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# Supplemental Health Insurance for Medicare Beneficiaries

*by Thomas Rice and Jill Bernstein**

Summary

Because Medicare leaves beneficiaries at risk for significant health care costs, most need to obtain some form of supplemental coverage to protect themselves against the financial burden of illnesses. Close to nine out of ten Medicare beneficiaries age 65 or older now have some health coverage that provides additional benefits beyond standard Medicare Part A and Part B. The most common types of supplementation are insurance coverage offered by former employers, policies that individual beneficiaries purchase, benefits offered by Medicare managed care plans and assistance provided through the Medicaid program. This supplementation is expensive – to beneficiaries, employers, states, and to the federal government. The availability and extent of financial protection offered by supplemental coverage provided by former employers and through managed care also appears to be increasingly unstable. Structural reform of the Medicare program needs to include a broad reexamination of the basic benefits package and of the potential benefits and costs of public and private supplementation of the health insurance coverage promised to beneficiaries.

The Medicare program consists of two parts: Part A, the Hospital Insurance (HI) system; and Part B, the Supplementary Medical Insurance (SMI) system, which provides coverage for services not covered by Part A, including physician services, outpatient diagnostic test, and other types of outpatient care. However, since the enactment of Medicare in 1965, gaps in the program's benefits created a need for additional insurance or other forms of protection from potentially ruinous health care costs. The issues and the terminology used to describe the array of public and private means of providing additional financial protection for elderly and disabled individuals enrolled in Medicare have, like the program itself, become increasingly complicated. This brief describes what is often termed "supplemental coverage" — that is, coverage in addition to Medicare Hospital and Supplementary Medical Insurance — that is currently available, as well as emerging issues that may shape the Medicare policy debate.

## Medicare Coverage

The basic design of the Medicare program was modeled on the private insurance system in place in the mid-1960s. As the health care system has changed, Medicare's benefits have not kept pace. Table 1 presents a list of the costs that Medicare does not cover. There are three areas where beneficiaries are exposed

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to potentially significant costs. "Front-end" costs, such as deductibles, must be met before any program benefits are paid. "Back-end" costs occur when program benefits are exhausted and also result because there is no maximum on out-of-pocket spending. Finally, some important health care costs (such as prescription drugs) are simply not covered by the program.

In 1999, the two main front-end costs beneficiaries face are a $768 deductible for each inpatient hospitalization covered under Part A, and a $100 annual deductible for Part B (physician) costs. The back-end costs are high daily copayments for hospital stays that exceed 60 days, and the lack of any limit on how much a beneficiary can pay in coinsurance for Part B services. Costs that are generally not covered at all by the program include long-term nursing home care, most outpatient prescription drugs, most routine physical examinations, and services used outside of the United States.

## Table 1

### Beneficiary Costs in the Traditional Medicare Fee-For-Service Program

| Part A | 1999 Payment |
|---|---|
| **Inpatient** | |
| Deductible for each illness spell | $768 |
| Co-payments days 61-90 | $192 per day |
| Co-payments for lifetime reserve days 91-150 | $384 per day |
| **Skilled Nursing Facility Care** | |
| Days 21-100 | $96 per day |
| Beyond 100 days | All costs |
| **Home Health Care** | |
| Durable medical equipment | 20% of approved amount |
| **Hospice Care** | |
| Outpatient drugs and inpatient respite care | Limited costs |
| **Blood** | |
| First 3 pints | All costs |
| **Part B** | |
| Medical expenses | $100 annual deductible |
| Physician costs | 20% of approved charges |
| Physician not-accepting assignment | 100% allowable excess charges |
| Monthly premium | $45.50 |
| **Other Costs Not Covered By Medicare** | |
| Routine exams and podiatric care | All costs |
| Long-term care | All costs |
| Care outside of the United States | All costs |
| All costs that are not medically necessary | All costs |
| Dental, hearing and vision care | All costs |
| Outpatient prescription drugs | All costs* |

* Medicare covers a limited number of drugs and antigens that cannot be self-administered. These are: erythropoietin, pneumococcal vaccine and flu shots, immunosuppressive drugs connected with covered organ transplants, and oral anti-cancer drugs if they are of the same chemical entity as similar drugs which are administered intravenously.

The primary purpose of insurance is to provide financial protection against large, unexpected losses. While there are good reasons to have patients pay some up-front costs such as deductibles and coinsurance to cover some administrative costs and to quell unnecessary utilization,[1] insurance should provide adequate financial protection in the event of a major illness. But Medicare fails to do this. A 1998 study that compared Medicare with a sample of 250 employer plans offering indemnity health insurance benefits concluded that 82 percent of those plans offered more comprehensive benefits than Medicare.[2] Thus, Medicare's benefit structure is not consistent with most current notions of good insurance: it fails to provide adequate financial protection when enrollees require extensive health care.

## Types of Supplemental Insurance and Problems with Coverage

Most Medicare beneficiaries have some form of coverage that supplements Medicare Part A and Part B. By the end of 1999 about 17 percent of elderly beneficiaries will be enrolled in Medicare+Choice plans (mostly HMOs), most of which offer benefits beyond those included in traditional Medicare fee-for-service coverage.[3] About 36 percent of beneficiaries have some form of employer-sponsored supplemental insurance (including some beneficiaries who also purchase additional supplemental insurance in the individual private insurance market in addition to that provided by a former employer). Twenty-seven percent have individually purchased Medigap insurance, 11 percent receive supplemental benefits through Medicaid, and 9 percent have only Medicare.[4] The distribution of types of supplemental coverage varies by income. Among beneficiaries age 65 or older, those with higher incomes are more likely to have either employer-sponsored or Medigap coverage (Figure 1). While Medicaid provides supplemental coverage for some poor and near-poor beneficiaries, those with family incomes below 200 percent of the poverty line are most likely to have no coverage other than Medicare. An estimated 13 percent of elderly beneficiaries with incomes between 100 and 125 percent poverty, and 11 percent of those with incomes between 125 percent and 200 percent of poverty, have no supplemental coverage of any kind, compared to fewer than 6 percent of those with incomes greater than 400 percent of poverty.[5]

