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Coordination of Health Coverage for Medicare Enrollees: A Case Study of HIV/AIDS

by June Eichner

Summary

When people with HIV/AIDS become eligible for Medicare, they find that it does not pay for a significant share of their health care needs. As enrollees seek supplemental health coverage (e.g., Medicaid, employer-sponsored and individually-purchased insurance, and premium payment programs), they find that though there are numerous potential benefit and insurance options, the rules are complex and often conflicting. The search for comprehensive health coverage is further complicated by the fact that each program is separately administered, with different eligibility requirements and application processes. Because each program and agency's staff knows little about other programs, they are often unable to help coordinate coverage.

Respondents to the study believe that people with a serious chronic condition would benefit from reforms that make Medicare's benefits more comprehensive and its eligibility, coverage, and payment rules less complicated. They also said that enrollees need better access to Medicare information and enhanced mechanisms to coordinate Medicare with supplemental health coverage. Some HIV/AIDS organizations have developed benefits counseling programs that help their clients piece together a synthetic health coverage "system." These and other issues discussed in this Medicare Brief illustrate possible policy reforms that could help enrollees with HIV/AIDS and other serious chronic conditions.

Since Medicare was enacted in 1965, it has focused on insuring against the costs associated with discrete episodes of illness. Over time, more effective pharmaceuticals and medical technology have become available to better control chronic conditions. Consequently, more Medicare enrollees can expect to live many years with one or more serious chronic conditions. While Medicare has never fully covered the range of services needed by those with acute care needs, its gaps are even more apparent to those with serious chronic conditions. Its lack of coverage for long-term care and other supportive services, and its omission of an outpatient prescription drug benefit, are most notable to those with chronic conditions. Thus, Medicare enrollees—both the disabled and the aged—must find supplemental health coverage to pay for the range of services they require.

Medicare is the road and you have to fill in the potholes.

—HIV benefits counselor

June Eichner is Senior Research Associate at the National Academy of Social Insurance. Financial support for this Brief is provided by the Robert Wood Johnson Foundation. Chris Collins, a consultant for the National Association of People with AIDS, contributed to this project. The *Medicare and HIV/AIDS in California* project funding was provided by the California HealthCare Foundation.

Medicare originally provided health coverage to the elderly and in 1972 expanded eligibility to include persons under age 65 with long-term disabilities and end stage renal disease. Medicare presently serves 34.4 million elderly and 5.5 million disabled under the age of 65. Nearly all of the disabled enrollees and 82 percent of the elderly enrollees have at least one chronic condition (Anderson, 2001). Eligibility is automatic for almost all of the over age 65 population. Those under age 65 become eligible for Medicare 24 months after becoming entitled to Social Security disability insurance (SSDI) benefits. Social Security Administration (SSA) requires that beneficiaries be deemed unable to work because of a physical or mental impairment that is expected to last at least a year or result in prior death. In addition, individuals must have paid Social Security taxes through their workplace for a minimum number of fiscal quarters.

To assess the programs and supports available to Medicare enrollees with HIV/AIDS and other chronic conditions, and the difficulties that they face, the National Academy of Social Insurance, in collaboration with the National Association of People With AIDS, conducted a research study. The study was conducted in California, a state with a high prevalence of HIV infection, a diverse patient population, and a variety of community-based models and resources available to people with HIV/AIDS. Study components included a series of structured interviews and a review of federal, state, and local program regulations (see Methodological Note, page 11). Structured interviews were conducted in July through November 2000. Respondents to the interviews included regional staff of the Health Care Financing Administration (HCFA) and the Health Services Research Administration (HRSA), state officials, field staff of the SSA, local welfare agencies, AIDS and aging organizations, and physicians and other service providers.

Using people with HIV/AIDS as an example of a Medicare population with a chronic disease, this brief describes:

- Medicare's strengths and weaknesses as a means of providing health security to people with long-term chronic heath conditions;
- Medicare's fit into the highly evolved web of programs utilized by people with a serious chronic illness;
- The role of benefits counseling in helping enrollees piece together a health coverage system; and
- Issues for policymakers and federal and state agency staff to address.

HIV/AIDS as an Example of A Chronic Disease

Though the experiences of people with HIV/AIDS are in some ways unique, they provide a window into the future of the Medicare population. Like many elderly enrollees with long-term chronic illnesses, HIV patients receive much of their health care outside of the hospital and are heavily dependent on expensive prescription drugs that are not covered by Medicare. People with HIV/AIDS also illustrate the complex care management needs that will become increasingly common among older Medicare enrollees. As with other disabled Medicare enrollees under the age of 65, the number of enrollees living with HIV/AIDS is expected to increase significantly as drug therapy transforms the disease into a long-term chronic condition. Such enrollees will likely live with the disease for many years, but will also have significant chronic care needs.

