CHAPTER 6

Improving traditional Medicare's benefit design

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Chapter summary

Fee-for-service (FFS) Medicare does not protect beneficiaries against catastrophic levels of out-of-pocket (OOP) spending. Lack of catastrophic protection means that beneficiaries with high spending on health care must pay substantial amounts unless they have supplemental insurance to cover Medicare's significant cost-sharing requirements. Yet coverage that fills in most or all of Medicare's cost sharing can lead to higher use of services and Medicare spending, and its prevalence prevents Medicare from being able to use cost sharing as a policy tool.

The most widely used sources of secondary coverage today are employer-sponsored retiree insurance, individually purchased medigap policies, and Medicaid coverage. There are important differences in beneficiaries' access to and prices for those sources of coverage. In turn, those differences lead to wide variation in beneficiaries' spending for premiums and cost sharing.

A Commission-sponsored study on the relationship between secondary coverage and Medicare spending provides evidence that beneficiaries

In this chapter

- Beneficiaries' financial liability varies widely
- Supplemental coverage can lead to higher Medicare spending
- Benefit design as a policy tool

are sensitive to cost sharing and that spending for beneficiaries with secondary insurance tends to be higher for:

- elective hospital admissions compared with emergency and urgent admissions for conditions that require more immediate medical attention,
- preventive care,
- office-based care compared with hospital-based care,
- medical specialists compared with primary care or generalist physicians, and
- services such as minor procedures, imaging, and endoscopy.

In the future, cost sharing could be used as a tool to complement various policy goals such as: improving financial protection for Medicare beneficiaries and distributing cost-sharing liability more equitably among individuals with different health care costs, encouraging use of high-value services and discouraging use of low-value ones, and reinforcing reforms in the payment system that seek better value for health care expenditures. An additional goal may be to improve Medicare's financial sustainability.

Inherent conflicts exist among these goals. For example, an OOP cap to the FFS benefit could improve financial protection for the sickest beneficiaries, but, without other measures, such catastrophic protection would result in substantially higher Medicare program spending and worsen the program's long-term financial situation. Several of the goals require more nuanced and targeted approaches to cost sharing than Medicare uses today and would need further development of methods to evaluate quality, compare effectiveness of therapies, and measure provider resource use. Steps toward each of the goals would be more effective if changes were made to Medicare's deductibles and coinsurance while the role of supplemental coverage was redefined. ■

Introduction

If policymakers were drawing up Medicare's fee-for-service (FFS) benefit from scratch, they would probably design it differently. For example, they might include catastrophic protection and design cost-sharing provisions in ways that encourage beneficiaries to weigh their use of discretionary care without discouraging needed care.

The structure of Medicare's traditional FFS benefit has shortcomings in its coverage that lead most beneficiaries to take up secondary insurance through former employers, individually purchased medigap policies, or Medicaid. Supplemental coverage often protects beneficiaries from high out-of-pocket (OOP) spending and reduces their paperwork burden. At the same time, some of the most widely used sources of secondary coverage fill in nearly all of Medicare's cost sharing without deductibles or copayments. Because access to secondary coverage is not equal across beneficiaries, the distribution of beneficiaries' financial liability varies widely. Supplemental coverage also leads to higher Medicare spending because it reduces or eliminates cost sharing for the services beneficiaries use.

Today, the prevalence of supplemental coverage prevents Medicare from being able to use cost sharing as a policy tool. Since Medicare's inception in 1965, employers and private insurers have experimented with benefit design to control growth in health spending. Some approaches have been more effective at redistributing the incidence of health costs than at affecting when and from whom patients seek care. Other approaches hold promise by using cost sharing in more targeted ways to steer beneficiaries toward preferred providers or more valuable therapies. For the future, FFS benefit design and cost sharing could be used to pursue policy goals, such as to encourage use of providers with better track records on quality and resource use, to encourage specific patients to adhere to certain treatments, and to discourage provision of overused services. But, for such measures to be effective, decision makers would also need to redefine when supplemental coverage may fill in Medicare's cost sharing.

Beneficiaries find it difficult to predict OOP costs in FFS Medicare

Under Medicare's FFS benefit alone, beneficiaries cannot easily predict their OOP costs. The FFS benefit has cost-sharing requirements that vary by type of service and site of care (see text box, pp. 142–143). A major shortcoming of the FFS benefit is that it has no catastrophic limit on OOP spending. These features, combined with the fact that patients rarely know what their providers charge or what detailed list of services they will need, make it difficult to predict OOP costs. For example, if a beneficiary has a hospitalization, she is responsible for a large inpatient deductible ($1,068 in 2009) and, after a separate Part B deductible ($135 in 2009), 20 percent coinsurance for services associated with the hospitalization, such as ambulance transportation and physician care (e.g., for the attending physician, surgeon, and anesthesiologist). The beneficiary cannot predict Medicare's cost sharing for these services.

For Medicare beneficiaries with lower incomes, unpredictable financial liability for health care (i.e., amounts paid OOP for cost sharing and premiums) can be especially burdensome. In 2005, 16 percent of beneficiaries had income less than the federal poverty level ($9,570 for a single person and $12,830 for a couple); 45 percent had income at 200 percent of that level or less (MedPAC 2008a). In 2006, Social Security payments were 50 percent or more of annual income for 52 percent of aged beneficiary couples and 72 percent of aged unmarried beneficiaries (Social Security Administration 2008).

About 90 percent of FFS beneficiaries take up secondary coverage

To reduce uncertainty about OOP spending, most FFS beneficiaries have some form of secondary insurance. Supplemental coverage increases predictability for beneficiaries by covering Medicare cost sharing at the point of service in return for regular monthly premiums. Excluding beneficiaries in private Medicare plans and those who were institutionalized, in 2005, 89 percent of beneficiaries had some form of secondary coverage (Figure 6-1). Employer-sponsored retiree coverage that wrapped around Medicare's benefit was the most common source, followed by individually purchased medigap policies and Medicaid. (A portion of beneficiaries included in the medigap category report that they have both employer-sponsored and medigap policy coverage.) Just 11 percent of FFS beneficiaries relied on Medicare alone.[1]

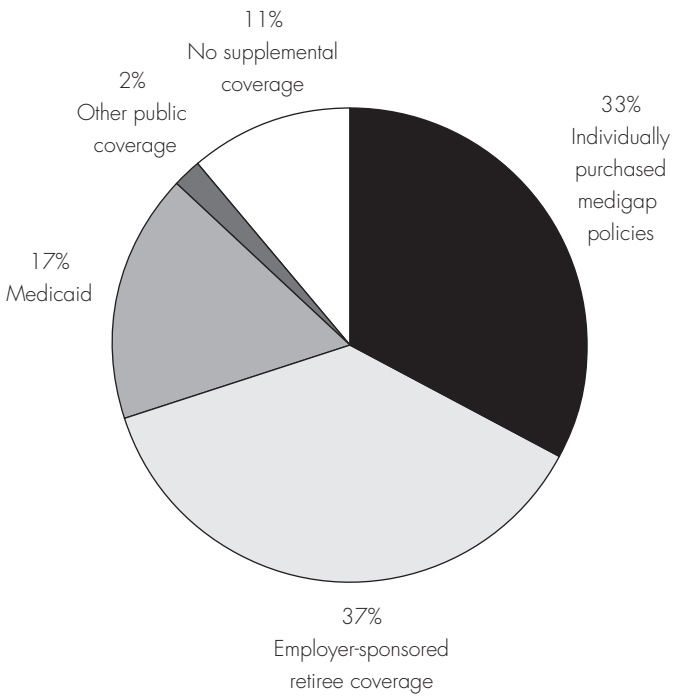
There are important differences among sources of supplemental coverage.

Employer-sponsored retiree coverage

The combination of FFS Medicare with an employer-sponsored policy often provides beneficiaries with

FIGURE 6–1

Most FFS beneficiaries have supplemental coverage that fills in some or all of Medicare's cost-sharing requirements



Note: FFS (fee-for-service). Analysis excludes beneficiaries with any enrollment in Medicare Advantage plans and those living in institutions such as nursing homes. It also excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2005 or who had Medicare as a secondary payer. Beneficiaries were assigned to the supplemental coverage category that applied for the most time in 2005. Beneficiaries with both individually purchased policies and employer-sponsored coverage are included in the medigap category.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files, 2005.

broader coverage for relatively low premiums. However, this combination may not fill in all cost sharing and is not available to everyone. Retiree policies through large employers typically include a lower deductible for hospitalizations than Medicare's; a cap on OOP spending; and sometimes benefits that FFS Medicare does not cover, such as dental care (Yamamoto et al. 2008). Employers who offer retiree plans often pay for much of the premium for supplemental coverage. One 2007 survey found that, on average, large employers subsidized 60 percent of the total premium for single coverage; retirees paid 40 percent, or about $1,600 annually ($133 per month) (Gabel et al. 2008). Many employer plans require retirees enrolled in Medicare to pay deductibles and cost sharing just as is common of active workers and younger retirees.

Retiree coverage is not available to all. Large employers in certain industries have been more likely to offer benefits than others; the availability of this source of coverage is correlated with the location of large firms in certain industries (KFF/HRET 2008).[2] The percentage of Medicare beneficiaries with retiree coverage has remained fairly constant since the early 1990s (Merlis 2006). However, the number of large employers offering retiree coverage to new retirees has been declining, which will affect future cohorts of Medicare beneficiaries. One survey found steady declines in the percent of large employers offering health insurance to Medicare-eligible retirees—from 40 percent in 1993 to 19 percent in 2006 (EBRI 2008). Evidence also suggests that a declining share of new entrants to Medicare (ages 65 to 69) have employer-sponsored insurance as a source of secondary coverage (Stuart et al. 2003).

Medigap policies

By comparison, individually purchased Medicare supplement (medigap) policies are available to most beneficiaries, cover nearly all of Medicare's cost sharing, and tend to have higher premiums. All beneficiaries age 65 or older are guaranteed the opportunity to purchase a medigap policy, regardless of health status, during the 6-month period beginning the month when they enroll in Part B.[3] Federal law does not require insurers to sell medigap policies to Medicare beneficiaries who are younger than 65 and are disabled or have end-stage renal disease. For these individuals, access to medigap policies is uneven—27 states require insurers to offer at least one type of medigap policy—and premiums may be higher because policies may be subject to medical underwriting. The most popular types of medigap policies—standardized Plan C and Plan F—completely fill in the FFS benefit's Part A and Part B deductibles, Part B coinsurance, and other Part A cost sharing, effectively providing catastrophic protection.[4] However, most do not cover additional benefits such as prescription drugs, dental care, or vision care. Enrollment in medigap policies has remained fairly steady, and beneficiary satisfaction with them is generally high (AHIP 2008a, AHIP 2008b). However, premiums for medigap policies can be expensive because individuals with higher health spending are more likely to purchase policies, and these policies have higher administrative costs (Moon 2006, Scanlon 2002).[5] In 2005, the median premium nationwide for a 65-year-old woman purchasing Plan C or Plan F was about $143 per month, or $1,700 annually, ranging between $1,400 and $2,600 across states (Weiss Ratings 2005). Although

prohibited in some states, in other states insurers have moved to attained-age rating, meaning that premiums increase as the beneficiary ages (Moon 2006).

