APPENDIX B

Sources of additional coverage for Medicare beneficiaries

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This section provides a detailed description of the major sources of additional coverage for Medicare beneficiaries, including employer-sponsored insurance, Medigap insurance, Medicaid, Medicare managed care, and the TRICARE program for military personnel.[1] (A brief description of health benefits provided to military veterans through the Department of Veterans Affairs [VA] is provided at the end of this appendix, although VA health benefits do not generally coordinate with Medicare coverage in the same way). Each of the sources of additional insurance provides, in varying degrees, coverage of Medicare's cost-sharing requirements, and many provide additional benefits such as outpatient prescription drugs or coverage for other services not covered by Medicare. Some of these insurance options require the beneficiaries to pay a premium, while others are available at no cost to beneficiaries. Most require that beneficiaries pay the Medicare Part B premium. All of these sources of additional coverage either have explicit eligibility restrictions, limited open enrollment periods, or are only available in certain areas of the country.

Employer-sponsored insurance

The most common form of supplemental coverage is employer-sponsored insurance, which covers 33 percent of non-institutionalized Medicare beneficiaries. Some of these beneficiaries have access to employer-sponsored coverage in their current jobs or through a spouse's employer, but the majority receive coverage as part of their retiree benefit packages. Employers have traditionally offered health insurance, including retiree coverage, as a way to recruit and retain workers. Offering retiree health benefits also makes it easier for employers to offer older workers early retirement options.

Employer-sponsored insurance typically provides some coverage for Medicare's cost-sharing requirements, as well as additional benefits such as outpatient prescription drug, dental, hearing, or vision coverage. Because the employer sometimes pays all or part of the premium, employer-sponsored insurance can be an inexpensive source of supplemental coverage for beneficiaries. However, the amount of coverage and the employees' share of the cost vary by firm.

Large firms are much more likely than smaller firms to offer employer-sponsored insurance and retiree benefits and generally offer more generous benefits at lower cost to the enrollee. One prominent employer survey found that about 23 percent of large firms nationwide offered health coverage to Medicare-eligible retirees in 2001.[2] The probability that a firm offered coverage increased with firm size; about 54 percent of firms with 20,000 or more employees offered retiree coverage to Medicare-eligible retirees, compared with 17 percent of firms with 500 to 999 employees (Mercer 2002).

In addition to size, firm location and industry type also influence the extent of coverage. Firms in the Northeast were more likely to offer retiree coverage in 2001 than those in the Midwest (26 percent versus 19 percent). Similarly, government jobs were more likely to offer coverage to Medicare-eligible retirees (57 percent) than financial services jobs (36

1 TRICARE is not an acronym; we present the name in all capital letters because it appears this way in statute.

2 Another survey of major employers in 2001 found that 61 percent of firms offered retiree health care coverage to Medicae-eligible retirees (Hewitt Associates 2001). The survey we cite in the text contains a more nationally representative sample of firms, while the Hewitt Associates survey consists primarily of larger employers that are more likely to offer coverage.

percent), transportation, communication, and utility jobs (29 percent), or wholesale/retail jobs (6 percent) (Mercer 2002).

Depending on the firm, employers use three main approaches to coordinate their health benefits with those of Medicare: traditional coordination of benefits, the "carve-out" method, and the exclusion method (sometimes called maintenance of benefits). Under traditional coordination of benefits, the employer-sponsored plan essentially pays whatever Medicare does not, up to the total dollar amount that the plan would have spent in the absence of Medicare. This method generally leaves beneficiaries with little or no out-of-pocket liability. With the carve-out method, the employer-sponsored plan computes what it would have paid in the absence of Medicare, deducts the Medicare payment, and then pays only the difference (if any) between the Medicare payment and the amount the plan would have paid. The beneficiary could be responsible for up to 100 percent of the remaining cost after Medicare pays. Finally, under the exclusion method, the employer-sponsored plan computes the total amount that remains after Medicare has paid and then covers whatever percentage of that amount the plan typically pays (for example, if the plan typically pays 80 percent of the cost of services, it would pay 80 percent of the amount that remains after Medicare pays, leaving the beneficiary responsible for the rest). Traditional coordination of benefits is the most generous, leaving retirees with the lowest out-of-pocket expenditures. Despite the generosity of this method, it continues to be commonly used.