HIV has forced the scientific world to look at how the immune system works, as well as how we provide a system of care. The AIDS community has founded a care system that helps piece together a benefits system. The cancer community and others have not yet set up such a system.

—HIV benefits counselor

People living with HIV are also an example of a relatively young and well-organized chronic disease pop-

ulation that has successfully lobbied for additional programs and regulations to support their health coverage. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, for example, was funded in response to the HIV/AIDS epidemic and in FY 2000 received nearly $1.6 billion in federal funds (Kaiser Family Foundation, 2000). While this and other programs uniquely target people with HIV/AIDS, the experience of this group may increase the understanding of policymakers grappling with the design of Medicare benefits and coverage, as well as the coordination of services across various public and private payers.

People are overwhelmed by the combination of bureaucracies.

—HIV benefits counselor

Supplementary Health Coverage Programs and Insurance

A number of health coverage programs and insurance options are available to Medicare enrollees in California. The major programs and insurance used by enrollees include California's Medicaid program (Medi-Cal), AIDS Drug Assistance Program (ADAP), private insurance, Medi-Cal/HIPP (Health Insurance Premium Payment) and CARE/HIPP. (See Table 1 on pages 4 & 5 for descriptions.) Some are available to enrollees without regard to health status (e.g., employer-sponsored insurance); others are designed specifically for those with a high-cost disease (e.g., Medi-Cal/HIPP); several are available only to people with HIV/AIDS (e.g., CARE/HIPP, ADAP). According to the benefits counselors, most of the Medicare enrollees they advise are successful at finding supplemental insurance that meets a large share of their health care needs.

Even if the disabled under-65 population could afford a MedSupp [California's Medigap] policy that has drug benefits, the drug limits are so low that the policy is not worth the cost.

—Health benefits consultant

Overview of Major Supplemental Health Coverage Programs Used by Medicare Enrollees with HIV/AIDS

Medi-Cal (California's Medicaid program)	provides comprehensive health coverage to low-income, low-asset aged, blind, and disabled individuals and families with children. It is jointly funded by federal and state funds. Medi-Cal automatically covers individuals who qualified for Supplemental Security Income. Individuals with somewhat higher incomes and a high-cost disease may qualify for Medi-Cal under its medically needy category.
AIDS Drug Assistance Program (ADAP)	helps to pay for HIV-related drugs for low and moderate-income individuals who lack coverage for those drugs. ADAP is jointly funded by state and federal funds under the Ryan White CARE Act.
Medi-Cal Health Insurance Premium Payment (Medi-Cal/HIPP)	assists Medi-Cal enrollees with a high-cost disease continue their private insurance. Under this program, Medi-Cal will pay the premium for the individual to continue any group or individual private health insurance that covers the disease.
Ryan White CARE Health Insurance Premium Payment (CARE/HIPP)	helps disabled individuals with HIV continue their private insurance. The private insurance must provide coverage for prescription drugs. The program, jointly funded by federal CARE funds and state funds, targets persons who are expected to be Medi-Cal or Medicare eligible within one year.

Table 1: Major Health Coverage Programs and Insurance Utilized by

	What is its Purpose?	Who is Eligible?
Medicare	Entitlement program to protect the aged and disabled from high medical expenditures by covering hospital, laboratory, and physician services	Over age 65 Under age 65 and have received Social Security disability benefits for 24 months
Medi-Cal (State of California's Medicaid program)	Benefits program to provide low-income aged and disabled persons, children and families with comprehensive health care	Aged, blind, and disabled persons, or certain parents and children with low income and limited assets. In 2000, Medi-Cal monthly income limit was $620; asset limit, $2,000. Medically needy people with high medical bills Low-income Medicare enrollees with incomes still above Medi-Cal limit[2]
ADAP (AIDS Drug Assistance Program)	Provides HIV-related drugs for low-income, uninsured, and underinsured individuals	Diagnosis of HIV infection, drugs not covered by health insurance, and income less than $50,000/yr. (no asset limits)
Private Insurance	Protection from high medical expenditures in the form of indemnity insurance or as prepaid health care Employees of employers offering health insurance	Non-working disabled sometimes permitted to continue employer coverage Dependent spouse/domestic partner coverage (if offered by employer) Individual policies through conversion of group policy or by continuing an individual policy obtained prior to becoming HIV+ (individual responsible for full premium)
Medi-Cal/HIPP (Health Insurance Premium Payment)	Assists Medi-Cal enrollees with high-cost medical diseases to continue their private insurance	Medi-Cal eligibility, a high-cost disease, and group or individually-purchased insurance that covers the beneficiary's high-cost disease Medi-Cal eligibility, a high-cost disease, and group or individually-purchased insurance that covers the beneficiary's high-cost disease
CARE/HIPP (Ryan White Comprehensive AIDS Resources Emergency Act/ Health Insurance Premium Payment)	Assists the disabled with HIV to continue their private insurance	Diagnosis of HIV infection, disabled or have applied for disability, and private health insurance that covers medical care and prescription drug coverage for HIV/AIDS