Policymakers, insurers, and regulators have taken several steps to develop more affordable types of medigap policies, but so far those products have not attracted a large share of enrollment. Medicare SELECT plans have the same standard designs as other medigap policies but require beneficiaries to use a provider network in return for lower premiums.[6] A 1997 evaluation found that SELECT plans provide a weak form of managed care in that they recruit hospitals willing to provide a discount for their networks but generally do not form physician networks (Lee et al. 1997). In 2006, insurers had 1.1 million Medicare SELECT plans in place—11 percent of all medigap policies (AHIP 2008b). After 1997, insurers were allowed to sell high-deductible versions of Plan F and Plan J in return for lower premiums.[7] Likewise, the Medicare Prescription Drug, Modernization, and Improvement Act of 2003 created two other types of standard products—Plan K and Plan L—that fill in less of Medicare's cost sharing in return for lower premiums.[8] As of 2006, Plan K and Plan L combined made up less than 0.5 percent of all medigap policies (AHIP 2008b). Effective June 2010, insurers may introduce two new types of medigap policies—Plan M and Plan N. Plan M will cover 50 percent of the Part A deductible but none of the Part B deductible. Plan N will cover all of the Part A deductible and none of the Part B deductible, and it will institute copays of up to $20 for office visits and up to $50 for emergency room visits (NAIC 2008).

Medicaid

Among all types of secondary coverage, Medicaid provides the most comprehensive benefits, but only to individuals with incomes and assets low enough to qualify for the program and who enroll in it. For all categories of dual eligibles (i.e., beneficiaries with both Medicare and Medicaid coverage), state and federal governments pay for their Medicare premiums and cost sharing. Most dual eligibles qualify for Supplemental Security Income cash assistance because of very low incomes or have "spent down" their resources to pay for health and long-term care (called medically needy).[9] In 2005, these beneficiaries made up 81 percent of the 8.8 million dual eligibles and they qualified to receive full Medicaid benefits (so-called "full duals"), including additional services not covered by Medicare, such as long-term care and dental and vision care. The remaining 19 percent had incomes or assets just above the other group; they received help only with Medicare's premiums and cost sharing (Holahan et al. 2009). Roughly two-thirds of dual eligibles are age 65 or older; one-third consists of younger individuals with disabilities or end-stage renal disease (Kaiser Commission on Medicaid and the Uninsured 2009). Although Medicaid supplemental coverage is comprehensive, in many states providers consider Medicaid payment rates to be relatively low, which may affect access to care (Moon 2006). Moreover, participation in the program is low. In one category of duals with incomes at or below 100 percent of the federal poverty level—known as Qualified Medicare Beneficiaries—only 33 percent of eligible beneficiaries participate (MedPAC 2008b).

States differ in their eligibility criteria for Medicaid benefits and in the degree to which they make individuals aware of the program. For example, about two-thirds of states have a medically needy program in which beneficiaries with incomes above eligibility criteria may qualify for Medicaid benefits if they qualify after netting out health costs from income (CMS 2005b). The remaining states do not have medically needy programs.

Beneficiaries' financial liability varies widely

All 45 million beneficiaries who use Part A are subject to cost sharing for those services.[10] The 92 percent of Medicare beneficiaries who are enrolled in Part B pay a premium—$96.40 per month in 2009, or about $1,157 annually for single beneficiaries with incomes of $85,000 or less or couples with incomes of $170,000 or less. They also incur cost-sharing requirements as they use Part B care. About 58 percent of Medicare beneficiaries pay an additional premium (about $29 per month in 2009, or $347 annually) to enroll in Part D for prescription drug coverage, along with cost sharing per prescription.[11] Further, many beneficiaries also pay premiums for supplemental coverage. For nearly all, these costs have been increasing more rapidly than income. However, FFS Medicare's benefit design puts relatively more cost sharing on beneficiaries who require hospital stays than benefit designs used by other payers. At the same time, differences in access to and affordability of supplemental coverage have led to wide variation in beneficiaries' financial liability for their health care.

Premiums and cost-sharing requirements in fee-for-service Medicare

Part A, Hospital Insurance, covers stays in hospitals and skilled nursing facilities, hospice care, and some home health care. Part A is a compulsory social insurance program tied to employment covered by Social Security. Beneficiaries who are entitled to Part A based on work history do not pay any premium. Others may enroll voluntarily for a monthly premium (Table 6-1).

Part B, Supplementary Medical Insurance (SMI), is voluntary and covers services such as physician visits and outpatient hospital care. Part B is available to all individuals eligible for Part A benefits as well as other citizens and permanent resident aliens age 65 or older. Part B enrollees must pay a monthly premium that varies according to income (Table 6-2). When Part B began in 1966, premiums were to finance 50 percent of

(continued next page)

TABLE 6–1 **Premiums and cost-sharing requirements for Part A services in 2009**

Category	Amount
Premiums	$0 if entitled to Social Security retirement or survivor benefits, railroad retirement benefits, Social Security or railroad retirement disability benefits, or end-stage renal disease benefits. $443 per month for individuals who are 65 or older and not described above.
Hospital stay	$1,068 deductible for days 1–60 each benefit period. $267 per day for days 61–90 each benefit period. $534 per "lifetime reserve day" after day 90 each benefit period (up to 60 days over lifetime).
Skilled nursing facility stay	$0 for the first 20 days each benefit period. $133.50 per day for days 21–100 each benefit period. All costs for each day after day 100 in the benefit period.
Home health care	$0 for home health care services. 20% of the Medicare-approved amount for durable medical equipment.
Hospice care	$0 for hospice visits. Up to a $5 copay for outpatient prescription drugs. 5% of the Medicare-approved amount for inpatient respite care.
Blood	All costs for the first 3 pints (unless donated to replace what is used).

Note: A benefit period begins the day a beneficiary is admitted to a hospital or skilled nursing facility and ends when the beneficiary has not received hospital or skilled nursing care for 60 days in a row. If the beneficiary is admitted to the hospital after one benefit period has ended, a new benefit period begins and the beneficiary must again pay the inpatient hospital deductible. Part A cost sharing increases over time by the same percentage update applied to payments to inpatient hospitals and adjusted to reflect real change in case mix.

Source: CMS. 2008b. *Medicare & You* 2009. Baltimore, MD: CMS. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

Increasing financial liability for all Medicare beneficiaries

The combination of Medicare's cost sharing, premiums for supplemental coverage, and spending for services not covered by Medicare (e.g., long-term care) requires a significant and growing share of elderly income. One recent study notes that, at the median, health care spending among Medicare beneficiaries required 16 percent of their incomes in 2005, up from about 12 percent in 1997 (Neuman et al. 2009).

Rapid growth in Medicare spending has important implications for beneficiaries' cost sharing and premiums. Between 2000 and 2007, growth in Part B spending (mostly spending on physician services) led to average

Premiums and cost-sharing requirements in fee-for-service Medicare (cont.)

covered benefits, with the reminder paid from general revenues. In 2009, most Medicare beneficiaries pay a premium of $96.40 per month, which finances roughly 25 percent of SMI program spending. However, about 5 percent of beneficiaries (those with higher incomes) pay considerably more. ■

TABLE 6–2 **Premiums and cost-sharing requirements for Part B services in 2009**

Category	Amount	
Premiums	$96.40 per month:	Single beneficiaries with incomes of $85,000 or less Couples with incomes of $170,000 or less
	$134.90 per month:	Single beneficiaries with incomes between $85,001 and $107,000 Couples with incomes between $170,001 and $214,000
	$192.70 per month:	Single beneficiaries with incomes between $107,001 and $160,000 Couples with incomes between $214,001 and $320,000
	$250.50 per month:	Single beneficiaries with incomes between $160,001 and $213,000 Couples with incomes between $320,001 and $426,000
	$308.30 per month:	Single beneficiaries with incomes above $213,000 Couples with incomes above $426,000
Deductible	The first $135 of Part B-covered services or items during the year	
Physician and other medical services	20% of the Medicare-approved amount for physician services, outpatient therapy (subject to limits), and most preventive services	
Outpatient hospital services	A coinsurance or copayment amount that varies by service, averaging 27% in 2009. These rates are scheduled to phase down to 20% over time. No copayment for a single service can be more than the Part A hospital deductible ($1,068 in 2009).	
Mental health services	50% of the Medicare-approved amount for outpatient mental health care. This coinsurance rate is scheduled to phase down to 20% by 2014.	
Clinical laboratory services	$0 for Medicare-approved services	
Home health care	$0 for home health care services	
Durable medical equipment	20% of the Medicare-approved amount	
Blood	All costs for the first 3 pints, then 20% of the Medicare-approved amount of additional pints (unless donated to replace what is used)	

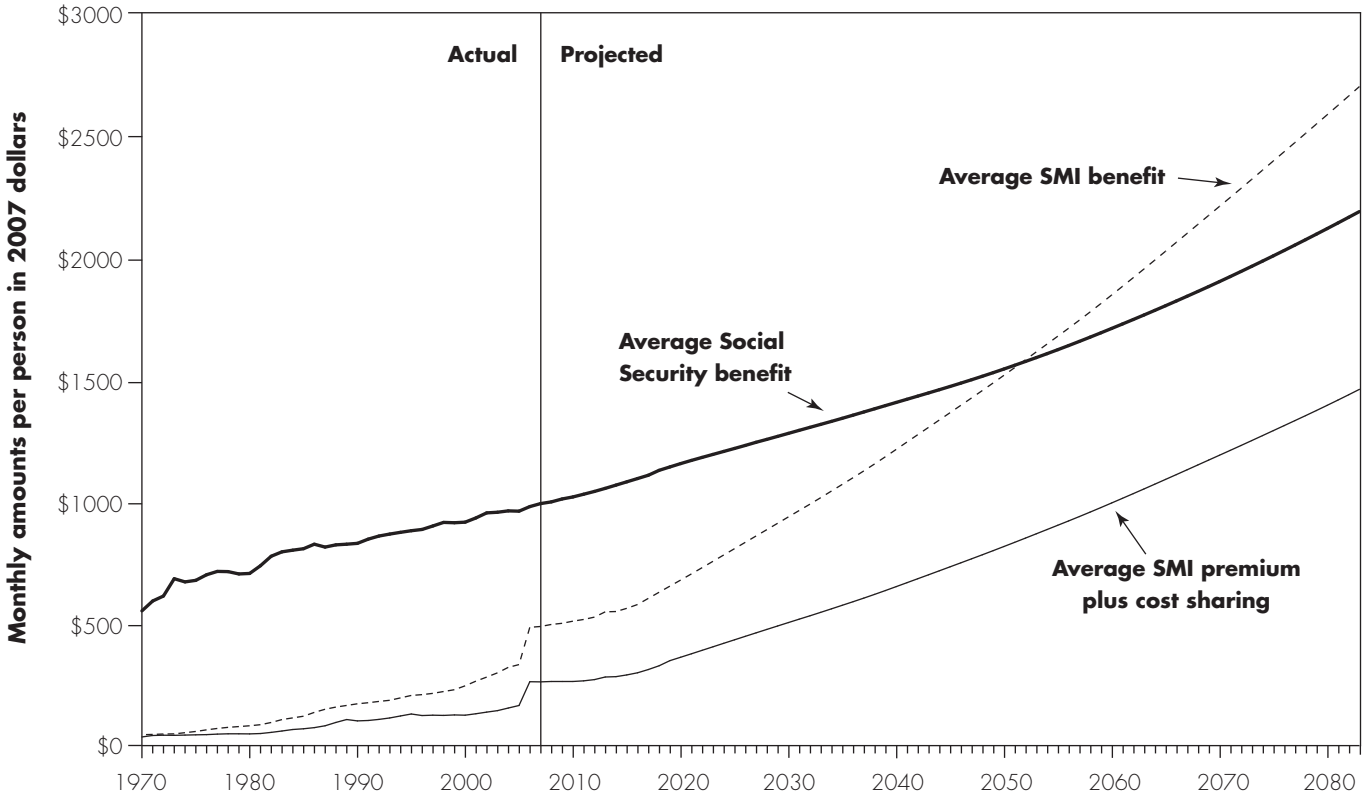
Note: Medicare began phasing in income-related premiums over a three-year period beginning in 2007. By 2010, higher income individuals will pay monthly premiums equal to 35 percent, 50 percent, 65 percent, or 80 percent of Medicare's average Part B costs for aged beneficiaries, depending on income. Usually all other individuals pay premiums equal to 25 percent of average costs for aged beneficiaries. CMS estimates that about 5 percent of Medicare beneficiaries pay the higher premiums. The Part B deductible increases over time by the rate of growth in per capita spending for Part B services.

