MODERNIZING MEDICARE COST-SHARING:
POLICY OPTIONS AND IMPACTS ON BENEFICIARY
AND PROGRAM EXPENDITURES

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EXECUTIVE SUMMARY

Because of a softening economy, a shrinking federal budget surplus, and new national security priorities, the attention of policymakers has shifted away from issues that were top agenda items during much of 2001. Taking its cue from these events, this paper discusses modest policy options that could modernize and improve the cost-sharing structure of the Medicare benefit package, reduce financial burdens on beneficiaries who are the sickest, and impose little or no additional federal spending requirements.

New Medicare Cost-Sharing Proposals

After reviewing trends in the stop-loss levels and deductible requirements of private-sector benefit packages, the authors developed and simulated the impact of several modest designs for modernizing cost-sharing under Medicare. The paper compares 12 specific cost-sharing policy options involving combinations of:

- an introduction of $3,000, $4,000, and $5,000 annual stop-loss levels (that is, ceilings on beneficiary annual cost-sharing contributions);

- an increase in the Part B deductible (for ambulatory care and related services) from $100 annually to $300 annually;

- a decrease in the Part A deductible (for hospital services) from $812 per inpatient spell, which ends 60 days after a hospital or skilled nursing facility discharge, to $500 annually;

- an elimination of hospital inpatient coinsurance requirements (in 2002, days 61–90: $203 per day; days 91–150: $406 per day; 100 percent of costs beyond day 150); and

- an elimination of the Part A and Part B deductibles and introduction of "combined" Part A and Part B deductibles set at $300, $400, and $500 annually.

All the key features simulated—stop-losses, higher ambulatory care deductibles, and lower inpatient cost-sharing requirements—are common features of private health plans. Medicare's cost-sharing requirements, in contrast, are outmoded in that they lack a stop-loss limit and are skewed toward the less discretionary inpatient services rather than the more discretionary ambulatory services. The inpatient deductible in 2002 is $812 per spell, while the Part B deductible remains at $100 per year. When Medicare was established in 1965, the two deductibles were nearly equal—$40 per inpatient spell and $50 per year for Part B services, or $229.84 per inpatient spell and $287.30 per year for Part B services when adjusted for inflation. The amounts have diverged because the

former deductible is indexed to growth in Medicare inpatient spending, while the latter was statutorily set and has been increased by law only twice.

Although each of the policy options simulated improves the Medicare benefit structure, four of them would require additional federal revenues. Budget-neutral versions of these four are simulated as well, by estimating Part B premium increases that would offset the aggregate additional revenues otherwise required to implement the options.

Distinguishing Between Beneficiary Liability and Out-of-Pocket Spending

The impacts of the policy options are presented in terms of elderly beneficiaries' Medicare cost-sharing, total liability (cost-sharing and Part B premium), beneficiary out-of-pocket spending, and federal program spending. For some individuals, liability and out-of-pocket spending may be nearly equivalent. However, these two measures typically are not equivalent for Medicare beneficiaries because many elderly enrollees purchase supplemental insurance policies and certain common health expenses are not included in the traditional Medicare benefit package (namely, prescription drugs, vision services and items, and dental services). Medicare beneficiary out-of-pocket expenses thus are the sum of an individual's supplemental insurance premium payments, health care services and items not covered by Medicare or supplemental insurance, and any remaining Medicare liability paid by the individual. In 1998, almost 29 percent of Medicare beneficiaries had supplemental insurance subsidized by their former employer, and over 21 percent purchased policies in the individual market.

Impact of the Cost-Sharing Proposals

In 2002, total Medicare spending for elderly beneficiaries in traditional (fee-for-service) Medicare is an estimated $6,611, on average (Table ES-1). Beneficiary liability (Part B premium and cost-sharing requirements) accounts for 22 percent ($1,470) of the total. Liability totals $3,000 or more for 8.5 percent of beneficiaries. More important from the individual beneficiary perspective, the elderly will spend an estimated $3,757 out-of-pocket for Medicare and other health care services in 2002, consuming 22.3 percent of their income.

**Table ES-1. Average Health Expenditures for
Elderly Medicare Beneficiaries, 2002**

Total Medicare Expenditures	$6,611
Federal Program Payments	5,141
Beneficiary Liability	1,470
Cost-Sharing (Coinsurance and Deductibles)	832
Part B Premium	638
Percentage with Greater than $3,000 in Medicare Liability	8.5%
Out-of-Pocket Spending	$3,757
Out-of-Pocket Spending as a Share of Income	22.3%

Source: The Urban Institute's 2002 Medicare Simulation Model.

Among the 12 policy options simulated, the two with the greatest cost-savings from the beneficiary perspective are a $3,000 stop-loss option and an option that reduces the Part A deductible from $812 per spell (in 2002) to $500 per year and eliminates hospital inpatient coinsurance (Table ES-2). The two options produce comparable reductions in average cost-sharing ($114 and $94, respectively) and average out-of-pocket spending ($69 and $57, respectively, assuming a "low-impact" model in which there is no change in Medigap purchasing behavior; and $317 and $306, respectively, assuming a "high-impact" model in which those with individually purchased policies decide to drop them). The key difference between the two options is the proportion of beneficiaries affected. While 5.4 percent of beneficiaries would reach a $3,000 stop-loss limit each year, more than three times as many (18.0%) would be aided each year by the revised Part A option.

Both options require comparable increases in aggregate additional federal funds ($4.6 billion and $3.8 billion, respectively). Annual premium increases of an estimated $114 and $94 exactly offset the cost of the respective options, while increases of the Part B deductible to $300 more than offset the cost. Even with these budget-neutral offsets, however, the options reduce average out-of-pocket spending by up to about 5.5 percent, depending on assumptions regarding Medigap purchasing behavior. Of the two offset mechanisms, the Part B deductible may be preferred because its increase would be more transparent than a premium increase and has the potential to promote more cost-sensitive use of ambulatory services. (This potential effect would be furthered to the extent that the catastrophic protection provided by these options would induce Medigap policyholders to drop their policies and because of the cost-insensitive effects of first-dollar coverage.)

Table ES-2. Simulated Spending Changes for Elderly Medicare Beneficiaries Under Alternative Cost-Sharing Policy Options, 2002

	Mean Change in Cost-Sharing $ (%)	Aggregate Change in Federal Payments Billion $ (%)	Mean Out-of-Pocket Change (Low-Impact Model) $ (%)	Mean Out-of-Pocket Change (High-Impact Model) $ (%)
Baseline Cost–Sharing = $832				
Baseline Out–of–Pocket Spending = $3,757				
Stop-Loss Policies				
$3,000 Stop-Loss	−$114 (−13.7%)	$4.6 (2.2%)	−$69 (−1.8%)	−$317 (−8.4%)
$4,000 Stop-Loss	−74 (−8.9)	3.0 (1.4)	−44 (−1.2)	−295 (−7.9)
$5,000 Stop-Loss	−52 (−6.3)	2.1 (1.0)	−31 (−0.8)	−283 (−7.5)
$3,000 Stop-Loss and Budget–Neutral ($114) Premium Increase	0 (0.0)	0 (0.0)	45 (1.2)	−203 (−5.4)
$4,000 Stop-Loss and Budget–Neutral ($74) Premium Increase	0 (0.0)	0 (0.0)	30 (0.8)	−221 (−5.9)
$5,000 Stop-Loss and Budget–Neutral ($52) Premium Increase	0 (0.0)	0 (0.0)	21 (0.6)	−231 (−6.1)
$300 Part B Deductible and $3,000 Stop-Loss	3 (0.4)	−0.1 (−0.1)	2 (0.1)	−236 (−6.3)
$300 Part B Deductible and $4,000 Stop-Loss	47 (5.6)	−1.9 (−0.9)	29 (0.8)	−193 (−5.1)
$300 Part B Deductible and $5,000 Stop-Loss	71 (8.5)	−2.8 (−1.4)	44 (1.2)	−170 (−4.5)
Combined A/B Deductible Policies				
$300 Combined A/B Deductible	15 (1.8)	−0.6 (−0.3)	10 (0.3)	−247 (−6.6)
$400 Combined A/B Deductible	77 (9.3)	−3.1 (−1.5)	47 (1.3)	−214 (−5.7)
$500 Combined A/B Deductible	136 (16.3)	−5.4 (−2.6)	83 (2.2)	−182 (−4.8)
Other Part A and Part B Policies				
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%	−94 (−11.3)	3.8 (1.8)	−57 (−1.5)	−306 (−8.1)
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%, and Budget-Neutral ($94) Premium Increase	0 (0.0)	0 (0.0)	37 (1.0)	−212 (−5.6)
$300 Part B Deductible, $500 Annual Part A Deductible, Inpatient Coinsurance = 0%	32 (3.8)	−1.3 (−0.6)	20 (0.5)	−238 (−6.3)
$300 Part B Deductible, Inpatient Coinsurance = 0%	113 (13.6)	−4.5 (−2.2)	69 (1.8)	−194 (−5.2)

Source: The Urban Institute's 2002 Medicare Simulations Model.

Not unexpectedly, the options simulated generally produce substantially greater reductions in cost-sharing and out-of-pocket spending among higher-utilization beneficiaries. Among the one-quarter of elderly identified as being in "poor health" (as indicated by self-ratings of health, limited functional status, or presence of selected diagnoses), the two cost-sharing options highlighted above produce larger reductions in average liability ($334 and $204, respectively) as well as substantial reductions in average out-of-pocket spending ($212 and $129, respectively). Among this group, however,

estimates of out-of-pocket savings are much less sensitive to assumptions regarding Medigap purchasing behavior. This is because the dollar difference between paying the cost-sharing expenses directly and purchasing a Medigap policy is smaller for this group of beneficiaries with higher-than-average Medicare expenditures.

For the majority of beneficiaries, however, estimates of out-of-pocket savings are highly dependent on the presence and type of supplemental insurance coverage. Currently, roughly 30 percent of beneficiaries have employer-sponsored supplemental insurance. These individuals are negligibly affected by the Medicare benefit improvements represented by most of these cost-sharing options. This source of coverage will be reduced dramatically in the future, however, because many employers are eliminating this benefit for future retirees. Consequently, the study's simulations specific to policyholders with individually purchased supplemental coverage and to those without additional coverage—which show substantial out-of-pocket savings, particularly for those in poorer health—may be more representative of the future impact of these Medicare cost-sharing options.

Finally, although the policy options simulated in this study produce relatively modest impacts on average out-of-pocket spending, their implementation would enable the Medicare program to offer a sounder insurance package. That is, significantly expanded benefits would become available for beneficiaries who need them, in exchange for relatively modest costs imposed elsewhere in the program and across a broader base of individuals.