Firms vary by the amount of the premium they pay versus the amount they require employees to pay. The majority of firms contribute part of the premium and require the employees to pay the remainder. However, some employers pay the full premium, while others offer coverage options but contribute nothing to the premium. The average premium in 2001 for a single retiree was $50 per month, 26 percent of the full premium. This premium is two-thirds higher than the premium that active workers pay in the same firms that offer retiree coverage (Henry J. Kaiser Family Foundation et al. 2002). About 40 percent of employers adjust the amount of their premium contribution according to the employees' age at retirement or number of years of service (Mercer 2002). The employers' contribution to the insurance premium is tax deductible, providing a tax subsidy to the firm. Indirectly, this also provides a tax benefit to the employee, who would otherwise receive the amount of the employer's premium contribution in the form of taxable wages.

Not all employees in firms that offer retiree coverage are eligible for it, but it is assumed that most eligible people choose to take it. On average, a retiree must have at least 10 years of service to be eligible for retiree health benefits (Henry J. Kaiser Family Foundation et al. 2002). One study found that employee participation tends to increase with income (Shea and Stewart 1995).

In 2001, the option most commonly chosen by retirees in firms that offered retiree coverage was the indemnity plan option (56 percent of retirees with an option) (Henry J. Kaiser Family Foundation et al. 2002). A number of employers have tried to encourage the use of managed care for retirees, but given the decreasing availability of Medicare managed care and the dissatisfaction of retirees with limited choices, employers have had difficulty promoting this option.

Private Medigap insurance

Medigap insurance is private coverage designed specifically to wrap around the Medicare benefit package; it is the second most common form of supplemental coverage. Most Medigap insurance is marketed directly to individual Medicare beneficiaries (75 percent of Medigap policyholders had individual policies in 1999), with the remainder sold as group policies (most likely association plans) (Chollet and Kirk 2001). Individual Medigap insurance premiums are not tax deductible.

Private supplemental insurance, similar to what we now call Medigap insurance, has existed since the beginning of Medicare, but changes have occurred over the years due to federal and state insurance regulations and the evolution of the market. The most important change occurred with passage of the Omnibus Budget Reconciliation Act of 1990, which standardized the benefits of most Medigap plans sold after 1992 (the 10 standard plans are commonly labeled A through J). These standard plans generally provide coverage of Medicare's cost-sharing requirements but offer few additional benefits beyond the basic Medicare benefit package (Table B-1). Three of the standard plans (H, I, and J) do offer limited coverage of outpatient prescription drugs, but all come with a $250 annual deductible, 50 percent coinsurance, and a cap on benefits of $1,250 per year (plans H and I) or $3,000 per year (plan J). Relatively few beneficiaries enroll in the three plans that offer prescription drug coverage.

Insurers issuing policies in Massachusetts, Minnesota, and Wisconsin are exempt from the standard plan requirements because, prior to 1992, these states had laws in effect mandating standard benefit packages. Massachusetts has three standard Medigap plans—a core plan that covers some of the basic Medicare cost-sharing requirements and some additional state-mandated benefits and two plans that add coverage of the Medicare Part A and Part B deductibles, skilled nursing facility coinsurance, and foreign travel coverage. One of these three plans includes outpatient prescription drug coverage that provides generic drugs at no cost and requires a $35 deductible per quarter and 20 percent coinsurance for brand-name drugs. Minnesota has two standardized plans that allow beneficiaries to add optional riders. Both plans add extra benefits beyond Medicare's benefit package. The more basic plan does not include prescription drug coverage (unless beneficiaries choose to add this as an

TABLE B-1

Benefits, enrollment, and average premiums in standardized Medigap plans, 2000

Benefits, enrollment, and premiums	Standardized Medigap plan									
	A	B	C	D	E	F	G	H	I	J
Cost sharing										
Part A hospital coinsurance	●	●	●	●	●	●	●	●	●	●
365 additional hospital days	●	●	●	●	●	●	●	●	●	●
Part B coinsurance	●	●	●	●	●	●	●	●	●	●
Blood products	●	●	●	●	●	●	●	●	●	●
Part A deductible		●	●	●	●	●	●	●	●	●
Part B deductible			●			●				●
Skilled nursing facility copayments			●	●	●	●	●	●	●	●
Part B balance billing						●	●		●	●
Additional benefits										
Foreign travel			●	●	●	●	●	●	●	●
Home health care				●			●		●	●
Preventive medical care					●					●
Prescription drugs								●	●	●
Enrollment	10%	10%	26%	6%	2%	35%	3%	2%	3%	4%
Average monthly premium	$87	$88	$106	$98	$95	$110	$87	$109	$159	$176

Note: Percentages do not sum to 100 because of rounding.