Source: CMS. 2008b. *Medicare & You* 2009. Baltimore, MD: CMS. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

annual increases in the Part B premium of nearly 11 percent. By comparison, monthly Social Security benefits grew by about 3 percent annually over the same period.[12] Medicare began offering Part D in 2006, which subsidizes a significant portion of beneficiaries' spending on prescription drugs. Yet, even with this financial relief, steep growth in Supplementary Medical Insurance benefit spending (which covers Part B and, after 2006, Part D services) in future years will bring with it increases in premiums and cost sharing that will outpace projected growth in Social Security benefits (Figure 6-2, p. 144).

FIGURE 6–2

Average monthly SMI benefits, premiums, and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs prior to 2006 is not shown.

Source: 2008 annual report of the Boards of Trustees of the Medicare trust funds.

FFS benefit design contributes to highly concentrated cost sharing

All beneficiaries are subject to the effects of rising Medicare premiums, but for beneficiaries in FFS Medicare, cost sharing puts inordinate liability on relatively few individuals. In 2007, 6 percent of FFS beneficiaries incurred more than $5,000 in cost sharing for Part A and Part B services (Figure 6-3). (Because many beneficiaries have supplemental coverage, the figure does not reflect OOP spending, just FFS Medicare's cost sharing.) Another 16 percent had between $2,000 and $5,000 in cost sharing. The 22 percent of beneficiaries who each had $2,000 or more in Medicare cost sharing together incurred about two-thirds of the $50 billion in aggregate cost sharing.[13] By comparison, 43 percent incurred less than $500 in cost sharing, making up just 7 percent of the $50 billion.

Several parts of FFS Medicare's benefit design lead to highly concentrated cost-sharing liability. Medicare's inpatient deductible is relatively high—$1,068 in 2009. A patient who requires several hospital stays in a year would have to pay the inpatient deductible repeatedly. Beneficiaries who require longer stays in hospitals or skilled nursing facilities are liable for sizable daily copays. In addition, patients who are hospitalized have little control over care associated with their stay—inpatient professional services for physicians, imaging, and physical therapy, among other services—and pay 20 percent coinsurance for those services. Beneficiaries who are hospitalized typically use outpatient therapies and procedures extensively as well, for which they

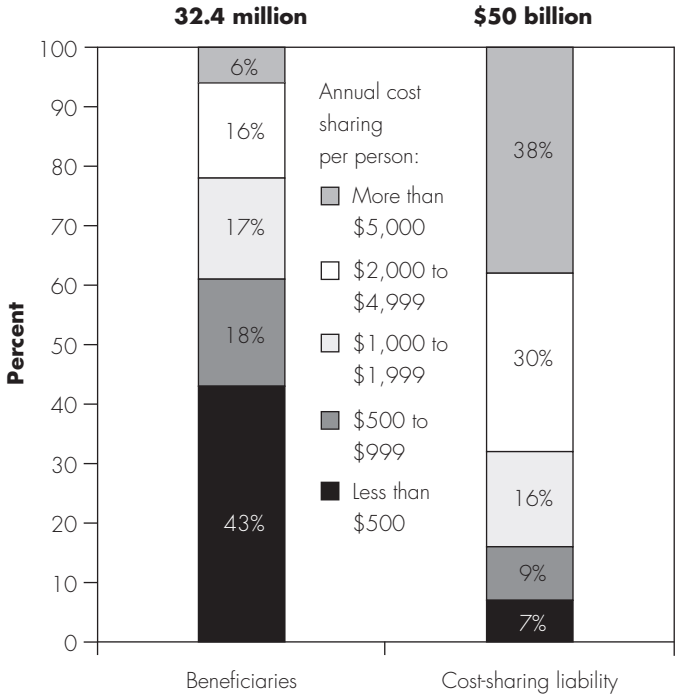
pay 20 percent coinsurance (or more). Twenty percent coinsurance for services such as expensive Part B drugs can amount to a substantial OOP cost for the beneficiary. At the same time, Medicare's FFS benefit design does not include a cap on beneficiaries' OOP spending.

By comparison, cost sharing would be lower than Medicare's for an average elderly beneficiary if a typical retiree health plan of a large employer or if the Blue Cross Blue Shield (BCBS) standard option preferred provider organization (PPO) of the Federal Employees Health Benefits (FEHB) program provided the primary coverage (Yamamoto et al. 2008). Researchers note that, in 2007, a typical large employer used a combined deductible for inpatient and outpatient care of $500 per individual ($1,000 per family) for in-network care. (For out-of-network providers, it was $1,000 per individual ($2,000 per family).) The enrollee also paid 20 percent of allowed charges for in-network inpatient professional services (40 percent out-of-network plus 100 percent of the difference between the provider's charge and allowed charges). The typical large employer capped enrollee deductibles and coinsurance at $2,500 for in-network services ($5,000 for out-of-network services).[14] By comparison, in 2007, FFS Medicare had a $992 inpatient deductible, a $131 deductible for Part B services (to include inpatient professional care), and then 20 percent coinsurance (or more) on allowed charges. Yamamoto and colleagues estimated that, for an average elderly beneficiary, Medicare paid a smaller share of total covered benefits than would be paid by a typical large employer's retiree plan or by the BCBS standard option in the FEHB program if they had provided primary coverage (Yamamoto et al. 2008).

Regardless of whether a beneficiary has high or low use of Medicare services, Part B coinsurance tends to make up most of the cost-sharing liability. Among patients with hospitalizations during the year, one might expect that Medicare's inpatient deductible would account for much of their cost sharing. However, among the 6 percent of FFS beneficiaries who incur costs of $5,000 or more, 58 percent of that liability comes from Part B coinsurance, compared with 12 percent from the Part A deductible (Figure 6-4, p. 146). In other words, coinsurance for Part B services associated with the inpatient stay such as physician care, imaging, and therapy—in addition to the patients' outpatient care—are larger contributors to OOP liability. Among beneficiaries who incurred less than $500 in cost sharing, Part B coinsurance made up 53 percent of their liability.

FIGURE 6–3

In 2007, the top 22 percent of FFS beneficiaries incurred two-thirds of all Medicare FFS cost-sharing liability



Note: FFS (fee-for-service). The bar on the left shows the distribution of FFS beneficiaries ranked by the Medicare cost sharing they incurred. The bar on the right shows the percent of all FFS Medicare cost-sharing liability incurred by each group of beneficiaries.

Source: MedPAC analysis of 2007 data from CMS's Medicare & Medicaid Statistical Supplement.

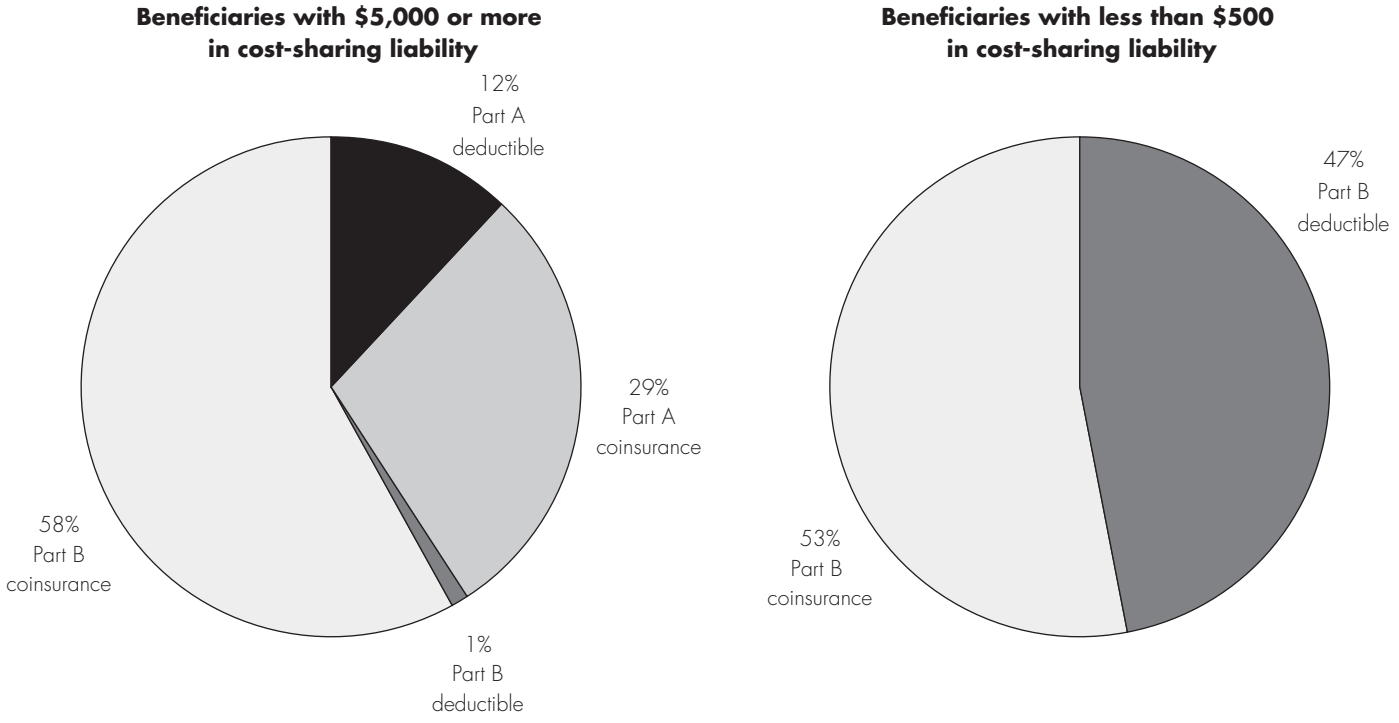
Beneficiaries' spending on premiums and cost sharing varies widely

At the median, Medicare beneficiaries spent about 16 percent of their income on premiums and other OOP health spending in 2005 (Neuman et al. 2009). However, that figure masks considerable variation across individuals. Generally, beneficiaries with higher Medicare spending pay a larger proportion of their income than those with lower Medicare spending, but the relative burden of financial liability depends on the beneficiary's type of supplemental coverage (Figure 6-5, p. 147).