MODERNIZING MEDICARE COST-SHARING:
POLICY OPTIONS AND IMPACTS ON BENEFICIARY AND PROGRAM EXPENDITURES

INTRODUCTION

Because of a softening economy, a shrinking federal budget surplus, and new national security priorities, the attention of policymakers has shifted away from issues that were top agenda items during much of 2001. These larger economic realities have created new challenges for nearly any policy issue being debated by Congress, but two issues that have been at the top of the Medicare agenda—prescription drug benefits and Medicare reform—already were confronting several obstacles related to the financing and structure of the proposals put forth before these new realities. For example, during policy debates throughout 2001 over Medicare prescription drug proposals, revised Congressional Budget Office cost estimates suggested that the federal funds considered available at the time for a drug benefit would produce a much smaller benefit than previously believed. The limited drug benefit based on the new cost estimates would yield, many feared, little or no improvement as perceived by beneficiaries.[1] In addition, some congressional leaders have indicated that they would not support a prescription drug benefit absent overall Medicare structural reform—and absent the budget savings they assume would result from that reform.

Despite the slowing economy and the more limited prospects for reform, analysts are predicting the highest growth rate in overall health care spending in 2002—between 13 and 16 percent—since the early 1990s.[2] In addition, the Centers for Medicare and Medicaid Services estimated that Medicare spending in 2001 rose 10 percent, the largest growth rate in expenditures since 1995.[3] The working nonelderly were cushioned from health care inflation in 2000 because of a tight national labor market. In the current economy, however, at least one-quarter of the predicted 2002 inflation is expected to be passed on to employees in the form of higher premium contributions, higher cost-sharing requirements, and reduced benefits.[4] A period of renewed health care inflation and Medicare spending growth also may spur instability in the already weakened Medicare+Choice market and accelerate existing erosions in the level of coverage furnished under

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[1] Dan Crippen, Director, Congressional Budget Office, testimony before the House Energy and Commerce Committee, Subcommittee on Health, May 16, 2001.

[2] Hewitt Associates, LLC, *Hewitt Health Value Initiative*. Lincolnshire, IL: October 2001.

[3] "2001 Spending Rose Ten Percent; Physician Cuts Likely," *American Health Line,* November 1, 2001.

[4] Hewitt Associates, LLC, October 2001.

employer-sponsored supplemental plans. Ultimately, such trends portend an increasing out-of-pocket burden on individuals.

One challenge, then, is to identify options that can improve the Medicare program from the beneficiary perspective but that require little or no additional federal spending. This paper discusses modest options that could modernize and improve the cost-sharing structure of the Medicare benefit package, reduce financial burdens on those beneficiaries who are the sickest, and impose little or no additional federal spending requirements. The paper compares options that incorporate a ceiling on beneficiary annual cost-sharing contributions (a stop-loss). It also simulates a single deductible for Parts A and B combined, as proposed by the administration last year. Alternatives to the "combined deductible" are simulated as well. Finally, it simulates budget-neutral versions of those options that otherwise require net additional federal revenues. The impacts of the options are presented in terms of both federal and beneficiary spending.[5]
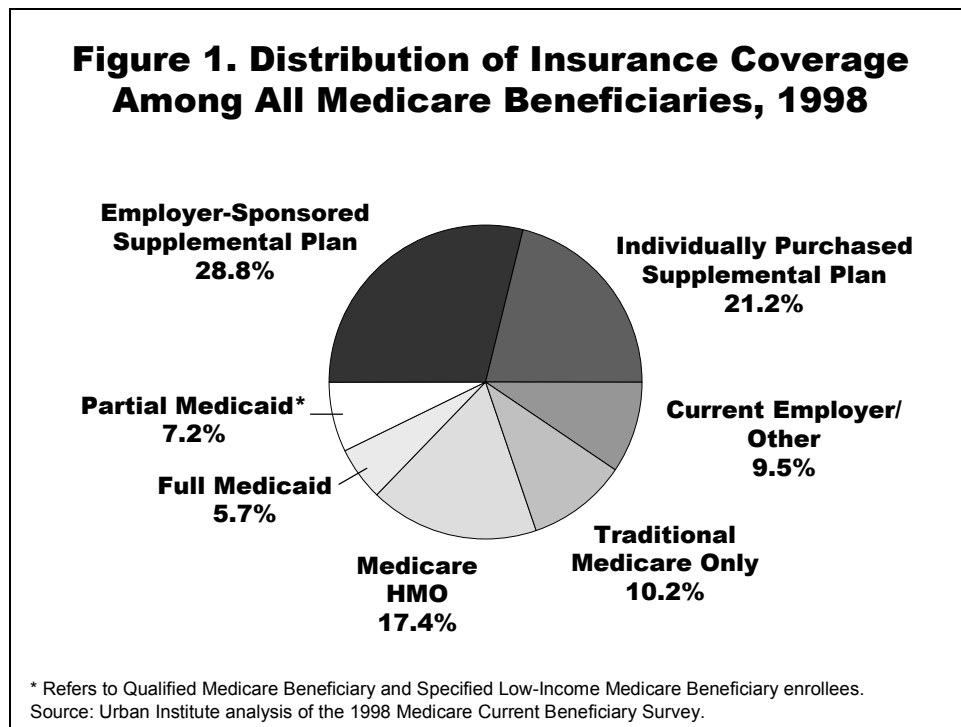
DISTINGUISHING BETWEEN BENEFICIARY LIABILITY AND OUT-OF-POCKET SPENDING

This analysis derives and discusses two measures of beneficiary spending: an individual's Medicare liability and his or her actual out-of-pocket spending. Both measures yield related but distinct information about beneficiaries' health care burdens. An individual's *liability* refers to the portion of spending on covered services that is the responsibility of the enrollee rather than the plan. An individual's Medicare liability thus is the sum of three components paid by or on behalf of a beneficiary: 1) Part B premium payments, for ambulatory care and related services; 2) Part A deductibles, for hospital services, and Part B deductibles; and 3) coinsurance amounts.

For an individual enrolled in a health plan with comprehensive benefits (for example, employees of most large businesses), liability and out-of-pocket spending may be nearly equivalent. These measures are not equivalent for Medicare beneficiaries, however, because many elderly people purchase supplemental insurance policies and certain common

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[5] This paper is part of a series sponsored by The Commonwealth Fund that examines the impact of health care burdens faced by Medicare beneficiaries and analyzes options for reducing those burdens. For analysis of four very diverse illustrations of benefit reform options and their impact on vulnerable groups of beneficiaries, see Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures.* The Commonwealth Fund, May 2001. For analysis of beneficiaries' Medicare liability and out-of-pocket spending projected to 2025, see Maxwell, Moon, and Segal; *Growth in Medicare Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries.* The Commonwealth Fund, January 2001. For analysis of out-of-pocket spending of beneficiaries in Medicare's managed care program, see Kasten, Moon, and Segal, *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* The Commonwealth Fund, August 2000. For a baseline analysis of per capita Medicare spending projections, see Moon, *Growth in Medicare Spending: What Will Beneficiaries Pay?* The Commonwealth Fund, May 1999.

health expenses are not included in the traditional Medicare benefit package (such as prescription drugs, vision services and items, and dental services). Medicare beneficiary *out-of-pocket* expenses, then, are derived by summing an individual's: 1) supplemental insurance premium payments; 2) health care services and items not covered by Medicare or supplemental insurance; and 3) any remaining Medicare liability paid by the individual (usually including, for example, the Medicare Part B premium). In 1998, almost 29 percent of Medicare beneficiaries had supplemental insurance subsidized by their former employer, and over 21 percent purchased policies in the individual market (Figure 1).[6]

Figure 1. Distribution of Insurance Coverage Among All Medicare Beneficiaries, 1998

* Refers to Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary enrollees.
Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

COMPARING COST-SHARING IN PRIVATE HEALTH PLANS AND TRADITIONAL MEDICARE

A key component of some of the options simulated in this study is catastrophic coverage, or an upper limit on an insured's deductibles and coinsurance requirements. A review of annual U.S. Department of Labor surveys of private health plan benefits indicated that stop-losses have been common features of those plans for at least 15 years. For example, among employees and family members insured through non–health maintenance organization (HMO) plans sponsored by medium and large firms, from 1989 to 1997, about 80 percent or more were enrolled in plans with a stop-loss provision (Table 1). In 1989, 37 percent of all enrollees were in plans with stop-loss amounts of less than $1,000

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[6] The percentage of beneficiaries with employer–sponsored supplemental insurance will decline markedly in the future because many employers are eliminating this benefit for future retirees. See discussion in Maxwell, Moon, and Storeygard, May 2001.

(in 1989 dollars); 38 percent were in plans with limits between $1,000 and $1,999; and 9 percent were in plans with limits of $2,000 or higher. In 1997, 20 percent had limits of less than $1,000 (in 1997 dollars); 33 percent had limits between $1,000 and $1,999; and 17 percent had stop-losses of $2,000 or more. The more frequent use over time of nominally higher stop-loss levels indicates that plans adjust their limits, to some degree, to account for inflation. For instance, a stop-loss limit of $500 in 1989 that did not keep pace with inflation would result in unrealistically generous limits over time, equaling $309 in 1997 terms and $192 in 2002 terms (not shown).

Table 1. Cost-Sharing Requirements for Nonelderly Enrollees in Private Non-HMO Plans, 1989–1997

	Percent of Plan Enrollees				
	1989	1991	1993	1995	1997
Stop-Loss Limit					
Percent with Any Stop-Loss Limit	83%	85%	83%	83%	79%
$499 or Less	13	11	8	6	5
$500–$999	24	23	18	15	15
$1,000–$1,499	32	28	25	25	23
$1,500–$1,999	6	9	11	11	10
$2,000 or Greater	9	11	14	15	17
Other/Varies	1	3	8	12	9
Deductible					
$99 or Less	6	4	3	2	1
$100–$149	35	28	22	17	13
$150 or Greater	53	53	54	49	53
None	5	9	12	23	28
Based on Employee Earnings	2	5	6	8	5
Coinsurance					
80 Percent	79	74	71	60	54
85 Percent	4	3	3	4	3
90 Percent	8	11	12	16	19
Other	4	5	3	3	4
None	3	7	10	16	20

Source: Urban Institute summary of U.S. Department of Labor Employee Benefits Surveys of medium and large private employers, 1989–1997.