Source: Medicare Payment Advisory Commission analysis of 2000 Medicare Supplemental Exhibits from the National Association of Insurance Commissioners.

optional rider), while the extended basic plan covers 80 percent of the cost of outpatient prescription drugs. Wisconsin has one basic plan plus optional riders. The basic plan offers prescription drug coverage that only insures beneficiaries against extremely high prescription drug costs; beneficiaries must spend $6,250 before receiving the benefit and pay 20 percent coinsurance for expenditures over this amount. In 2000, an estimated 4 percent of all Medigap enrollees were in plans issued in one of these three states.[3]

Beneficiaries who purchased Medigap policies prior to 1992 are generally allowed to retain these policies. About 31 percent of Medigap enrollees in 2000 were in these so-called pre-standard plans. Because insurers are prohibited from issuing new policies for pre-standard plans, the estimated minimum age of policyholders in these plans today is about 75 and the number of beneficiaries enrolled in these plans has been declining, from 3.7 million in 1998 to 3.3 million in 2000. While it is thought that many pre-standard Medigap policies include coverage for outpatient prescription drugs, the covered benefit may be less generous than that offered in the standard policies. For example, AARP's pre-standard Medigap policy, which enrolls about 20 percent of all beneficiaries in pre-standard plans, offers prescription drug coverage with a $50 deductible, 50 percent coinsurance, and a $500 cap on benefits (Chollet and Kirk 2001, Smolka 2002).

Medigap premiums vary substantially among beneficiaries because insurers factor in the costs of benefits offered by the 10 standardized plans, federal and state access and consumer protection regulations, geographic differences in health care costs, and characteristics of individual applicants and enrollees. In addition, Medigap insurers in most states can, under certain conditions, medically underwrite—meaning that they can consider a beneficiary's health and medical history in deciding whether to offer a policy and how much to charge.[4]

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

4 Insurers are prohibited from medically underwriting for the first 6 months after a beneficiary over the age of 65 first enrolls in Medicare Part B (the open enrollment period).

This practice is common, particularly for Medigap plans that include prescription drug coverage.

A Medicare beneficiary's current age or age at the time of enrollment also plays an important role in determining the Medigap premium. Under community rating, all enrollees in a product are charged the same premium regardless of their current age or their age at the time of enrollment. Under issue-age rating, insurers set premiums based on beneficiaries' age at the time of enrollment. Finally, under attained-age rating, insurers base annual premiums on the current age of the enrollees.

Each rating approach creates issues for insurers and beneficiaries. Because community rating requires insurers to average the premiums across all age groups, insurers argue that it tends to produce much higher premiums for people age 65 than other rating systems. Because most beneficiaries purchase Medigap policies at age 65, this may discourage early enrollment. Issue-age rating may discourage beneficiaries from changing Medigap plans because the beneficiaries will generally be older and consequently will face a higher premium when they purchase the new product. Insurers that use attained-age rating increase the premiums as beneficiaries age, charging the highest premiums to the oldest beneficiaries, who are often those least able to afford it. One study found that the annual claim cost per insured beneficiary was lowest for those in attained-age rated plans, probably because beneficiaries whose premiums were growing faster than their income—likely older beneficiaries with more health problems—dropped such coverage (American Academy of Actuaries 2000). Recognizing these issues, 10 states have prohibited attained-age rating, 6 have prohibited entry-age rating, and 8 have required community rating as of 1999 (Chollet and Kirk 2001).

The average premium for individual Medigap insurance across all plan types—standardized and non-standardized—was $115 per month in 2000. The average premium for plan F, the most common standardized plan option, was $110 per month; premiums for standardized plans that include outpatient prescription drug coverage ranged from $109 for plan H (cap of $1,250) to $176 for plan J (cap of $3,000). Medigap premiums vary considerably by state. For example, premiums in California, Indiana, and Florida tend to be much higher (more than twice as much for all plans and more than four times as much for standardized plans) than premiums in New Hampshire, Pennsylvania, Utah, and Montana. Some, but not all, of this variance can be explained by regional differences in beneficiaries' preference for different plans, regional variation in health care costs, regional availability of different plans, and characteristics of enrollees (Chollet and Kirk 2001). Premiums also vary substantially according to the age of the beneficiary and the rating methodology used. For example, policies for older beneficiaries in attained-age rated policies may cost considerably more than policies that use other approaches to rating. In 1999, for example, a Pennsylvania insurer that offered both attained-age and issue-age policies for the same plan would have charged an 80 year-old male $112 per month for an issue-age policy that he purchased at age 65 and $132 for an attained-age policy (General Accounting Office 2001).