Typical beneficiaries with Medicare and Medicaid coverage paid 5 percent or less of their incomes for premiums and OOP spending in 2005, whether they were ranked among the highest or lowest in terms of Medicare spending.[15] At the other extreme, individuals

FIGURE 6–4

Part B coinsurance accounts for most of FFS cost-sharing liability



Note: FFS (fee-for-service).

Source: MedPAC analysis of 2007 data from CMS's Medicare & Medicaid Statistical Supplement.

with no supplemental coverage in the lowest quartile of FFS spending paid about 8 percent of their income for Part B premiums and cost sharing, while those lacking secondary coverage in the highest spending group spent about 35 percent of their income. Beneficiaries who purchase medigap policies typically pay about 12 percent of their income on premiums and OOP costs. Individuals who receive retiree coverage as a form of deferred compensation for past employment tend to have both higher incomes and relatively lower spending on premiums and OOP health spending.

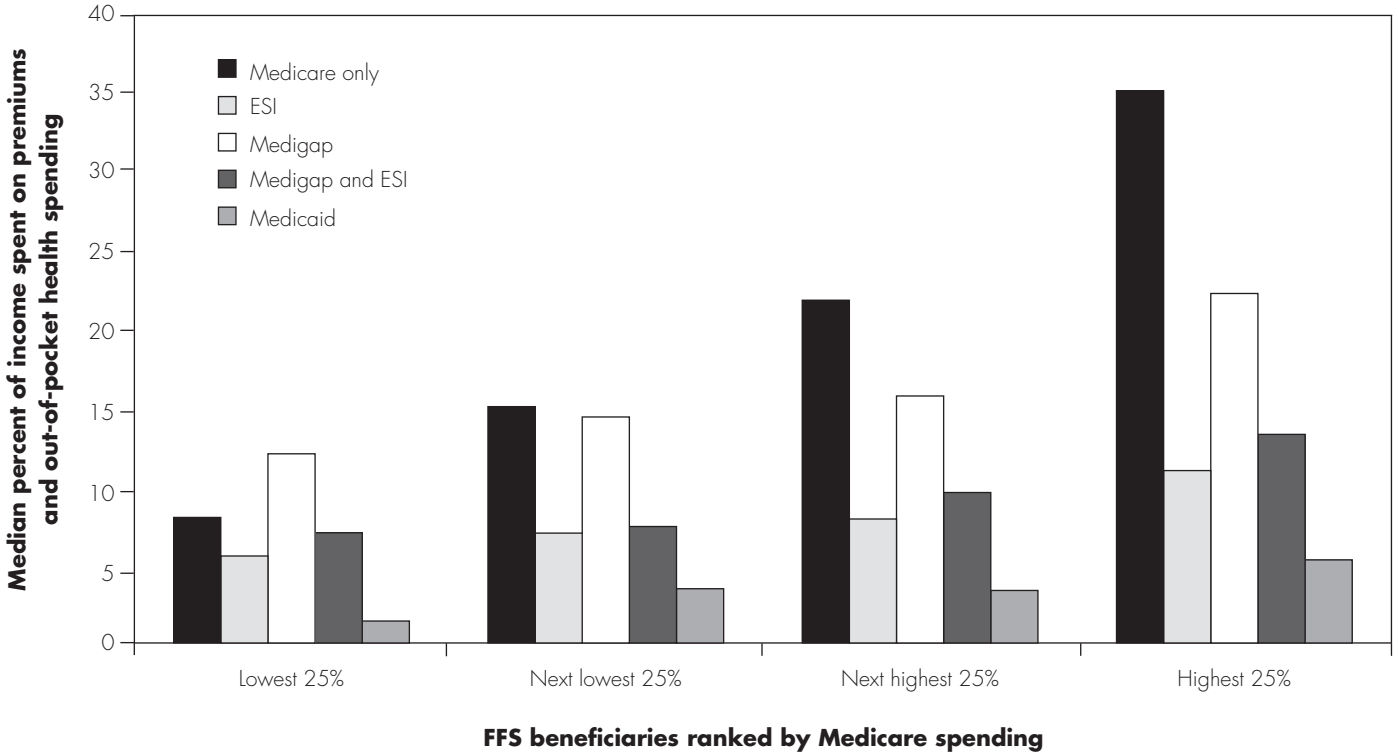
The dollar amount that FFS beneficiaries pay in premiums and cost sharing varies substantially, depending on their use of care and whether they have supplemental coverage. Two groups tend to pay comparatively more than others: 1) beneficiaries with medigap policies, and 2) those with no supplemental coverage and high use of Medicare services (Figure 6-6, p. 148). Unlike retiree health plans in which employers often pay part of the premium for supplemental coverage of their former workers, beneficiaries with medigap policies pay the full premium. In 2005, a typical beneficiary with a medigap policy paid $2,500 to $3,000 in combined premiums for Medicare Part B and for their medigap coverage and then also incurred other OOP expenses such as FFS cost sharing and prescription drugs. Individuals with no supplemental coverage and high use of Medicare services also tend to pay more. In 2005, the typical individual who ranked in the top 25 percent of FFS Medicare spending and had no supplemental coverage paid more than $5,400—nearly $4,500 on OOP costs and more than $900 for Part B premiums.

Supplemental coverage can lead to higher Medicare spending

By filling in FFS Medicare's cost-sharing requirements, supplemental insurance can spare beneficiaries from catastrophic financial liability. At the same time, supplemental coverage shields beneficiaries from seeing

FIGURE 6–5

Medicare FFS beneficiaries' financial burden varies considerably, depending on their use of care and type of supplemental coverage, 2005



Note: FFS (fee-for-service), ESI (employer-sponsored insurance). Bars show median percent of income spent on premiums including for Part B, Part A (if applicable), supplemental coverage, and other types of policies (e.g., for dread diseases and long-term care) and out-of-pocket health costs (e.g., prescription drugs) by category of supplemental coverage. Beneficiaries are grouped in the supplemental coverage category in which they spent most of the year. Some beneficiaries have several sources of coverage during a year. Note that 2005 was prior to the start of Part D, Medicare's prescription drug benefit.

Source: MedPAC analysis of 2005 Medicare Current Beneficiary Survey, Cost and Use files.

the cost of care which, in turn, can lead them to use more or higher priced services than if they had to pay more of the cost themselves. A pattern of higher service use may reflect, in part, beneficiaries' greater willingness to seek care when they pay less OOP. In addition, higher service use may reflect differences in providers' willingness to deliver more care or more intensive care to beneficiaries who have supplemental coverage.

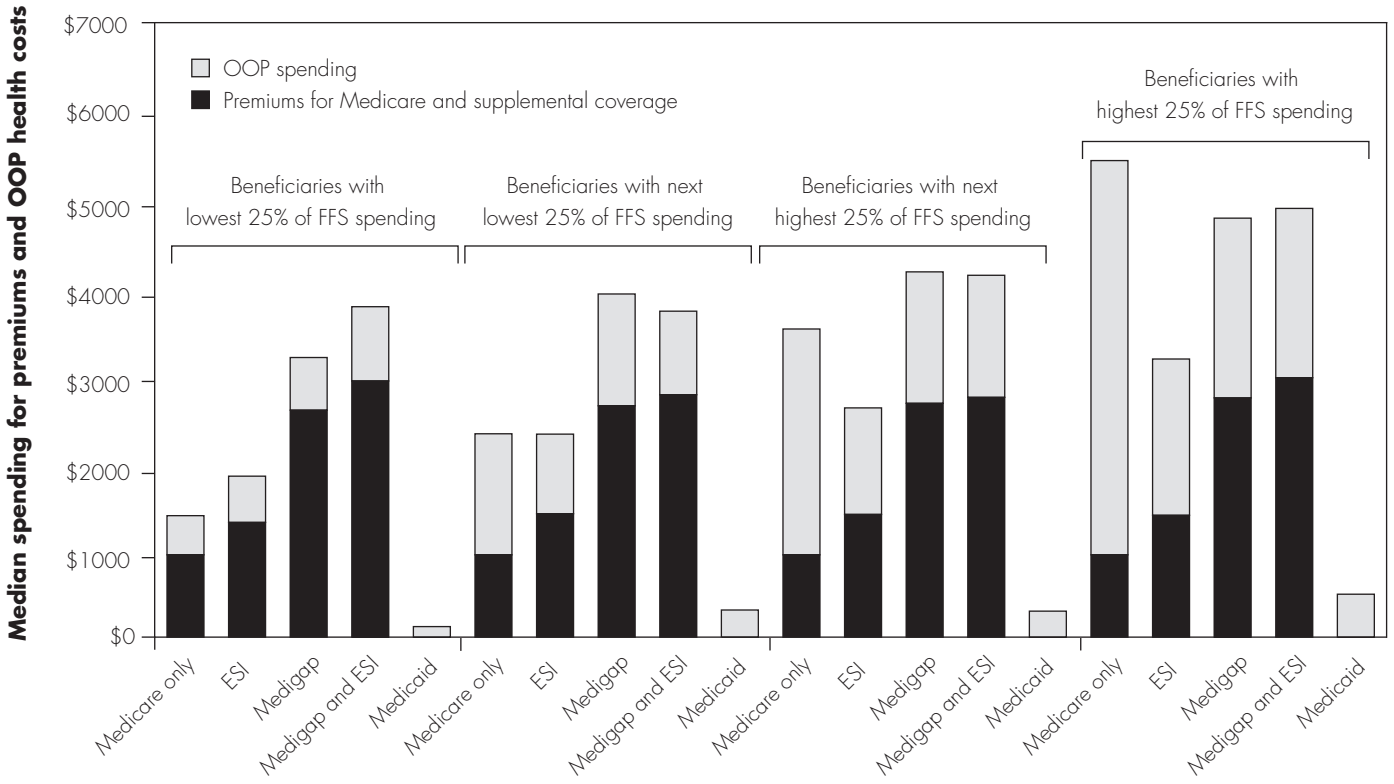
Previous health services literature showed mixed effects of health insurance on spending

The issue of how much Medicare spending is induced by supplemental coverage is contentious. Researchers agree that beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage. However, they disagree about what proportion of this difference is due to the pure effect of insurance (called moral hazard or insurance effect) compared with the tendency of sicker individuals to seek insurance coverage (adverse selection).

Studies that attribute at least a portion of higher spending to this "insurance effect" find an average increase of about 25 percent, but estimates vary widely from 6 percent to 44 percent (Atherly 2001). Separate analyses in 1997 by the Physician Payment Review Commission (PPRC) and Congressional Budget Office (CBO) staff were consistent with this range of results (Christensen and Shinogle 1997, PPRC 1997). Using data for elderly and disabled individuals in the Medicare Current Beneficiary Survey (MCBS), the PPRC estimated that medigap coverage was associated with a 35 percent increase in Medicare spending.[16] Using the National Health Interview Survey, CBO estimated that use of services ranged from 17 percent higher for those with employer coverage to 28

FIGURE 6–6

Beneficiaries with medigap policies and those with high FFS spending and no supplemental coverage pay the largest dollar amounts for premiums and cost sharing, 2005



Note: FFS (fee-for-service), OOP (out of pocket), ESI (employer-sponsored insurance). Bars show median dollar amount spent on premiums for Part B, Part A (if applicable), supplemental coverage, other types of policies (e.g., for dread diseases and long-term care) and OOP health costs (e.g., prescription drugs). Beneficiaries are grouped in the supplemental coverage category in which they spent most of the year. Some beneficiaries have several sources of coverage during a year. Note that 2005 was prior to the start of Part D, Medicare's prescription drug benefit.