In debates about structural reform of Medicare, the program often is compared with the Federal Employees Health Benefits Program (FEHBP). Federal employees choose from several nationally and locally available private health plans, including HMOs and preferred provider organizations (PPOs). In 2002, stop-loss limits in the nationally available PPO plans range from $2,000 to $5,000 and most often are $3,000 (Table 2).

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When utilizing non-PPO (non-network) providers, the limits range from $3,000 to $6,000, with most set at $3,500 or $4,000.

Another key component of the options simulated in this study is the restructuring of Medicare's deductibles. As shown in Table 2, many FEHBP plans require two or three deductibles—one each for ambulatory care, inpatient care, and prescription drugs. The plans' deductibles are higher for ambulatory services than they are for inpatient services in recognition of the fact that the former are much more discretionary and under the control of individuals than the latter. The ambulatory deductibles are $250 on average ($330 on average for non-network utilization), while the inpatient deductibles are zero for most PPO plans ($180 per stay on average for non-network utilization).

Medicare's cost-sharing requirements, in contrast, are outmoded in that they lack a stop-loss limit and are skewed toward the less discretionary inpatient services rather than the more discretionary ambulatory services. The inpatient deductible in 2002 is $812 per inpatient spell, which ends 60 days after a hospital or skilled nursing facility discharge, while the Part B deductible remains at $100 per year. When Medicare was established in 1965, the two deductibles were nearly equal—$40 per inpatient spell and $50 per year for Part B services. The amounts have diverged because the former deductible is indexed to growth in Medicare inpatient spending, while the latter was statutorily set and has been increased by law only twice.

Although Medicare's cost-sharing structure today remains outmoded, there have been prior attempts to add stop-loss coverage. The Medicare Catastrophic Coverage Act of 1988 included provisions that limited Part B cost-sharing to $1,370 in 1990 (equivalent to $1,800 in 2002), eliminated hospital coinsurance, and changed the hospital deductible from a per spell requirement to an annual one. To be budget-neutral, these changes were to be funded by income-related additions to the Part B premium. However, after a year of criticisms voiced by pharmaceutical representatives regarding a drug provision in the act, and by some beneficiary groups concerning premium increases associated with both the drug benefit and stop-loss provisions, the act was repealed.[7]

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[7] For detailed discussion of the Medicare Catastrophic Coverage Act and its repeal, see chapter five of M. Moon, *Medicare Now and in the Future*. Washington, DC: The Urban Institute Press, 1993.

Table 2. Cost-Sharing Requirements in Nationally Available FEHBP Non-HMO Plans and Traditional Medicare, 2002

Plan Name	Type of Use (in PPO Network or Out of Network)	Stop-Loss Limit[1]	Deductibles			Copay ($) or Coinsurance (%)		
			Ambulatory Services	Hospital Inpatient (per stay)	Prescription Drugs	Physician and Outpatient Services	Hospital Inpatient	Prescription Drugs
Alliance	PPO	$2,000	$100	$150	$200	10%	10%	10%/50%
	Out of PPO	3,000	300	250	200	30	30	10%/50% ★
APWU	PPO	4,000	275	None	None	10	10	$7[2]
	Out of PPO	6,000	350	200	None	30	30	45%
BCBS Standard	PPO	3,000	250	100	None	10	None	25%
	Out of PPO	5,000	250	300	None	25	30	45%
BCBS Basic	PPO	5,000	None	100/day; 500	None	$20/$30	None	$10[3]
GEHA High	PPO	2,500	300	None	None	10%	10	$5/50%[4]
	Out of PPO	3,500	300	None	None	25	25	$5/50%[4]
GEHA Standard	PPO	3,000	450	None	None	15	15	$5[5]
	Out of PPO	4,000	450	None	None	35	35	$5 ★
Mail Handlers High	PPO	2,500	200	None	250	10	None	25%
	Out of PPO	4,000	200	250	250	30	None	50%
Mail Handlers Standard	PPO	4,000	250	150	600	10	None	30%
	Out of PPO	4,000	250	300	600	30	None	50%
NALC	PPO	3,000	250	None	None	15	10	25%
	Out of PPO	3,500	300	100	$25/retail	30	30	40% ★
Postmasters High	PPO	3,000	200	None	100	10	10	$10/20%[6]
	Out of PPO	3,500	400	150	150	20	25	20% ★
Postmasters Standard	PPO	3,500	250	None	100	10	10	$15/20%[7]
	Out of PPO	5,000	500	250	150	30	30	30% ★
Traditional Medicare	Fee-for-Service	None	100	812 (per spell)[8]	n/a	20	$203 per day — Days 61–90 $406 per day — Days 91–150 All costs after day 150	n/a

[1] Stop-loss limits are 2001 values.
[2] 25% coinsurance if brand-name drug is used.
[3] $25 copay if brand-name drug is used.
[4] $15/$30/50% tiered structure if brand-name drug is used.
[5] 50% coinsurance if brand-name drug is used.
[6] $25/20% structure if brand-name drug is used.
[7] $30/20% structure if brand-name drug is used.
[8] Medicare's inpatient spell ends 60 days after a beneficiary's hospital or skilled nursing facility discharge.

Notes: Alliance is Alliance Health Plan. APWU is American Postal Workers Union Health Plan. BCBS is Blue Cross and Blue Shield. GEHA is Government Employees Hospital Association. Mail Handlers is The Mail Handlers Benefit Plan. NALC is National Association of Letter Carriers. Postmasters is Postmasters Benefit Plan.

★ Enrollee must pay amount shown plus a non-PPO differential. n/a is not applicable.

Source: Urban Institute summary of 2001–02 "Guide to Federal Employees Health Benefits Plans" and 2002 "Medicare & You."

NEW PROPOSALS FOR MEDICARE COST-SHARING

After reviewing trends in the stop-loss levels and deductible requirements of private-sector benefit packages, the authors developed and simulated the impacts of several modest designs for modernizing cost-sharing under Medicare by adding a stop-loss limit and orienting the deductibles more toward ambulatory service use (Table 3).

Table 3. Modernizing Medicare Cost-Sharing:
16 Illustrative Policy Options

Stop-Loss Policies
$3,000 Stop-Loss
$4,000 Stop-Loss
$5,000 Stop-Loss

    $3,000 Stop-Loss and Budget-Neutral ($114) Premium Increase
    $4,000 Stop-Loss and Budget-Neutral ($74) Premium Increase
    $5,000 Stop-Loss and Budget-Neutral ($52) Premium Increase

$300 Part B Deductible and $3,000 Stop-Loss
$300 Part B Deductible and $4,000 Stop-Loss
$300 Part B Deductible and $5,000 Stop-Loss

Combined A/B Deductible Policies
$300 Combined A/B Deductible
$400 Combined A/B Deductible
$500 Combined A/B Deductible

Other Part A and Part B Policies
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%
    $500 Annual Part A Deductible, Inpatient Coinsurance = 0%,
    Budget-Neutral ($94) Premium Increase
$300 Part B Deductible, $500 Annual Part A Deductible,
  Inpatient Coinsurance = 0%
$300 Part B Deductible, Inpatient Coinsurance = 0%

Source: The Urban Institute's 2002 Medicare Simulations Model.

The first three options introduce maximum Medicare cost-sharing limits (stop-losses) at $3,000, $4,000, and $5,000 annually. The next three options introduce a higher Part B deductible ($300) with each of the stop-loss policy options. If any component of Medicare's cost-sharing structure is to increase to offset part of the cost of a stop-loss provision, the Part B deductible makes the most sense. It has not increased since 1992, and other health plans commonly require higher ambulatory care deductibles to help reduce unnecessary service utilization.

The next three options simulate a deductible for Parts A and B combined. In 2001, administration officials proposed to merge the two components of Medicare in efforts to streamline the overall operations and financing of the program.[8] A combined deductible is one of the smaller changes that would result from merging the components. Combined deductibles of $300, $400, and $500 are simulated here.

From a benefit design perspective, a combined deductible is aimed at ambulatory care users, who are the majority of users relative to inpatients. A combined deductible also effectively reduces the level of burden associated with Part A service use. The last three options simulated are alternatives that can meet the design aims of a combined deductible, although within the current, two-part structure of Medicare. These options consist of three combinations of increased Medicare Part B deductibles and decreased Part A deductibles or hospital inpatient coinsurance requirements.
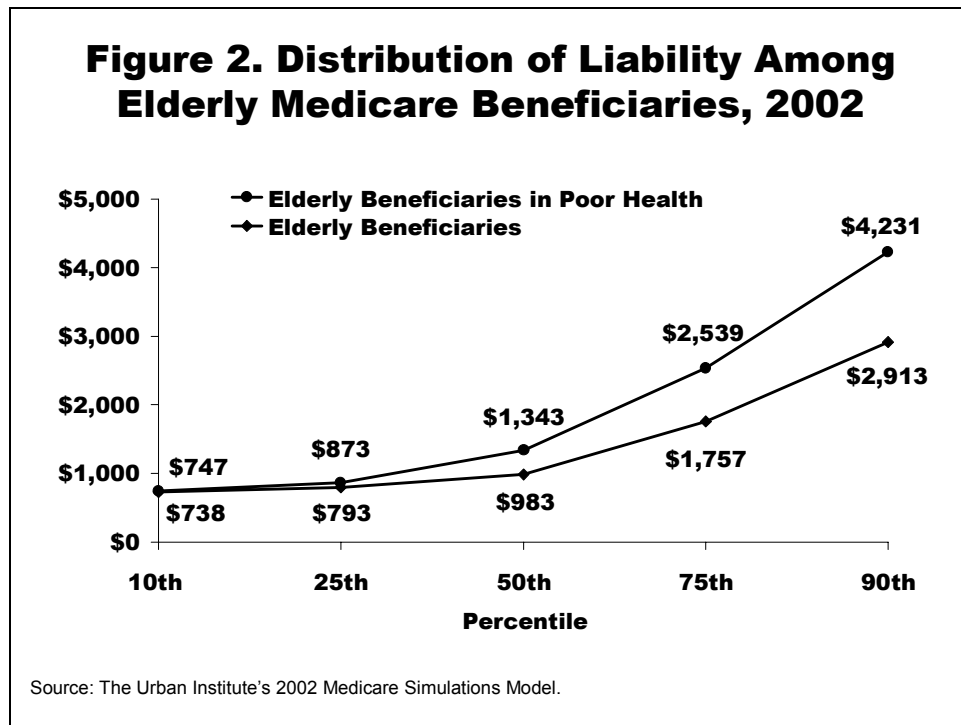
Finally, while each of these 12 options improves the Medicare benefit structure, four of them would require additional federal revenues. The authors simulate budget-neutral versions of these four by estimating Part B premium increases that would exactly offset the aggregate additional revenues otherwise required to implement the options.