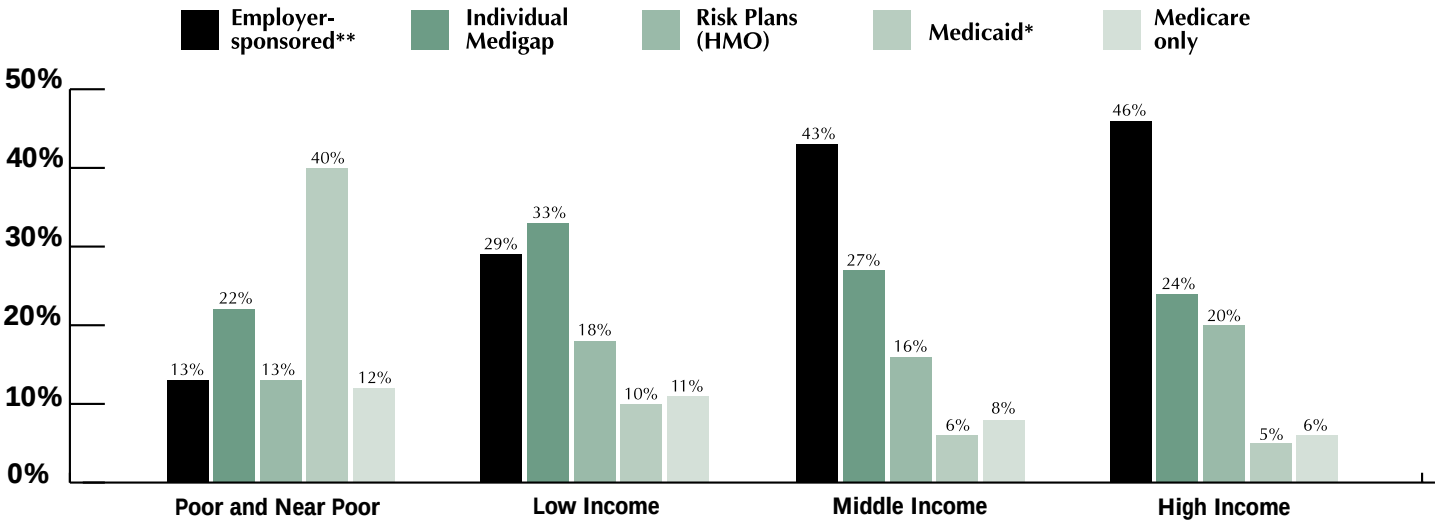
## Medigap Policies

Individual Medicare beneficiaries purchase Medigap policies to cover some or all of the deductibles and copayments associated with receipt of Part A or Part B services, as well as some uncovered services. More than almost any other type of insurance, Medigap policies have been subject to a great deal of federal regulation. Federal legislation known as the "Baucus Amendment" enacted in the Omnibus Budget Reconciliation Act of 1980 established criteria for a voluntary certification program that almost all states implemented. Under the Baucus Amendment criteria, Medigap policies were to provide minimum benefits and meet minimum loss ratios,[6] as well as provide various information to prospective purchasers and proscribe abusive practices on part of agents and their companies.

Most states complied with the Baucus Amendment by establishing a certification plan for Medigap policies, and the reform was deemed a success in reducing marketing abuses and ensuring that policies provided minimum coverage.[7] However, a problem remained that with so many different configurations of benefits available, it was almost impossible for consumers to engage in effective comparison shopping. Moreover, there was significant evidence that the marketplace had become a fertile ground for consumer fraud.[8] To address these problems, Congress enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). The statute replaced voluntary state certification with national requirements that all Medigap policies sold after July, 1992 conform to one of the standardized sets of benefits that the National Association of Insurance Commissioners developed as "model" policies. The ten standardized Medigap plan options are shown in Table 2. In 1997, 5.8 million beneficiaries were enrolled in standardized plans, while 6.1 million remained in the non-standardized plans in which they had enrolled before OBRA-90 reforms were put into place.[9]

## Figure 1

### Medicare Beneficiaries Age 65 and Older, by Supplemental Coverage and Beneficiary Income Status, 1999




**Note:** Excludes all-year institutionalized individuals. Income measure is family income. For individuals age 65 and older the 1999 projected poverty levels are as follows:

**Poor and Near Poor:** 125% of poverty or less (less than $10,094 for individuals and less than $12,731 for couples)

**Low Income:** 125.01%-200% of poverty ($10,094-$16,150 for individuals and $12,731-$20,370 for couples)

**Middle Income:** 200.01%-400% of poverty ($16,150-$32,300 for individuals and $20,370-$40,740 for couples)

**High Income:** more than 400% of poverty (more than $32,300 for individuals and more than $40,740 for couples)

*A small percentage of Medicare beneficiaries with Medicaid are reported in the AARP model to have incomes above 200 percent of poverty. This may reflect the fact that poverty level is based on reported household income, while Medicaid is based on individual income. Some beneficiaries living with family members may have personal incomes low enough to qualify for Medicaid, while others may incur sufficiently high medical costs to spend down their incomes and assets at some point in the year and qualify for Medicaid.

**Includes people with both employer-sponsored and individual medigap policies.

**Source:** National Academy of Social Insurance, 1999. Data based on AARP/PPI analysis using the Medicare Benefits Simulation Model (1999 projections).

Medigap insurance poses several difficult problems for policymakers. First, the possession of Medigap policies stimulates higher health care expenditures, most of which are borne by the Medicare program itself. While having any form of supplemental insurance (employer-sponsored or purchased in the individual market) is associated with higher rates of service use, there is convincing evidence that ownership of Medigap policies is associated with particularly high rates of utilization of Medicare-covered services.[10] The Congressional Budget Office has estimated that Medigap coverage increases enrollees' use of services by close to 24 percent.[11] Analysis by the Physician Payment Review Commission found that what Medicare spent for beneficiaries with only Medicare coverage was 72.5 percent of what the program spent for beneficiaries with Medigap coverage, even when controlling for factors such as age, sex, health status, institutional or disability status. Expenditures for beneficiaries with employer-provided benefits averaged 90 percent of those for beneficiaries with Medigap.[12] The fact that Medigap policies increase health care costs is hardly surprising, given that all policies cover the 20 percent copayment for Part B services, and

## Table 2

### Benefits Covered by Standardized Medigap Policies

| Benefits | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| Core Benefits[a] | X | X | X | X | X | X | X | X | X | X |
| SNF coinsurance[b] | | | X | X | X | X | X | X | X | X |
| Part A deductible | | X | X | X | X | X | X | X | X | X |
| Part B deductible | | | X | | | X | | | | X |
| Part B excessive charges | | | | | High[c] | Low[c] | | High[c] | High[c] | |
| Foreign travel | | | X | X | X | X | X | X | X | X |
| At-home recovery | | | | X | | | | | | X |
| Prescription drugs | | | | | | | | Low[d] | Low[d] | High[d] |
| Preventive medical care | | | | X | | | | | | X |