California's Medicare Enrollees with HIV/AIDS

Who Manages Eligibility and Enrollment?	Who Administers and Manages the Program?
The Social Security Administration (SSA)	Administered and managed by the Health Care Financing Administration (HCFA)
Automatic eligibility granted by the State of California to those deemed eligible for Supplemental Security Income (SSI) by SSA. Others' eligibility determined by the state of California, with applications reviewed by local social service and welfare offices Enrollment managed by the state of California	Jointly administered by HCFA and the state of California Managed by counties through their local social service agencies or welfare department
The state of California through its ADAP contractor	Funded and administered jointly by the Health Research Services Administration (HRSA) (under the Ryan White CARE Act) and the state of California Managed by the state of California through its ADAP contractor
Employers, health insurers, within federal and state regulations	Group policies purchased through employers, the state of California, professional associations Individual policies purchased directly from insurance companies Some oversight by state of California Departments of Insurance & Managed Health Care
The state of California	See Medi-Cal
The state of California	See ADAP

Figure 1

Supplemental Benefit Programs and/or Insurance for Medicare Enrollees with HIV/AIDS

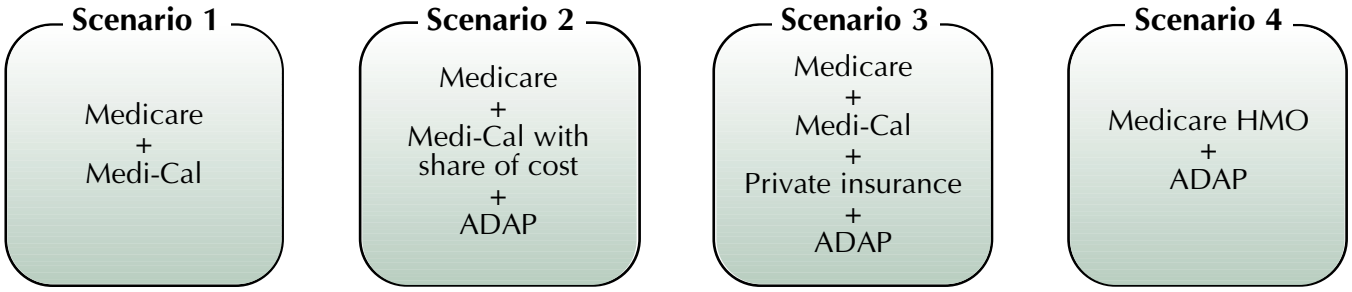

Table 1 lists the major coverage and insurance programs used by Medicare enrollees with HIV/AIDS in California. It also shows the differing purposes of each program, the various administrators and managers, and the beneficiary groups targeted by each of these programs. Eligibility requirements for most programs are detailed, complicated, and have many exceptions and caveats. Thus, eligibility requirements shown in the table are not complete and are meant only to illustrate general parameters.

Though there are numerous permutations, Figure 1 depicts four of the most common ways that Medicare enrollees with HIV/AIDS in California pay for their health care.

As shown in Scenario 1 of Figure 1, dual enrollment (Medicare—Medi-Cal) represents a common way that Medicare enrollees supplement their Medicare coverage. During the two-year wait for Medicare, many low-income, low-asset SSDI beneficiaries automatically qualify for full Medi-Cal by receiving Supplemental Security Income (SSI) and continue on Medi-Cal after Medicare coverage begins. Other SSDI beneficiaries, particularly those who have experienced a decline in income and assets since becoming eligible for SSDI, apply directly to the state for Medi-Cal benefits. Dual coverage meets most of enrollees' needs because Medi-Cal pays for Medicare's Part B premiums, deductibles, and coinsurance, and fills many of Medicare's gaps, including prescription drugs.