To produce the simulations, the authors used Medicare and other health expenditure data from the latest available (1998) Medicare Current Beneficiary Survey (MCBS). The authors first derived baseline per beneficiary estimates of Medicare liability, federal payments, and out-of-pocket health care spending and then projected the baseline estimates to 2002 using growth trends in Medicare and other national health spending. In simulating beneficiaries' out-of-pocket expenditures, the authors accounted for the presence and type of supplemental insurance. In addition, they simulated two behavioral alternatives regarding purchasing supplemental policies. The first alternative conservatively assumes that beneficiaries who purchase Medigap coverage would maintain their policies despite the Medicare reforms. The second alternative assumes that beneficiaries would drop their Medigap policies, given the expanded Medicare coverage. Although numerous factors shape an individual's purchasing behavior in practice, the two alternatives modeled in this analysis represent the upper and lower bounds of the impact of the options on out-of-pocket spending in relation to supplemental insurance. (See the Appendix for details about the baseline and simulated expenditure methodology.)

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[8] The White House, *The President's Framework to Strengthen Medicare*. Washington, DC: July 2001. Available at: http://www.whitehouse.gov/news/releases/2001/07/medicare.html.

ELDERLY BENEFICIARY EXPENDITURES, 2002

In 2002, elderly beneficiaries will incur an estimated $1,470 of Medicare liability (Part B premium and cost-sharing), on average. As shown in Figure 2, one-half of the elderly incur an estimated $983 of liability or less, while the top 10 percent are responsible for $2,913 or more. About one-quarter of elderly beneficiaries are in poor health, as indicated by self-ratings of health, limitations in the activities of daily living (ADLs), or the presence of particular diagnoses.[9] Among this subgroup, median liability is $1,343; and 10 percent have $4,231 or more in liability.

Figure 2. Distribution of Liability Among Elderly Medicare Beneficiaries, 2002

Source: The Urban Institute's 2002 Medicare Simulations Model.

The elderly's mean out-of-pocket spending in 2002 is an estimated $3,757, consuming 22.3 percent of their income (not shown). As shown in Figure 3, median out-of-pocket spending is $2,994—more than three times higher than median liability. The top 10 percent pay $6,523 or more out-of-pocket, while the top 10 percent of those in poor health pay $9,174 or more out-of-pocket.

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[9] Criteria used in constructing an MCBS subsample of elderly beneficiaries in "poor health" included combinations of self-ratings of poor health, use of skilled nursing care, limitations in the activities of daily living (ADLs), such as walking or dressing, or instrumental ADLs, such as housekeeping or preparing food, and presence of selected conditions (stroke, diabetes, rheumatoid arthritis, emphysema, osteoporosis, Parkinson's disease, Alzheimer's disease, and mental or psychiatric conditions).

Figure 3. Distribution of Out-of-Pocket Spending Among Elderly Medicare Beneficiaries, 2002
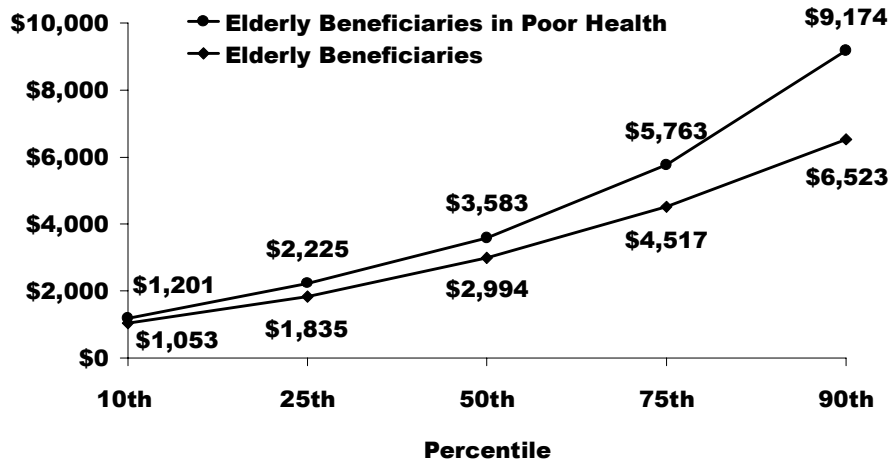
Source: The Urban Institute's 2002 Medicare Simulations Model.

The presence and type of Medicare beneficiaries' supplemental insurance coverage are important factors in explaining differences in out–of–pocket spending. As illustrated in Figure 4, median spending by insurance status is $3,832 (Medigap policyholders), $2,646 (policyholders with employer-subsidized coverage), and $1,495 (those without additional coverage). At most points along the spending distribution, Medigap policyholders spend roughly $1,000 more than those with subsidized coverage; the latter group in turn pays $1,000 more out-of-pocket than those without any supplemental coverage.[10] Among each group, roughly half of the out-of-pocket spending goes to uncovered services (such as prescription drugs).

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[10] Analyses of MCBS data suggest that the higher out-of-pocket spending among Medigap policyholders, relative to those with subsidized policies or no policies, is largely because of higher prescription drug utilization and payment of the full price of supplemental policy premiums.

Figure 4. Distribution of Out-of-Pocket Spending Among Elderly Medicare Beneficiaries, by Type of Supplemental Insurance, 2002
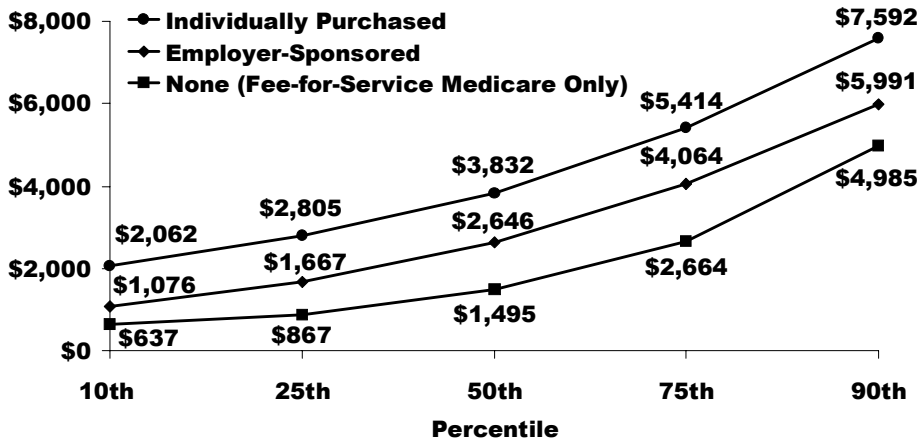
Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

IMPACT OF COST-SHARING PROPOSALS

Beneficiary Liability and Federal Program Expenditures

Table 4 demonstrates the impact on beneficiary cost-sharing, total liability (cost-sharing plus Part B premium), and federal program expenditures of the alternative cost-sharing policy options.

Stop-loss policy options. Across all elderly beneficiaries, the $3,000 stop-loss policy reduces cost-sharing by an average of $114 (13.7%), while the $4,000 and $5,000 stop-loss policies yield roughly half as much in reduced beneficiary spending. In 2002, only an estimated 5.4 percent of the elderly will reach $3,000 in cost-sharing requirements, and would thus be affected by the stop-loss policy. The cost-sharing reductions among this affected group, however, average almost $2,500 (not shown). Overall, the $3,000 option produces the greatest cost-sharing savings of all the policies simulated. Correspondingly, the $3,000 proposal increases federal spending the most—by an estimated $4.6 billion (2.2%) in 2002. This increase in federal outlays is relatively modest. Nonetheless, budget neutrality could be achieved by increasing beneficiaries' Part B premium by $114 annually ($9.50 per month).

Another method to offset the cost of stop-loss protection is to raise the Part B deductible rather than the Part B premium. Unlike premium increases, deductible increases affect most—but not all—beneficiaries. That is because each year, a small share of

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Table 4. Simulated Medicare Expenditures for Elderly Medicare Beneficiaries Under Alternative Cost-Sharing Policy Options, 2002

	Simulated Cost-Sharing	Change in Cost-Sharing $ (%)	Simulated Liability (Cost-Sharing + Premium)	Change in Liability $ (%)	Share of Beneficiaries with Decreased Liability	Share of Beneficiaries with Increased Liability	Change in Aggregate Program Payments Billion $ (%)
Baseline Cost-Sharing = $832							
Baseline Liability = $1,470							
Stop-Loss Policies							
$3,000 Stop-Loss	$718	−$114 (−13.7%)	$1,356	−$114 (−7.8%)	5.4%	0.0%	$4.6 (2.2%)
$4,000 Stop-Loss	758	−74 (−8.9)	1,396	−74 (−5.0)	2.9	0.0	3.0 (1.4)
$5,000 Stop-Loss	780	−52 (−6.3)	1,418	−52 (−3.5)	1.8	0.0	2.1 (1.0)
$300 Part B Deductible and $3,000 Stop-Loss	835	3 (0.4)	1,473	3 (0.2)	5.5	78.9	−0.1 (−0.1)
$300 Part B Deductible and $4,000 Stop-Loss	879	47 (5.6)	1,517	47 (3.2)	2.9	81.5	−1.9 (−0.9)
$300 Part B Deductible and $5,000 Stop-Loss	903	71 (8.5)	1,541	71 (4.8)	1.9	82.5	−2.8 (−1.4)
Combined A/B Deductible Policies							
$300 Combined A/B Deductible	847	15 (1.8)	1,485	15 (1.0)	17.3	67.5	−0.6 (−0.3)
$400 Combined A/B Deductible	909	77 (9.3)	1,547	77 (5.2)	16.8	68.0	−3.1 (−1.5)
$500 Combined A/B Deductible	968	136 (16.3)	1,606	136 (9.3)	15.9	68.8	−5.4 (−2.6)
Other Part A and Part B Policies							
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%	738	−94 (−11.3)	1,376	−94 (−6.4)	18.0	0.0	3.8 (1.8)
$300 Part B Deductible, $500 Annual Part A Deductible, Inpatient Coinsurance = 0%	864	32 (3.8)	1,502	32 (2.2)	18.0	66.8	−1.3 (−0.6)
$300 Part B Deductible, Inpatient Coinsurance = 0%	945	113 (13.6)	1,583	113 (7.7)	0.3	84.1	−4.5 (−2.2)

Source: The Urban Institute's 2002 Medicare Simulations Model.

beneficiaries consume no services or services that amount to less than the deductible. Accordingly, deductible increases must be slightly higher than premium increases to offset the cost of a given stop-loss. As shown in Table 4, increasing the Part B deductible to $300 produces a nearly exact offset to a $3,000 stop-loss, but a $300 deductible produces more savings in federal program spending than is paid out for stop-loss protection at the less-generous $4,000 and $5,000 stop-loss levels.[11] Although this set of options reduces cost-sharing for nearly the same percentage of beneficiaries as the stand-alone stop-loss options, the higher deductible results in net increased liability for about 80 percent of beneficiaries. (Net cost-sharing is unchanged for the balance of beneficiaries.)