**Source:** Rice, T., M.L. Graham, and P.D. Fox, "The Impact of Policy Standardization on the Medigap Market," *Inquiry* 34, Summer 1997, based on data from NAIC, Medicare Supplement Insurance Minimum Standards Model Act (30 July 1991).

a Core benefits include coverage of all Part A (hospital) coinsurance for stays longer than sixty days, the 20 percent Part B coinsurance, and the Parts A and B blood deductible.

b SNF is skilled nursing facility.

c Low excess charge coverage pays 80 percent of the difference between the physician's charge and the Medicare allowable rate; high coverage pays 100 percent of the difference.

d Low prescription drug coverage has a $250 annual deductible, 50 percent coinsurance, and a maximum annual benefit of $1,250; high coverage is similar but it has a $3,000 maximum annual benefit.

nearly all cover the $768 Part A deductible. Medicare pays for 80 percent of the costs of the additional covered services that beneficiaries with supplemental insurance use.[13]

From the perspective of some policy analysts, the fact that Medigap insurers are responsible for only one fifth of the costs of additional covered services used by individuals with supplemental coverage means that, in effect, Medicare is subsidizing the purchase of Medigap policies. They observe that supplemental insurance would be more expensive (and presumably less appealing) were it not for this cross-subsidy.[14] It is not entirely clear, however, that all of the increased utilization of services associated with having Medigap coverage is unnecessary or "discretionary." Substantial copayment or deductible costs at the time of service or the possibility that seeking medical care could lead to a complicated course of treatment that is not affordable could prevent people from seeking appropriate care when they need it. Survey data have shown that beneficiaries without any form of supplemental insurance report more problems getting care, not seeking care for a perceived health care problem, and more delays in getting care due to cost.[15] For low-income beneficiaries, access to care and insurance coverage are interconnected: lower-income people are not only less likely than wealthier beneficiaries to have Medigap (or employer-sponsored) insurance, but also to be without a usual source of care.[16] Determining the extent to which having Medigap or other forms of supplemental insurance facilitates cost-effective use of medical care (in distinction from encouraging the use of discretionary or possibly unnecessary services) is therefore critically important.

Another set of problems concerns the design of Medigap policies themselves. Some of the benefits

have little insurance value and there are some notable gaps in coverage as well. Certain Medigap benefits differ from most insurance products. For example, over one-half of the standard plans cover the $100 Part B annual deductible, which is not common in most health insurance plans purchased by or on behalf of employees. About 45 percent of Medigap owners have coverage for non-assigned physician services, often at a substantial cost.[17] This is puzzling because program assignment rates are well over 90 percent, and physicians are not permitted to charge more than 15 percent above the Medicare fee schedule.[18]

Medigap benefits also are limited in scope and their design is inflexible. Like Medicare, Medigap policies provide limited coverage for post-acute or rehabilitative care, and do not cover long-term care services. In addition, beneficiaries are limited in their choices. For example, they cannot choose a "catastrophic coverage" option, where they are allowed to choose to pay a high annual deductible for lower premiums and thus avoid many of the restrictions that the legislation puts on Medigap plan design.[19] Standardization requires that Medigap policies "bundle" specific combinations of options together. If a beneficiary wants to buy a supplemental policy that includes a prescription drug benefit, the only standard Medigap options available also include most of the other benefits offered in the more comprehensive plans. Further, because these plans offer broader coverage, and because people who are more concerned about protecting themselves against high out-of-pocket costs may be those with greater health care needs, the high-end plans are prone to adverse selection. Sicker people buying more comprehensive plans (because they need more services) drives up the cost of those plans.

Medigap premium costs vary significantly by market and underwriting category (including age and health history). The premium for Policy C, the most commonly purchased policy in 1998, averaged $1,295 for a 75 year old in Dallas market in 1998, compared to $1,046 for a 65 year old in Dallas. In Los Angeles, the same policy's premium averaged $1,820 for someone age 75, compared to $1,502 for someone age 65.[20] According to one study, the average premium for those policies has increased significantly in the 1990s: from 1994 through 1998, the average price of Plan C rose an estimated 44 percent, and Plan F rose about 22 percent.[21] In 1999 a survey of over 37,000 quotes on policy prices offered by over 100 insurers found Plan C premium quotes over $1,400 and Plan F premiums over $1,300 per year in some markets.[22] The median total money income of families with householders age 65 or older in 1998 was $31,588.[23] For a large proportion of retired couples, buying Medigap policies could easily add up to ten percent of total household income.

## Medicare Managed Care Plans

A growing proportion of beneficiaries are obtaining supplemental benefits from Medicare+Choice managed care plans. These plans usually provide benefits in addition to those provided by Medicare, including free routine physical exams, eye and hearing exams, discounts on prescription drugs as well as hearing aids and eyeglasses, and an array of health education programs. There is, however, considerable variation in the design and the generosity of these benefits, as well as for the structure of the copayments required for hospitalization or physician visits.

*…flux in Medicare markets may cause significant problems for beneficiaries who lose access to plans or providers…*

In 1999, 83 percent of the plans included in the Health Care Financing Administration (HCFA)'s Medicare+Choice database of participating plans offered some form of prescription drug benefit.[24] Most of the plans charge a fixed copayment (often in the $5.00 to $10.00 range) for each generic prescription filled, and higher fixed copayment (often in the $10.00 to $15.00 range) for name-brand drugs. Many beneficiaries in Medicare+Choice plans also have maximum limits on drug benefits: 11 percent are enrolled in plans that set the limit under $600 per year in 1999, but others had more generous benefits (e.g. caps of $3,000 to $4,000 per year), and almost one-fourth

have an unlimited drug benefit.[25] However, as the need for help with drug costs makes managed care drug benefits increasingly attractive to beneficiaries, the cost of providing this benefit is of great concern to the plans.[26] Steady increases in prescription drug expenses are leading to reductions in coverage. HCFA has reported that by the year 2000, 86 percent of all participating Medicare+Choice plans will have an annual dollar limit (cap) on their prescription drug benefit, and 32 percent of plans will have a cap of $500 or less.[27]

Although plans are allowed to charge a premium in addition to the Medicare Part B premium, most do not. In 1999, 64 percent of plans did not charge an additional premium, and among those that did, average charges were only about $15.50 per month — a small fraction of the costs of Medigap premiums.[28] A growing number of plans are, however, planning to increase premiums, or to require a premium (above the basic Medicare Part B payment) for the first time. HCFA reports that the number of beneficiaries for whom the lowest available Medicare+Choice premium will be in the $20 to $60 range will increase by 50 percent in the year 2000, and that there will be a decline of about 3 million in the number of beneficiaries who have access to any plan that does not charge an additional premium. But it is also important to note that premium increases and reductions in extra services are not uniform across market areas. In some markets, access to zero-premium plans will increase in the year 2000.[29] Therefore many beneficiaries currently can obtain the sort of benefits available in costly Medigap policies from Medicare+Choice plans at lower or no costs.