Source: MedPAC analysis of 2005 Medicare Current Beneficiary Survey, Cost and Use files.

percent higher for those with medigap policies. Both analyses suggested that larger differences occurred for Part B services like office visits than for Part A services like hospitalizations.

Other researchers find a small or statistically insignificant insurance effect from supplemental insurance after controlling for adverse selection (Wolfe and Goddeeris 1991).[17] Some contend that previously reported differences in spending might be overstated, as supplemental coverage encourages beneficiaries to adhere to medical therapies that prevent hospitalizations or future use of other services. Because most studies on supplemental coverage are cross sectional or have short time horizons, they may not detect lower use of services over a longer period (Chandra et al. 2007).[18] Yet another line of research suggests that the responsiveness of beneficiaries to cost sharing is varied and the effects of supplemental coverage are more modest for individuals in poorer health (Remler and Atherly 2003).

New analysis of secondary coverage

The Commission contracted with Direct Research, LLC, to look at the effects of secondary insurance on the use of and spending for Medicare services (see text box, pp. 150–151). The analysis concludes that after controlling for demographics, income, education, and health status, the presence of secondary insurance is strongly associated with higher Medicare spending, notably for Part B services (Hogan 2009).

Secondary coverage affects use of Part A and Part B services differently

To take a "big-picture" look at the relationship between secondary coverage and use of care, our contractor

TABLE 6–3

Beneficiaries with private secondary insurance had significantly higher Medicare spending than beneficiaries with no secondary coverage

	Total	Part A	Part B
Average spending for Medicare-only beneficiaries	$4,015	$2,335	$1,680
Percent increase associated with secondary insurance:			
Individually purchased	33%*	18%	54%*
Employer sponsored	17*	9	30*
Individually purchased plus employer sponsored	25*	9	48*

Note: *Significantly different from the Medicare-only group at p = 0.05 level or lower, after adjusting for survey design.

Source: Direct Research, LLC, using Medicare Current Beneficiary Survey, Cost & Use files pooled for 2003–2005.

examined each MCBS respondent's amount of Medicare spending with respect to demographic characteristics, health status, income, education, and indicators of whether the individual had an employer-sponsored retiree plan, an individually purchased medigap policy, or both. Consistent with researchers' 1997 estimates, total Medicare spending was 33 percent higher for beneficiaries with medigap policies than for those with no supplemental coverage (Table 6-3). Beneficiaries with employer-sponsored coverage had 17 percent higher Medicare spending, and those with both types of secondary coverage had spending 25 percent higher.

Results of this analysis were also consistent with earlier findings on the effect of secondary insurance on Part A and Part B spending individually. Specifically, it found no statistically significant difference in spending for Part A services but large effects on Part B spending. Beneficiaries with medigap policies spent 54 percent more on Part B services than individuals without supplemental coverage, after adjusting for covariates. Those with employer-sponsored secondary coverage had a slightly smaller effect—30 percent higher spending—and beneficiaries with both a medigap policy and employer coverage had 48 percent higher spending on Part B.

Effects by type of service

We analyzed different components of beneficiaries' Medicare spending in some detail to see what patterns emerged with respect to secondary coverage.

Emergency and urgent care appear unaffected by secondary coverage It is expected that beneficiaries are less likely to consider cost sharing in emergency, life-threatening situations when the health benefit is more immediate. For example, an individual facing an emergency appendectomy would not likely weigh the cost of the Part A deductible in seeking care. However, the inpatient deductible might be more of a consideration when deciding about treatments that could be postponed, such as knee-replacement surgery.

Our contractor's results are consistent with these expectations. For example, using a pertinent variable from inpatient claims data, the contractor classified MCBS respondents' inpatient admissions as emergency, urgent, or elective.[19] This variable is admittedly crude, as it does not distinguish among elective hospital stays for clinically important procedures that, if delayed or avoided, would likely lead to emergency hospitalizations.[20] Notwithstanding this caveat and after controlling for numerous covariates, the analysis found that beneficiaries with private supplemental coverage did not have statistically different spending for emergency and urgent admissions (Table 6-5, p. 152). For elective admissions, however, average Medicare spending for those with private secondary coverage was 90 percent higher than for those without it.

Office-based care more responsive than hospital-based care Along the same lines, the effects of secondary coverage on Medicare Part B spending for care provided in office-based settings were statistically significant and of larger magnitude than effects for physician care provided in a hospital setting. Physician care provided in physicians' offices was 75 percent higher among beneficiaries with supplemental coverage, compared with 32 percent to 33 percent higher spending for care provided in inpatient facilities, hospital outpatient departments,

Method for analysis of the effects of secondary insurance

To examine the effects of secondary insurance on Medicare spending and utilization of services, Direct Research, LLC, performed a regression analysis controlling for several factors. It used data from the cost and use files of the Medicare Current Beneficiary Survey (MCBS) pooled for the three years between 2003 and 2005. The analysis reflects the average annual experience over the three years and accounts for MCBS's survey design. Roughly half of the MCBS's panel of survey respondents overlaps across years—meaning that some of the individuals surveyed one year were surveyed in later years. To ensure that results were not skewed by any extreme cases among these individuals, Direct Research considered only statistically significant results that represented effects for at least 30 different respondents.[21]

The regression analysis included individuals age 65 or older and excluded beneficiaries who were institutionalized, had any enrollment in Medicare Advantage plans, or had not enrolled in both Medicare Part A and Part B. It excluded disabled Medicare beneficiaries younger than 65 because in many states those individuals have more limited opportunities to purchase supplemental coverage. The analysis also excluded beneficiaries who reported any use of care through the Department of Veterans Affairs (VA) to address a concern that the substitution of VA care could artificially lower average levels of Medicare spending among beneficiaries labeled in the MCBS as having no supplemental coverage (Lemieux et al. 2008).[22]

Although Medicaid is an important source of secondary insurance, most of this analysis compares beneficiaries with private supplemental insurance (individually purchased medigap policies and employer-sponsored retiree policies) and those with no supplemental coverage. While having Medicaid benefits is also associated with higher Medicare spending, we assumed that policymakers would want to retain some type of secondary coverage for beneficiaries with low incomes and assets. In addition, there are considerable differences among the states in their eligibility rules for Medicaid and their degree of outreach.

The regressions shown here use several controls for health status. One is a series of indicators for the presence of conditions in the hierarchical condition category (HCC) model based on same-year diagnoses in MCBS claims.[23] A second control is self-reported general health status scored on a five-point scale from excellent to poor. The analysis also includes a count of limitations in activities of daily living, an indicator for current employment, and an indicator for death.

Complex factors affect whether individuals have supplemental coverage, including their aversion to risk, health status, knowledge about Medicare, income, demographic characteristics, and the availability of coverage. Interactions among these factors make it very hard to disentangle selection bias from moral hazard. In fact, short of running a randomized controlled trial like the RAND Health Insurance Experiment, it may be impossible to estimate the "pure" effect of insurance on spending. Econometric studies have used different ways to correct for adverse selection—including the choice of instrumental variables for identification—resulting in a wide range of estimates (Atherly 2001). The analysis by Direct Research attempts to control for adverse selection through variables that reflect health status and other factors, rather than through instrumental variables. We believe this analysis provides convincing evidence that supplemental coverage is associated with higher Medicare spending. Still, analysts will disagree about how much lower Medicare spending would be if supplemental policies could not fill in FFS cost sharing. To the extent that our approach does not fully capture differences between beneficiaries with and without secondary coverage, it would tend to overstate potential savings.[24]

We asked Direct Research to further investigate the role of factors such as individuals' underlying predilection for insurance in their use of Medicare services. In each category of supplemental insurance, beneficiaries with coverage that filled in nearly all of Medicare's cost sharing had statistically significant higher Medicare spending than individuals with no supplemental coverage (Table 6-4). Results for individuals with less generous coverage were not statistically significant and

(continued next page)

Method for analysis of the effects of secondary insurance (cont.)

were relatively small. This pattern held not only for beneficiaries with medigap policies but also for those with employer-sponsored retiree plans or Medicaid coverage. It suggests that the design of supplemental coverage—that is, whether the insurance fills in virtually all of Medicare's cost sharing or retains some that the beneficiary must pay—strongly affects Medicare spending.

As a final piece of evidence about the role of secondary coverage, our contractor turned to the responses of individuals who participated in the MCBS about their use of health care. Compared with beneficiaries with private secondary coverage, those without supplemental insurance were more likely to worry about their health and more likely to avoid going to a doctor (CMS 2005a). When asked why they avoided seeing a doctor, 19 percent of individuals without secondary coverage reported that it was due to cost, compared with 5 percent or less for those with private supplemental coverage. ■

TABLE 6–4

In each category of secondary coverage, beneficiaries with little or no cost sharing spent significantly more on Part B services than beneficiaries without secondary coverage

Category of secondary coverage	Percent of beneficiaries within the secondary coverage category	Percent change in Part B spending associated with secondary coverage relative to the average spending of a beneficiary with no secondary coverage
Individually purchased (medigap) policy		
No use of Part B services	5%	–44%
Paid less than 5 percent of allowed costs OOP	50	68*
Paid 5 percent or more of allowed costs OOP	45	0
Employer-sponsored retiree health policy		
No use of Part B services	1	–31
Paid less than 5 percent of allowed costs OOP	52	77*
Paid 5 percent or more of allowed costs OOP	46	23
Individually purchased plus employer-sponsored		
No use of Part B services	3	–30
Paid less than 5 percent of allowed costs OOP	63	85*
Paid 5 percent or more of allowed costs OOP	34	12
Medicaid coverage		
No use of Part B services	5	–43
Paid less than 5 percent of allowed costs OOP	71	96*
Paid 5 percent or more of allowed costs OOP	24	32

Note: OOP (out of pocket). Percent increases in Part B spending are negative for individuals with no use of Part B services because the comparison group is made up of all individuals with no supplemental coverage, some of whom used Part B care. Full regression results include the OOP groups shown above and control for demographics, health status (self-reported and claims-based condition indicators), income, and education.
*Significantly different from the Medicare-only group at p = 0.001 level, after adjusting for survey design.

Source: Direct Research, LLC, using Medicare Current Beneficiary Survey, Cost and Use files pooled for 2003–2005.

TABLE 6–5

Secondary coverage was associated with higher Medicare spending for elective hospital admissions, office-based care, specialist care, and preventive services

	Average Medicare spending for beneficiaries with no supplemental coverage	Percent change associated with private secondary coverage
Part A inpatient claims by admission type		
Elective	$405	90%*
Urgent	$405	6
Emergency	$1,221	–6
Part B carrier claims by place of service		
Office	$643	75*
Hospital outpatient department or ambulatory surgical center	$261	33*
Inpatient	$281	32*
Other	$127	23*
Part B carrier claims by self-designated physician specialty (nonphysicians omitted)		
Medical specialists	$341	89*
Surgical specialists	$329	50*
Generalists	$316	36*
Radiologists	$119	30
Preventive services (Part B physician office and outpatient department claims combined)		
Payments for preventive services	$21	97*

Note: *Significantly different from the Medicare-only group at p = 0.05 level or lower, after adjusting for survey design.