Combined deductible policy options. Combining the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) components of Medicare occasionally is proposed as one element within larger Medicare reform efforts. One result of merging the program components is that a single Medicare deductible could be designed. Proponents note that a combined deductible in effect reduces the beneficiary costs of inpatient care and promotes cost-sensitive behavior by beneficiaries regarding ambulatory services.

As shown in the "Combined A/B Deductible Policies" rows of Table 4, a combined deductible of $300 produces a negligible change ($15 or a 1.8 percent increase) in average cost-sharing. This level of change suggests that the option effectively imposes a $200 increase in deductible payments on ambulatory services, which in turn offsets the federal revenue loss associated with the current deductibles paid by inpatient users. Overall, combined deductibles set at levels higher than $300 raise beneficiary cost-sharing and generate federal savings. The $400 and $500 combined deductibles increase average cost-sharing by $77 (9%) and $136 (16%) annually, and lower federal spending by $3.1 billion (1.5%) and $5.4 billion (2.6%). Although the average impacts vary substantially across this set of options, a nearly equal percentage of the elderly are affected by them. The options yield cost-sharing reductions for about 17 percent of beneficiaries (most of whom incur hospital stays) and cost-sharing increases for 68 percent of beneficiaries. The $300 combined deductible raises liability by $110 on average among those incurring an increase; it lowers liability by $303 on average among those incurring a decrease (not shown).

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[11] Health economics literature suggests that an increased deductible would reduce ambulatory utilization, thereby producing additional cost-sharing and federal program savings. This behavioral change most likely would occur among the 10 percent of beneficiaries without supplemental benefit coverage of any type and among a portion of the 20 percent of beneficiaries who might drop their Medigap plans, given the catastrophic protection offered by some of the options simulated. We did not adjust estimates for this assumption of reduced demand for ambulatory services among some beneficiaries because we intentionally produced relatively conservative estimates of change associated with the cost-sharing alternatives.

Other Part A and Part B policy options. Table 4 shows the impact of three cost-sharing alternatives that are conceptually similar to the combined deductible policy options. The first option of this set reduces the Part A deductible (from $812 per spell to $500 per year) and eliminates the daily copayments currently required after day 60 of a hospital inpatient spell. The second option adds a $300 Part B deductible to these Part A changes. The third option eliminates inpatient coinsurance and increases the Part B deductible to $300 but does not alter the current Part A deductible. The options discussed earlier (stop-losses and combined deductibles) may appear to be the simplest and most straightforward options simulated. The Part A and Part B changes simulated here likely would be the simplest for Medicare's fiscal intermediaries and carriers to implement, however, because they do not require running totals of Part A and Part B expenditures combined (necessary to implement stop-loss limits) and they eliminate running totals of Part A days (needed for the current Part A coinsurance requirement).

The first of these options reduces average cost-sharing by $94 (11.3%)—roughly the same impact as the $3,000 stop-loss option—and increases program spending by an estimated $3.8 billion (1.8%) in 2002. Across all the options, this one reaches the largest proportion of beneficiaries, reducing cost-sharing for 18 percent of the elderly. Among those, cost-sharing is reduced by $400, on average (not shown). The option could be self-funded by increasing the Part B premium by $94 annually ($7.83 per month). Alternatively, the second of these options shows that the Part A reductions contained in this option can be more than offset by increasing the Part B deductible to $300. This raises average cost-sharing by $32 (3.8%). The third policy option raises average cost-sharing by $113 (13.6%), and is nearly equivalent in impact to introducing a $450 combined deductible (not shown). Although this set of policy options simulates both a decrease in the Part A deductible and an elimination of the hospital inpatient coinsurance requirement, the former component is the driving force. Elimination of the hospital coinsurance requirement affects only an estimated one-quarter of 1 percent of elderly each year (not shown).

Beneficiary Out-of-Pocket Spending
Tables 5 through 7 show the impact on beneficiary out-of-pocket spending of the cost-sharing alternatives. Lower and upper estimates of the impacts are simulated, based on demand assumptions regarding supplemental insurance. The low-impact model assumes that Medigap policyholders will maintain their policies (as modified given the Medicare cost-sharing changes), while the high-impact model assumes that these policyholders will drop the coverage, given the additional financial protection afforded by the cost-sharing

proposals.[12] Although beneficiaries under the high-impact model would now pay their Medicare cost-sharing expenses directly out-of-pocket, average out-of-pocket savings are greater under this model because Medigap premiums exceed average Medicare cost-sharing expenses. Beneficiaries thus would reap additional savings because they would no longer pay the relatively high administrative charges associated with individually purchased supplemental policies.

Impact on elderly beneficiaries. As shown in Table 5, the $3,000, $4,000 and $5,000 stop-loss policy options produce negligible reductions in average out-of-pocket spending ($31 to $69, or 0.8% to 1.8% savings) assuming no change in Medigap purchasing behavior, but each of the three options produces substantial average out-of-pocket savings ($283 to $317, or 7.5% to 8.4% savings) if individually purchased coverage is dropped. This pattern is closely repeated across all the options. Each of the options affects average out-of-pocket spending by less than 2 percent under the low-impact model but produces between 4.5 percent and 8.4 percent average out-of-pocket savings under the high-impact model.

Compared with the cost-sharing findings, the average effects on out-of-pocket spending are blunted under the low-impact model. Under the high-impact model, however, all the options produce savings in average out-of-pocket spending—even those options that raise average cost-sharing—because of the extra savings related to Medigap administrative costs. Examining the impact on beneficiaries by supplemental insurance status further illustrates this result.

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[12] In practice, the proportion of beneficiaries who would forgo Medigap coverage would vary by option and would be greater under the more generous options.

Table 5. Simulated Out-of-Pocket Spending for Elderly Medicare Beneficiaries Under Alternative Cost-Sharing Policy Options, 2002

	Low-Impact Model*		High-Impact Model**	
	Simulated Out-of-Pocket Spending	Change $ (%)	Simulated Out-of-Pocket Spending	Change $ (%)
Baseline Out-of-Pocket Spending = $3,757				
Stop-Loss Policies				
$3,000 Stop-Loss	$3,688	−$69 (−1.8%)	$3,440	−$317 (−8.4%)
$4,000 Stop-Loss	3,713	−44 (−1.2)	3,462	−295 (−7.9)
$5,000 Stop-Loss	3,726	−31 (−0.8)	3,474	−283 (−7.5)
$3,000 Stop-Loss and $114 Premium Increase	3,802	45 (1.2)	3,554	−203 (−5.4)
$4,000 Stop-Loss and $74 Premium Increase	3,787	30 (0.8)	3,536	−221 (−5.9)
$5,000 Stop-Loss and $52 Premium Increase	3,778	21 (0.6)	3,526	−231 (−6.1)
$300 Part B Deductible and $3,000 Stop-Loss	3,759	2 (0.1)	3,521	−236 (−6.3)
$300 Part B Deductible and $4,000 Stop-Loss	3,786	29 (0.8)	3,564	−193 (−5.1)
$300 Part B Deductible and $5,000 Stop-Loss	3,801	44 (1.2)	3,587	−170 (−4.5)
Combined A/B Deductible Policies				
$300 Combined A/B Deductible	3,767	10 (0.3)	3,510	−247 (−6.6)
$400 Combined A/B Deductible	3,804	47 (1.3)	3,543	−214 (−5.7)
$500 Combined A/B Deductible	3,840	83 (2.2)	3,575	−182 (−4.8)
Other Part A and Part B Policies				
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%	3,700	−57 (−1.5)	3,451	−306 (−8.1)
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%, $94 Premium Increase	3,794	37 (1.0)	3,545	−212 (−5.6)
$300 Part B Deductible, $500 Annual Part A Deductible, Inpatient Coinsurance = 0%	3,777	20 (0.5)	3,519	−238 (−6.3)
$300 Part B Deductible, Inpatient Coinsurance = 0%	3,826	69 (1.8)	3,563	−194 (−5.2)

* Low-impact model assumes that Medigap policyholders keep their coverage.

** High-impact model assumes that Medigap policyholders drop their coverage.

Source: The Urban Institute's 2002 Medicare Simulations Model.

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Impact by beneficiary supplemental insurance status. As shown in Table 6, reductions in average out-of-pocket spending are produced across the board only under the high-impact model for policyholders with individually purchased supplemental coverage. Under that model, out-of-pocket reductions range from $678 or 13.9 percent (under the $300 Part B deductible and zero inpatient coinsurance option) to $911 or 18.7 percent (under the $3,000 stop-loss policy option).

The effects on policyholders with individually purchased supplemental coverage under the low-impact model and on the Medicare-only group are roughly similar; the options alter these groups' out-of-pocket spending by about 1 to 3 percent. In terms of out-of-pocket spending, beneficiaries with employer-sponsored insurance are affected the least by these options. These minimal average impacts, however, reflect the design of most of the cost-sharing policies simulated in that the average costs of catastrophic coverage are offset by increased premiums or deductibles. Thus the larger beneficiary savings associated with these options are seen in the simulations of those beneficiaries with higher-than-average health care utilization and expenses.

Impact on elderly beneficiaries in poor health. As shown in Table 7, all but two of the options (the $500 combined deductible policy and the $300 Part B deductible and zero inpatient coinsurance policy) produce out-of-pocket savings for the one-quarter of the elderly who are in poor health. Even policy options with budget-neutral premium offsets and increased Part B deductibles thus yield average savings among this group of beneficiaries. Across all the options, the $3,000 stop-loss option reduces out-of-pocket spending the most ($212 or 4.0%). Three other options yield roughly $140 (2.6%) in savings—the $4,000 stop-loss option; the $300 Part B deductible and $3,000 stop-loss option; and the $500 annual inpatient deductible and zero inpatient coinsurance option.