Growth in Medicare managed care plans has been rapid, as shown in Figure 2. However, some plans have withdrawn from participation or reduced the number of markets in which they offer Medicare managed care options in the past two years, as a result of changes in the way in which federal payments to managed care plans are determined.[30] It is therefore difficult to anticipate the extent to which managed care will continue to provide drug coverage, or other supplemental benefits, to a growing number of Medicare beneficiaries.

There are some clear potential advantages to managed care over Medigap coverage: the benefit package is typically broader and the premiums lower.[31] Marketplace competition may encourage plans to innovate with benefits design or tailor benefits to meet beneficiaries' needs, which may work to the advantage of some beneficiaries. There is, however, considerable variation in the scope and generosity of the benefits even within market areas, and managed care plans are not available across all geographic areas. The generosity of benefits appears to reflect the level of Medicare reimbursement and/or the degree of local market competition. This leaves other beneficiaries without the option of choosing a Medicare+Choice plan that can provide benefits they cannot otherwise afford.

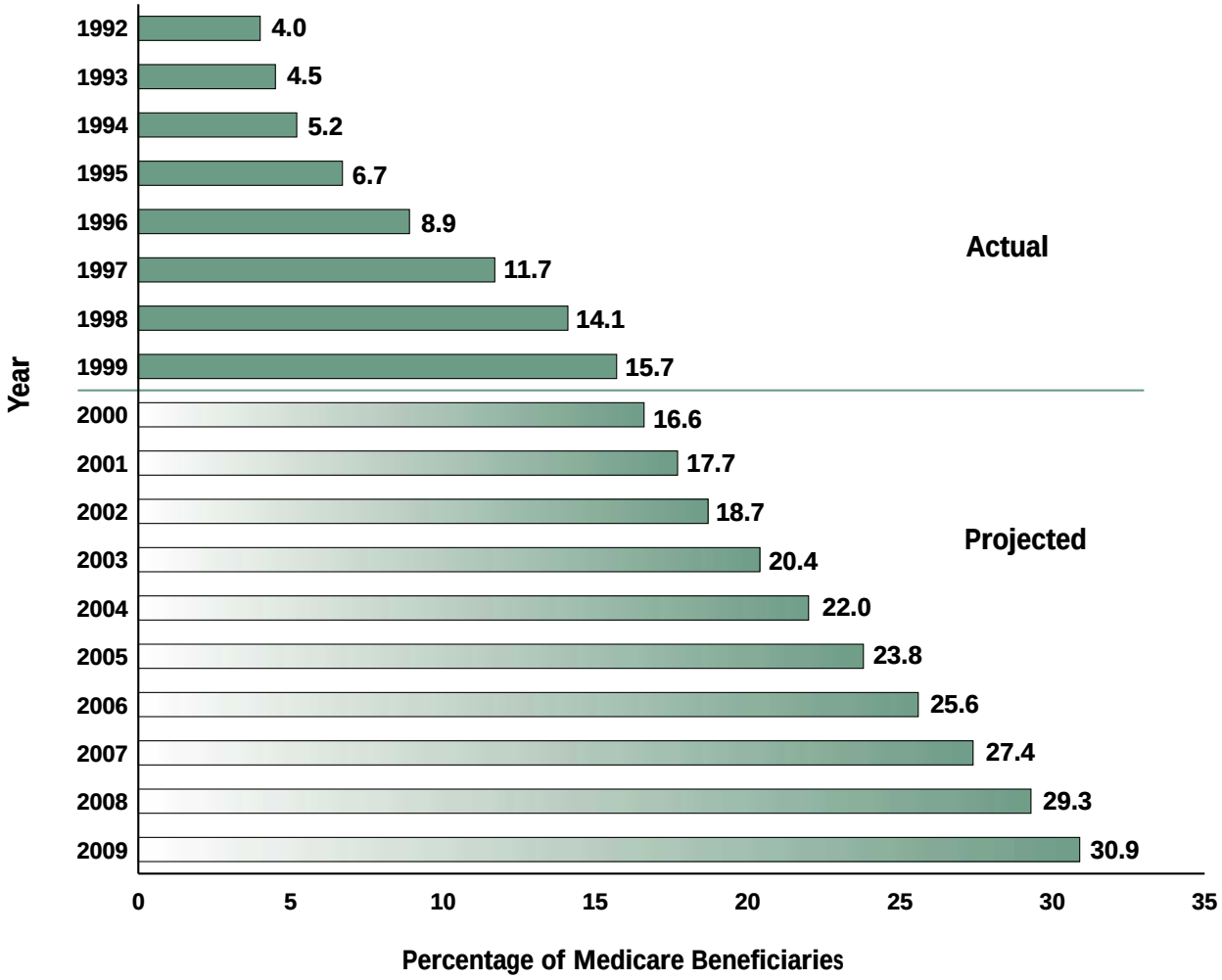
A broader concern about relying on managed care to provide supplemental benefits stems from some limited evidence that those with chronic conditions, and the poor, may fare worse than their fee-for-service counterparts in capitated health plans,[32] although few studies have found substantive differences in quality and outcomes.[33] Finally, there is growing concern that flux in the structure of local Medicare markets may cause significant problems for beneficiaries who lose access to plans or providers with whom they have long-standing relationships, or who can no longer find a participating Medicare+Choice plan, and must return to Medicare fee-for-service and obtain supplementary coverage in the Medigap market.[34]

## Employer-Sponsored Policies

About one-third of all Medicare beneficiaries have some supplemental coverage provided by employers or former employers (or spouses' employers). Large firms are more likely than small firms to provide retiree health benefits, and the benefits are more likely to be available to employees in some employment sectors (e.g., finance and manufacturing) than in others (e.g., service industries).[35] In 1999, only 8 percent of small firms (under 200 employees) offered retiree health benefits, compared to 41 percent of employers with 200 or more employees.[36] As is the case with employer-sponsored insurance for the working population, the value of these benefits is not subject to income tax, and employers' contributions are tax deductible. Taxpayers therefore subsidize the costs of this form of supplemental insurance. Because it is not purchased by individuals, but rather provided

## Figure 2

### Actual and Projected Enrollment in Risk-Based HMO Plans (Medicare+Choice)




**Source:** National Academy of Social Insurance, 1999. Figures based on data from the congressional testimony of Steven M. Lieberman. Executive Associate Director, Office of the Director, Congressional Budget Office, Washington, DC, *Medicare+Choice, Oversight of Risk Adjustment Methodology* and other *Implementation Issues*, hearing before the Committee on Finance, Senate U.S. Congress, June 9, 1999, http:www.senate.gov/~finance/6-9lieb.htm.

through employment, this coverage is not subjected to extensive Medigap regulations — specifically, standardized benefits.

