



REFORMING MEDICARE'S BENEFIT PACKAGE: IMPACT ON BENEFICIARY EXPENDITURES

Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard
The Urban Institute

May 2001

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff, or to the Urban Institute or its trustees or staff.

Copies of this report are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering publication number 461. The report can also be found on the Fund's website at www.cmwf.org.

CONTENTS

List of Figures and Tables.....	iv
Executive Summary	v
Supplemental Coverage Among Medicare Beneficiaries	2
Reforming the Medicare Benefit Package	5
Methods.....	8
Adjusting for Supplemental Insurance Coverage	9
Constructing Beneficiary Cohorts.....	10
Impact of Options	11
Beneficiary Liability.....	11
Out-of-Pocket Spending.....	14
Spending in Relation to Income.....	18
Effect of Supplemental Insurance Coverage	20
Impact on Medicare Program Expenditures	22
Discussion	23
Appendix: Medicare Benefit Simulations.....	27
Option 1: Basic Catastrophic Coverage and Restructured Deductible.....	27
Option 2: Additional Catastrophic Coverage and Lower Cost-Sharing Rates.....	28
Option 3: Zero Coinsurance and Budget-Neutral Premium	28
Option 4: Medicare Prescription Drug Coverage.....	29
Adjusting Effects of Options for Supplemental Insurance Coverage.....	29

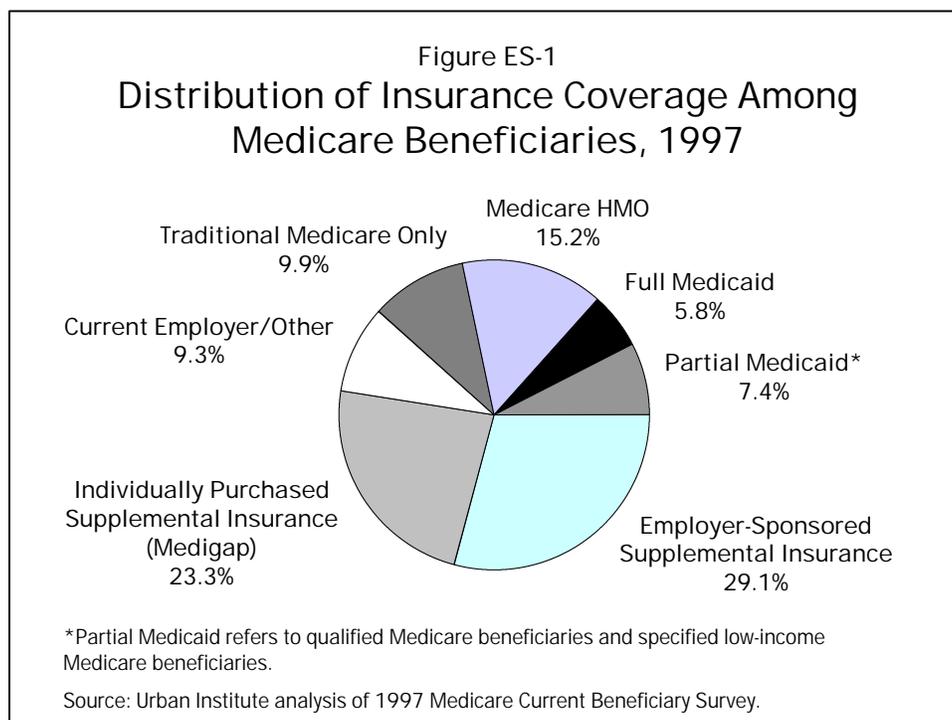
LIST OF FIGURES AND TABLES

Figure ES-1	Distribution of Insurance Coverage Among Medicare Beneficiaries, 1997	v
Figure ES-2	Savings in Out-of-Pocket Spending for the Elderly and the Disabled Under Four Options, 2000.....	xi
Figure ES-3	Savings in Out-of-Pocket Spending for the Sick Elderly and Sick, Aged, Low-Income Women Under Four Options, 2000	xii
Figure ES-4	Savings in Out-of-Pocket Spending for Elderly Beneficiaries in Poor Health Under Four Options, by Type of Supplemental Coverage, 2000	xiii
Figure 1	Distribution of Insurance Coverage Among Medicare Beneficiaries, 1997	2
Figure 2	Beneficiary Liability, by Cohort, 2000.....	12
Figure 3	Impact of Options on Beneficiary Liability, by Cohort	13
Figure 4	Out-of-Pocket Health Care Spending, by Cohort, 2000	15
Figure 5	Impact of Options on Out-of-Pocket Spending, by Cohort	16
Figure 6	Total and Out-of-Pocket Prescription Drug Expenditures, by Cohort, 2000.....	18
Figure 7	Out-of-Pocket Spending as a Share of Income, by Cohort, 2000	19
Figure 8	Out-of-Pocket Spending as a Share of Income Among Elderly Beneficiaries, by Option	20
Figure 9	Effect of Supplemental Insurance on the Impact of Options: Out-of-Pocket Spending of Elderly Beneficiaries in Poor Health.....	21
Table ES-1	Reforming the Medicare Benefit Package: Four Illustrative Options.....	viii
Table ES-2	Impact of Four Options on Out-of-Pocket Spending, by Cohort, 2000	x
Table ES-3	Impact of Four Options on Federal Spending for Medicare, 2000.....	xiv
Table 1	Cost-Sharing Requirements in Traditional Medicare, 2000	6
Table 2	Reforming the Medicare Benefit Package: Four Illustrative Options.....	7
Table 3	Impact of Options on Federal Spending for Medicare, 2000	23
Table A-1	Impact of Options on Beneficiary Liability and Out-of-Pocket Spending, by Cohort, 2000	32

EXECUTIVE SUMMARY

For more than 35 years, the Medicare program has been a cornerstone of the nation's efforts to maintain the health and economic security of the elderly population. But Medicare's benefit package—though considered standard when the program began in 1965—has been outpaced over the years by most health insurance plans covering the nation's nonelderly population, in terms of providing comprehensive benefits that reflect current medical practice. Due in part to this inadequacy, beneficiaries spend 22 percent of their income on health care, a figure that will rise to an estimated 30 percent in 2025.¹ In addition, federal outlays for Medicare account for a significant portion of the federal budget.

Clearly there is a need to improve Medicare benefits, both in terms of beneficiary cost-sharing and the provision of prescription drug coverage, while still controlling federal spending. The overwhelming numbers of beneficiaries who purchase supplemental insurance on their own demonstrate the need for change. In 1997, less than 10 percent of beneficiaries were covered only by the traditional fee-for-service Medicare program, without any form of additional coverage (Figure ES-1).



¹ S. Maxwell, M. Moon, and M. Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

Advantages of Improving Medicare Benefits

Expanding Medicare's benefit package would enhance equity of coverage among beneficiaries, who currently obtain coverage through a patchwork of sources at varying costs. Coordinating coverage under a single source also would allow for greater overall efficiency in furnishing health insurance coverage to Medicare beneficiaries, while at the same time producing administrative savings for beneficiaries and society as a whole. Moreover, administrative costs for public insurance programs are lower than those for private insurance plans: a public program does not need to maintain reserves to protect against adverse risk, nor does it need to pay marketing or sales commissions.

Expanded Medicare coverage would clearly result in decreased out-of-pocket costs for many beneficiaries, particularly those with the highest expenses. But it could also be structured to be budget-neutral, or nearly neutral, in terms of federal spending. Such a structure would likely include an increased premium and higher cost-sharing requirements to help encourage more effective utilization of services without imposing hardship on beneficiaries. Any Medicare cost savings achieved through improved efficiencies are especially important, since beneficiaries' already high health care spending makes it unviable to finance prescription drug coverage solely by raising beneficiary costs.

Concerns About the Affordability and Stability of Private Supplemental Coverage

On one hand, the fact that as many as 90 percent of beneficiaries have some sort of additional insurance coverage points to the success of the patchwork of private and government sources in furnishing additional coverage to those who want it. But this high rate also attests to the perceived inadequacy of the Medicare benefit package. Unfortunately, traditional sources of supplemental coverage are becoming less reliable in some cases, and are relatively costly in others. Employer-sponsored supplemental insurance (ESI) has traditionally been integral to the retiree benefit package of many large companies. Recent trends, however, indicate that most employers that offer ESI have increased the costs for their current retirees and eliminated the coverage for future ones.

Medicare's managed care program, which sometimes is a source of additional benefits, has become destabilized in the last few years as well. Legislative changes, including limits on Medicare payments to plans, and the overall managed care market helped galvanize a trend of eroding benefits for Medicare beneficiaries, declining plan participation in the Medicare program, and limits by existing plans in enrolling new

Medicare enrollees.² Although supplemental coverage for basic benefits can nearly always be individually purchased, these policies (known as Medigap) have relatively expensive premiums, high overhead costs, and often offer poor insurance value.

For very low-income beneficiaries, coverage of Medicare premium and cost-sharing expenses is available through one of four types of Medicaid programs. Despite their availability, the Health Care Financing Administration (HCFA) estimates that nearly 60 percent of eligible beneficiaries are not enrolled. Limited participation severely curtails the potential of these programs.

Four Options Illustrating Benefit Reform

We have developed four options that reflect a range of efforts to expand and restructure the Medicare benefit package. These options could reduce the need for private supplemental insurance and make out-of-pocket expenses more affordable for beneficiaries. The first three options restructure deductible and premium costs to reduce beneficiary liability and out-of-pocket spending, especially among those with relatively high expenses. Option 1 combines the Part A and Part B deductible at an annual total of \$400 and adds a catastrophic ceiling of \$3,000. Option 2 features separate deductibles of \$200 each for Part A and Part B, applies a 10 percent coinsurance rate to Part B (including home health), and adds a catastrophic ceiling of \$2,000. The third option eliminates the Part A deductible and coinsurance, raises the Part B deductible to \$200, and, to achieve budget neutrality, raises the Medicare premium to \$105 a month. Option 4 adds prescription drug coverage to the Medicare benefit package with 50 percent coinsurance, a \$2,500 catastrophic ceiling, and a \$26 monthly premium for beneficiaries. The first three options should be seen as alternatives, while the fourth could be combined with any of the first three.

² M. Gold and L. Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001*, The Commonwealth Fund, April 2001; A. Cassidy and M. Gold, *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* The Commonwealth Fund, August 2000.