In Scenario 2, enrollees supplement Medicare with Medi-Cal (though in this example they pay a share of their medical costs) and ADAP. This combination is used by disabled Medicare enrollees with incomes above the Medi-Cal limits (though within its asset limits) but who have high medical expenses. Medi-Cal pays Medicare's premiums, deductibles, and/or coinsurance. Medi-Cal does not pay Medi-Cal expenditures until its enrollees fulfill their share of cost. (As an example of "share of cost," if an SSDI beneficiary has income of $950 per month while Medi-Cal allows the disabled a monthly maintenance need of $620 per month, the beneficiary is required to pay $330 per month to share in the cost of their Medi-Cal.) Drugs received through ADAP, however, are applied towards this share of cost. (After receiving authorization from the ADAP contractor, the dispensing pharmacy posts the

Clients are told to get their ADAP drugs on the first of the month so their share of cost is cleared. Also, since Medi-Cal has a six-prescription/ month limit [which excludes most HIV-specific drugs], they need to coordinate their ADAP and Medi-Cal drugs. For many, pharmacists are their most important care managers.

—County Health Dept. ADAP Staff Member

authorized amount payable by ADAP into the Medi-Cal system.) ADAP covers HIV-related drugs up to the share of cost amount. After the share of cost is met, Medi-Cal pays for those Medi-Cal services that Medicare does not pay for, including prescription drugs.

Scenario 3 represents Medicare enrollees who have private insurance (most through a former employer; some through an individually-purchased policy) and who also qualify for Medi-Cal (based on income and/or medical expenses). Medi-Cal's HIPP program then pays the private insurance premium. The private insurance covers most of the medical expenses and prescription drugs. Those who also have ADAP use ADAP to pay for prescription drug copayments and HIV-related drugs that their private insurance does not pay for. For those with a Medi-Cal share of cost (share of cost must be $200 or less to qualify for Medi-Cal/HIPP), copayments and drugs that are paid by ADAP are applied towards their share of cost.

In Scenario 4, enrollees voluntarily join a Medicare HMO. Many HMOs, however, charge a premium (on top of the Medicare Part B premium that is deducted from beneficiaries' SSDI checks), provide limited prescription drug coverage, charge copayments for drugs, and have formularies that do not include the full range of HIV-related drugs. For those who qualify for ADAP, ADAP will pay for those HIV-related drug copayments and drugs not covered by the HMO.

Coordination and Information Issues

The complexity of Medicare's interaction with other health coverage programs accentuates the need for coordination among agencies and increases the demand for information. The lack of coordination among payers and programs, however, makes it less likely that information is shared among agencies and staff.

The biggest problem is that all the different entities don't coordinate.

—HIV benefits counselor

Coordination among agencies and programs

The multiple programs needed to provide complete health coverage result in a piecemeal and complex conglomeration. Lack of coordination exacerbates the difficulties of navigating the "system."

- The multiple programs are administered by different agencies. For example, Medicare is administered by HCFA (federal), while ADAP is administered by HRSA (federal) and the state of California.

Most government workers tend to specialize in only one area. People need to understand how programs fit together. They need the big picture.

—AIDS organization policy staff member

- Some programs are managed by separate divisions within an agency. For example, Medicare and Medicaid are run by different divisions of HCFA Central and Regional offices (with Medicaid also being administered by the state and counties, according to federal rules.)

- Programs lack coordination with regard to eligibility requirements and benefits structure. Many of the programs have conflicting requirements, and what qualifies persons for one program may disqualify them for another.

Whether a dual eligible [enrollee] is allowed to join a Medi-Cal and/or a Medicare managed care plan is a question we have been unable to get a clear answer to.

—HICAP staff member

- Roles of agencies managing a single program are unclear. For example, the roles of SSA and HCFA regarding Medicare are blurred: HCFA regional staff told us that SSA staff does not need to know about Medicare because "Medicare is HCFA's job." SSA staff, however,

find their roles deeply entangled in Medicare as a result of SSA's responsibility for Social Security disability determinations and questions from disability beneficiaries.

- As their health improves, many people with HIV/AIDS desire to return to work but are concerned about losing their health coverage. The federal Ticket to Work and Work Incentives Improvement Act of 1999, Section 202, Extending Medicare Coverage for Social Security Disability Beneficiaries Who Work, was intended to address this issue. However, study participants cited tremendous concern about returning to work because many of their clients are covered by multiple health and income support programs, each with its own policies. (The new federal guidelines had not been issued at the time of our interviews.)