Typically, retirees with this coverage enjoy the same benefits as active workers in a firm, and they pay lower premiums and cost-sharing than owners of Medigap policies.[37] For example, in 1997, the average annual premium for those with employer coverage was $712 versus $1,249 for those with Medigap.[38] In spite of their lower premiums, those with employer-sponsored policies tend to be better off economically, and they receive more in benefits. For example, in 1995, 86 percent of those with employer-sponsored coverage had a prescription drug benefit, versus only 29 percent of those with Medigap.[39]

Employer-sponsored coverage, when it is offered, has several advantages over individually-purchased Medigap policies. Employers share in the cost, and may be more effective than individuals in purchasing good coverage; group coverage is likely to be cheaper than individual coverage irrespective of any employer

subsidy because insurers' average administrative costs generally are lower for group plans.

A basic problem with employer-sponsored coverage for retirees is that it may not be a reliable source of insurance over time. Fewer firms are offering these benefits as part of the employee retirement package, and when they do provide these benefits, there are typically more eligibility restrictions and higher premium and copayment costs for the retiree than in the past. One study reports that among a constant sample of large employers (most with over 5,000 workers), 78 percent offered health benefits to retirees age 65 or older in 1998, down from 87 percent in 1991. Thirty percent of the large employers surveyed for this same study in 1999 said they would seriously consider terminating coverage prospectively for retirees age 65 and older.[40] Another finds that in 1999, 41 percent of employers with 200 or more workers offered retiree health benefits, down from 66 percent in 1988.[41] Employers that continue to offer retirees health insurance benefits are also introducing an array of benefit design changes to control costs. These include capping total costs that the employer will pay, raising retirees' required contributions, increasing copayment and deductible amounts, tightening eligibility rules, or inducing or requiring beneficiaries to enroll in managed care.[42] These changes stem from many factors, but were sparked by the Statement of Financial Accounting Standards No. 106, which was adopted by the Financial Accounting Standards Board in 1992. This rule requires employers to recognize future retiree health benefit obligations in their current financial statements.

Finally, because federal law allows employers to alter or terminate retiree health benefits, they are far from secure. These benefits are regulated by the Employee Retirement and Income Security Act (ERISA), rather than federal or state insurance regulation (as are Medigap policies). Whereas ERISA provides various protections for the design and continuation of pension benefits, it requires little of health benefits, and employers generally are free to modify them, subject to limitations imposed by contract with employees or their representatives.[43] The way in which employer-sponsored benefits are distributed across firm type and industry also may reduce the role of this type of supplemental protection over time, as more people retire from service industry jobs, where they are less likely to receive these benefits.[44]

## Supplementing Medicare through Medicaid

There are four ways in which Medicare beneficiaries with low incomes can qualify for assistance with all or some of the health care costs that Medicare does not cover:

- Medicare beneficiaries who, because of low income qualify for Supplemental Security Income, or who are deemed to be medically needy because of their extensive medical costs, can qualify for "full coverage" Medicaid benefits. They pay neither the Medicare Part B premium nor any of Medicare's deductibles and copayments (these are paid by states through the Medicaid program). In addition, they are eligible for all benefits provided by their state Medicaid program such as coverage for preventive services, prescription drugs, and long-term nursing home care.

- Beneficiaries who do not qualify for Medicaid may be eligible for the Qualified Medicare Beneficiary (QMB) program if their incomes are at or below the poverty level ($8,292 for an individual and $11,100 for a couple). Medicaid pays the Part B premium and the Medicare copayments and deductibles for qualified beneficiaries.

- Beneficiaries with incomes just above the poverty level (not more than 20 percent) may apply for the Specified Low-Income Medicare Beneficiary (SLMB) program. Medicaid will cover their Medicare premium costs.

- Beneficiaries with incomes that are 20 to 35 percent higher than the poverty level can apply for benefits from the Qualified Individuals (QI-1s) program. Medicaid pays the Medicare premiums for qualified individuals, but annual funding for the program is capped, so that only those who apply before the funds appropriated for the program annually are expended actually receive the benefits.[45]

Of the 16.5 percent of all Medicare beneficiaries who are dually covered by Medicaid, just over one-half (8.3 percent) are enrolled under the traditional program, almost one-half (7.4 percent) are eligible through QMB, and 0.8 percent have SLMB coverage.[46] Only about 0.1 percent have QI-1 coverage.

One problem with using Medicaid as a means of supplementing Medicare coverage is that eligibility is episodic: seniors go on and off depending on their income. Even very small adjustments in pensions, other cash benefits, or assets can result in losing eligibility for Medicaid. When individuals lose their Medicaid eligibility, they find themselves at considerable financial risk for Medicare's substantial premium and cost sharing requirements. The uncertainty of remaining eligible for Medicaid (full coverage, or QMB/SLMB) benefits may make Medigap coverage appealing to lower-income beneficiaries, even though the age-adjusted premiums for individual Medigap policies can be quite high.

In addition, many individuals who are eligible for assistance through Medicaid are unaware of the fact. HCFA estimates that about 45.3 percent of beneficiaries eligible for QMB benefits and 84.3 percent of those eligible for the SLMB program were not enrolled in 1996. Altogether, this represents about 57.2 percent of those eligible for the two programs.[47] Just 5,000 of the half million people eligible for QI-1 have it,[48] perhaps due to the fact that this is a very new program. Nevertheless, these figures are disturbing in light of research that suggests that these individuals may be likely to receive less medical care because of the financial cost.[49] If someone is eligible for but not receiving QMB, SLMB, or QI-1, he or she receives also $546 less annually in Social Security benefits because the Part B premium is withheld. Those who are eligible but not receiving QMB benefits are paying the substantial Medicare cost sharing requirements, or may be paying for a Medigap policy that they do not need.