Beneficiaries in all parts of the country are guaranteed to be able to purchase a Medigap policy under certain conditions. Within 6 months of enrolling in Medicare's Part B, any beneficiary over the age of 65, regardless of health status, is guaranteed access to a Medigap policy.[5] In addition, federal law guarantees elderly beneficiaries the right to purchase Medigap plan A, B, C, or F if they enroll in a Medicare managed care plan and the plan stops serving their area, if they lose employer-sponsored insurance, if they are enrolled in a Medigap policy provided by an insurer that goes bankrupt, or if they are forced to disenroll from a Medicare managed care plan (either because the plan goes out of business, commits fraud, or the beneficiary moves out of the plan's service area). Similarly, beneficiaries who join a Medicare managed care plan when they are first eligible for Medicare and disenroll within one year have the right to purchase any plan sold in their state, and beneficiaries who join a managed care plan for the first time and want to leave within one year have the right to return to their original Medigap coverage (if the same plan is available) or to purchase plan A, B, C, or F (if the same plan is not available). These guaranteed issue rights do not extend to plans that include outpatient prescription drug coverage. For this reason, Medicare managed care plans that include such coverage provide an attractive alternative to Medigap insurance in areas where managed care plans are offered. Medicare beneficiaries under the age of 65 do not have the same federal protections as elderly beneficiaries; they are only guaranteed access to a Medigap policy in certain states (Centers for Medicare & Medicaid Services 2002a).

Once an individual purchases a Medigap policy, the policy cannot be cancelled (except for failure to pay the premiums) and the beneficiary can continue to hold the policy even after moving to another state. Because most Medigap insurance protections are for entry into the system, beneficiaries have limited protections if they decide to change policies.

Beneficiaries in all areas of the country have access to Medigap policies, although they may not necessarily have access to all 10 standard policies. All insurers who issue Medigap policies are required to offer at least plan A, the most basic policy, but not all of the plans. The three plans that include prescription drug coverage are often the most difficult to find (Chollet and Cook 2001). In addition, the fact that plans are offered in a

5 Medigap insurers may limit coverage for pre-existing medical conditions for a certain amount of time after issuing a policy, but the law generally requires insurers to reduce the length of time by the amount of previous health insurance coverage.

particular area does not necessarily mean that they are affordable or that they will accept new enrollees. Insurers may, in fact, raise the price of their less profitable plans to discourage enrollment.[6] Fewer than half of all Medigap enrollees (48 percent), and 68 percent of those in standard policy options, are enrolled in plans that are still accepting new enrollees. This fraction varies by plan type; almost 80 percent of beneficiaries in plan F are in plans that are still accepting new enrollees, compared with 21 percent of beneficiaries in plan H (one of the plans with prescription drug coverage) (Chollet and Kirk 2001).

It is difficult to assess the participation rates in Medigap plans, given the complexity of their availability and the variation in their premiums. A review of studies on supplemental coverage found that beneficiaries who were most likely to purchase individual Medigap policies tended to be older, female, white, more educated, and wealthier than beneficiaries who did not purchase Medigap policies. The studies generally did not agree on whether Medigap enrollees differ significantly by health status from other beneficiaries, although most studies found that Medigap enrollees in plans with prescription drug coverage tended to have more health problems than those who did not enroll in these plans (Atherly 2001). Medigap participation rates appear to be higher among Medicare beneficiaries with fewer alternatives. Beneficiaries in rural areas, for example, are much less likely to have access to either retiree coverage or Medicare managed care and are more likely to have purchased a Medigap policy than beneficiaries in urban areas: 39 percent of beneficiaries in rural areas had a Medigap policy in 1999 compared with 23 percent of beneficiaries in urban areas.[7]

Among beneficiaries enrolled in standard plans, enrollment is highest in the four "guaranteed issue" plans—A, B, C, and F. The most popular plans are plan F, which covers most of Medicare's cost-sharing requirements but offers little in the way of extra benefits (35 percent) and plan C, which is similar to F but does not cover the excess amount beneficiaries may be required to pay for doctors who do not accept payment of the Medicare-approved amount as payment in full (26 percent) (Table B-1).[8] Plans H, I, and J together amount to about 9 percent of Medigap enrollees in standard plans.