Table ES-1
Reforming the Medicare Benefit Package: Four Illustrative Options

Option 1. Basic catastrophic coverage and restructured deductible

- Eliminate the current Part A deductible (\$776 per spell of illness) and Part B deductible (\$100 per year) and introduce a combined (Part A and B) annual deductible of \$400
- Introduce a \$3,000 annual beneficiary limit on cost-sharing and deductible expenses

Option 2. Additional catastrophic coverage and lower cost-sharing rates

- Reduce the Part A deductible from \$776 per spell of illness to \$200 per spell of illness
- Increase the annual Part B deductible from \$100 currently to \$200
- Reduce the coinsurance rate from 20 percent of approved charges to 10 percent
- Introduce a 10 percent coinsurance requirement for home health services
- Introduce a \$2,000 annual beneficiary limit on cost-sharing and deductible expenses

Option 3. Zero coinsurance and budget-neutral premium

- Eliminate the Part A deductible (\$776 per spell of illness), Part A coinsurance (specified copayments applied to extraordinarily long hospital and skilled nursing facility stays), and Part B coinsurance (20 percent of approved charges)
- Increase the annual Part B deductible from \$100 currently to \$200
- Eliminate the Part B premium (\$45.50 per month) and introduce a combined (Part A and B) premium of \$105 per month

Option 4. Medicare prescription drug coverage

- Add prescription drugs to Medicare with a 50 percent coinsurance requirement
 - Introduce a \$2,500 annual beneficiary limit on cost-sharing expenses for prescription drugs
 - Introduce a premium of \$26 per month
 - Subsidize the premium at 100 percent for beneficiaries at or below 135 percent of the federal poverty level (FPL). Subsidize the premium on a linear sliding scale for beneficiaries between 135 percent and 150 percent of FPL
-

Note: Figures are expressed in 2000 amounts.

This paper simulates the impact of these four options on beneficiaries using two measures. The first, “beneficiary liability,” includes those expenses that are the responsibility of the beneficiary: the Part B premium, deductibles, and coinsurance amounts. It does not distinguish between costs paid directly out-of-pocket or individually through premiums for supplemental coverage. The second measure is beneficiary “out-of-pocket” spending. This includes expenses paid directly by beneficiaries for deductibles and coinsurance on covered services and costs of noncovered services, such as prescription drugs and premiums paid by beneficiaries for private supplemental coverage. Separate estimates are also provided for the impact of the options on three groups of beneficiaries: those with employer-sponsored insurance, those with Medigap policies, and those with no supplemental coverage.

We constructed several cohorts of beneficiaries to allow us to evaluate the diversity of each option's impacts, particularly with regard to groups of vulnerable populations. The cohorts offer contrast with respect to health status, age, income, and presence and type of supplemental insurance coverage.³ Six population cohorts are analyzed in this paper:

- **Elderly:** All beneficiaries age 65 or older.
- **Elderly in poor health:** Beneficiaries age 65 or older with physical or cognitive health problems.⁴
- **Elderly, low-income women age 85+ in poor health:** Single women age 85 or older with annual household income of \$5,000 to \$20,000 and with physical or cognitive health problems.
- **Women with QMB protection:** In the qualified Medicare beneficiary (QMB) program, Medicaid pays the Medicare premium and cost-sharing expenses for Medicare beneficiaries with incomes less than the FPL. This cohort consists of women enrolled in the QMB program.
- **Disabled beneficiaries ages 45 to 64:** Beneficiaries ages 45 to 64 who qualify for Medicare due to a physical disability.
- **High-income beneficiaries ages 65 to 74:** Beneficiaries ages 65 to 74 with annual household incomes of \$50,000 or more. Beneficiaries in this cohort also are married and have employer-based supplemental insurance coverage.

Impact on Out-of-Pocket Spending

In 2000, elderly beneficiaries spent an estimated \$3,142 out-of-pocket for health care (Table ES-2). The first three options reduce out-of-pocket spending by improving covered Medicare benefits and/or reducing or eliminating the need to purchase Medigap coverage. The fourth option introduces coverage for a previously noncovered service—prescription drugs. All the options reduce out-of-pocket spending, though the degree to

³ Certain beneficiaries (those enrolled in managed care plans, residing in nursing homes, or diagnosed with end-stage renal disease) are excluded from *all* the cohorts because of insufficient data or because they differ substantially from most beneficiaries. Managed care beneficiaries in particular were excluded because differences in the MCBS survey methodology prevent reliable and valid comparisons of out-of-pocket spending between fee-for-service and managed care beneficiaries. Except for the cohort of Qualified Medicare Beneficiaries, the cohorts also exclude those dually eligible for any level of Medicaid coverage.

⁴ Cognitive impairments indicating poor health include Alzheimer's disease and mental or psychiatric conditions. Physical impairments are indicated by the presence of several conditions (stroke, diabetes, rheumatoid arthritis, emphysema, osteoporosis, or Parkinson's disease), and by combinations of skilled nursing facility use, self-rating of poor health and limited function. Function is measured in terms of activities of daily living (ADLs) and instrumental ADLs.

which they do varies greatly depending on the characteristics of each group of beneficiaries.

Table ES-2
Impact of Four Options on Out-of-Pocket Spending, by Cohort, 2000

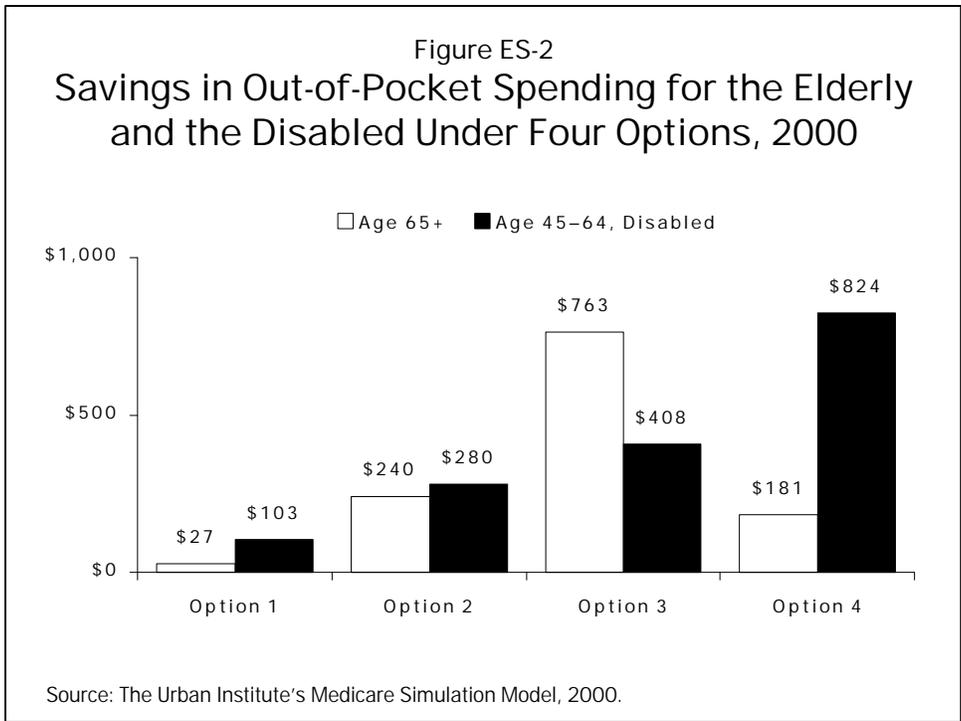
Cohort	Current Law	Option 1		Option 2		Option 3		Option 4	
	\$	\$	%	\$	%	\$	%	\$	%
Age 65+	\$3,142	-\$27	-0.9%	-\$240	-7.7%	-\$763	-24.3%	-\$181	-5.8%
Age 65+, Poor Health	4,815	-285	-5.9	-587	-12.2	-1,591	-33.1	-415	-8.6
Age 45–64, Disabled	3,870	-103	-2.7	-280	-7.2	-408	-10.5	-824	-21.3
Age 65–74, High- Income, ESI	2,715	-12	-0.4	-68	-2.5	-571	-21.0	-24	-0.9
QMB Women	1,628	0 ^a	0.0 ^a	0 ^a	0.0 ^a	0 ^a	0.0 ^a	-473	-29.0
Age 85+, Low- Income Women, Poor Health	5,969	-495	-8.3	-753	-12.6	-2,092	-35.1	-394	-6.6

^a Impacts under options 1–3 yield savings to Medicaid programs rather than beneficiary out-of-pocket savings.

Note: ESI is employer-sponsored supplemental insurance; QMB is qualified Medicare beneficiary.

Source: The Urban Institute's Medicare Simulation Model, 2000.

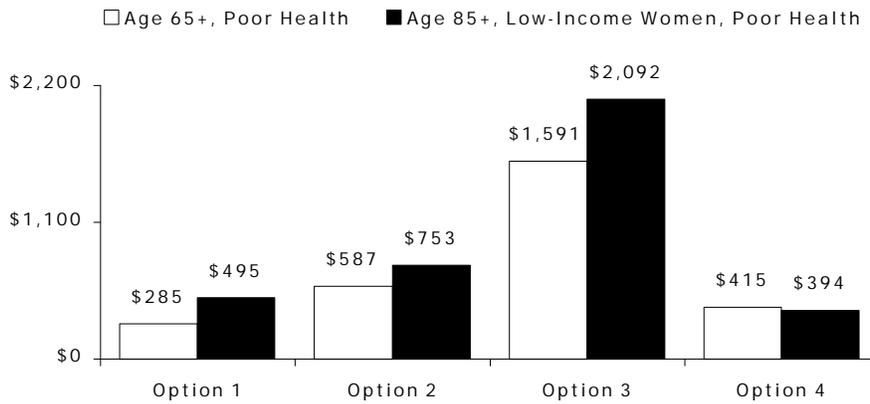
For all Medicare beneficiaries over age 65, option 3 affords by far the greatest average decline in out-of-pocket spending (Figure ES-2). Even though a budget-neutral premium that is more than double the current premium is a central feature of the option, out-of-pocket spending drops by \$763 (24%). The out-of-pocket savings reflect both the cost efficiencies of furnishing benefits through the Medicare program (rather than through ESI and Medigap policies) and the cost-averaging effects of spreading risk across all beneficiaries.



For disabled beneficiaries ages 45 to 64, option 4 provides the greatest average decline in out-of-pocket spending. With an \$824 (21%) decline in out-of-pocket spending, this group's savings are two to eight times greater than under the other options. The impact of this option on disabled beneficiaries demonstrates the importance of pharmaceuticals to them relative to other beneficiaries. They incur the highest drug expenditures, averaging \$2,445 in total drug expenditures in 2000 and \$1,181 in drug expenditures out-of-pocket. In contrast, total and out-of-pocket drug expenditures of elderly beneficiaries in 2000 were \$1,006 and \$565, respectively.