Having full Medicaid coverage makes a tremendous difference in how much a person has to pay out-of-pocket for medical care. In 1997, average out-of-pocket costs for those with Medicaid were $337 per year, compared to $1,738 for those with Medicare coverage only. Those who are officially poor who had Medicaid paid on average only eight percent of their income towards medical expenses and insurance premiums. In contrast, the poor without Medicaid spent about half their family income on health care (54 percent for those without Medicaid who are in traditional fee-for-service Medicare, 48 percent for those enrolled in Medicare HMOs).[50]

## Policy Considerations

The large market for supplemental insurance attests to the inadequacy of Medicare benefits. Unlike insurance that would provide financial coverage against unaffordable health care costs, Medicare leaves a number of gaping holes. Beneficiaries must obtain some form of additional insurance if they are to have what is considered standard health insurance coverage in the employment-based health insurance market.

The supplemental insurance system that has developed to address the limitations of Medicare is not working well. While the OBRA-90 reforms alleviated problems of consumer "fraud and abuse" in the Medigap market, Medigap premiums are high and rising quickly, probably due in part to adverse selection, as healthier people join Medicare managed care plans. In this situation, low and moderate-income beneficiaries whose incomes are too high to qualify for assistance through Medicaid may have to go without any supplemental coverage.[51] The fact that Medigap plans are locked into providing a standard set of benefits limits their ability to offer coverage designed to meet particular beneficiary needs, and may exacerbate adverse selection into plans that offer specific benefits, such as prescription drug coverage. Revising the configuration of the standardized policies set out in OBRA-90, or eliminating the standardization requirements altogether, could give Medigap insurers the freedom to design plans that might better meet beneficiaries' needs, but too much flexibility could create the same potential for consumer confusion that necessitated the original reforms. The "customizing" of Medigap benefits that could result from relaxing standardization requirements might also exacerbate problems of risk selection (and therefore higher premium costs), particularly if beneficia-

ries with serious health care problems continue to feel a need to purchase policies designed to protect them against increasing costs of prescription drugs or coinsurance associated with frequent outpatient visits.

Medicare managed care plans now provide an alternative to individual Medigap coverage. Their premiums usually are cheaper for elderly people who are able to enroll in these plans, and they often provide the coverage people need to avoid financial catastrophe (with the exception of coverage for long-term care). But while membership in these plans is growing, some plans are leaving the Medicare market; among the plans that remain and the new plans entering the Medicare market, the generosity of the supplemental benefits appears to be decreasing. An additional concern is that those who should find these plans most appealing — the sick and the poor — are the same groups who appear to have the most difficulty navigating managed care.

In some ways, employer-sponsored coverage is appealing because the benefits are broad, tending to mimic the benefits available to the working-age population, and it is subsidized by employers. However, supplemental employer-based coverage is generally concentrated among employees of larger firms. Even for these retirees, this supplemental insurance may no longer be reliable. As costs increase, even those who retain coverage are likely to find themselves bearing a larger cost-sharing burden.

For those eligible, Medicaid coverage is perhaps the most ideal in that it covers nearly all health costs with very modest cost sharing requirements. But not all beneficiaries with incomes below the poverty level are eligible for Medicaid, and not all those eligible either for full Medicaid benefits or for assistance with Medicare premiums and copayments are receiving these benefits. The current system may also limit states' ability to implement programs to provide effective coordinated care programs for low-income beneficiaries. Beneficiaries who receive full Medicaid benefits may have very limited incentives to enroll in managed care plans — they have complete supplemental coverage through Medicaid and do not need many of the add-ons offered by managed care plans. Other qualified low-income beneficiaries have substantial protection against cost-sharing if they remain in fee-for-service Medicare. Current law prevents states from requiring that Medicare beneficiaries who are also eligible for Medicaid receive their care through managed care plans. This limits states' and the federal government's ability to take advantage of the potential for cost savings that might be obtained through managed care.

Improving Medicare's benefits package could eliminate many of the inefficiencies that result in high costs to beneficiaries and to the government, as well as inequalities in access to supplemental benefits. It could reduce employers' costs (for administration as well as providing benefits). Improving the benefits package could help states by reducing Medicaid costs for newly-covered services and by reducing the number of individuals who become eligible for Medicaid because of catastrophic health care costs.

At the same time, reforms that would provide incentives to employers to reduce the scope or generosity of employer-sponsored benefits would obviously take valuable benefits away from those retirees who currently enjoy them. From an employer's perspective, reducing the need for retiree benefits could also take away a popular means of attracting and retaining employees. Limiting the need for Medigap insurance would clearly have major consequences for the private insurance industry (including managed care organizations) if supplemental benefits were no longer as attractive to potential enrollees.

*The [supplemental insurance] system is not reliable, equitable, or efficient.*

Those who suffer the most from Medicare's limitations in coverage are near-poor individuals who have substantial needs for medical services. Individual coverage for them is increasingly expensive and absorbs a very large proportion of income. Employer coverage is becoming less available, and for the most part has never been available to retirees from low-wage jobs. Many cannot or do not enroll in Medicaid. Those designing Medicare reforms must consider the consequences of the current system for these beneficiaries in particular, and how trends in coverage and costs may affect future beneficiaries if gaps in Medicare's

benefits package are not addressed as part of Medicare reform.

The problems with the financial protection offered by Medicare are well-known. In fact, the need to fill the gaps prompted the passage of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), while some beneficiaries' concerns about the benefits available to them in the patchwork system of Medicare supplementation underlay its repeal in the following year. That legislation would have provided a cap on out-of-pocket spending as well as some coverage for prescription drugs. At the time of this writing, President Clinton has proposed a voluntary prescription drug benefit as part of a new Part D of Medicare,[52] and other proposals to improve the Medicare benefits package are being developed on Capitol Hill.

As the debate about Medicare's future continues, it is becoming increasingly clear that the system of supplemental insurance that has evolved over the past generation does not provide a stable foundation for the future. The system is not reliable, equitable, or efficient. Structural reform of the Medicare program needs to include a broad reexamination of the basic benefits package and of the potential benefits and costs of public and private supplementation of the health insurance coverage promised to beneficiaries.

## Notes

1 Copayments and deductibles are generally thought to create incentives for patients to use more judgment when deciding to seek out medical services. This can discourage the unnecessary or inappropriate use of health care. Cost-sharing may, however, create barriers to care for people with very limited resources. There is also some evidence that patients do not necessarily have the information they need to make informed decisions about when to seek care, so that cost-sharing may discourage some from seeking appropriate care. See, for example, Manning, W., et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment, *The American Economic Review* 77(3): 251-277, June 1987, and Lohr, K.N., et al., "Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis and Service-specific Analyses in a Randomized Controlled Trial," Medical Care 24(9): supplement, September 1986.