Comparing the effects of our two Medigap purchasing assumptions reveals that among this group of elderly beneficiaries, simulated savings under the low-impact model (no change in Medigap purchasing behavior) are similar to savings under the high-impact model (policyholders drop their Medigap plans). This indicates that among this relatively high-use, high-cost group, the average amount of Medicare cost-sharing approaches the average Medigap premium paid. Consequently, for this group there is only a small cost advantage in paying Medicare cost-sharing directly, rather than purchasing an individual policy. With respect to "all elderly" beneficiaries, by contrast, average cost-sharing does not approach Medigap premiums and, consequently, savings are greater under the high-impact model.

Table 6. Simulated Out-of-Pocket Spending for Elderly Medicare Beneficiaries Under Alternative Cost-Sharing Policy Options, by Supplemental Insurance Status, 2002

| | Employer-Sponsored | | None (Fee-for-Service Medicare Only) | | Individually Purchased | | | |
| | | | | | Low-Impact* | | High-Impact** | |
	Simulated Out-of-Pocket Spending	Change $ (%)	Simulated Out-of-Pocket Spending	Change $ (%)	Simulated Out-of-Pocket Spending	Change $ (%)	Simulated Out-of-Pocket Spending	Change $ (%)
Baseline Out-of-Pocket Spending	$3,370		$2,473		$4,868		$4,868	
Stop-Loss Policies								
$3,000 Stop-Loss	3,344	−$26 (−0.8%)	2,391	−$82 (−3.3%)	4,742	−$126 (−2.6%)	3,957	−$911 (−18.7%)
$4,000 Stop-Loss	3,352	−18 (−0.5)	2,418	−55 (−2.2)	4,793	−75 (−1.5)	4,000	−868 (−17.8)
$5,000 Stop-Loss	3,357	−13 (−0.4)	2,437	−36 (−1.5)	4,821	−47 (−1.0)	4,023	−845 (−17.4)
$3,000 Stop-Loss and $114 Premium Increase	3,458	88 (2.6)	2,505	32 (1.3)	4,856	−12 (−0.2)	4,071	−797 (−16.4)
$4,000 Stop-Loss and $74 Premium Increase	3,426	56 (1.7)	2,492	19 (0.8)	4,867	−1 (0.0)	4,074	−794 (−16.3)
$5,000 Stop-Loss and $52 Premium Increase	3,409	39 (1.2)	2,489	16 (0.6)	4,873	5 (0.1)	4,075	−793 (−16.3)
$300 Part B Deductible and $3,000 Stop-Loss	3,369	−1 (0.0)	2,474	1 (0.0)	4,888	20 (0.4)	4,079	−789 (−16.2)
$300 Part B Deductible and $4,000 Stop-Loss	3,378	8 (0.2)	2,503	30 (1.2)	4,947	79 (1.6)	4,128	−740 (−15.2)
$300 Part B Deductible and $5,000 Stop-Loss	3,383	13 (0.4)	2,523	50 (2.0)	4,976	108 (2.2)	4,152	−716 (−14.7)
Combined A/B Deductible Policies								
$300 Combined A/B Deductible	3,376	6 (0.2)	2,473	0 (0.0)	4,877	9 (0.2)	4,070	−798 (−16.4)
$400 Combined A/B Deductible	3,390	20 (0.6)	2,515	42 (1.7)	4,955	87 (1.8)	4,135	−733 (−15.1)
$500 Combined A/B Deductible	3,403	33 (1.0)	2,553	80 (3.2)	5,030	162 (3.3)	4,197	−671 (−13.8)
Other Part A and Part B Policies								
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%	3,350	−20 (−0.6)	2,411	−62 (−2.5)	4,754	−114 (−2.3)	3,967	−901 (−18.5)
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%, $94 Premium Increase	3,444	74 (2.2)	2,505	32 (1.3)	4,848	−20 (−0.4)	4,061	−807 (−16.6)
$300 Part B Deductible, $500 Annual Part A Deductible, Inpatient Coinsurance = 0%	3,377	7 (0.2)	2,500	27 (1.1)	4,912	44 (0.9)	4,099	−769 (−15.8)
$300 Part B Deductible, Inpatient Coinsurance = 0%	3,393	23 (0.7)	2,561	88 (3.6)	5,021	153 (3.1)	4,190	−678 (−13.9)

* Low-impact model assumes that Medigap policyholders keep their coverage.

** High-impact model assumes that Medigap policyholders drop their coverage.

Source: The Urban Institute's 2002 Medicare Simulations Model.

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Table 7. Simulated Out-of-Pocket Spending for Elderly Medicare Beneficiaries in Poor Health Under Alternative Cost-Sharing Policy Options, 2002

	Low-Impact Model*		High-Impact Model**	
	Simulated Out-of-Pocket Spending	Change $ (%)	Simulated Out-of-Pocket Spending	Change $ (%)
Baseline Out-of-Pocket Spending = $5,291				
Stop-Loss Policies				
$3,000 Stop-Loss	$5,079	–$212 (–4.0%)	$5,075	–$216 (–4.1%)
$4,000 Stop-Loss	5,143	–148 (–2.8)	5,131	–160 (–3.0)
$5,000 Stop-Loss	5,184	–107 (–2.0)	5,169	–122 (–2.3)
$3,000 Stop-Loss and $114 Premium Increase	5,193	–98 (–1.9)	5,189	–102 (–1.9)
$4,000 Stop-Loss and $74 Premium Increase	5,217	–74 (–1.4)	5,205	–86 (–1.6)
$5,000 Stop-Loss and $52 Premium Increase	5,236	–55 (–1.0)	5,221	–70 (–1.3)
$300 Part B Deductible and $3,000 Stop-Loss	5,154	–137 (–2.6)	5,141	–150 (–2.8)
$300 Part B Deductible and $4,000 Stop-Loss	5,222	–69 (–1.3)	5,202	–89 (–1.7)
$300 Part B Deductible and $5,000 Stop-Loss	5,266	–25 (–0.5)	5,241	–50 (–0.9)
Combined A/B Deductible Policies				
$300 Combined A/B Deductible	5,239	–52 (–1.0)	5,218	–73 (–1.4)
$400 Combined A/B Deductible	5,286	–5 (–0.1)	5,260	–31 (–0.6)
$500 Combined A/B Deductible	5,332	41 (0.8)	5,300	9 (0.2)
Other Part A and Part B Policies				
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%	5,162	–129 (–2.4)	5,148	–143 (–2.7)
$500 Annual Part A Deductible, Inpatient Coinsurance = 0%, $94 Premium Increase	5,256	–35 (–0.7)	5,242	–49 (–0.9)
$300 Part B Deductible, $500 Annual Part A Deductible, Inpatient Coinsurance = 0%	5,250	–41 (–0.8)	5,227	–64 (–1.2)
$300 Part B Deductible, Inpatient Coinsurance = 0%	5,360	69 (1.3)	5,326	35 (0.7)

★ Low-impact model assumes that Medigap policyholders keep their coverage.
★★ High-impact model assumes that Medigap policyholders drop their coverage.
Source: The Urban Institute's 2002 Medicare Simulations Model.

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DISCUSSION

Key benefit designs discussed in this paper—stop-loss limits, lower inpatient deductibles, and higher ambulatory deductibles—have been common features of private-sector health plans for several years. The paper simulates several combinations of these features and estimates their impact on federal and beneficiary spending under the Medicare program.

From the beneficiary perspective, the two most effective cost-saving options simulated are: 1) a $3,000 stop-loss, and 2) a restructuring of the Part A deductible from $812 per spell in 2002 to $500 per year (combined with elimination of hospital inpatient coinsurance). The two options produce comparable reductions in average liability ($114 and $94, respectively) and average out-of-pocket spending ($69 and $57, respectively, assuming no change in Medigap purchasing behavior, and $317 and $306, respectively, assuming individuals drop their Medigap policies).

Among the one-quarter of elderly beneficiaries in poor health, however, the $3,000 stop-loss yields substantially larger reductions than the other option in average liability ($334 and $204, respectively) and average out-of-pocket spending ($212 and $129, respectively). Because the dollar difference between paying the cost-sharing expense directly and purchasing a Medigap policy is smaller for this group of beneficiaries with higher-than-average Medicare expenditures, estimates of this group's out-of-pocket savings are much less sensitive to assumptions regarding Medigap purchasing behavior. A key difference between the two options is the proportion of beneficiaries affected. While 5.4 percent of elderly beneficiaries would reach a $3,000 stop-loss limit each year, more than three times as many (18.0%) would be aided each year by the revised Part A option.

Both options require considerable increases in aggregate additional federal funds ($4.6 billion and $3.8 billion, respectively). Premium increases of an estimated $114 and $94, respectively, exactly offset the costs of the two options, while increases in the Part B deductible to $300 more than offset the costs. Even with these budget-neutral offsets, however, the policies reduce average out-of-pocket spending by up to about 5.5 percent, depending on assumptions regarding Medigap purchasing behavior. Of the two offset mechanisms, the Part B deductible may be preferred because that increase would be more transparent than a premium increase and has the potential to promote more cost-sensitive use of ambulatory services. Further, this effect would be heightened to the extent that the catastrophic protection furnished by these options would induce Medigap policyholders to drop their policies—and the first-dollar coverage that they provide.

Across all the policies simulated, estimates of out-of-pocket savings are highly dependent on the presence and type of supplemental insurance coverage. Although the nearly 30 percent of beneficiaries with employer-sponsored supplemental insurance are negligibly affected by these revisions in the Medicare benefit package, this source of coverage will be reduced dramatically in the future because employers are eliminating this benefit for future retirees. Consequently, the study's simulations specific to policyholders with individually purchased supplemental coverage and to those without additional coverage may be more representative of the future impact of the cost-sharing options.

Further, although the options simulated in this study produce relatively modest impacts on average out-of-pocket spending, their implementation would enable the Medicare program to offer a sounder insurance package. That is, significantly expanded benefits would become available for beneficiaries who need them, in exchange for relatively modest costs imposed elsewhere in the program and across a broader base of individuals.

APPENDIX. DERIVING BASELINE AND SIMULATED EXPENDITURES

To compare the impact of Medicare benefit changes, the authors used the latest available (1998) Medicare Current Beneficiary Survey (MCBS) and first derived baseline, 2002 per beneficiary estimates of Medicare liability, program payments, and out-of-pocket health care spending.

Data Source and Study Population

The MCBS, a nationally representative survey of about 12,500 beneficiaries funded by the Centers for Medicare and Medicaid Services (CMS), queries respondents about their Medicare and other health care use and spending, supplemental insurance policies, self-rated health status, functional status, and satisfaction with care. Surveyors use actual Medicare claims (bills) when possible to reconcile and correct responses about Medicare use and spending. The authors inflate the 1998 Medicare expenditure data to 2002 using CMS's latest actuarial projections of annual Medicare expenditure growth. The authors inflated prescription drug spending using annual expenditure data from CMS's compilation of national health expenditures. Between 1998 and 2002, drug spending among the elderly grew 15.4 percent per year, on average. Medicare growth rate assumptions were used for all other health care spending data.