For Medicare beneficiaries who are vulnerable because of their poor health, low income, and/or age, option 3 produces the greatest average decrease in out-of-pocket spending (Figure ES-3). Out-of-pocket spending among elderly beneficiaries in poor health declines by \$1,591 (33%), while out-of-pocket spending among older low-income women in poor health declines by \$2,092 (35%). By eliminating these beneficiaries' need for private supplemental insurance—which is likely made even more expensive by their health status—the third option results in particularly high savings.

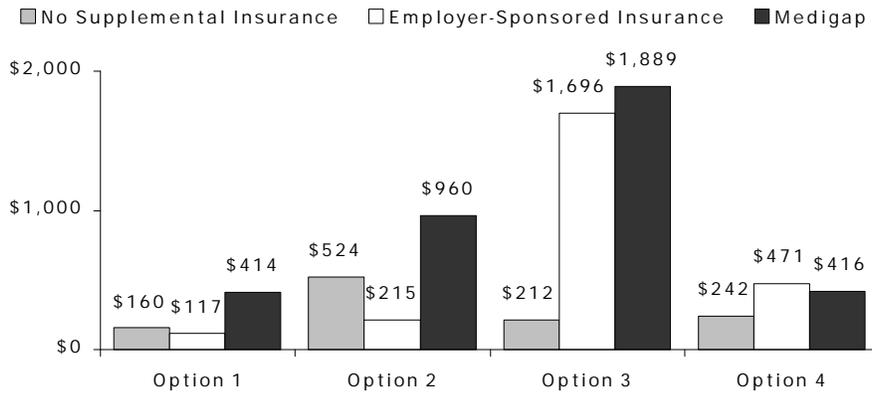
Figure ES-3
 Savings in Out-of-Pocket Spending for the Sick Elderly and Sick, Aged, Low-Income Women Under Four Options, 2000



Source: The Urban Institute's Medicare Simulation Model, 2000.

For beneficiaries in poor health, the impact of these options does vary by the type of supplemental coverage they have. Those with no supplemental coverage experience moderate savings under option 2, with out-of-pocket spending decreasing by \$524 (12%) (Figure ES-4). For those in poor health with either employer-sponsored insurance or Medigap, option 3 results in striking savings of \$1,696 (37%) and \$1,889 (34%), respectively. This effect is essentially due to beneficiaries dropping their supplemental plans and saving the money spent on premiums. Savings for those with Medigap insurance result from the tendency of policyholders to bear the full price of these plans and from the fact that Medigap plans having relatively high administrative costs. For beneficiaries with employer-sponsored insurance, the savings permit employers, if they choose, to improve coverage for other services.

Figure ES-4
Savings in Out-of-Pocket Spending for Elderly Beneficiaries in Poor Health Under Four Options, by Type of Supplemental Coverage, 2000



Source: The Urban Institute's Medicare Simulation Model, 2000.

The options, as designed, affect federal spending on Medicare in quite different ways. Option 1 results in an estimated net increase of 1.3 percent in Medicare spending (Table ES-3). This option would produce savings mainly for very vulnerable, high-utilization beneficiaries through its \$3,000 stop-loss feature. However, Medicare's outlays for those individuals are nearly netted out by the increased liability that some healthier beneficiaries would owe in terms of the \$400 combined premium. Option 2 substantially expands coverage and reduces liability across all beneficiaries. Consequently, this option would increase federal spending on Medicare substantially, by 6.8 percent. Option 3, in contrast, practically eliminates beneficiary cost-sharing yet does not increase the federal Medicare budget. Instead, this option includes a new premium calculated at the amount that would offset federal outlays which otherwise would be necessary to cover the reduced beneficiary liability. Finally, the prescription drug benefit (option 4), as constructed, would increase Medicare spending by 5.8 percent. It is important to note that these estimates are calculated simply as the flip-side of the options' savings in beneficiary liability. They are not intended to represent formal cost estimates, which would include adjustments for changes in service use that could be expected because of the altered benefit package.

Table ES-3
Impact of Four Options on Federal Spending for Medicare, 2000

Option	Per Capita Medicare Spending	Aggregate Medicare Spending (in millions)	Percent Increase in Federal Spending Due to Option
Current Law	\$6,213	\$240,949	—
Option 1: Basic Catastrophic Coverage	6,295	244,117	1.3%
Option 2: Additional Catastrophic Coverage and Lower Cost-Sharing Rates	6,636	257,368	6.8
Option 3: Zero Coinsurance and Budget-Neutral Premium	6,213	240,949	0.0
Option 4: Medicare Prescription Drug Coverage	6,572	254,882	5.8

Although four options are detailed in this paper, numerous options are available to policymakers in the form of alternative combinations of benefit elements and alternative benefit amounts. Furthermore, the combinations could be adjusted to be budget-neutral or nearly neutral. The level of federal costs associated with option 4 (prescription drug coverage), however, implies that it would be difficult to modernize Medicare's current cost-sharing requirements *and* introduce meaningful drug coverage in a fully budget-neutral manner.

Discussion

An expanded Medicare benefit package would typically reduce the out-of-pocket burdens of beneficiaries. Although average reductions in spending would be small in some cases and those with retiree health plans might even pay more under some of the options described above, several of the most vulnerable categories of beneficiaries would be aided substantially under most options. Furthermore, because the level and availability of ESI is declining, this paper's simulations underestimate the impacts over time of expanding the Medicare benefit package. Since most employers who offer ESI to their current retirees will not do so for future ones, the share of all beneficiaries with this type of coverage will diminish sharply over time.

Some may argue that Medicare cannot afford to expand its benefit package, because health care costs and the number of beneficiaries are growing more rapidly than the nation's ability to fund the program. However, most expansion options can be designed in a budget-neutral or near-neutral manner by restructuring the program's current cost-sharing requirements or by adding such requirements to services currently paid fully by the program. Moreover, an expanded and redesigned benefit package could actually reduce some types of Medicare utilization, by reducing the excess demand associated with "first-dollar" coverage. Finally, specific elements of the benefit package could be better designed to keep pace with inflation. The current Part B deductible, for example, has remained at \$100 for several years. Pegging such items to inflation would ensure the program's share of expenditures do not grow over time, making a benefit more costly or unsustainable in the future.

Overall, restructuring and expanding Medicare's benefit package in a budget-neutral manner could greatly benefit both beneficiaries and taxpayers. The elderly would enjoy more comprehensive coverage from a single source and reduced financial burden in terms of out-of-pocket spending. The federal government and the states could experience some fiscal relief due to increased efficiencies while simultaneously being in a better economic position to provide the enhanced benefit package demanded by constituents.

REFORMING MEDICARE'S BENEFIT PACKAGE: IMPACT ON BENEFICIARY EXPENDITURES

Since its inception in 1965, the Medicare program has been a cornerstone of the nation's efforts at maintaining the health and basic security of the elderly population. Despite the adequacy of the program originally, however, its comprehensiveness has been outpaced by most health insurance plans that cover the nation's nonelderly population. Indeed, a 1998 study found that 82 percent of 250 employer health plans are more generous than the traditional Medicare plan.⁵

Medicare's scope of benefits has not been without improvements. It has expanded over time, like those of private insurance plans, to cover new procedures and technologies. For example, the Balanced Budget Act of 1997 added several clinical preventive services to Medicare's benefit package, including annual mammograms and Pap smears with no deductibles, prostate cancer screening, colorectal cancer screening, and diabetes self-management services.⁶ Coverage of clinical preventive services also was improved by the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000.⁷

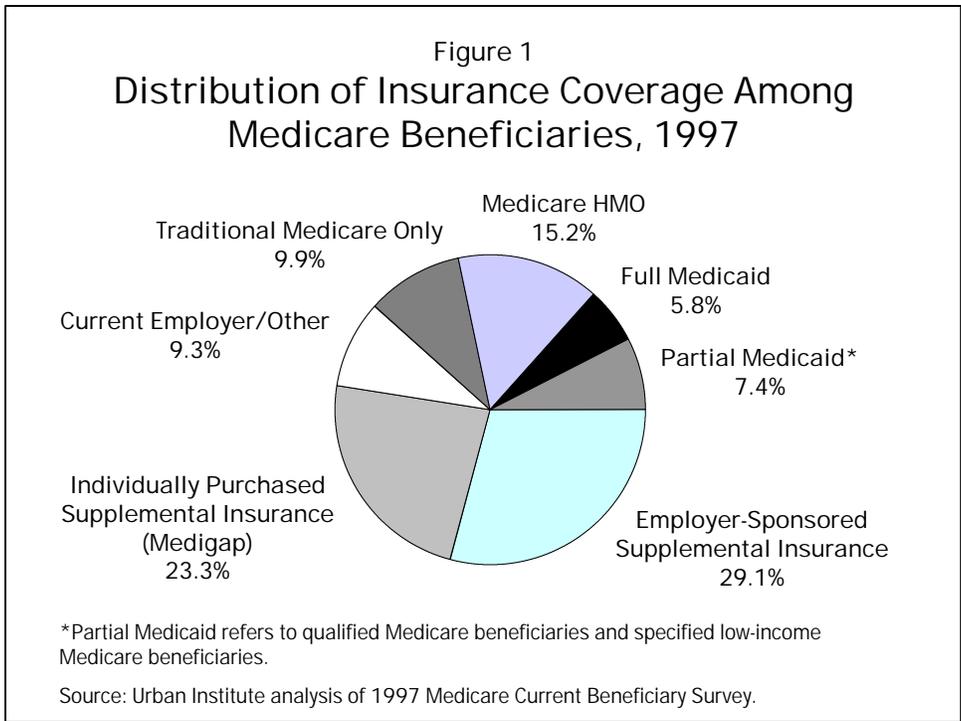
Policymakers have refrained, however, from substantially expanding Medicare and adding benefits that are commonplace among private health plans, such as stop-loss (catastrophic) coverage and prescription drug coverage, largely due to concerns about cost.⁸ The popularity of additional insurance in general is evident, though, from the share of Medicare beneficiaries receiving some sort of supplemental coverage. In 1997, just 9.9 percent of beneficiaries were covered only by the traditional (fee-for-service) Medicare program and had no form of additional coverage (Figure 1). Fifteen percent of beneficiaries were enrolled in Medicare managed care plans (and some received additional benefits through them). About 29 percent had employer-sponsored supplemental insurance (ESI), and 23 percent purchased supplemental plans individually (known as Medigap). About 13 percent of beneficiaries had some level of Medicaid coverage as well—almost 6 percent were fully enrolled in Medicaid and about 7 percent had partial coverage through Medicaid.