2 McArdle, F., and Yamamoto, D., "Summary," *Presentation on Employer-Based Retiree Health Benefits*, before the Reform Task Force of the National Bipartisan Commission on the Future of Medicare, Washington, DC, July 14, 1998.

3 U.S. Department of Health and Human Services, Health Care Financing Administration, *Medicare+Choice: Changes for the Year 2000* (Baltimore, MD: September 1999).

4 Based on AARP / PPI analysis of the Medicare Benefits Simulation Model (1999 projections), see Bernstein, J., "Should Higher Income Beneficiaries Pay More for Medicare," *Medicare Brief No. 2* (Washington, DC: National Academy of Social Insurance, May 1999).

5 *Ibid*. About 35 percent of elderly beneficiaries have incomes under 200 percent of poverty. About half of those below the poverty line, and 28 percent of the near poor have supplemental coverage through Medicaid.

6 Loss ratios are the percentage of premiums collected that are spent on providing covered health care benefits. If a policy has a 75 percent loss ratio, that means that 25 percent of premiums are retained for administrative costs such as claims payment and marketing, and for profits.

7 U.S. General Accounting Office, *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies*, GAO / HRD-87-8 (Washington, DC: 1986).

8 Rice, T., et al., "The Impact of Policy Standardization on the Medigap Market," *Inquiry* 34: 106-116, Summer 1997.

9 National Bipartisan Commission on the Future of Medicare, *Private Supplemental Coverage Summary*, prepared for the January 5, 1999 Commission meeting, http://thomas.loc.gov/medicare/K-P-1499.html. The figures were tabulated by the U.S. General Accounting Office from data supplied by the National Association of Insurance Commissioners.

10 McCall, N., et al., "Private Health Insurance and Medical Care Utilization: Evidence from the Medicare Population," *Inquiry* 28: 276-287, Fall 1991; U.S. Physician Payment Review Commission, "Private Supplemental Insurance for Medicare Beneficiaries," *PPRC Update #13* (Washington, DC: March 1997); Ettner, S.L., "Adverse Selection and the Purchase of MediGap Insurance, *Journal of Health Economics* 16(5): 499-624, 1997.

11 *Long-Term Budgetary Pressures and Policy Options: Report to the Senate and House Committees on Budget* (Washington, DC: U.S. Government Printing Office, May 1998).

12 U.S. Physician Payment Review Commission, "Private Supplemental Insurance for Medicare Beneficiaries," *PPRC Update #13* (Washington, DC: March 1997).

13 Suppose that a Medigap policy encourages a person to use two more physician services in a year, each of which costs $50. If the person had already met the $100 Part B annual deductible, then $80 of these additional costs would be paid by Medicare since the patient (or Medigap insurer) is responsible for only 20 percent of these extra costs.

14 Dowd, B., et al., "Issues Regarding Health Plan Payments Under Medicare and Recommendations for Reform," *Milbank Quarterly* 70(3): 423-453, 1992.

15 U.S. Physician Payment Review Commission, *Annual Report to Congress* (Washington, DC: 1997).

16 *Ibid*.

17 Physicians can choose whether to accept "assignment" for all Medicare services. For assigned services, total payment is limited to a Medicare fee schedule. If the physician chooses to not accept assignment, he or she can bill the patient up to 15 percent more. Medicare discourages this, however, by offering physicians various incentives to accept assignment.

18 McCormack, L.A., et al., "Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Financing Review* 18(1): 157-174, Fall 1996; and Rice, T., et al., "The Impact of Policy Standardization on the Medigap Market," *op. cit.*

19 Medigap carriers can apply to their state insurance department to add an "innovative" benefit to their policies, but few if any have been approved by any states.

20 In some markets, a Medigap plan that included a basic drug benefit cost more than $4,000 per year for beneficiaries over age 75 in 1999; a comparable Medigap plan without drug coverage cost less than half as much, even though the maximum insurance payout for drugs under the plan is $1,250, after a $250 deductible, and a 50 percent beneficiary coinsurance. See Gluck, M., "A Medicare Prescription Drug Benefit," *Medicare Brief No.1*, (Washington, DC: National Academy of Social Insurance, April 1999).

21 Medicare: New Choices, New Worries," *Consumer Reports* (September 1998): 27-39.

22 Weiss Ratings, Inc., "Many Consumers Severely Overcharged for Medigap Policies," press release (Palm Beach Gardens, FL: May 27, 1999) found at http://weissratings.com.medigap52799.htm.

23 U.S. Census Bureau, *Money Income in the United States:* 1998, Current Population Reports, P60-206 (Washington, DC: U.S. Government Printing Office, 1999).

24 Current HCFA data indicate how many plans offer drug benefits, and how many beneficiaries have access to plans with drug benefits, but, because plans can offer additional benefits (at extra cost) as well as a "basic" plan, data on the benefits individuals actually receive are more difficult to track. A study published in 1999 that used data from the 1995 Medicare Current Beneficiary Survey reported that 95 percent of beneficiaries in Medicare "risk" plans had some drug coverage. Davis, M., et al., "Prescription Drug Coverage, Utilization, and Spending among Medicare Beneficiaries," *Health Affairs* 18(1): 231-243, January/February 1999.

25 Langwell, K., Topoleski, C., and Sherman, D., *Analysis of Benefits Offered by Medicare HMOs, 1999: Complexities and Implications*, prepared for the Henry J. Kaiser Family Foundation (Washington, DC: Barents Group LLC, August 1999).

[26] Spending for prescription drugs almost doubled in the United States between 1992 and 1998; and drug costs are expected to rise between 14 percent and 18 percent in 1999 (while total health care spending is projected to increase by 5.3 percent, see Gluck, M., *op. cit.*

[27] U.S. Department of Health and Human Services, *op. cit.*

[28] Langwell, K., Topoleski, C., and Sherman, D., *op. cit.*; The proportion of plans charging no additional premium has remained relatively stable. In 1996, 63 percent of plans charged no additional premium, and among those that did, the average premium was $13.52 per month. Lamphere, J.A., et al., "The Surge in Medicare Managed Care: An Update," *Health Affairs* 16(3): 127-133, May/June 1997.

[29] *Ibid*.