We derived per beneficiary estimates from the sample of survey respondents who were: 65 years of age and older, enrolled in traditional (fee-for-service) Medicare, resided in the community (rather than a nursing home), and were not dually enrolled in Medicaid. MCBS expenditure data are considered less accurate regarding the beneficiaries we excluded, because of difficulties associated with accurately identifying some of their health care utilization and expenditures. To reduce the margin of error in this study, we therefore excluded those individuals from our simulations.

Estimating Baseline Beneficiary Liability and Program Expenditures

Calculating Medicare program expenditures at the beneficiary level involved a fairly straightforward summation of the provider reimbursement data that originated from survey respondents' claims information linked to the survey. As defined in the body of the paper, a beneficiary's Medicare *liability* equals the Part B premium plus applicable cost-sharing payments required for services used. For beneficiaries not consuming program services, total liability in 2002 is $637 (the annual Part B premium). For those using services, we calculated total liability by summing: 1) the Part B premium, 2) the Part B deductible, 3) coinsurance payments (identified in the MCBS), and 4) our estimate of total Part A deductible payments. Part A deductible information is not available from the survey. We estimated these deductible payments using each individual's inpatient stay

count (identified from the MCBS) and an extant distribution of beneficiaries' inpatient stays per spell and spells per year. Finally, we derived beneficiary *out-of-pocket* spending by summing: 1) Medicare liability net of all insurers' payments, 2) premium payments for supplemental policies, and 3) payments for noncovered health care services and items.

Simulating Beneficiary Liability and Program Expenditures

To simulate the addition of a stop-loss to the Medicare benefit package, a beneficiary's cost-sharing (that is, coinsurance and deductible amounts) in excess of a particular stop-loss amount was subtracted from her total liability and added to her federal program payments. Similar calculations were used to estimate the effect of lower Part A deductibles and lower coinsurance rates. To simulate a proposed higher Part B deductible, a beneficiary's liability was increased and his or her federal program payments were decreased by amounts, up to the proposed new deductible, that were dependent on his or her baseline federal Part B program payments.

Combined Part A and Part B deductible policies are intended to effectively increase liability for ambulatory care patients and decrease liability for hospital inpatients. To simulate A/B deductibles for users of Part B services only, additional liability (up to the proposed new deductible) was estimated based on a beneficiary's Part B program payments and then added to the beneficiary's baseline liability. The individual's program payments were correspondingly reduced by the net increase in liability. Liability for hospital users under this option was simulated by subtracting from their baseline liability the difference between: 1) the baseline estimated total Part A deductible, and 2) the proposed A/B deductible minus the current Part B deductible.

Some of the options simulated resulted in increased per capita federal program payments, indicating that additional federal revenues would be required to fund the benefit changes. We calculated budget-neutral variants of each of these options by adding to beneficiaries' existing annual Part B premium a premium surcharge equal to the per capita program payment increase due to the option. Under the budget-neutral variants, then, no additional federal revenue is required but per capita liability estimates were increased because of the offsetting premium.

Simulating Out-Of-Pocket Spending and Adjusting for Supplemental Insurance Coverage

Although impacts on beneficiary liability and federal program spending are important in assessing options from the perspective of Medicare program costs, impacts on out-of-pocket spending—rather than liability—are more important from the beneficiary's perspective. The adjustments made to account for the presence of supplemental insurance

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are central to estimating impacts on out–of–pocket spending. A beneficiary's Medicare liability savings translate to an equal amount of out–of–pocket savings only if the beneficiary has no supplemental insurance coverage.

We present two sets of out–of–pocket simulations for each Medicare option. One set of simulations assumes that beneficiaries who individually purchase supplemental insurance (known as Medigap policies) would drop that coverage, given the additional financial protection offered by the Medicare benefit revisions.[13] The second set of simulations assumes that Medigap policyholders would keep their policies. Under this scenario, insurers would modify their Medigap premiums to reflect the lower average beneficiary liability resulting from the Medicare benefit revision.[14] In practice, some beneficiaries would keep their policies while others would drop them; numerous factors would shape an individual's response to the Medicare benefit revisions and his or her choices regarding Medigap. The two sets of simulations performed here model the upper and lower bounds of the Medigap purchasing behavior of beneficiaries, in response to revisions in Medicare's cost–sharing structure.

Although Medigap policyholders bear the full price of these supplemental plans, those with employer-sponsored supplemental insurance for retirees pay on average only 20 percent of the policy premium.[15] Because these beneficiaries are relatively insulated from the cost of carrying supplemental insurance, we assumed they would keep their employer-sponsored coverage under any of the Medicare cost-sharing options discussed in this study. To simulate out-of-pocket spending among these beneficiaries for a given option, we thus assumed that insurers would modify their group premiums to reflect the lower average beneficiary liability resulting from the Medicare benefit revisions.[16]

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[13] When we assumed that Medigap policyholders would drop their policies, we subtracted from their simulated out-of-pocket spending their Medigap premium payments and added their new Medicare cost-sharing amount (that otherwise would be paid by the Medigap policy).

[14] When we assumed that Medigap policyholders would maintain their coverage, we adjusted beneficiaries' Medigap premium payments to account for changes in Medicare cost-sharing under a given option. Medicare cost-sharing savings translate into higher Medigap premium savings, on average, because the administrative overhead (load factor) of Medigap plans is relatively high. We assumed a load factor of 1.23, based on "Medicare Supplement Loss Ratio Report, 1998," *NAIC Research Quarterly,* Fall 2000; and U.S. General Accounting Office, *Medigap Insurance: Compliance with Federal Standards Has Increased,* GAO/HEHS-98-66. Washington, DC, March 1998.

[15] Levit et al. and Gabel et al., *Employer Health Benefits: 2000 Annual Survey*. Kaiser Family Foundation and Health Research and Educational Trust, 2000.

[16] When we assumed that employer-sponsored supplemental coverage policyholders would maintain their coverage, we adjusted these beneficiaries' premium payments to account for changes in Medicare cost-sharing under a given option. Compared with Medigap policyholders, Medicare cost-sharing savings translate into relatively small savings for those with employer-sponsored coverage because they pay on average only 20 percent of their premium. Further, the load factor on group policies is relatively small. A load factor of 1.05 was used in this adjustment, based on U.S. General Accounting Office, *Retiree Health Insurance: Erosion in Retiree Health Benefits Offered by Large Employers,* GAO/T-HEHS-98-110. Washington, DC, 1998.

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#573 *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate over Drug Benefits* (September 2002). Betsy Briesacher, Bruce Stuart, Jalpa Doshi, Sachin Kamal-Bahl, and Dennis Shea. In this report from The Commonwealth Fund and the Henry J. Kaiser Family Foundation, the authors conclude that the 5 million disabled Americans under age 65 who are Medicare-eligible have few options other than Medicaid for obtaining prescription coverage, and that a Medicare drug benefit designed for the elderly will not suffice for the disabled unless their particular needs are assessed and addressed.

#562 *Medicare+Choice After Five Years: Lessons for Medicare's Future—Findings from Seven Major Cities* (September 2002). Brian Biles, Geraldine Dallek, and Andrew Dennington. This field report argues that, five years later, Medicare+Choice has not become what program proponents had envisioned. While it was originally forecast that program enrollment would rise to 34 percent of total Medicare enrollment by 2005, the enrollment has now fallen from its 1997 level of 14 percent to just 13 percent.

#561 *Geographic Inequity in Medicare+Choice Benefits—Findings from Seven Communities* (September 2002). Geraldine Dallek, Andrew Dennington, and Brian Biles. In this field report, the authors show that Medicare+Choice plans in Los Angeles and New York City provide far more generous benefits at lower costs to beneficiaries than plans in five other study sites.

#548 *Medicare+Choice in New York City: So Far, So Good?* (September 2002). Jennifer Stuber, Andrew Dennington, and Brian Biles. In this field report, the authors suggest that New York City's more than 200,000 elderly and disabled enrollees in Medicare+Choice plans—representing about 20 percent of all New York City Medicare beneficiaries—may soon begin to experience large-scale health plan withdrawals, premium increases, benefit reductions, and provider network instability, as have beneficiaries in most other markets.

#544 *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (August 2002). Marilyn Moon and Matthew Storeygard, The Urban Institute. In this policy brief, the authors suggest that a modest Medicare prescription drug benefit could be crafted that provides some coverage to all beneficiaries while protecting those with low-incomes and high out-of-pocket expenses.

#530 *State Pharmaceutical Assistance Programs: Approaches to Program Design* (May 2002). Kimberley Fox, Thomas Trail, and Stephen Crystal, Rutgers Center for State Health Policy. State pharmacy assistance programs for Medicare beneficiaries help only a small proportion of the Medicare population—just 3 percent, or 1.2 million beneficiaries out of 39 million nationwide. According to the authors, a federal program is needed to fill this gap in coverage, and it should coordinate with the 28 state programs currently in place.

#538 *A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the significant policy challenge of designing an effective and politically viable Medicare prescription drug benefit. Available online only at www.cmwf.org.

#537 *Medicare Managed Care: Medicare+Choice at Five Years* (April 2002). Colleen L. Barry and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, examines trends in enrollment, benefits and premiums, plan payments, and satisfaction and quality in Medicare+Choice. Available online only at www.cmwf.org.

#533 *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (March 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. In this report (available on the Fund's website only), the authors note that while increases in monthly premiums will affect all enrollees in 2002, sicker beneficiaries will bear the brunt of changes in the structure of prescription drug benefits and cost-sharing requirements as more plans restrict drug coverage to generics only and raise cost-sharing requirements for services such as inpatient and outpatient hospital care.

#497 *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. The authors report that mean premium and cost-sharing levels in Medicare+Choice plans continued to increase in 2001 while coverage of prescription drugs was reduced. This trend continued despite congressional action that increased the payment rate MCOs received.

#494 *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001* (February 2002). Lori Achman and Marsha Gold, Mathematica Policy Research, Inc. Analysis by the authors of Medicare Compare found that out-of-pocket spending for Medicare+Choice enrollees can be substantial and varies significantly with health status. In 2001, the average enrollee in good health spent $1,195 annually out-of-pocket on health care, while an enrollee in poor health spent $3,578, or about three times as much.