⁵ F. McArdle and D. Yamamoto, Presentation on Employer-Based Retiree Health Benefits, before the Reform Task Force of the National Bipartisan Commission on the Future of Medicare, Washington, D.C., July 14, 1998.

⁶ Public Law No. 105-33 §4101-08.

⁷ Public Law No. 106-554 §101-15.

⁸ The Medicare Catastrophic Coverage Act of 1988 (Public Law No. 100-360) would have capped beneficiary out-of-pocket expenses and covered a share of outpatient prescription drug expenses. However, the Act was repealed in 1989. Contributing to its repeal was the fact that beneficiaries would have begun paying for the benefit a few years before the benefit was to become available.



This paper is part of a series sponsored by The Commonwealth Fund that analyzes the impact of the health care burdens faced by Medicare beneficiaries.⁹ The paper first discusses supplemental insurance coverage; it then describes four illustrative options to reform Medicare's benefit package by restructuring the current cost-sharing requirements and introducing additional coverage. The results of the options are presented in terms of their estimated impact on beneficiary liability (premium and required cost-sharing expenses) and out-of-pocket spending (expenses beneficiaries pay after accounting for any expenses for noncovered services and for any supplemental insurance coverage).

Supplemental Coverage Among Medicare Beneficiaries

On one hand, the fact that as many as 90 percent of beneficiaries have some sort of additional insurance coverage indicates a success of the patchwork of private and government sources in furnishing additional coverage to those who want it. On the other hand, the figure attests to the perceived inadequacy of the Medicare benefit package.

Traditionally, large employers have included ESI as part of their retiree benefit packages. This coverage typically has been broad and reflective of the insurance coverage available for firms' current employees. However, most medium and small firms (those

⁹ For earlier papers in the series, see: Maxwell, Moon, and Segal, *Growth in Medicare Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001; Kasten, Moon, and Segal, *What Do Medicare HMO Enrollees Spend Out-of-Pocket?* The Commonwealth Fund, August 2000; and Moon, *Growth in Medicare Spending: What Will Beneficiaries Pay?* The Commonwealth Fund, May 1999.

with fewer than 200 employees) and many low-wage employers do not offer this coverage. Further, spurred by certain changes in financial accounting standards (adopted in 1992) and continued escalation of health care costs, employers that offer ESI have taken several steps to limit their costs associated with retirees. These include capping firms' contributions to ESI and raising retiree contributions, eliminating coverage of Medicare cost-sharing expenses, substituting a Medicare managed care plan for ESI, or eliminating coverage for future retirees.¹⁰ Several surveys of employer benefits have identified the steady erosion of ESI. For example, among firms with 200 or more employees, the share offering ESI dropped from 66 percent in 1988 to 37 percent in 2000.¹¹ Furthermore, retirees' share of ESI premiums increased from 38 percent in 1993 to 60 percent in 1998.¹² Among firms with 5,000 or more employees, the share offering ESI to *future* retirees fell from 40 percent in 1993 to 20 percent in 1999.¹³

As a source of supplemental coverage, Medicare's managed care program also has destabilized in the last few years. The managed care program originally was intended as a means to furnish care more efficiently to beneficiaries and to generate savings for Medicare. However, until recently, the program's payment methodology resulted in particularly generous payments to plans in many areas of the country, which by law had to return these excess payments to Medicare or spend them on enrollees in the form of additional services or reduced cost-sharing. Plans generally did the latter, which effectively created another source for beneficiaries to obtain supplemental coverage. Prescription drugs have been an especially popular additional benefit. During the last few years, though, plans have faced a confluence of pressures, including changes in Medicare's payment methodology, double-digit increases in the use of and prices for pharmaceuticals, and an aging (and more costly) Medicare enrollee population. Plans claim that, in addition, provider networks have negotiated more successfully against plans' proposed provider payment rates. These changes helped spur a trend of eroding benefits for Medicare beneficiaries, declining plan participation in the Medicare program, and limits by existing plans in enrolling new Medicare enrollees. To curb their benefits, plans have

¹⁰ Levit et al. and Gabel et al., *Employer Health Benefits: 2000 Annual Survey*, Henry J. Kaiser Family Foundation, and Health Research and Educational Trust, 2000; and 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.

¹¹ Levit et al. and Gabel et al., *op. cit.*

¹² Employee Benefits Research Institute, *Health Data Book*, 1st edition, Washington, D.C.

¹³ L. L. Hewitt Associates, *Retiree Health Trends and Implications of Possible Medicare Reforms*, Henry J. Kaiser Family Foundation, September 1997.

instituted or increased their premiums and copayment amounts, instituted or increased limits on coverage, or have dropped some services from coverage altogether.¹⁴

An alternative source of supplemental coverage more readily available for some beneficiaries is Medigap. Unfortunately, these policies have relatively expensive premiums and very high administrative loads (overhead costs). They also often provide relatively poor insurance value: roughly 45 percent of Medigap policy holders, for example, are covered for expenses incurred by using physicians not accepting Medicare assignment—even though assigned payments account for over 95 percent of physician payments.¹⁵ Meanwhile, drug coverage is available only in the more comprehensive (and thus expensive) standard Medigap policies. Although insurers argue for more flexibility in designing these benefits to meet consumer demand, Medigap policies in fact were standardized into 10 different designs as a response to marketing fraud and abuses and consumer difficulties in comparing benefits and prices across policies.¹⁶ Despite the benefit standardization, Medigap premiums vary substantially by underwriting category and market.¹⁷ Policies are expressly more costly for older beneficiaries, because Medigap plans generally are age-rated.¹⁸ The more comprehensive policies are unusually costly because of adverse selection—that is, more frequent users or sicker beneficiaries, rather than a cross-section of all beneficiaries, tend to purchase these policies. Finally, Medigap insurers are not required to guarantee access to Medicare’s disabled beneficiaries, nor (after an initial enrollment period) to beneficiaries over age 65 who want to switch from one policy to another.

For very low-income beneficiaries, coverage of Medicare liability is available through one of four types of Medicaid programs.¹⁹ Despite the availability of these

¹⁴ M. Gold and L. Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001*, The Commonwealth Fund, April 2001; A. Cassidy and M. Gold, *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* The Commonwealth Fund, August 2000.

¹⁵ Weiss Ratings, Inc., *Many Consumers Severely Overcharged for Medigap Policies*, Weiss Ratings, Inc., May 27, 1999.

¹⁶ Omnibus Budget Reconciliation Act of 1990.

¹⁷ Weiss Ratings, Inc., *Florida and New York Residents Charged Most for Medigap Policies, Utah and Maryland Residents Charged Far Less*, Weiss Ratings, Inc., June 12, 2000.

¹⁸ L. Alecxih et al., *Key Issues Affecting Consumers’ Accessibility to Medigap Insurance*, The Commonwealth Fund, June 1997.

¹⁹ Beneficiaries with incomes less than the federal poverty level (FPL) and very limited assets can qualify for full Medicaid benefits. This covers a beneficiary’s Medicare liability and other services furnished by the Medicaid program (such as nursing home care). Legislation in 1988 established the “Qualified Medicare Beneficiary program” (QMB), which covers Medicare liability for those with incomes less than the FPL. Later legislation initiated the “Specified Low-income Medicare Beneficiary program” (SLMB), which covers the Medicare premium for those with incomes from 100 percent to 120 percent of the FPL. Finally, the “Qualified Individuals 1 program” (QI-1) was established to cover the Medicare premium for those with incomes from 120 percent to 135 percent of the FPL.

programs, HCFA estimates that nearly 60 percent of those eligible are not enrolled.²⁰ Although limited participation curtails the potential of these programs, state governments have no incentive to increase participation in the future and add to their Medicaid program expenditures.

Reforming the Medicare Benefit Package

After reviewing typical private plans' benefit packages, policymakers' proposals to restructure Medicare's cost-sharing requirements, and recent Medicare prescription drug proposals, we developed four illustrative options that have alternative objectives and would expand the Medicare benefit package by varying levels. The first option reduces liability for those with catastrophic expenses and restructures it for those with average Medicare expenses. The second one substantially expands coverage, and reduces liability for most beneficiaries. The third option goes further in reducing liability for those with relatively high liability, but accomplishes this in a budget-neutral manner. The fourth option adds outpatient prescription drugs to the list of Medicare-covered services and items. The latter option would increase beneficiaries' Medicare liability, but would decrease their out-of-pocket health care spending.

The first illustrative option is designed primarily to introduce a very basic level of catastrophic coverage and, secondarily, to restructure the deductibles and spread costs associated with them. (See Table 1 for Medicare cost-sharing requirements under current law and Table 2 for the financial elements, calculated in 2000 dollar amounts, of the four options.) Consequently, the new deductible increases average beneficiary liability; however, it significantly reduces liability for the roughly 20 percent of beneficiaries who are hospitalized each year. The deductible itself decreases spending required by Medicare, and offsets roughly one-half of the increased spending required by the program to pay for the catastrophic coverage element of the option. Program costs would rise modestly, compared with option 2.

²⁰ Barents Group LLC, *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries*, Washington, D.C.: Barents Group LLC, April 7, 1999, under HCFA Contract No. 500-95-0057/TO-2.

Table 1
Cost-Sharing Requirements in Traditional Medicare, 2000

Requirement	2000 Amounts
Part A:	
Inpatient	
Deductible	\$776 per illness spell
Copayment for days 61–90	\$194 per day
Copayment for lifetime reserve days 91–150	\$388 per day
Copayment beyond day 150	100% of costs
Skilled Nursing Facility Care	
Copayment for days 21–100	\$97 per day
Copayment beyond 100 days	100% of costs
Home Health Care	
Coinsurance for durable medical equipment	20% of approved amount
Hospice Care	
Copayment for outpatient drugs	\$5
Coinsurance for inpatient respite care	5% of payment amount
Blood	
First 3 pints	100% of costs
Part B:	
Premium	\$45.50 per month
Deductible	\$100 per year
Coinsurance	20% of charges
Coinsurance for services of physicians not accepting assignment	100% of allowable excess charges

Source: Health Care Financing Administration.