Medicaid and other state programs

Medicaid provides supplemental insurance coverage for certain low-income, sick, and disabled beneficiaries. It was created in 1965 as a companion program to Medicare to provide health assistance to people qualifying for welfare and to pay for nursing home care for the elderly. Over the years, it has evolved to cover community-based long-term care services and Medicare's cost-sharing requirements. Dual eligibles—Medicare beneficiaries who are also entitled to Medicaid benefits—are among the most costly Medicare beneficiaries. In 1997, they represented just 17 percent of the Medicare beneficiary population yet accounted for 28 percent of total Medicare spending. Similarly, dual-eligible beneficiaries accounted for 19 percent of the total Medicaid population but accounted for 35 percent of total Medicaid costs (Clark and Hulbert 1998).

States reported that in the first quarter of fiscal year 1999 there were approximately 5.5 million dual-eligible beneficiaries.[9] Of these, 58 percent were eligible for the full package of Medicare and Medicaid benefits, 11 percent were eligible to receive coverage for some part of Medicare's cost-sharing requirements, and the remaining 31 percent were classified as "other" or "unknown." In 1999, the proportion of Medicare beneficiaries classified as dual eligible varied by state, ranging from a high of almost 28 percent in Mississippi and Tennessee to less than 8 percent in Arizona, Idaho, and Utah (Ellwood and Quinn 2002). Dual-eligible beneficiaries, compared with the rest of the eligible Medicare population, tend to be disproportionately female (63 percent versus 55 percent), over age 85 (18 percent versus 10 percent), and members of racial or ethnic minority groups (38 percent versus 14 percent) (Centers for Medicare & Medicaid Services 2002b).

Dual-eligible beneficiaries can be categorized into three main types. The first category includes Medicare beneficiaries who, because of low income and assets or because of a disability, qualify for the Supplemental Security Income (SSI) program, which automatically triggers Medicaid eligibility in most states.[10] SSI is a nationwide income-support program for people age 65 and older and people who are blind or disabled who have limited resources and incomes below about 75 percent of the

6 Insurers that want to continue offering a particular plan type in a given market may keep a product "open"—meaning that the plan continues to accept new enrollees—but may charge a high premium for it. They have an incentive to do so because if they stop marketing that product state insurance regulators may prohibit them from reentering the market with products for that plan type for five years. However, the extent to which insurers can charge excessive premiums is also limited by regulation (General Accounting Office 2001).

7 Estimates from MedPAC analysis of National Association of Insurance Commissioners' data.

8 Federal law allows doctors who refuse to accept Medicare's approved payment amount as payment in full to charge beneficiaries up to 15 percent more than the approved payment amount. This is sometimes referred to as "balance billing."

9 Estimates from the Medicaid Statistical Information System, which are state-reported data, tend to be lower than estimates obtained from the Medicare Current Beneficiary Survey, which are based on beneficiaries' self-reported data.

10 In 1998, 11 states obtained waivers allowing them to impose more restrictive Medicaid eligibility restrictions than those for SSI.

federal poverty level.[11] The second category includes beneficiaries who qualify through optional "medically needy" or "300 percent of SSI" programs. Most states allow certain individuals to deduct medical expenses from income to qualify for Medicaid or allow institutionalized individuals to qualify for Medicaid if their incomes are at or below 300 percent of the SSI income standard, as long as they meet SSI's resource eligibility standards (Bruen et al. 1999). Most nursing home residents and many individuals with high prescription drug or medical equipment costs qualify for Medicaid this way. Third, states have options to extend Medicaid eligibility to non-institutionalized elderly or disabled individuals through home and community-based services waiver programs or through options that allow states to set more liberal income and asset eligibility standards than SSI (Schwalberg et al. 2001).

Medicaid offers several levels of coverage to dual-eligible beneficiaries. First, many dual-eligible beneficiaries are eligible to receive coverage for health services beyond those covered by Medicare. Medicaid law requires that all participating states cover a core set of services—hospital, physician, and nursing facility care—and that they offer the same services to all eligible beneficiaries (except those in waiver programs, described later). Many states go beyond this requirement and take advantage of options that allow them to provide a more comprehensive set of Medicaid benefits—including outpatient prescription drugs—to dual-eligible beneficiaries. Otherwise, states would likely have to pay the costs of uncompensated care for these same beneficiaries, and the federal government does not pay the states matching funds for the costs of uncompensated care.