Source: Direct Research, LLC, using Medicare Current Beneficiary Survey, Cost & Use files pooled for 2003–2005.

or ambulatory surgical centers. (See Table 6-5, data for carrier claims by place of service.)

Specialist care and preventive care strongly associated with secondary coverage Several related hypotheses can be made about secondary coverage and the use of specialist care and preventive care. One is that beneficiaries are more amenable to pay OOP for short, noninvasive, low-risk treatments and procedures relative to therapies that carry risks of mortality and morbidity that the individual can anticipate. For example, if promised equal outcomes from drug-based or surgically based treatment, beneficiaries—with or without secondary coverage—would be more likely to pay for drug treatment than for surgery. A second hypothesis is that, to the extent that specialists are more likely to deliver therapies perceived as riskier or more invasive, a larger effect of supplemental coverage on the use of specialist care is expected. Our empirical analysis supports these hypotheses. We estimate statistically higher use (36 percent) of Part B generalist care among beneficiaries with secondary coverage, but the magnitude of higher spending is larger for surgical and medical specialist care (50 percent and 89 percent, respectively).

We found similar results when we grouped services by Berenson-Eggers Type of Service codes. Individuals with private secondary insurance had significantly higher Medicare spending for services such as office visits, imaging, minor procedures, and endoscopy than did beneficiaries without supplemental coverage. However, there was no statistically significant difference in spending for ambulance services, emergency visits, and major procedures between individuals with and without secondary insurance (Hogan 2009).

Individuals may believe they can delay receiving preventive care. For example, a beneficiary may not see any immediate health effects from waiting a year before receiving a mammogram. Patients are expected to be less

TABLE 6–6

The presence of private secondary coverage was strongly associated with Part B spending, even among beneficiaries with serious conditions

	Total spending		Part A spending		Part B spending	
Beneficiary category	Average Medicare spending for Medicare-only beneficiaries	Percent change associated with private secondary coverage	Average Medicare spending for Medicare-only beneficiaries	Percent change associated with private secondary coverage	Average Medicare spending for Medicare-only beneficiaries	Percent change associated with private secondary coverage
Diabetes	$8,481	6%	$5,198	–4%	$3,283	22%*
Cancer	$12,070	13	$7,146	–1	$4,924	32*
CHF	$15,260	20	$10,692	13	$4,568	36*
Cardiovascular other than CHF	$11,786	14	$8,023	4	$3,763	34*
COPD	$10,945	23	$7,068	13	$3,877	41*
Decedents	$20,367	25	$15,873	20	$4,494	44*
None of the above	$1,003	67*	$357	51	$646	76*

Note: CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease). Estimates reflect total spending for beneficiaries with these conditions, not spending only for those conditions. Beneficiaries with conditions identified through diagnoses on Medicare claims.
*Significantly different from the Medicare-only group at p = 0.05 level or lower, after adjusting for survey design.

Source: Direct Research, LLC, using Medicare Current Beneficiary Survey, Cost and Use files pooled for 2003–2005.

inclined to seek preventive services when they must pay cost sharing OOP. Our contractor's estimates support this expectation. Among beneficiaries with secondary coverage, spending for preventive services was nearly double that of those without secondary coverage, and more beneficiaries with supplemental coverage sought preventive care.

Decedents and beneficiaries with serious chronic illnesses are sensitive to cost sharing Direct Research also analyzed Medicare spending for beneficiaries with serious illnesses. Specifically, they examined spending for MCBS respondents who had died during the year as well as those who had at least one of the five most common causes of death in the elderly (diabetes, cancer, congestive heart failure (CHF), cardiovascular disease other than CHF, and chronic obstructive pulmonary disease). The expectation was that those diagnosed with these serious conditions would be insensitive to OOP costs—that is, the presence of secondary coverage would not matter to these individuals.

Our analysis suggests that individuals with a severe illness are somewhat less sensitive to cost sharing, but they do not ignore it entirely. For each condition, beneficiaries with and without secondary coverage did not exhibit statistically significant differences in Part A spending, but there were large and significant differences in Part B spending (Table 6-6). For example, beneficiaries with diabetes and supplemental coverage had 22 percent higher Part B spending than diabetics with no supplemental coverage. Even among the seriously ill, cost sharing can affect when and from whom patients seek care.

At the same time, however, the effects of private secondary coverage were much more pronounced on Part B spending among beneficiaries who had not died or did not have a diagnosis for any of the common conditions causing death (Table 6-6). Their Part B spending was 76 percent higher than a comparable beneficiary with no supplemental coverage.

Differential effects of cost sharing by income

A further issue of interest is whether the presence of supplemental coverage affects low-income and high-income individuals differently. One might expect filling in Medicare's cost sharing to be more valuable to low-income people, and therefore it might have a stronger effect on their willingness to seek care. In general, Direct Research found similar results for low-income and high-income beneficiaries. However, there was some evidence that, relative to individuals without supplemental coverage, the presence of secondary insurance had a moderately

TABLE 6–7

The effects of secondary insurance are modestly stronger among beneficiaries with incomes of $10,000 or less

Beneficiary category	Total spending	Part A spending	Part B spending
Beneficiaries with incomes less than $10,000			
Average spending for Medicare-only beneficiaries	$3,530	$1,962	$1,569
Percent change associated with secondary insurance:			
Individually purchased	39%*	19%	63%*
Employer sponsored	10	–4	28*
Employer sponsored plus individually purchased	55	82	20
Beneficiaries with incomes greater than or equal to $10,000			
Average spending for Medicare-only beneficiaries	$4,372	$2,611	$1,762
Percent change associated with secondary insurance:			
Individually purchased	31%*	17%	50%*
Employer sponsored	18*	11	28*
Employer sponsored plus individually purchased	22*	4	48*

Note: *Significantly different from the Medicare-only group at p = 0.05 level or lower, after adjusting for survey design.

Source: Direct Research, LLC, using Medicare Current Beneficiary Survey, Cost and Use files pooled for 2003–2005.

stronger effect on Medicare spending for lower income beneficiaries. For example, beneficiaries with incomes less than $10,000 who purchased medigap policies had 63 percent higher Part B spending than low-income beneficiaries with no secondary coverage (Table 6-7). By comparison, individuals with incomes of $10,000 or more who purchased medigap policies had Part B spending 50 percent greater than higher income beneficiaries with no supplemental coverage.

Beneficiaries without secondary insurance use less care

Other findings from the contractor's analysis indicate that beneficiaries with only Medicare coverage and no secondary insurance obtain less health care. These beneficiaries appear to get acute care services in response to serious illness, but they appear to get less well-patient care, less preventive care, fewer scheduled inpatient admissions, and fewer procedures that are costly but do not address life-threatening conditions. On the basis of MCBS data, Direct Research estimated that 20 percent of elderly individuals with no supplemental coverage had no Part B spending at all during the year, compared with 5 percent of beneficiaries who had private secondary insurance.[25] Whether Medicare's cost sharing impedes the use of care for people without secondary coverage, who typically have lower incomes, or whether cultural reasons or other factors make these beneficiaries less inclined to seek care needs to be studied further.

Benefit design as a policy tool

The Medicare program allows private plans that deliver Part C and Part D benefits to vary their benefit designs within certain limits (see text box, pp. 156–157). Cost-sharing strategies used by these private plans to achieve quality and efficiency gains may have lessons for FFS Medicare and raise questions about the role of supplemental coverage.

Cost sharing is an important part of benefit design

The literature suggests that, in some circumstances, cost sharing may keep patients from seeking appropriate care (Rice and Matsuoka 2004). There is also substantial evidence that beneficiaries are sensitive to cost sharing for prescription drugs—higher copays and capped benefits are associated with lower medication adherence and spending (Goldman et al. 2007, Goldman et al. 2006, Hsu and Huang 2006, Rice and Matsuoka 2004). To the extent that secondary insurance reduces cost-sharing hurdles, it may

encourage the use of therapies that avoid exacerbations of chronic conditions.[26]

At the same time, many supplemental policies fill in all or nearly all of FFS Medicare's cost-sharing requirements, while covering services regardless of their value. That is, the policies are no more selective about covering medical services that have better evidence of preventing hospitalizations than services that tend to be used inappropriately. Thus, some portion of higher spending by beneficiaries with this coverage is arguably due to the pure inducement effect of insurance. Our empirical analysis supports this argument.

Most economists believe that well-designed insurance should, from society's perspective, both reduce a beneficiary's financial risk and leave some spending for covered services unreimbursed to deter the use of services that are of low value. The crux of insurance design involves understanding beneficiaries' price sensitivity to health care and the circumstances under which medical services are of more or less value to them.

Potential goals for redesigning Medicare's FFS benefit

Cost sharing could be used as a tool to complement various policy goals such as: improving financial protection for Medicare beneficiaries and distributing cost-sharing liability more equitably among individuals with different health care costs, encouraging use of high-value services and discouraging use of low-value services, and reinforcing payment system reforms that seek better value for health care expenditures. An additional goal may be to improve Medicare's financial sustainability.

Inherent conflicts exist among these goals. For example, adding an OOP cap to the FFS benefit could improve financial protection for the sickest beneficiaries, but without other measures that catastrophic protection would result in substantially higher Medicare program spending and worsen the program's long-term financial situation. Several of the goals require more nuanced and targeted approaches to cost sharing than Medicare uses today and would need further development of methods to evaluate quality, compare effectiveness of therapies, and measure provider resource use. Steps toward each of the goals would be more effective if changes were made to Medicare's deductibles and coinsurance at the same time the role of supplemental coverage was redefined.

Improve financial protection and distribute cost-sharing liability more equitably among individuals with different health care costs

FFS Medicare lacks fundamental protections against catastrophic levels of OOP spending. Medicare's cost-sharing requirements and its lack of catastrophic protection have been important catalysts behind supplemental coverage. However, coverage that fills in most or all of Medicare's cost sharing can lead to higher Medicare spending. As a consequence, Part B premiums are somewhat higher for all beneficiaries—including those without secondary coverage.

One design difficulty is that if catastrophic protection were added to the FFS benefit without adding to Medicare program costs, a sizable percentage of beneficiaries with lower health care spending would face higher FFS cost-sharing requirements. As an example, the CBO estimated the effects of replacing current FFS benefits with a single combined deductible that applies to the first $525 of Part A and Part B services, uniform 20 percent coinsurance for amounts above the deductible (including inpatient expenses and other services such as lab and home health to which no cost sharing currently applies), and a cap set at $5,250 in OOP spending (CBO 2008). CBO estimated this option would lower federal mandatory spending by $26.4 billion between 2010 and 2019. Under the option, cost sharing would rise by an average of $500 for three-quarters of FFS enrollees, would remain the same for 13 percent, and would be lower by an average of $4,500 for 9 percent of enrollees. Even under an option that breaks even (rather than reducing federal spending), most beneficiaries would see increases in cost sharing.

If adding a combined deductible and catastrophic protection were the only changes to the FFS benefit (unlike the CBO option described above), such a measure would lower the cost of benefits that supplemental insurers must pay, potentially leading to lower medigap premiums.[27] Lower supplemental premiums could, in turn, offset some of the higher Medicare cost sharing that many beneficiaries would face under a combined deductible.