Table 2
Reforming the Medicare Benefit Package: Four Illustrative Options

Option 1. Basic catastrophic coverage and restructured deductible

- Eliminate the current Part A deductible (\$776 per spell of illness) and Part B deductible (\$100 per year) and introduce a combined (Part A and B) annual deductible of \$400
- Introduce a \$3,000 annual beneficiary limit on cost-sharing and deductible expenses

Option 2. Additional catastrophic coverage and lower cost-sharing rates

- Reduce the Part A deductible from \$776 per spell of illness to \$200 per spell of illness
- Increase the annual Part B deductible from \$100 currently to \$200
- Reduce the coinsurance rate from 20 percent of approved charges to 10 percent
- Introduce a 10 percent coinsurance requirement for home health services
- Introduce a \$2,000 annual beneficiary limit on cost-sharing and deductible expenses

Option 3. Zero coinsurance and budget-neutral premium

- Eliminate the Part A deductible (\$776 per spell of illness), Part A coinsurance (specified copayments applied to extraordinarily long hospital and skilled nursing facility stays), and Part B coinsurance (20 percent of approved charges)
- Increase the annual Part B deductible from \$100 currently to \$200
- Eliminate the Part B premium (\$45.50 per month) and introduce a combined (Part A and B) premium of \$105 per month

Option 4. Medicare prescription drug coverage

- Add prescription drugs to Medicare with a 50 percent coinsurance requirement
 - Introduce a \$2,500 annual beneficiary limit on cost-sharing expenses for prescription drugs
 - Introduce a premium of \$26 per month
 - Subsidize the premium at 100 percent for beneficiaries at or below 135 percent of the federal poverty level (FPL). Subsidize the premium on a linear sliding scale for beneficiaries between 135 percent and 150 percent of FPL
-

Note: Figures are expressed in 2000 amounts.

The second option is designed as a Medicare benefit with cost-sharing and catastrophic protections similar to that of private plans held by most of the nonelderly population. Compared with the first option, this one introduces more generous catastrophic coverage and also reduces cost-sharing rates. While the option could be designed in a budget-neutral or nearly neutral manner (by increasing the premium), in this paper we assume that Medicare funds the coverage, and thus program costs would increase.

The third option illustrates a conceptually logical extension of the preceding option: it is intended to eliminate the need for supplemental policies—but to do so in a manner that is budget-neutral for the Medicare program. The option accomplishes budget neutrality by eliminating most cost-sharing requirements (Part A deductible and coinsurance and Part B coinsurance) and fully offsetting the resulting program outlays with an increased Part B deductible and a combined premium. By spreading cost-sharing

expenses across beneficiaries in the form of a higher premium, the option provides additional coverage to beneficiaries in a community-rated manner, and with a minimum of administrative overhead. In contrast, most Medigap policies (and some employer-sponsored ones) are age- or experience-rated and carry relatively high levels of overhead.

The fourth option is illustrative of some recent proposals to extend coverage within the Medicare program to prescription drugs. Advocates of adding prescription drugs to the Medicare package point to the fundamental role that pharmaceuticals currently play in the medical management of numerous diseases and conditions. A prescription drug benefit would ensure that all beneficiaries have access to a stable source of coverage and could increase compliance with disease-management protocols that rely on outpatient use of pharmaceuticals. Although a number of prescription drug plans have been proposed, most can be categorized along three key design issues: voluntary or mandatory; Medicare or private plans to bear the risk; or varying levels of subsidy for low-income beneficiaries. We designed an option that is consistent with the study's preceding options, in that it assumes Medicare is the risk-bearer. Although it is unclear ultimately whether a prescription drug benefit would be voluntary or mandatory, we assume in this study that all beneficiaries would enroll in the Medicare drug plan, and that supplemental plans would drop or restructure their drug coverage. An assumption of 100 percent take-up allows us to identify an upper bound of the estimated impact of a particular proposal. Finally, with a coinsurance requirement and a drug stop-loss limit, the option is designed to help beneficiaries with modest drug expenses as well as those with catastrophic outlays.

Methods

Simulating the options and their impact on Medicare liability and on out-of-pocket spending required that we first estimate Medicare expenditures and beneficiary liability under current law, and also estimate beneficiary out-of-pocket spending and income.

Liability is the portion of Medicare spending that is the responsibility of the beneficiary: the Part B premium, deductibles, and coinsurance amounts. Beneficiary liability is the purest measure of the impact of benefit options, because it can be simulated with a minimum of assumptions and adjustments about medical care prices and beneficiary behavior. Because it does not indicate what beneficiaries actually pay, however, it is important to simulate out-of-pocket spending. For beneficiaries without supplemental insurance, out-of-pocket expenditures include their Medicare liability as well as any expenses for the range of health services and items purchased that are not covered in the Medicare benefit package. Beneficiaries with supplemental insurance typically are covered for their Medicare deductibles and coinsurance amounts, and sometimes for other services not covered by Medicare. Their out-of-pocket expenses, then, include their policy

premiums and any remaining services covered neither by Medicare nor by their supplemental policy. Finally, for low-income beneficiaries enrolled in the various Medicaid programs, Medicaid pays all or some Medicare liability (depending on the program).

The primary data source for our model of baseline liability and out-of-pocket spending is the 1995 Medicare Current Beneficiary Survey (MCBS). Figures from the survey are inflated to the year 2000 using trends in the growth of Medicare expenditures and in prescription drug expenditures. (See an earlier paper by Maxwell, Moon, and Segal for detail regarding data sources and baseline model development methodology).²¹ We then simulated the four options on several cohorts of beneficiaries, and adjusted the options' impacts by beneficiary supplemental insurance status. The insurance adjustments and beneficiary cohorts are summarized below. (See the Appendix for additional detail about the simulation and insurance adjustment methodologies.)

Adjusting for Supplemental Insurance Coverage

The effect of supplemental coverage on out-of-pocket spending varies significantly by general type of insurance—ESI or Medigap. The variation is due mainly to differences in administrative overhead (the loading factor), share of premiums paid by the insured, and the range of services covered. Our primary data source includes payments by type of insurer and beneficiary premium expenses; we determined premium payment shares for those with ESI, and average loading factors from the published literature.

Under option 1 (basic catastrophic coverage) and option 2 (additional catastrophic coverage and lower cost-sharing rates), we assume that insurers would modify their policies and premiums to reflect the new, lower levels of beneficiary liability, and that beneficiaries who have supplemental coverage would keep their policies. This assumption allows us to compare the two options more cleanly. In practice, however, option 2 may be comprehensive enough to induce some beneficiaries to drop their supplemental coverage. In that case, our estimates understate the out-of-pocket savings, particularly for beneficiaries carrying plans with high administrative costs (such as the Medigap policies). The coverage simulated under option 3 is so comprehensive that we assume beneficiaries would drop their supplemental policies under the option.

The supplemental insurance market could respond in numerous ways to the introduction of a Medicare prescription drug benefit (option 4). In the employer-sponsored market, in which drug coverage is common, an employer likely would determine its response after analyzing several factors, including the employer's current drug coverage; the level and patterns of its retiree drug expenses; the new Medicare drug

²¹ Appendix A in Maxwell, Moon, and Segal, *op. cit.*

benefit; and the expected Medicare drug liability of its retirees. Regardless of the response, the net impact of a Medicare drug benefit would be smallest for these beneficiaries, since they often have some level of drug coverage through their existing ESI.

We evaluated a range of possible employer responses from the perspective of change in out-of-pocket expenses. Holding beneficiaries' total drug outlays constant, out-of-pocket spending could decrease under several circumstances, depending on the value of the Medicare drug benefit relative to retiree drug benefit policies and on the interest of employers in maintaining or increasing the actuarial value of the original retiree policy. Out-of-pocket spending could increase if an employer chose not to cover the Medicare drug liability. Out-of-pocket spending might change very little or not at all, if an employer's ultimate objective is to contribute at a maximum the same net amount to its retiree policy after introduction of the Medicare benefit. Because of recent and projected declines in the availability and level of ESI,²² we assume that the latter response is the most likely. That is, in simulating this option we assume that an employer would cover the new Medicare drug benefit to the extent that it had covered drugs prior to this change. Any excess actuarial value in the original plan would be pocketed by the employer, rather than spent on its retirees in the form of additional benefits or reduced premiums.

In contrast to ESI, drug coverage is uncommon in the Medigap market. In 2000, for example, beneficiaries with Medigap policies had an estimated \$62 of drug expenses paid by their policies (equaling about 10 percent of the amount paid out by ESI policies). Because drugs are such a small share of this market, we assume that sellers of Medigap policies with a drug benefit would remove the benefit and re-price their policies, and that beneficiaries would continue their Medigap plans for coverage of other Medicare cost-sharing expenses.

Constructing Beneficiary Cohorts

We constructed several cohorts of beneficiaries to allow us to evaluate the diversity of each option's impacts, particularly with regard to groups of vulnerable populations. The cohorts offer contrast regarding health status, age, income, and presence and type of supplemental insurance coverage.²³ Six population cohorts are analyzed in this paper:

²² Hewitt Associates LLC, *op. cit.*

²³ Certain beneficiaries (those enrolled in managed care plans, residing in nursing homes, or diagnosed with end-stage renal disease) are excluded from *all* the cohorts because of insufficient data or because they differ substantially from most beneficiaries. Managed care beneficiaries in particular were excluded because differences in the MCBS survey methodology prevent reliable and valid comparisons of out-of-pocket spending between fee-for-service and managed care beneficiaries. Except for the cohort of Qualified Medicare Beneficiaries, the cohorts also exclude those dually eligible for any level of Medicaid coverage.

- Elderly: All beneficiaries age 65 or older.
- Elderly in poor health: Beneficiaries age 65 or older with physical or cognitive health problems.
- Elderly, low-income women age 85+ in poor health: Single women age 85 or older with annual household income between \$5,000 and \$20,000 and with physical or cognitive health problems.
- Women with QMB protection: Women enrolled in the QMB program, in which Medicaid pays the Medicare premium and cost-sharing expenses for Medicare beneficiaries with incomes less than the FPL.
- Disabled beneficiaries ages 45 to 64: Beneficiaries ages 45 to 64 with physical limitations, who qualify for Medicare due to their disability.
- High-income beneficiaries ages 65 to 74: Beneficiaries ages 65 to 74 with annual household incomes of \$50,000 or more. Beneficiaries in this cohort also are married and have employer-based supplemental insurance coverage.

We used several variables related to health status to identify beneficiaries in poor health. Cognitive impairments indicating poor health include Alzheimer’s disease and mental or psychiatric conditions. Physical impairments are indicated by the presence of several conditions (stroke, diabetes, rheumatoid arthritis, emphysema, osteoporosis, or Parkinson’s disease), and by combinations of skilled nursing facility use, self-rating of poor health, and limited function. Function is measured in terms of activities of daily living (ADLs) and instrumental ADLs.