Most dual-eligible beneficiaries and some low-income beneficiaries who do not entirely meet the requirements for dual eligibility receive Medicaid coverage for part or all of their Medicare premiums or cost-sharing requirements.[12] As such, Medicaid resembles a Medigap plan C or F (covering most of Medicare's cost-sharing requirements without providing additional benefits). Several mandatory Medicaid programs pay beneficiaries' Medicare premiums or cost-sharing requirements. The qualified Medicare beneficiary (QMB) program pays Medicare's premiums, deductibles, and coinsurance for all beneficiaries whose income is at or below 100 percent of the federal poverty level and whose assets are at or below twice the SSI limit. The specified low-income Medicare beneficiary (SLMB) program pays the Medicare Part B premium for beneficiaries with incomes between 100 percent and 120 percent of poverty. The qualifying individual-1 (QI-1) program pays the Part B premium for beneficiaries with incomes between 120 and 135 percent of poverty, and the Qualifying Individual-2 (QI-2) program subsidizes a portion of the Part B premium for beneficiaries with incomes between 135 percent and 175 percent of poverty.[13] Because the QI program's federal funding is limited, assistance is available on a first-come, first-serve basis (General Accounting Office 1999). Although Medicaid's QMB, SLMB, and QI programs are defined by federal law, states have discretion in how they implement these programs (Nemore 1999).

Lastly, states can use waivers to extend comprehensive or limited Medicaid benefits to other dual-eligible beneficiaries. The most common type of waiver is known as a home and community-based services (1915(c)) waiver. States can, with federal approval, provide a state-designed set of health and long-term care services to individuals living in the community who do not qualify for Medicaid only because they are not institutionalized. All states used some form of home and community-based services waiver program to provide benefits to an estimated 622,000 beneficiaries in 1998 (Smith et al. 2000). In addition, some states have applied for Section 1115 Research and Demonstration waivers to extend prescription drug coverage to dual-eligible beneficiaries. States have found these waivers difficult to use, however, because they must demonstrate that their Medicaid programs will cost no more with the implementation of the prescription drug program than they would have cost had the program not been implemented. The Bush Administration has proposed legislation to expand the use of waivers for increasing outpatient prescription drug coverage.[14] In addition, the National Governors' Association reports that about 30 states have implemented non-Medicaid state pharmaceutical assistance programs to, at a minimum, provide greater discounts on prescription drugs and in some cases provide beneficiaries assistance in purchasing comprehensive prescription drug benefits (National Governors' Association 2002).

The benefits package for dual-eligible beneficiaries who are fully eligible to receive Medicaid is one of the most

11 Specifically, the SSI monthly income standard is $545 for an individual and $817 for a couple in 2002 (disregarding the first $20 per month). The SSI resource limit is $2,000 for an individual and $3,000 for a couple and generally excludes the home, a car (depending on use and value), burial plots, and the first $1,500 in burial funds and life insurance (Social Security Administration 2002).

12 The Balanced Budget Act of 1997 (PL 105-33) allowed states to pay providers the lower of Medicare's cost-sharing requirements or the states' Medicaid rates, although providers are not permitted to charge beneficiaries the difference. In 1999, only 16 states reimbursed providers for the full amount of Medicare's cost-sharing requirements (Nemore 1999).

13 Income and resource standards and methodologies cannot be more restrictive in the QMB, SLMB and QI programs than they are for SSI; however, they can be more generous (Schneider et al. 1999).

14 The President's fiscal year 2003 budget includes a proposal to allow states to expand prescription drug coverage to beneficiaries with incomes up to 100 percent of poverty through the regular Medicaid program and to access a federal matching rate of 90 percent for prescription drug coverage for Medicare beneficiaries with incomes between 100 percent and 150 percent of the federal poverty level (Department of Health and Human Services 2002).

comprehensive of all Medicare supplemental options. The vast majority of dual-eligible beneficiaries do not pay premiums for Medicare or Medicaid, and any cost-sharing requirements are nominal. Medicaid is also one of the few programs, public or private, that pays for long-term care; in 2000, Medicaid paid for 48 percent of all nursing home care (Levit et al. 2002). In addition, dual-eligible beneficiaries generally receive a comprehensive prescription drug benefit through Medicaid.