#505 *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy* (January 2002). Becky Briesacher, Bruce Stuart, and Dennis Shea. In this issue brief, the authors evaluate trends in prescription drug coverage for Medicare beneficiaries during the 1990s as a way to project their future coverage, costs, and needs. Based on data from 1993 to 1998, the projections indicate that beneficiary drug coverage most likely peaked in 1998 or shortly thereafter, and has been in decline ever since.

#496 *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (January 2002). Jennifer Stuber, Geraldine Dallek, Claire Edwards, Kathleen Maloy, and Brian Biles. This executive summary of an unpublished report (available on the Fund's website only) examines recent changes in seven Medicare+Choice markets and the effects of these changes on Medicare beneficiaries.

#495 *Physician Withdrawals: A Major Source of Instability in Medicare+Choice* (January 2002). Geraldine Dallek and Andrew Dennington, George Washington University. The authors find that provider turnover rates within Medicare+Choice plans vary dramatically from state to state. Of the 38 states with reported data for 1999, six states plus the District of Columbia had turnover rates of 20 percent or higher.

#510 *The 2002 Medicare+Choice Plan Lock-In: Should It Be Delayed?* (December 2001). Geraldine Dallek, Brian Biles, and Andrew Dennington, George Washington University. This issue brief

points to large-scale health plan withdrawals and provider turnover in the Medicare+Choice market as being among the reasons to delay or repeal the Medicare+Choice policy to lock beneficiaries into their plans for a specified period.

#491 *National and Local Factors Driving Health Plan Withdrawals from Medicare+Choice* (October 2001). Jennifer Stuber, Geraldine Dallek, and Brian Biles, George Washington University. The authors of this field report found a substantial decline in the number of Medicare+Choice plans in five of seven large markets around the country.

#490 *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (October 2001). Geraldine Dallek and Claire Edwards, George Washington University. In this field report, the authors discuss the benefit packages of five Medicare+Choice plans in Cleveland, Ohio, and Tampa, Florida, and find that beneficiaries would have to spend hours calling plans, poring over data, and making complicated calculations in order to make any kind of reasonable comparison of plans.

#474 *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (September 2001). Marilyn Moon and Matthew Storeygard, The Urban Institute. The authors argue that any major change to the Medicare program—such as requiring coinsurance for home health care—must take into account the steep costs seriously ill beneficiaries already pay for health services.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author gives Medicare+Choice (M+C) a "barely passing grade," noting disparities between what Congress intended under M+C and what was achieved. The author suggests that while operational constraints help explain experience to date, fundamental disagreements in Congress over Medicare's future mean that dramatic growth in M+C was then, and remains now, highly unlikely.

#467 *Raising Payment Rates: Initial Effects of BIPA 2000* (June 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This "Fast Facts" brief, published by Mathematica, examines how the Benefits Improvement and Protection Act (BIPA) changed payment rates to Medicare+Choice plans in counties with a metropolitan area of 250,000 people or more. Available online at www.mathematica-mpr.com/PDFs/fastfacts6.pdf *or* www.cmwf.org/programs/medfutur/gold_bipa_467.pdf.

#463 *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing* (May 2001). Karen Davis. In invited testimony before a House Ways and Means Health Subcommittee hearing, the Fund's president cautioned that any effort to reform Medicare's benefit package must take into account the circumstances of all beneficiaries, including those who are older, low-income, and chronically ill.

#461 *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures* (May 2001). Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, The Urban Institute. This report presents four possible options for modernizing Medicare that would reverse spiraling costs for beneficiaries and reduce or eliminate the need for private supplemental insurance.

#460 *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (April 2001). Marsha Gold and Lori Achman, Mathematica Policy Research, Inc. This issue brief provides an early look at trends in Medicare+Choice plans from 1999 to 2001, revealing continued growth in premiums and a simultaneous continued decline in benefit comprehensiveness.

Medicare Works (Spring 2001). Bruce Vladeck. *Harvard Health Policy Review,* vol. 2, no. 1. Reprinted from *New Jersey Medicine,* March 2000. Available online at http://hcs.harvard.edu/~epihc/currentissue/spring2001/vladeck.html.

#498 *Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers* (March/April 2001). Bruce Stuart, Dennis Shea, and Becky Briesacher. *Health Affairs,* vol. 20, no. 2. The authors analyze the sources and stability of prescription coverage maintained by Medicare beneficiaries in 1995 and 1996. The results show that fewer than half of all beneficiaries had continuous drug coverage over this period, while nearly a third gained, lost, or had spells without coverage.

Health Policy 2001: Medicare (March 22, 2001). Marilyn Moon. *New England Journal of Medicine,* vol. 344, no. 12. Copies are available from Customer Service, *New England Journal of Medicine,* P.O. Box 549140, Waltham, MA 02454-9140, Fax: 800-THE-NEJM, (800-843-6356), www.nejm.org.

#430 *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries* (January 2001). Stephanie Maxwell, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare beneficiaries will have to pay substantially more out of their own pockets for health care in the future, according to this new report. The authors find that those with low incomes and health problems will be at even greater risk than average beneficiaries for costs such as Medicare premiums, medical services, and prescription drugs.

A Moving Target: Financing Medicare for the Future (Winter 2000/2001). Marilyn Moon, Misha Segal, and Randall Weiss, The Urban Institute. *Inquiry,* vol. 37, no. 4. Copies are available from *Inquiry,* P.O. Box 527, Glenview, IL 60025, Tel: 847-724-9280.

#436 *Designing a Medicare Drug Benefit: Whose Needs Will Be Met?* (December 2000). Bruce Stuart, Becky Briesacher, and Dennis Shea. Many current proposals for providing a prescription drug benefit under Medicare would cover only beneficiaries with incomes at the federal poverty level or slightly above. In this issue brief, the authors propose a broader definition of need that includes beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions. Under this expanded definition, nearly 90 percent of beneficiaries would be eligible for coverage.

Socioeconomic Differences in Medicare Supplemental Coverage (September/October 2000). Nadereh Pourat, Thomas Rice, Gerald Kominski, and Rani E. Snyder. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#395 *Early Implementation of Medicare+Choice in Four Sites: Cleveland, Los Angeles, New York, and Tampa–St. Petersburg* (August 2000). Geraldine Dallek and Donald Jones, Institute for Health Care Research and Policy, Georgetown University. This field report, based on research cofunded by The Commonwealth Fund and the California Wellness Foundation, examines the effects of Medicare+Choice—created by the Balanced Budget Act of 1997—on Medicare beneficiaries in four managed care markets.

#394 *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (August 2000). Amanda Cassidy and Marsha Gold, Mathematica Policy Research, Inc. Using information from HCFA's Medicare Compare consumer-oriented database of Medicare+Choice plans, this report provides a detailed look at changes in benefits offered under Medicare+Choice in 1999–2000, focusing on benefit reductions and small capitation rate increases that are shifting costs to beneficiaries.

#393 *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* (August 2000). Jessica Kasten, Marilyn Moon, and Misha Segal, The Urban Institute. Medicare+Choice plans are scaling back benefits and shifting costs to enrollees through increases in service copayments and decreases in the

value of prescription drug benefits. This report examines the financial effects of these actions on Medicare managed care enrollees.

#371 *An Assessment of the President's Proposal to Modernize and Strengthen Medicare* (June 2000). Marilyn Moon, The Urban Institute. This paper discusses four elements of President Clinton's proposal for Medicare reforms: improving the benefit package, enhancing the management tools available for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

#382 *Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension* (March/April 2000). Jan Blustein. *Health Affairs,* vol. 19, no 2. This article shows that Medicare beneficiaries age 65 and older with high blood pressure are less likely to purchase hypertension medication if they are without drug coverage.

Who Is Enrolled in For-Profit vs. Nonprofit Medicare HMOs? (January/February 2000). Jan Blustein and Emma C. Hoy. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#365 *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter* (January 2000). Bruce Stuart, Dennis Shea, and Becky Briesacher. This issue brief reports that prescription drug coverage of Medicare beneficiaries is more fragile than previously reported, that continuity of this coverage makes a significant difference in beneficiaries' use of prescription medicine, and that health status affects drug coverage for beneficiaries primarily through their burden of chronic illness.

#360 *Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform* (November 1999). Tricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Elaine Puleo, and Michelle Kitchman. *Journal of Aging and Social Policy,* vol. 10, no. 4. This profile of Medicare beneficiaries, based on an analysis of the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, reveals that a relatively large share of the Medicare population has serious health problems and low incomes.

#353 *After the Bipartisan Commission: What Next for Medicare?* (October 1999). Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford, and Katherine E. Garrett. This summary of a panel discussion held at New York University's Robert F. Wagner Graduate School of Public Service considers what may happen now that the National Bipartisan Commission on the Future of Medicare has finished its work without issuing recommendations to President Clinton. It also examines possible reform opportunities following the November 2000 elections.

#346 *Should Medicare HMO Benefits Be Standardized?* (July/August 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. *Health Affairs,* vol. 18, no. 4. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this article the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

#232 *Risk Adjustment and Medicare* (June 1999). Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman, Harvard University. Medicare's payments to managed care plans bear little relationship to the cost of providing needed care to beneficiaries with different health conditions. In this revised paper, the authors suggest using two alternative health risk adjusters that would contribute to more cost-effective care and reduce favorable risk selection and the incentive to stint on care.

#318 *Growth in Medicare Spending: What Will Beneficiaries Pay?* (May 1999). Marilyn Moon, The Urban Institute. Using projections from the 1998 Medicare and Social Security Trustees' reports to examine how growth in health care spending will affect beneficiaries and taxpayers, the author explains that no easy choices exist that would both limit costs to taxpayers while protecting Medicare beneficiaries from the burdens of health care costs.

#317 *Restructuring Medicare: Impacts on Beneficiaries* (May 1999). Marilyn Moon, The Urban Institute. The author analyzes premium support and defined contribution—two of the more prominent approaches proposed to help Medicare cope with the health care needs of the soon-to-retire baby boomers—and projects these approaches' impacts on future beneficiaries.

#310 *Should Medicare HMO Benefits Be Standardized?* (February 1999). Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice. The only Medicare supplement (Medigap) policies that can be sold are those that conform to the 10 standardized packages outlined in federal legislation enacted in 1990. In this paper the authors address whether Medicare HMO benefits should also be standardized for the roughly 6 million Medicare beneficiaries now enrolled in HMOs.

Budget Bills and Medicare Policy: The Politics of the BBA (January/February 1999). Charles N. Kahn III and Hanns Kuttner. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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The Political Economy of Medicare (January/February 1999). Bruce C. Vladeck. *Health Affairs,* vol. 18, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.