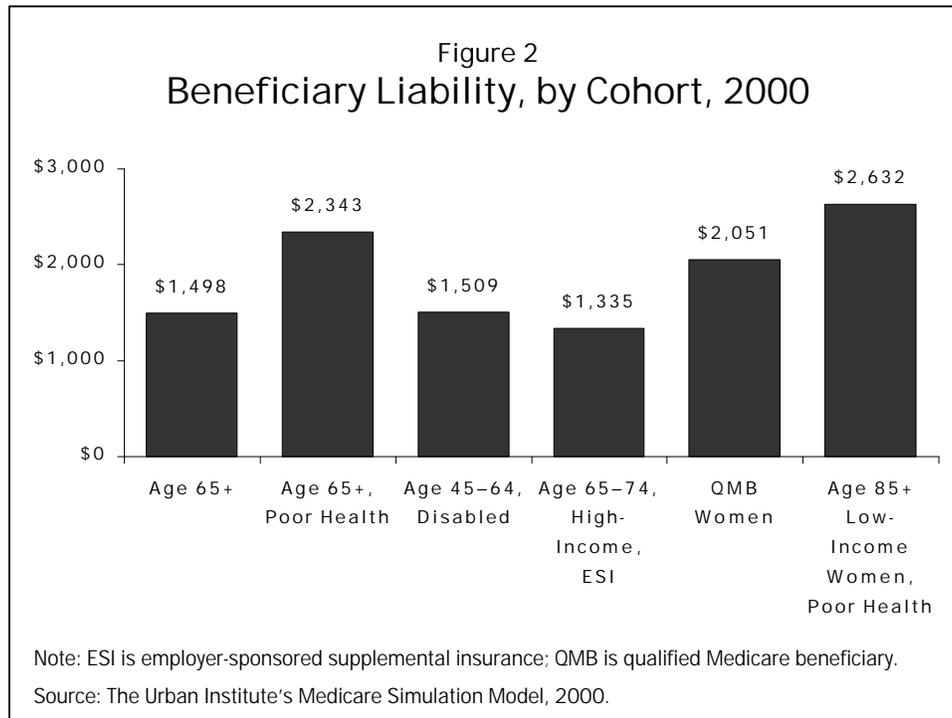
Impact of Options

Beneficiary Liability

Among all elderly (in traditional Medicare), beneficiary liability is an estimated \$1,498 in 2000 (Figure 2).²⁴ Across our cohorts, that figure ranges from a low of \$1,335 for younger, high-income beneficiaries with ESI to a high of \$2,632 for older low-income women in

²⁴ Note that throughout the paper, liability and out-of-pocket figures refer to beneficiaries in the traditional (fee-for-service) program that reside in the community and do not suffer from end-stage renal disease.

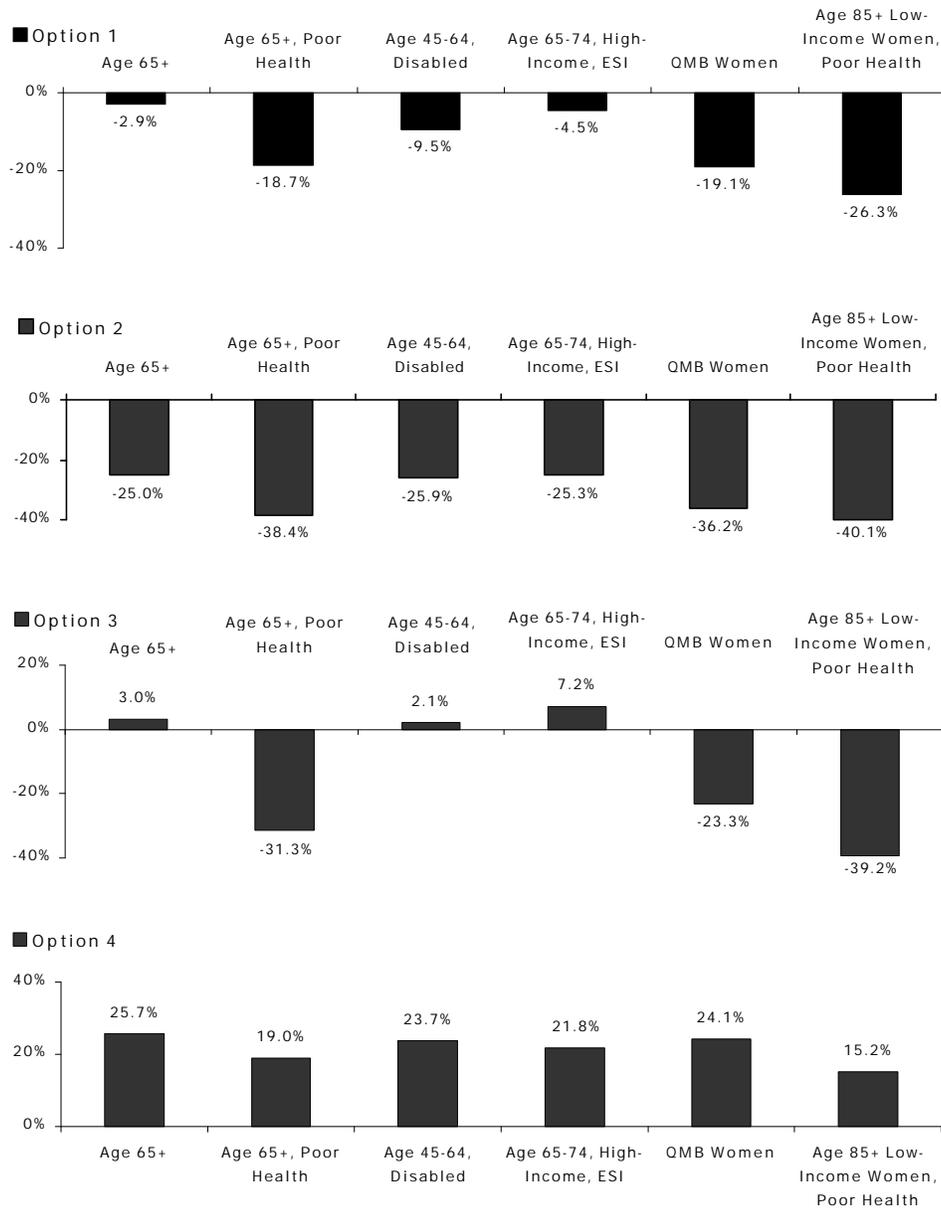
poor health. (See an earlier paper for detailed analyses of current and projected beneficiary liability and out-of-pocket spending.²⁵)



The first option (a basic catastrophic benefit expansion) produces relatively modest savings in liability for beneficiaries with average health care utilization (Figure 3). The option lowers the liability of all elderly beneficiaries by only 2.9 percent (\$43) and by 4.5 percent (\$60) for the cohort of younger high-income beneficiaries with ESI. However, the option greatly reduces liability for those with higher Medicare expenditures. Among older low-income women in poor health and all elderly in poor health, for example, liability falls 26.3 percent (\$692) and 18.7 percent (\$438), respectively.

²⁵ Maxwell, Moon, and Segal, op. cit.

Figure 3
Impact of Options on Beneficiary Liability, by Cohort



Note: ESI is employer-sponsored supplemental insurance; QMB is qualified Medicare beneficiary.

Source: The Urban Institute's Medicare Simulation Model, 2000.

Unlike option 1, the second option yields liability savings for beneficiaries across the spectrum of medical use and spending. Comparing the four options, this one produces the greatest reductions in liability (and the greatest increase in program costs). Liability falls 25.0 percent (\$375) among the all-elderly cohort. High-utilization beneficiaries would benefit from the relatively low stop-loss limit (\$2,000) and the lower Part A deductible (which would be reduced from \$776 per spell of illness to \$200 per year). For example,

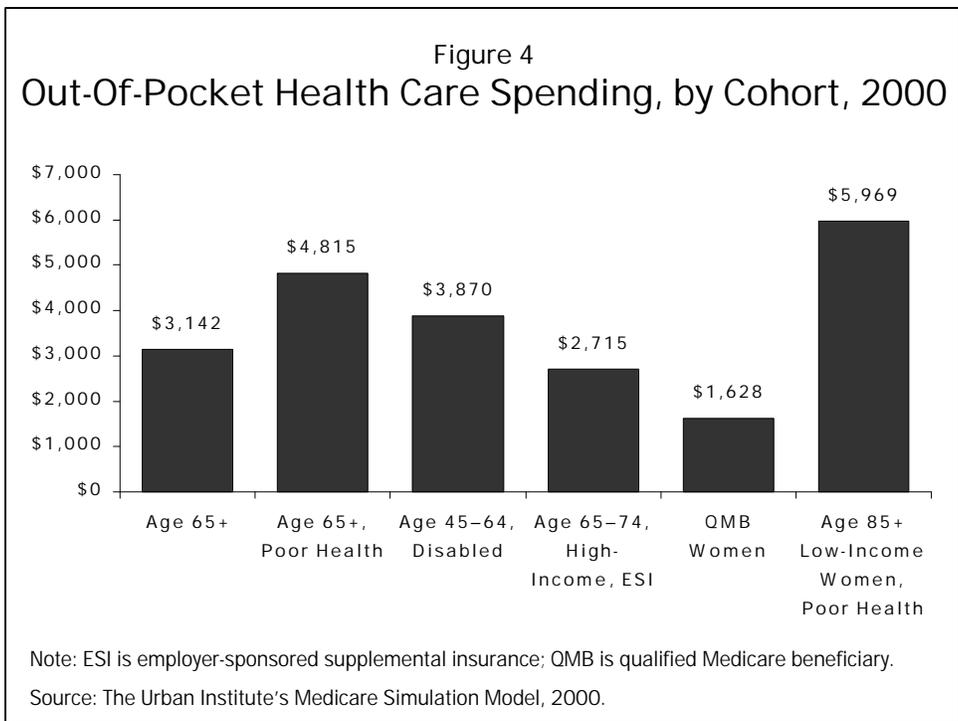
substantial liability reductions, in both percentage terms and absolute dollars, are afforded to women in the QMB program (36.2% or \$742) and older low-income women in poor health (40.1 percent or \$1,055). Liability would drop for lower-utilization beneficiaries under this option as well, through reduction in coinsurance rates (which would be reduced from 20 percent to 10 percent). For example, even the cohort with the lowest liability (younger high-income beneficiaries with ESI) would see their liability fall 25.3 percent (\$338).