Despite the generosity of benefits available to dual-eligible beneficiaries, participation in Medicaid by eligible Medicare beneficiaries is low in most states. Given the characteristics of the Medicare population, an estimated 24 percent of all non-institutionalized beneficiaries are eligible for or enrolled in one of the Medicaid programs. However, fewer than half of those eligible to receive Medicaid assistance actually do (Laschober and Topoleski 1999). Common explanations for the low participation rate include lack of knowledge of the programs, the stigma associated with Medicaid, and barriers to enrollment (such as a complex application process). Beneficiaries commonly believe that Medicaid is only for "poor people" and that applying could put their estates at risk (General Accounting Office 1999). The way a state implements its Medicaid programs also affects participation rates. For example, in 1999, more than half of states did not use a simplified enrollment application, more than three-quarters of states did not provide outreach materials in other languages, and about two-thirds of states did not make eligibility screening tools available to outside agencies, clinics, or senior centers (Nemore 1999). Medicare beneficiaries who are eligible but not enrolled in Medicaid are more likely to be 80 years old or older, married, and otherwise insured (through Medicare managed care or private supplemental insurance) than enrolled beneficiaries (Laschober and Topoleski 1999).

Medicare managed care

The Medicare managed care program allows beneficiaries the option of joining a private health plan, which then receives payment from Medicare for providing Medicare-covered services. These private plans are allowed to charge beneficiaries an additional premium and provide additional benefits. However, if plans' reported costs are lower than their Medicare payments, they are required by law either to return the difference to enrollees in the form of additional benefits or contribute the money to a reserve fund for future use (few plans choose this option).

Thus, although Medicare managed care is technically an alternative method of delivering Medicare benefits through private plans instead of through traditional Medicare, beneficiaries in certain areas of the country have joined managed care plans to take advantage of the supplemental benefits they offer. Recent surveys have found that obtaining outpatient prescription drug coverage, keeping premiums down, and lowering out-of-pocket costs topped the list of reasons beneficiaries cited for choosing a health plan or for switching among health plans. In fact, about half the time, beneficiaries switching from one health plan to another cited reasons involving issues of benefits, premiums, or related matters, including reaching a benefit limit (19 percent), high out-of-pocket costs (11 percent), premiums that are too high (7 percent), or the desire for a prescription drug benefit (5 percent). Individuals moving into a Medicare health maintenance organization (HMO) for the first time or into a new HMO also typically gave reasons connected with benefits and premiums (Gold et al. 2001).

Private managed care plans have participated in Medicare since the program first began in 1965. However, two major changes have occurred during the course of the program. In the mid-1980s, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorized Medicare to begin paying HMOs a fixed amount each month, called a capitation rate, to provide care to Medicare enrollees (other types of plans, such as cost plans and health care prepayment plans, continued to be paid on a cost basis). By law, TEFRA plans were paid a county-level payment rate equal to 95 percent of the estimated cost of providing Medicare services to an average beneficiary, adjusted for some basic demographic characteristics of enrolled beneficiaries.

Later, the Balanced Budget Act of 1997 created the Medicare+Choice (M+C) program, which revised and expanded the rules governing private health plan participation in Medicare. Under M+C, new types of private health plans were allowed to provide Medicare benefits in exchange for capitated payments, and the formula for calculating plan payments was changed. The types of plans allowed to participate now include the HMOs formerly authorized to participate under TEFRA, point-of-service plans, preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. Few of these new plan types have entered the program; M+C plans continue to be mostly HMOs.

Medicare managed care plans are not available to beneficiaries in all parts of the country. Throughout the history of the program, plans have tended to locate mainly in certain parts of Florida, the West Coast, and New England. However, plan participation in Medicare has been cyclical, with plans expanding to more areas of the country during peak periods and cutting back on their service areas during periods of increasing costs and lower Medicare plan payments. Plans tend to operate primarily in areas with greater concentrations of health care providers and beneficiaries, and with higher-than-average Medicare payment rates.

By the mid-1990s, Medicare's plan payments exceeded plans' costs in some areas. At the same time, managed care plans were gaining prominence in the overall health care market. Taking advantage of increasing profits and popularity, HMOs boosted their benefit offerings and expanded service to more areas of the country. As a result, total enrollment in these plans grew rapidly (nearly 1 million new enrollees per year), peaking at 6.35 million enrollees in 1999. In 1998, 74 percent of all Medicare beneficiaries were living in areas where they could choose to join a Medicare HMO.[15]

Medicare managed care plans generally offer reduced Medicare cost-sharing requirements, some preventive services, more predictability in out-of-pocket expenditures, and additional benefits, such as coverage for dental services, eyeglasses, and outpatient prescription drugs. In recent years, coverage for outpatient prescription drugs has been one of the most popular features of Medicare managed care plans. In 1999, 84 percent of plans offered prescription drug coverage, often unlimited or with relatively high limits (Gold and Achman 2001). Prescription drug coverage through a Medicare managed care plan was an option for about 65 percent of beneficiaries.