There is no formal coordination between agencies and staff. Coordination happens by making personal relationships.

—HIV benefits counselor

- Health coverage options are intertwined with income and other related benefits. SSDI and SSI provide income support as well as a direct link to Medicare and Medi-Cal. People with chronic diseases may also have access to private long-term disability insurance, food stamps, and housing assistance, each with its own income and asset limits.

ADAP is one example of a program that coordinates well with other agencies and programs. Designed to fill the gaps in prescription drug benefits for people with HIV/AIDS, ADAP serves individuals covered by Medicare, private insurance, and share of cost Medi-Cal. ADAP also coordinates with Medi-Cal by applying the cost of ADAP prescription drugs towards the beneficiary's share of cost. According to respondents, HRSA, HCFA, the state, and the counties have worked well together to support the coordination of ADAP with other programs.

Information about Medicare

Medicare information is difficult to access, according to study respondents. Community-based providers, federal, state, and local agency staff all reported difficulty finding answers to their questions.

Some Medi-Cal eligibility workers do not mention the Buy In and HIPP programs to clients because they do not understand the process; others because they have too many clients and too little time.

—HCFA regional staff member

- Many welfare and SSA staff said that they and their clients turn to SSA to answer their questions about Medicare, with most calling the SSA 1-800 line. This line, however, was said to be unreliable—the wait to speak with a staff member is often long and the information is often incorrect. According to respondents, most SSA workers do not know to refer clients to the Medicare Fiscal Intermediary or Carrier (the private insurance companies contracted by Medicare to process Part A claims and Part B claims).

Timing is important. People must find out about CARE & Medi-Cal/HIPP and fill out the application before they drop private insurance. Some find out too late.

—State CARE/HIPP staff member

- While HCFA Region IX Medicare staff said that a Medicare 1-800 hotline number was available, few other respondents knew of it. None of the respondents mentioned HCFA's Medicare website.
- California's Medicare Fiscal Intermediary and Carrier were said to be a resource for benefit and claims questions by some of the benefits counselors and consumer advocacy staff. None

mentioned them as a source of information on other Medicare topics (e.g., eligibility, return to work policies).

- The Health Insurance Counseling and Advocacy Program (HICAP), California's state-federal funded State Health Insurance Assistance Program (SHIP), designed to provide free health insurance counseling and assistance to people with Medicare, are known as a source of Medicare information in some counties. Some respondents said that they do a better job at reaching the elderly than the disabled. In other counties they were not mentioned as a resource.
- HCFA Region IX Medicare staff was generally not known by the study respondents and few respondents utilize them for information. Only 28 employees staff the Division of Beneficiary Services and their job descriptions do not specify that they directly serve enrollees or community staff.

Doctors need succinct things that explain the process and eligibility criteria. That information never gets to us. My assumption is that rules change frequently so that it's hard to keep up with.

—Private practice physician

- Medicare information from HCFA to enrollees is provided through HCFA's "Medicare and You" booklet. Though respondents said that the booklet is helpful to their more educated clients (few of their less educated clients read it), the booklet is mailed out only once a year to all enrollees. Because it is not timed to coincide with enrollment, a new enrollee could wait nearly a year to receive a booklet.

Importance of Benefits Counseling

A number of AIDS organizations have created staff positions devoted specifically to benefits counseling. These counselors are trained to provide information on the range of health coverage options. The training process, however, is long and difficult. One AIDS organization's training manual is over 250 pages long; another has its new counselors apprentice for nine months before allowing them to counsel on their own. A number of the counselors are attorneys.

It is a maze to help clients figure out what programs are available to them.

—AIDS organization staff

Benefits counselors are instrumental in providing the following:

- information and advice on SSDI, SSI, Medicare, and other health coverage programs
- assistance with eligibility forms
- advocacy and appeals (Social Security disability determinations, Medicare Part B reinstatement, claim denials)
- coordination of benefits
- relationship building with local SSA, welfare, state, and other office staff

According to respondents, the role of the AIDS organizations' benefits counselors is crucial. Along with assisting their own clients, they provide education, training, and assistance to staff at other community organizations. The most sophisticated of the AIDS organizations help clients complete the applications for all programs in their office. The Los Angelos and San Francisco HIV organizations that were interviewed receive partial funding for benefits counselors from the local Ryan White Planning Council (responsible for setting service activities for the allocation of HRSA's Ryan White CARE Act funds). Additional funding comes from the organization's general fund or from grants solicited by the benefits staff themselves.

