Medicare spending—$45 billion—is attributable to prescription drug coverage. The remaining $5 billion increase results from changes in the cost sharing structure for currently covered services, partially offset by reduced use of services.

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

TABLE 3-6

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

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

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

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

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

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

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

If the increase in Medicare spending was financed entirely by higher beneficiary premiums, such premiums would be about $104 per month higher ($1,250 per year), compared with the $130 monthly premium increase under scenario one. Beneficiaries who retained scaled-down Medigap plans or dropped their plans could use their Medigap premium savings to help cover higher Medicare premiums. For example, beneficiaries who currently have Medigap Plan H—which has an average monthly premium of $110 and covers the inpatient deductible, Part B coinsurance, and limited prescription drug spending (Table B-1, p. 77)—could drop this plan and use the savings to cover the $104 increase in monthly Medicare premiums.[32] Such beneficiaries would obtain more complete coverage for drugs under the comprehensive Medicare package but give up some coverage of cost sharing for other services under Medigap Plan H. Beneficiaries with employer-sponsored coverage could not control whether employers used savings on supplemental coverage to subsidize their retirees' Medicare premiums.

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

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

TABLE 3-7

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

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

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

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

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

Summary of modeling results

Our modeling shows that a more comprehensive Medicare benefit package could be substituted for the current one without increasing total health spending on beneficiaries, if supplemental coverage declined. Higher spending by Medicare could be offset at least partially by reducing the higher administrative costs and additional use of services associated with supplemental insurance. A restructured cost-sharing system also could encourage more prudent use of services by beneficiaries. Some beneficiaries, such as those who have high direct spending on health services, would spend less out of pocket, and others, such as retirees with generous employer-sponsored insurance, could end up spending more. Regardless of changes in out-of-pocket spending, all beneficiaries would have improved insurance protection from high medical costs and better access to prescription drugs than under the current benefit package.

Conclusion

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

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