Relatively low premiums have made the Medicare managed care option even more attractive to beneficiaries. The average monthly premium for an M+C plan in 1999 was $6, while 80 percent of plans charged no premium, and the average monthly premium among beneficiaries paying a premium was $32 (Gold and Achman 2001). A managed care plan without a monthly premium was an option for a full 61 percent of beneficiaries. In fact, more than half (54 percent) of all beneficiaries could enroll in a plan that offered prescription drug coverage and charged no monthly premium.

Where beneficiaries live influences how much they have to pay to join plans and how generous the benefits are. In areas in which plans have an easier time providing Medicare services at costs that are below the Medicare plan payment amounts, beneficiaries typically pay lower premiums and receive more generous coverage than do beneficiaries in other areas.

Unlike most other sources of additional insurance, Medicare HMOs often restrict beneficiaries' freedom to see any provider. Many HMOs only cover services provided by specific health care providers (those that participate in the plans' designated networks); others provide incentives for beneficiaries to use network providers.

The past four years have seen a reversal in the expansion of Medicare HMO enrollment that took place during the early and mid-1990s. This reduction in the number of plans and the number of enrollees has coincided, in part, with the implementation of a new plan payment methodology that has constrained growth in payment rates in many high-payment areas. Also, HMOs generally began experiencing rising costs and lower enrollments during this period, with health care consumers in all segments of the market—not just Medicare beneficiaries—rejecting many of the methods HMOs had used successfully to contain costs. Finally, health care providers are increasingly reluctant to offer HMOs the deep discounts on services they had before. As a consequence, Medicare HMO premiums have risen and the benefits offered have generally declined (see Chapter 2).

TRICARE For Life/ Department of Defense

TRICARE For Life is a new program that provides supplemental coverage for military personnel and retirees enrolled in Medicare. The National Defense Authorization Act for Fiscal Year 2001 created the program (effective October 1, 2001) to wrap around the Medicare benefits. The Act also created a new prescription drug benefit (effective April 1, 2001), which provides eligible Medicare beneficiaries with the same pharmacy benefit enjoyed by military personnel not eligible for Medicare.

TRICARE covers virtually all of Medicare's cost-sharing requirements, including deductibles and coinsurance for inpatient and outpatient services. It provides unlimited coverage for inpatient hospitalizations and skilled nursing facility stays, with beneficiaries responsible for 20-25 percent coinsurance for stays beyond the normal Medicare-covered allowance. The program also offers a comprehensive prescription drug benefit that gives beneficiaries the option to obtain prescription drugs at no cost from military treatment facilities or with only nominal copays from any pharmacy. In general, for most Medicare-covered services, Medicare will pay first and TRICARE will pay the beneficiaries' remaining out-of-pocket expenses. If beneficiaries have other sources of coverage, TRICARE pays after the other sources have paid. The program includes a $3,000 annual out-of-pocket limit (Politi 2002).

To be eligible for the program, all beneficiaries must pay the Medicare Part B premium, but are not required to pay any additional premium to join. Eligible beneficiaries include uniformed service

15 Unless otherwise noted, all Medicare managed care estimates are from MedPAC analyses of the Medicare Compare database and the Medicare managed care market penetration files, from the Centers for Medicare & Medicaid Services.

retirees (including retired guard and reservists) who served at least 20 years in the military, family members of uniformed service retirees (including widows/widowers), and certain former spouses of uniformed service retirees if they were eligible for TRICARE before age 65.

Medicare beneficiaries who meet the eligibility criteria are automatically enrolled in TRICARE and in the pharmacy benefit program with no application process. Approximately 1.5 million people are eligible for this benefit.

Department of Veterans Affairs

Another coverage option for beneficiaries who are military veterans is to receive health care services through the Department of Veterans Affairs (VA). This option is unlike the others described here in that Medicare is prohibited by law from paying for any part of the services provided in VA facilities, and the VA does not generally pay for services rendered outside of VA facilities (so it does not function as a source of coverage for Medicare cost-sharing requirements, for example). Still, for those who qualify, the VA program provides generous benefits—including broad coverage of most inpatient and outpatient services at little or no charge to the beneficiaries, preventive care, and outpatient prescription drug coverage—and has become increasingly popular in recent years, with more than 1 million new enrollees in the past 5 years. The growth has largely been fueled by elderly veterans seeking prescription drug coverage (Simmons 2002).

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