Benefits counselors should not [need to] exist, but we are needed to do magic in order to get people covered.

—HIV benefits counselor

Issues for Medicare

There are important lessons to be learned from California's HIV/AIDS community. The great majority of Medicare enrollees with chronic diseases have even less access to supplemental program and counseling supports than do people with HIV/AIDS. Coordination of health coverage is critically important for a large proportion of Medicare enrollees with one or more chronic conditions.

The following is a summary of the major Medicare coordination issues highlighted by this study. Policymakers, HCFA, other federal and state staff, and chronic disease and aging association staff will need to work together to effectively address these issues.

- Benefit package is incomplete.
- Complicated rules and regulations.
- Insufficient information about Medicare and its coordination with other payers.
- Lack of coordination of eligibility requirements and benefits.
- Lack of coordination among agencies and staff.
- Insufficient attention to the disabled, under age 65 population.
- Insufficient support and funding for benefits counselors.

A number of respondents also expressed the view that the solution to the coordination of coverage problem would be a national health program. In its absence, improved coordination and increased information would help. Those who have seen the impact of the HIV/AIDS benefits counselors believe that the benefits counselors have an immediate and positive impact in helping their clients piece together a health care "system." They recommended that Medicare and other aging and chronic disease groups consider developing benefits counseling programs.

Methodological Note

The core of the project on Medicare and HIV/AIDS in California was structured qualitative research to examine the design of Medicare benefits and coverage, as well as the coordination of the other multiple programs available. A total of 37 pre-site and on-site interviews were conducted with regional and state program staff, public health and policy experts, and health care and social service providers (e.g., physicians, local welfare, Social Security Administration (SSA), AIDS and aging organizations). Three sites in California were chosen: San Francisco, Los Angeles, and Kern counties. In addition, interviews were conducted in the Bay Area with state officials, field staff of the Health Research Services Administration (HRSA), and Region IX (covering California, Nevada, Arizona, Hawaii, Guam, and the Pacific territories) staff of the Health Care Financing Administration (HCFA). The structured interviews were augmented by a review of federal, state and local program regulations.

This study of Medicare and HIV/AIDS is meant to explore the health coverage situation that Medicare enrollees face. It also illustrates how state and local communities have addressed these health coverage issues. The results may not be fully generalizable to other states; many of California's public programs (e.g., Medi-Cal (the state of California's Medicaid program), State Disability Insurance, and AIDS Drug Assistance Program are more generous than in many other states. Those interviewed are also among those in their communities who are most knowledgeable about health benefits for people with HIV/AIDS. In addition, San Francisco and Los Angeles have long-established HIV/AIDS community-based providers and organizations, with their medical and social support systems considered among the most advanced in the United States. Thus, the experiences of people with HIV/AIDS described here are a "best case" scenario—in much of the nation and for those with other chronic diseases, the situation can be even more difficult.

Notes

1 Recipients of Social Security disability benefits include three categories of disabled individuals: a) Disabled worker beneficiaries eligible based on their own work in employment covered by Social Security; b) Disabled widow(er)s age 50 and older eligible for survivor benefits based on a deceased spouse's work record; c) Disabled adult children with a severe disability that began in childhood are eligible as the dependent of a parent who is retired, disabled or deceased.

2 Qualifies them for the Medicare Buy In program, with Medi-Cal paying Medicare's premiums, deductibles, and/or coinsurance.

3 In January 2001, after interviews were conducted, a new benefit program, the Aged and Disabled Federal Poverty Level program, was instituted. This new program is expected to provide Medi-Cal without requiring a share of cost to approximately 58,000 eligible California residents.

4 Though Medicare HMOs (Health Maintenance Organizations) enroll residents of Los Angelos and San Francisco counties, not all counties have Medicare HMOs in operation.

References

Anderson, Gerard, presentation at the National Academy of Social Insurance 2001 Annual Conference, January 25, 2001.

Kaiser Family Foundation, "Financing HIV/AIDS Care: A Quilt with Many Holes," October, 2000.

Acronyms

ADAP	AIDS Drug Assistance Program
CARE	Ryan White Comprehensive AIDS Resources Emergency Act
HCFA	Health Care Financing Administration
HICAP	Health Insurance Counseling and Advocacy Program
HIPP	Health Insurance Premium Payment
HMO	Health Maintenance Organization
HRSA	Health Research Services Administration
SHIP	State Health Assistance Program
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

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202/452-8111 Fax
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