As an alternative to making changes to the basic FFS benefit design, some analysts would like the Medicare program to offer supplemental benefits—including a catastrophic cap—directly to beneficiaries (Aaron and Lambrew 2008, Davis et al. 2005). The proposal would not fill in all of Medicare's cost sharing and so would raise OOP spending for some beneficiaries, but it could also lead to premiums

How private Medicare plans use benefit design

In 2009, more than 28 million beneficiaries enrolled in private Medicare plans (CMS 2009a). Nearly 11 million of them are in Part C Medicare Advantage (MA) and other capitated managed care plans that deliver Part A and Part B services (and typically Part D as well). Another 17.5 million are in stand-alone Part D prescription drug plans. Private Medicare plans are permitted to use a combination of benefit design, restricted networks of providers, and utilization management tools (e.g., prior authorization) to manage enrollees' care.

The Medicare program gives Part C and Part D plan sponsors flexibility in designing their benefits and cost sharing within certain limits. The program allows this flexibility because cost sharing can be an important tool for managing care when applied to discretionary services—when enrollees play more of a role in initiating care and determining how much to use. A recent analysis found that MA plans tend to simplify the Medicare benefit structure, generally using copayments rather than deductibles and coinsurance (Gold and Cupples Hudson 2009). Many plans use cost sharing as a tool to steer members toward certain types and levels of care and toward preferred providers. But there are inherent trade-offs between giving plans flexibility and protecting beneficiaries from discriminatory behavior.

Part C plans must provide all services covered by Part A and Part B, and many provide extra benefits or lower cost sharing than fee-for-service (FFS) Medicare to enrollees at no or low additional premiums beyond those for Part B. Generally, these premiums have been much lower than premiums for medigap policies. Plan benefits and cost-sharing requirements must apply uniformly to plan enrollees. Part C plans must not discriminate, discourage enrollment, or hasten disenrollment of sicker beneficiaries through the design of their benefit packages. Each year, CMS sets a maximum out-of-pocket (OOP) amount for FFS Medicare-covered services that serves as a "safe harbor" threshold for Part C plans. CMS gives plan sponsors that set an OOP cap at this amount (or lower) greater flexibility in setting cost sharing for individual services. Plans that do not use an OOP cap or that apply a cap only to a subset of services are subject to greater scrutiny.

In a 2004 mandated report, the Commission noted that while most MA enrollees had lower OOP spending than FFS beneficiaries, a small number of MA plans charged more than FFS's cost sharing for certain services, such as Part B-covered drugs (MedPAC 2004). The Commission encouraged CMS to monitor the issue and recommended ways to strengthen the agency's role in preventing discriminatory benefit designs. In plan guidance for 2010, CMS includes additional criteria to its "safe harbor" provision: The agency will likely not consider a benefit design discriminatory if—in addition to having an OOP cap of $3,400 or less that applies to all Part A and Part B services—it uses cost sharing no greater than that of FFS Medicare for Part B drugs, renal dialysis, psychiatric hospitalizations, and skilled nursing facility services (CMS 2009b).

In 2009, more than a million beneficiaries are enrolled in special needs plans (SNPs)—a type of MA plan that provides Part A, Part B, and Part D benefits. SNPs generally function like and are paid the same as other MA plans, but they can target certain types of enrollees: dual eligibles, institutionalized beneficiaries, and individuals with severe or disabling chronic conditions. In practice, beneficiaries in other categories are also enrolled in SNPs. SNPs follow the same guidelines as other MA plans with respect to benefit designs, and they must also apply cost-sharing requirements uniformly to all members.[28] However, to the extent that their enrollees have health conditions in common, SNPs could use benefit design as a mechanism for encouraging enrollees to adhere to therapies of high value or for discouraging use of low-value therapies. In 2008, the Commission made a number of recommendations to help ensure that SNPs limit their enrollment to targeted populations and provide members with specialized care (MedPAC 2008b).

CMS also gives Part D plans flexibility in designing prescription drug benefits. Sponsors may offer a plan with Part D's defined standard benefit (Table 6-8) or, within certain constraints, basic coverage that has the

(continued next page)

How private Medicare plans use benefit design (cont.)

same average dollar value of insured benefit spending. Many basic actuarially equivalent plans charge no deductible and use tiered copays that result in the same average benefit value (MedPAC 2009). (Under tiered copays, for example, a plan might charge $7 per prescription for a generic drug, $38 for a preferred brand-name drug, and $75 for a nonpreferred brand-name drug. The differences in cost sharing are meant to steer plan enrollees toward generic and preferred brand-name drugs.) Once a sponsor offers at least one basic benefit package, it may also offer an enhanced plan—one that includes basic and supplemental benefits.

One aspect of Part D benefits that CMS monitors is how plan sponsors operate their formularies—the list of drugs they cover and the terms under which they cover them. When designing formulary systems, sponsors strike a balance between providing enrollees with access to medications and controlling growth in drug spending by negotiating drug prices and managing use. Plan sponsors must also select the cost-sharing tier for each listed drug and whether any utilization management tools apply to the drug, taking into account clinical and financial factors. In recent years, most Part D plans have moved toward using specialty tiers for high-priced drugs and biologics. Cost-sharing requirements for specialty tier drugs are at least 25 percent of the plan sponsor's negotiated price, until the enrollee reaches Part D's true OOP limit. In addition, enrollees may not appeal cost sharing as they can for other drugs, such as those on nonpreferred brand tiers. ■

TABLE 6–8

Premiums and cost-sharing requirements for Part D's defined standard benefit in 2009

Category	Amount
Premiums	$30.36 per month*
Deductible	295
25% coinsurance after the deductible up to the initial coverage limit of	2,700
100% coinsurance between the initial coverage limit and the true OOP spending limit of	4,350
Total covered drug spending at true OOP limit	6,153.75
Minimum cost sharing above the true OOP limit:	
Copay for generic/preferred multisource prescription drug	2.40
Copay for other prescription drugs	6.00

Note: OOP (out of pocket). The term true OOP refers to a feature of Part D that directs fewer federal subsidy dollars toward enrollees who have supplemental coverage. Only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's own OOP spending, that of a family member or official charity, supplemental drug coverage provided through qualifying state pharmacy assistance or Part D's low-income subsidies, and, under CMS's demonstration authority, supplemental drug coverage paid for with Medicare Advantage rebate dollars.
*Base beneficiary premium. Premiums for specific Part D plans may be more or less than this amount.

Source: CMS. 2008. Notification of changes in Part D payment for calendar year 2009. Baltimore, MD: CMS. http://www.cmhs.hhs.gov/MedicareAdvtgSpecRateStats/downloads/PartDAnnouncement2009.pdf.

for supplemental coverage that are substantially lower than those for many existing medigap policies.

Our analysis of the role of private secondary coverage on Medicare spending suggests some ways policymakers may want to rethink FFS benefits. For example, our analysis showed that the presence or absence of secondary coverage does not appear to affect whether beneficiaries receive emergency or urgent inpatient care. Rather than a benefit design tool that affects whether a beneficiary will seek hospital care, Medicare's high inpatient deductible seems to be more of a mechanism for apportioning some hospitalization costs to beneficiaries. An alternative approach could use a lower inpatient deductible for emergency hospitalizations and a higher inpatient deductible for stays where there is less evidence of a procedure's comparative effectiveness. However,

identifying which hospitalizations are for care that is of greater or lesser value would be difficult, as information on comparative effectiveness is limited.

A variant of capping beneficiaries' OOP costs under FFS would be to require nominal copays above a catastrophic threshold—similar to what Part D requires. Our analysis showing that even beneficiaries with very serious illnesses are somewhat sensitive to cost sharing suggests that nominal cost sharing above the catastrophic cap could encourage beneficiaries to be mindful of their use of care without imposing excessive financial burden on them.

Create incentives for beneficiaries to consider the value of services

Medicare could set different levels of cost sharing for the same medical intervention based on its clinical benefit to the patient. For example, patients with diabetes could be charged lower cost sharing for medical interventions shown to prevent or reduce long-term complications of the disease, such as drugs that control blood pressure. A patient with only slightly elevated blood pressure but no diabetes would face higher cost sharing for the same medication. When evidence shows that certain therapies are comparatively more effective for certain patients, lowering their cost sharing to help increase their adherence could improve health outcomes. If higher adherence leads to fewer exacerbations of the patient's condition, this approach could also lower spending. However, to achieve net savings, value-based insurance design (VBID) requires careful targeting. Spending would be reduced if medical interventions were not used as often when the cost outweighs the clinical benefit (Chernew et al. 2007, Fendrick et al. 2001).

Insurers, large employers, and researchers have tested key elements of VBID with some success at increasing adherence to medication therapies. In a study of the nonelderly, researchers found that charging individuals at higher risk of coronary heart disease lower copays for cholesterol-lowering drugs increased their adherence and reduced their use of hospital and emergency services (Goldman et al. 2006). Another study examining the use of angiotensin-converting enzyme inhibitors among Medicare beneficiaries with diabetes found that lower cost sharing for these drugs could extend life and reduce overall program spending (Rosen et al. 2005). The University of Michigan, Pitney Bowes, and the municipality of Asheville, North Carolina, have implemented programs that lower copays for diabetes patients for certain high-value interventions related to their condition, while maintaining lower cost sharing for generic drugs (Chernew et al. 2007).

A program that lowers copays for a drug or service for everyone would not save resources. Instead, a targeted VBID approach could lead to savings by encouraging greater adherence only for patients most likely to benefit clinically. However, this approach requires solid evidence about the comparative effectiveness of alternative therapies as well as the ability to accurately identify patients' conditions and their severity. Therapies for some diseases have a thorough body of evidence on comparative effectiveness. For others, policymakers and payers need significantly more investment in comparative effectiveness research and alternative methods of identifying relevant patient characteristics (e.g., information typically found in an electronic medical record). For insurers, other key barriers to implementation include higher administrative costs, near-term cost increases associated with lower copayments, legal issues, and the potential for fraud. Other stakeholders might be concerned about the complexity and equity of the benefit design as well as the need to protect the privacy of patient data (Chernew et al. 2007).

Today, examples of VBID among private payers typically aim to increase beneficiaries' adherence to prescription drug therapies to avoid hospitalizations and other medical services. However, one specific obstacle to using VBID in Medicare arises because prescription drug benefits are not part of an integrated package of medical services; FFS beneficiaries obtain prescriptions through stand-alone prescription drug plans that have no financial incentive to consider the combined cost of delivering Part A, Part B, and Part D services.

Reinforce payment reforms that seek better value for health care expenditures

We may want to use FFS cost sharing in ways that reinforce payment system reforms. For example, as CMS develops its ability to measure providers' quality of care and resource use, Medicare could use tiered copays for Part A and Part B services in the way that Part D plans use them today: to steer beneficiaries toward preferred providers. Medicare could also use differential cost sharing, such as tiered copayments, to discourage the use of services prone to overuse and to encourage the use of recommended services.

An understanding of the relationship between secondary coverage and higher Medicare spending—for nonurgent hospital admissions, preventive care, office visits,

specialist services, and diagnostic imaging—underlies recommendations the Commission has made in its annual payment update reports to the Congress. For example, in March 2009, the Commission recommended changes in how Medicare reimburses providers for imaging because of concern about rapid growth in the use of those services, regardless of their value (MedPAC 2009). The Commission also recommended that CMS revisit how it pays for primary care based on analysis that those services are undervalued (MedPAC 2009, MedPAC 2008c). In both cases, policymakers could use Medicare's cost-sharing requirements as a tool to steer beneficiaries toward care of better value—charging higher copays for certain discretionary imaging services and lower copays for primary care visits. In this way, Medicare cost sharing would serve as a tool to reinforce broader payment system reforms focused on attaining greater value for dollars spent.