Option 3 is budget-neutral, and thus includes an increased Medicare premium to fully offset its cost-sharing reductions. Consequently, on average it results in a small increase (3.0 percent or \$45) in liability among all elderly. A small increase also would occur for the cohort of 45- to 64-year-old disabled beneficiaries (2.1 percent or \$32); a larger increase would occur for younger high-income beneficiaries with ESI (7.2 percent or \$96). This option spreads the aggregate liability necessary to fund the option across all beneficiaries, rather than concentrating cost-sharing on those who use services the most. As a result, the option substantially reduces liability for those in poor health, such as the group of older low-income women in poor health (39.2 percent or \$1,032 decline in liability) and the cohort of all elderly in poor health (31.3 percent or \$733 liability decline).

Because the prescription drug simulation (option 4) brings these expenses into the Medicare benefit package, the option increases Medicare liability across all the cohorts. Among all elderly, for example, the option would increase liability by 25.7 percent (\$385). All cohorts would incur a roughly similar percentage increase in liability—except for older low-income women in poor health, who would see a much lower increase (15.2% or \$400). This group's relatively small increase, in percentage terms, reflects its relatively high health care utilization and baseline liability rather than a low level of drug expenditures. The liability increase under this option highlights the importance, though, of also examining the impact of reform options in terms of beneficiaries' spending out-of-pocket.

Out-of-Pocket Spending

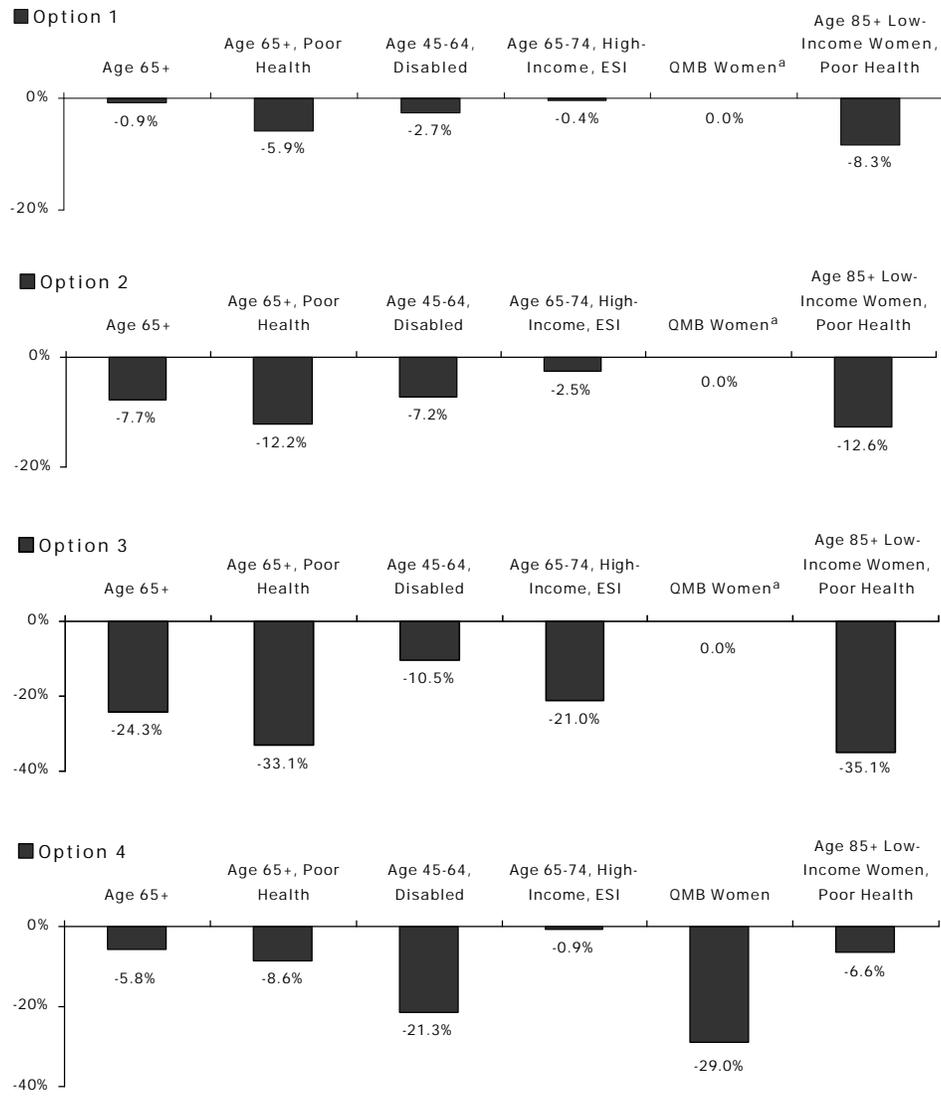
In 2000, elderly beneficiaries spent an estimated \$3,142 out-of-pocket for health care (Figure 4). Among the cohorts, spending out-of-pocket ranged from \$1,628 by women in the QMB program to nearly \$6,000 by the cohort of older low-income women in poor health. The high liability of women in the QMB program, in contrast to their low out-of-pocket burden, clearly illustrates the financial assistance of this program for those enrolled.



While two options simulated increase beneficiary liability, they nonetheless are designed to reduce out-of-pocket spending by eliminating the need for supplemental insurance (option 3) or by introducing coverage for a previously noncovered service (option 4). All the options reduce out-of-pocket spending, though to greatly varying degrees. After accounting for the mix of supplemental coverage, the options' impacts on out-of-pocket spending range from a decline of 1 percent to a decline of 25 percent in spending among elderly beneficiaries.

Across the four options, the first one produces the most modest decline in out-of-pocket spending. The decline also is smaller than the reduction in liability, reflecting the effect of beneficiaries' existing supplemental plans (see "Effect of Supplemental Insurance Coverage," on page 20 for further explanation). Among the elderly, option 1 lowers spending by only 0.9 percent or \$27 (Figure 5). The greatest decline in out-of-pocket spending is experienced by the cohort of older low-income women in poor health (8.3 percent or \$496). Note that under option 1 (as well as options 2 and 3), women in the QMB do not realize any out-of-pocket savings themselves. These three options reduce the cost-sharing required for *existing* Medicare-covered services, and because Medicare liability is fully paid by Medicaid for QMB enrollees, any reduction in their liability results in commensurate savings to states' Medicaid programs.

Figure 5
Impact of Options on Out-Of-Pocket Spending,
by Cohort



^a Impacts under options 1–3 yield savings to Medicaid programs rather than beneficiary out-of-pocket savings.

Note: ESI is employer-sponsored supplemental insurance; QMB is qualified Medicare beneficiary.

Source: The Urban Institute's Medicare Simulation Model, 2000.

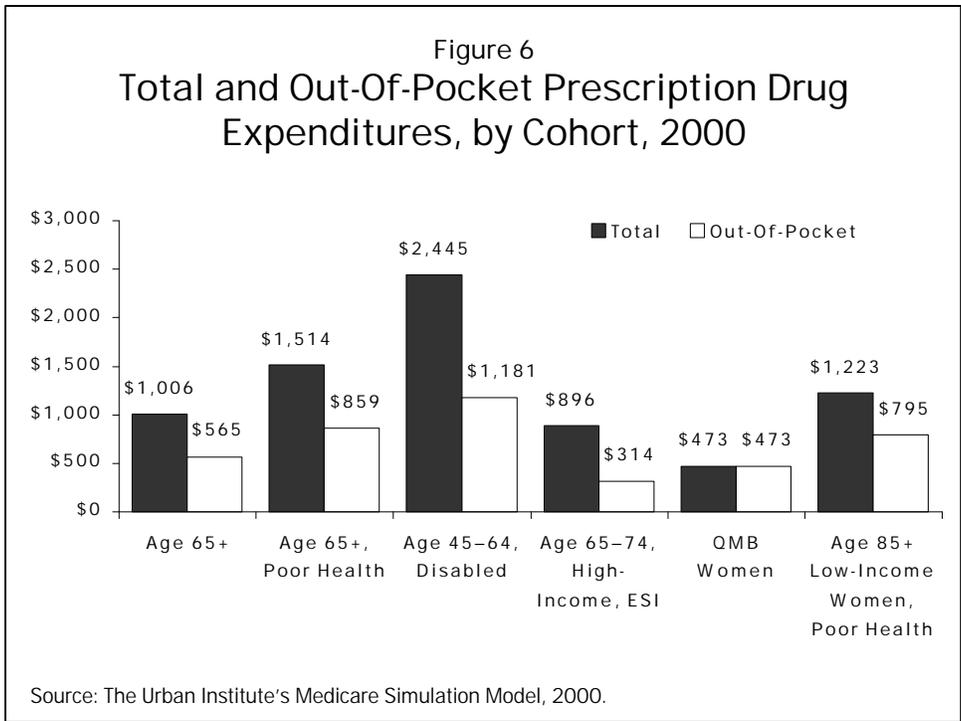
With a 7.7 percent average decline (\$240), option 2 results in substantially greater reductions in out-of-pocket spending. Spending reductions are greatest among two cohorts: elderly in poor health, with a 12.2 percent (\$587) decline; and older low-income women in poor health, with a 12.6 percent (\$753) decline. Because of the nature of their existing coverage, beneficiaries with ESI are generally affected the least by these options.

For example, among younger higher-income beneficiaries with ESI, spending declines due to option 2 only 2.5 percent (\$68).

Across the options, the third one affords by far the greatest average decline in out-of-pocket spending, even though a budget-neutral premium that is more than double the current premium is a central feature of the option. Among elderly beneficiaries, out-of-pocket spending drops 24.3 percent (\$763). Medicare coverage is so comprehensive under this option that we assume beneficiaries would drop their supplemental policies. Consequently, the out-of-pocket savings reflects both the cost efficiencies of furnishing benefits through the Medicare program (rather than through ESI and Medigap policies) and the cost-averaging effects of spreading risk across all beneficiaries. The largest savings, in percent and dollar amounts, occur among the cohort of older low-income women in poor health (35.1 percent decline or \$2,092).

Although the prescription drug benefit (option 4) is conceptually different from the others, it is most similar to option 2 in its impact on out-of-pocket spending. Among the elderly, spending is reduced 5.8 percent (\$181) by this drug benefit. In percentage terms, women in the QMB program are aided the most by this option. Their out-of-pocket spending declines 29 percent (\$473). While the prior options reduce liability on existing Medicare-covered services, this option extends coverage to another service. For QMB enrollees, then, drugs previously paid out-of-pocket are now covered by Medicare, and fully paid by Medicaid.