[30] By the end of 1998, more than 40 Medicare health plans decided not to renew their contracts with HCFA, and another 52 decided to reduce their service areas, affecting more than 400,000 beneficiaries in 371 counties. In 1999, another 41 plans decided to withdraw, and 58 announced plans to reduce their service areas, affecting an estimated 327,000 beneficiaries. Most of the beneficiaries affected lived in areas in which other plans still served Medicare beneficiaries, but some (an estimated 51,000 affected by the withdrawals announced in 1998, and 79,000 more in 1999) were left without a managed care option after the retrenchments (HCFA Press Office, "Protecting Medicare Beneficiaries after HMOs Withdraw," *Fact Sheet*, July 15, 1999). A 1999 study by the U.S. General Accounting Office, however, found that BBA payment revisions had reduced, but not fully eliminated excess payment to plans, and that, overall, the actual enrollment in Medicare managed care plans was expected to increase slightly in 1999. (Scanlon, W.J., Director of Health Financing and Public Health Issues, Health, Education and Human Services Division, U.S. General Accounting Office, "Medicare+Choice: Impact of the 1997 Balanced Budget Act Payment Reforms on Beneficiaries and Plans," testimony presented at hearings before the Finance Committee, Senate, U.S. Congress, June 9, 1999 [GAO/T-HEHS-99-137].) This estimate was reinforced by HCFA's September 1999 report which showed that even with the enrollment slowdowns caused by plan withdrawals, the net monthly enrollment in Medicare+Choice plans averaged about 28,000 throughout 1999, and the rate of enrollment in the late 1990s still exceeded the rate of growth in the number of beneficiaries entering the program as a whole (*Medicare+Choice: Changes for the Year 2000, op. cit.*).

[31] Some of these advantages are likely to partly be the result of favorable selection – beneficiaries in Medicare HMOs tend, on average, to be healthier. Because Medicare's payment formula to HMOs does not do a good job in adjusting for this, HMO payments are perceived by many to be excessive, allowing these HMOs to offer a benefit package that is often more attractive than those that can be offered by Medigap plans. In addition, because standardization requirements stipulate that Medigap plans offering prescription drugs must also provide a number of other benefits, these policies can be very expensive, both because of the costs associated with the enhanced coverage and due to adverse selection.

[32] Ware, J.E., Jr., et al., "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study," *Journal of the American Medical Association* 276: 1039-1047, 1996.

[33] Miller, R.H., and Luft, H.S., "Does Managed Care Lead to Better or Worse Quality of Care?" *Health Affairs* 16(5): 7-25, September/October 1997.

[34] The Medicare provisions of the Balanced Budget Act of 1997 (P.L. 105-33) provide some protection to beneficiaries if their managed care plan withdraws from Medicare. If a beneficiary age 65 chooses to return to fee-for-service after the managed care plan in which they were enrolled withdraws from Medicare participation (or has to return to fee-for-service because there are no other Medicare managed care plans in which to enroll in their area) current law provides for guaranteed issue for Medigap policies for a limited time period — insurers may not refuse to sell them a policy because of age or health status. Guaranteed issue does not, however, prevent insurers from charging high premiums to persons considered to be at risk of high medical costs.

[35] See U.S. General Accounting Office, *Retiree Health Insurance: Erosion in Retiree Health Benefits Offered by Large Employers,* GAO/T-HEHS-98-110 (Washington, DC: 1998); and Levitt, L. et al, and Gabel, J. et al., *Employer Health Benefits, 1999 Annual Survey*. (Menlo Park, CA: Kaiser Family Foundation, and Chicago. IL: Health Research and Educational Trust, 1999).

[36] *Employer Health Benefits, 1999 Annual Survey, op. cit.*

[37] Morrisey, M.A., Jensen, G.A., and Henderlite, S.E., "Employer-Sponsored Health Insurance for Retired

Americans," *Health Affairs* 9(1): 57-73, Spring 1990.

38 These figures were derived from Figure 9 in Gross, D.J. et al., "Out-of-Pocket Spending by Medicare Beneficiaries Age 65 and Older: Further Analysis of 1997 Projections," paper prepared by the Public Policy Institute of the American Association of retired Persons, and the Lewin Group, Inc., presented at the Association for Health Services Research Annual Meetings, Washington, DC, June 23, 1998, which shows the sum of private insurance and Part B premiums for those with employer vs. Medigap coverage. The figures listed here were obtained by subtracting the annual Part B premium.

39 Gluck, M., *op. cit*.

40 McArdle, F., et al, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits.* Prepared for the Henry J. Kaiser Family Foundation (Washington, DC: Hewitt Associates, October, 1999).

41 *Employer Health Benefits, 1999 Annual Survey, op. cit.*

42 U.S. General Accounting Office, Retiree Health Insurance: *Erosion in Retiree Health Benefits Offered by Large Employers,* GAO / T-HEHS-98-110 (Washington, DC: 1998).

43 *Ibid*. Contractual issues, the threat of litigation, and ethical and public relations issue can arise when employers reduce benefits. The General Accounting Office found evidence that firms are more likely to terminate benefits for future employees than current retirees.

44 *Ibid*.

45 A final category (called QI-2's) includes individuals with incomes that are below 175 percent of the poverty line, who are eligible for only very limited assistance. Qualifying individuals can apply to Medicaid to pay for a portion of their Medicare premium that is the result of a shift in program costs for most home health services from Part A to Part B by the 1997 Balanced Budget Act. See U.S. Congress, Congressional Budget Office, *Long-Term Budgetary Pressures and Policy Options, Report to the Senate and House Committees on Budget* (Washington DC: U.S. Government Printing Office, May 1998).

46 Eppig, F.J., and Chulis, G.S., "Trends in Medicare Supplementary Insurance: 1992-96," *Health Care Financing Review* 19(1), 201-206, Fall 1997.

47 Barents Group, LLC, *A Profile of QMB-Eligible and SLMB eligible Medicare Beneficiaries* (Washington, DC: Barents Group LLC, April 7, 1999), prepared for the Health Care Financing Administration, Contract #500-95-0057 / Task Order 2.

48 Families USA Foundation, *Shortchanged: Billions Withheld from Medicare Beneficiaries* (Washington, DC: July 1998).

49 *Ibid*.

50 Gross, D.J. et al., *op. cit.*

51 Moon, M., Brennan, N., and Segal, M., "Improving Coverage for Low-Income Medicare Beneficiaries," *Policy Brief* (New York, NY: The Commonwealth Fund, December 1998). The authors estimate that among beneficiaries with annual incomes less than $15,000, 16.3 percent lack any supplementation, compared to 11.6 percent of the total Medicare population.

52 After a phase-in period, this benefit would cover 50 percent of prescription drug costs up to a maximum benefit of $2,500 a year, for a premium estimated by the Administration to be $44 per month.

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