Help improve Medicare's financial sustainability

Changes to the FFS benefit have become more urgent in view of the Medicare program's serious financial challenges. Raising cost-sharing requirements could rein in spending for health services that are more prone to overuse, particularly if accompanied by limits on the portion of Medicare's cost sharing that secondary coverage could fill in. Increasing the share of Medicare's costs borne by beneficiaries through premiums would also reduce the federal government's share of Medicare spending. Because indiscriminate increases could impose financial barriers to essential care or cause hardship for some Medicare beneficiaries, policy changes would need to balance these concerns with the goal of improving Medicare's financial sustainability.

One approach is to levy an excise tax on medigap policies, with the revenue dedicated to offsetting Medicare program costs. This tax could reduce incentives for Medicare beneficiaries to purchase medigap policies, encourage them to purchase less expensive plans, and help compensate the Medicare program for the added costs that stem from supplemental coverage. CBO estimates that a 5 percent tax on each medigap policy premium would increase federal revenues and decrease mandatory spending by $12.1 billion between 2009 and 2018 (CBO 2008). Drawbacks to this approach are that it would treat medigap policies differently from employer-sponsored retiree plans, which are also associated with higher Medicare spending, and could boost enrollment in Medicare Advantage, which the Commission and others have found currently requires more program spending per beneficiary than FFS Medicare (MedPAC 2009).

Under another approach, policymakers could redefine medigap policies so that they no longer completely filled in FFS cost-sharing requirements. For example, CBO estimates that if medigap policies did not pay any of the first $525 of a beneficiary's FFS cost sharing, and if coverage of the next $4,725 in Medicare cost sharing were limited to 50 percent, those measures would lead to $41 billion in federal mandatory savings between 2010 and 2019 (CBO 2008). Savings could be even larger by combining changes to medigap policies with other FFS benefit design changes. CBO estimated that if medigap policies no longer covered any of a new $525 combined deductible and covered only 50 percent of the new uniform coinsurance on services up to a Medicare OOP cap set at $5,250, it could reduce federal mandatory spending by $73 billion between 2010 and 2019 (CBO 2008).

Addressing the goal of Medicare's financial sustainability may require setting priorities among health coverage needs. That is, society may need to "differentiate between health care that supports the most essential aspects of human functioning and that which serves to enhance an individual's quality of life" (Ginsburg 2007). ■

Endnotes

1 The percent of Medicare beneficiaries who enrolled in Medicare Advantage plans increased considerably between 2005 and 2008, from about 13 percent of enrollees to about 20 percent. We do not know yet how this situation affected the distribution of supplemental coverage among those beneficiaries who remained in FFS Medicare.

2 Firms in the Midwest and Northeast are more likely to offer retiree coverage than firms in the South and West. Historically, manufacturing industries and federal, state, and local governments have been more likely to offer retiree coverage.

3 During this open enrollment period, medigap insurers may not use medical underwriting to refuse to issue a beneficiary a policy or charge her a higher premium because of her health status. However, the insurer may refuse to cover OOP costs for a preexisting condition for up to 6 months unless the beneficiary had creditable coverage before Part B. If an individual does not purchase medigap coverage during the open enrollment period and later applies, insurers are permitted to use medical underwriting: They may decide not to write the policy, or they may charge a higher premium based on health status. The law gives beneficiaries guaranteed issue rights to purchase certain medigap policies under other circumstances such as if creditable coverage through an employer ends, or if the individual was enrolled in a Medicare Advantage plan that withdrew from the beneficiary's service area (CMS 2008a).

4 Plan C does not provide coverage for Part B balance billing while Plan F does. Neither Plan C nor Plan F covers home health care, preventive care, or outpatient prescription drugs.

5 On average, administrative load for medigap plans is 20 percent and sometimes higher, largely due to the need for medigap insurers to market directly to individuals.

6 When a policy holder does not use a network provider for nonemergency care, she must pay some or all of Medicare's cost sharing.

7 Under the terms of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, insurers cannot issue new Plan J policies because they would compete with Part D by including prescription drugs in their covered benefits. In 2009, enrollees must pay the first $2,000 in Medicare cost sharing under the high deductible of Plan F.

8 Neither of the new plans—designated Plan K and Plan L—covers the Part B deductible. After the Part B deductible, Plan K pays for 50 percent of most Medicare cost sharing and, once the beneficiary has paid a yearly limit of $4,620 in OOP spending (in 2009), it pays remaining cost sharing for covered services. After the Part B deductible, Plan L covers 75 percent of FFS cost sharing and has a yearly OOP limit of $2,310 (in 2009).

9 Generally, individuals qualify to receive Supplemental Security Income if their income is at or below 74 percent of the federal poverty level. In 2009, 100 percent of the federal poverty level is an income of $10,830 for a single person and $14,570 for a two-person household.

10 A small share of individuals also pay a premium for Part A services because they or their spouse do not have enough credits of paying payroll taxes to automatically receive Part A benefits. In 2009, the Part A premium is $443 per month.

11 Persons with high drug spending may also have to pay 100 percent of their Part D plan's negotiated price for a drug if they reach the coverage gap—a dollar limit on covered benefits before the enrollee incurs enough cost sharing to qualify for catastrophic protection.

12 Under hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in an individual's Social Security benefit. Still, in many recent years the dollar amount of increases in Part B premiums has absorbed 20 percent to 40 percent of the dollar increase in the average Social Security benefit. Part D premium increases are not subject to a hold-harmless provision.

13 Some Medicare beneficiaries do not pay their hospital deductibles and coinsurance. In a report prepared under contract to the Commission, Direct Research estimated that in 2005, hospitals incurred about $1.1 billion of bad debt (calculated from Sutton et al. 2007). It is probably reasonable to assume that much of this is for the care of beneficiaries with no supplemental coverage.

14 In 2007, the BCBS standard PPO option in the FEHB program had a $100 per admission inpatient copay for unlimited days at preferred providers ($300 for nonpreferred providers). In addition, after a deductible of $250 per person ($500 per family), the enrollee paid 10 percent of allowed charges for inpatient professional services from preferred providers (25 percent from nonpreferred). The BCBS standard option capped OOP spending at $4,000 in cost sharing from preferred providers ($6,000 for a combination of preferred and nonpreferred providers). For 2009, the BCBS standard option in the FEHB program has become somewhat less generous. It uses an inpatient copay of $200 per admission for preferred providers ($300 nonpreferred), a general deductible

of $300 per person ($600 per family), and then 15 percent coinsurance for inpatient professional services (30 percent for nonpreferred).

15 This estimate of 5 percent reflects the experience of a typical (median) beneficiary with Medicaid and Medicare coverage. Note, however, that some individuals must "spend down" their income and assets to become eligible to receive Medicaid benefits. When we examined the average (mean) percentage of income spent on premiums and cost sharing, duals in the highest ranking quartile of FFS spending spent about 21 percent of their incomes.

16 Costs for beneficiaries with no secondary insurance were 20 percent below the all-Medicare average, while costs for those with medigap were 8 percent above average, after adjusting for health status and demographic differences (PPRC 1997).

17 One recent analysis contends that previous studies that find a relatively large "insurance effect" did not take into account care that beneficiaries who do not report having supplemental coverage receive through the Department of Veterans Affairs and the military health care system (Lemieux et al. 2008). Under contract for the Commission, Direct Research was unable to replicate this result.

18 The topic of whether lower cost-sharing requirements could lead to "spending offsets" due, for example, to lower rates of hospitalizations is controversial. One recent study using data for a commercially insured population found evidence that higher cost sharing for prescription drugs led to the substitution of greater outpatient care a year later. However, the magnitude of higher outpatient spending was smaller than the revenue from raising drug copays: 35 percent of the savings from reductions in drug spending were offset by increases in other medical spending. The study found little measurable substitution between drugs and inpatient care (Gaynor et al. 2007).

19 The admission type variable on inpatient claims categories classifies admissions these ways:

• *Emergency*—the patient required immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.

• *Urgent*—the patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation in the hospital.

• *Elective*—the patient's condition permitted adequate time to schedule the availability of suitable accommodations.

20 Our contractor looked at admission source and other information to validate this variable. Almost 90 percent of Medicare admissions occurred either through the emergency department or from a physician referral. By admission source, fewer than 2 percent of emergency department admissions were marked as elective, while nearly 60 percent of physician referral admissions were marked as elective. The contractor also examined a specific clinical indication, segregating hip replacement admissions by the presence of fracture. Almost all fracture cases were marked as emergency or urgent, while almost all other cases were marked as elective. Both of these tests suggest that the type of admission variable provides a reasonable average measure of admission urgency.

21 To confirm that aggregate results were not sensitive to this issue, the contractor repeated our regressions on each individual year of data. The results were not sensitive to pooling data across years. For the service-specific analysis, the contractor applied the screen of needing at least 30 different people because statistics used for significance tests may be inaccurate when there are few cases. This criterion helps weed out findings that are most likely the result of outliers and helps present a more conservative estimate.

22 Direct Research could not replicate the findings of Lemieux and colleagues (Lemieux et al. 2008). They were correct that VA users make up a larger fraction of the Medicare-only population than they do of the rest of the Medicare population. However, Direct Research's analysis found that VA users were too few to affect average spending levels by insurance category, and they tended to have significant levels of Medicare spending even though they also used VA care.

23 Using HCC disease categories as a control for health status raises a methodological issue. The HCC model was designed as a prospective rather than a concurrent model—that is, predictive of spending in the subsequent year rather than in the current year. In addition, including a concurrent HCC risk score raises the question of endogeneity of health care use. In other words, is the presence of fewer disease markers among Medicare-only individuals due to their relative health or to having fewer claims on which diagnoses were reported? A beneficiary might appear to have fewer disease markers because she is healthy, or she might have fewer because she is part of a population that is underserved or faces barriers to access. Including indicators for HCC disease categories in the regressions should give a more conservative estimate of the impact of secondary insurance. If one excluded those variables, they might mistakenly attribute part of the lower health care use of the Medicare-only population to better health status. To the degree that HCC indicators over- or misstate the good health of the Medicare-only population, they will "explain" their lower spending and result in attributing a smaller portion of the spending differential solely to the effects of insurance coverage.

24 A recent study of the effects of insurance on Medicare beneficiaries' drug spending found some evidence of nonobservable selection (i.e., not measurable with variables like those in the regressions by Direct Research). However, the authors estimated that this effect had a small magnitude (Shea et al. 2007).

25 Beneficiaries without supplemental coverage also had a somewhat higher rate of mortality averaged across all three years of MCBS data, but that result did not hold true in each year, 2003 to 2005. Also, other aspects of the analysis, such as our exclusion of residents of long-term care facilities, suggest a need to look more closely at this issue rather than concluding that it is a problem.

26 Because most studies on supplemental coverage are cross sectional or have short time horizons, they may not detect lower use of services over a longer period (Chandra et al. 2007).

27 The same is true even if medigap policies filled in the combined deductible, because secondary coverage would no longer cover catastrophic costs.

28 Dual-eligible SNPs (and MA plans generally) are obligated to ensure that cost sharing for dual-eligible beneficiaries is the same as under FFS Medicare—generally close to zero.

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