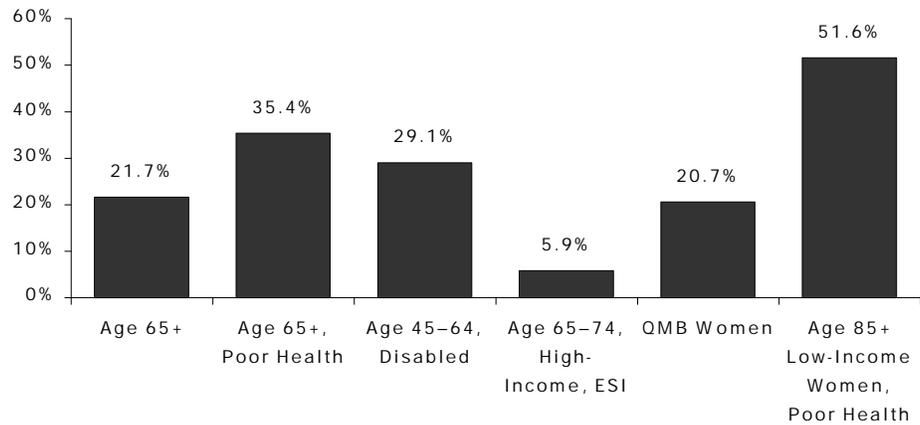
In absolute terms, beneficiaries helped the most by the prescription drug option are 45- to 64-year-olds eligible for Medicare due to a physical disability. With a 21.3 percent decline (\$824) in out-of-pocket spending, this group's savings are three to eight times greater than their savings under the other options. Except for the cohort of QMB women, disabled beneficiaries' savings are roughly three times higher in percent terms than the savings experienced by other cohorts under this option. The option's impact on disabled beneficiaries indicates the importance of pharmaceuticals to this group, relative to others. These beneficiaries have the highest drug expenditures, averaging \$2,445 in total drug expenditures in 2000 and \$1,181 in drug expenditures out-of-pocket (Figure 6). In contrast, the total and out-of-pocket drug expenditures of elderly beneficiaries in 2000 are \$1,006 and \$565, respectively.



Spending in Relation to Income

In 2000, health care spending out-of-pocket among the elderly accounted for an estimated 21.7 percent of their income (Figure 7). Older low-income women in poor health spend a striking proportion (51.6%) of income on health care. In contrast, the QMB program provides a clear protective effect for its enrollees: Women in that program spent only an average share (20.7%) of their income out-of-pocket on health care, despite their relatively high Medicare expenses and low incomes. Without the QMB benefits, these women's income share spent on health would approach 50 percent.

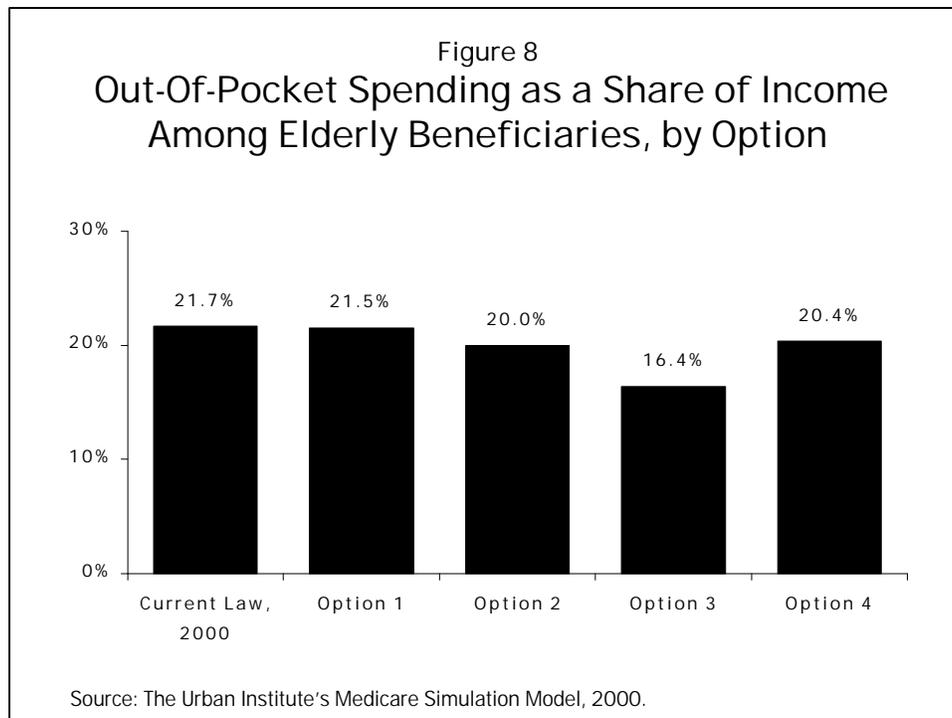
Figure 7
 Out-Of-Pocket Spending as a Share of Income,
 by Cohort, 2000



Note: ESI is employer-sponsored supplemental insurance; QMB is qualified Medicare beneficiary.

Source: The Urban Institute's Medicare Simulation Model, 2000.

The percentage changes in income shares resulting from the simulations are exactly the same as the percentage changes in out-of-pocket spending. When viewing only the percentage change results on the shares of income devoted to health, however, the impression of the options is one of limited impact with little variation. For example, in terms of income shares, options 1, 2, and 4 all have a negligible impact on the cohort of elderly beneficiaries—income shares under these options only range from 20.0 percent to 21.5 percent (Figure 8). Only option 3 results in a substantially lower income share for elderly beneficiaries (16.4 percent of income under the option, compared with 21.7 percent actually spent in 2000).



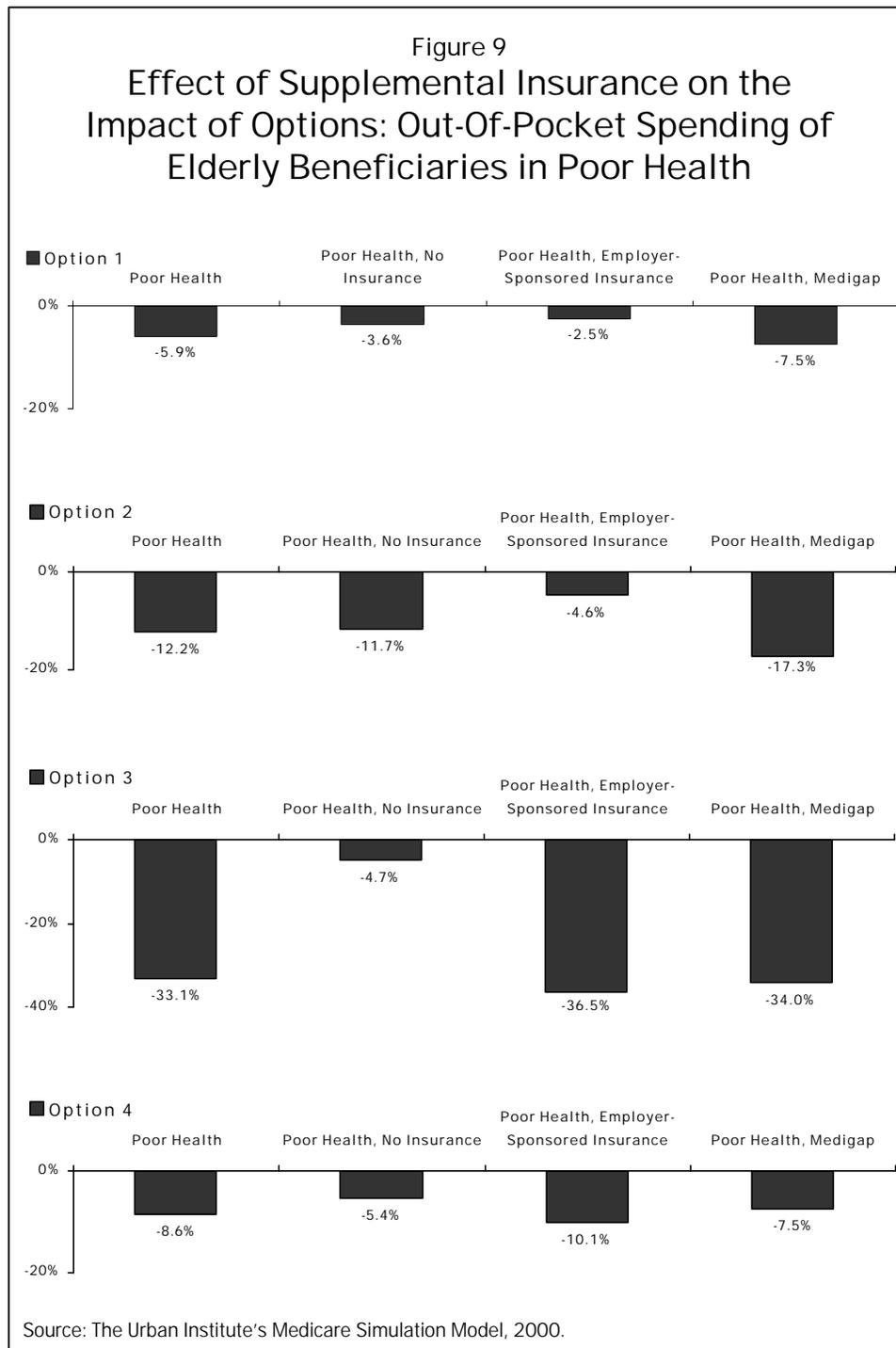
Although the change in income shares due to the options are mostly negligible for the average beneficiary, a significant change occurs among cohorts in poor health or with lower incomes. For example, among older low-income women in poor health, option 1 reduces their income share spent on health from 51.6 percent to 47.3 percent. Option 2 drops their share to 45.1 percent, and option 3 reduces it to 33.5 percent. As seen, in dollar terms option 4 particularly assists the disabled beneficiaries and women in the QMB program. In terms of income, the option reduces disabled beneficiaries' share spent on health from 29.1 percent to 22.9 percent, and QMB women's share from 20.7 percent to 14.7 percent.

Effect of Supplemental Insurance Coverage

Recall that to simulate options 1, 2, and 4 we assume supplemental policies would be kept; but given the Medicare expansions under the options, the supplemental plans would be scaled down commensurately. The Medicare expansion reflected in option 3 is so broad, however, that we assume beneficiaries would drop their supplemental policies under this option.

Our simulations indicate that among all elderly, out-of-pocket savings afforded by the options are largest for those with Medigap policies. Among elderly in poor health, this pattern also exists under options 1 and 2 (Figure 9). Among elderly in poor health, options 1 and 2 result in a 7.5 percent and 17.3 percent savings, respectively, for those with Medigap. Option 3 results in striking savings for those in poor health with either ESI or Medigap (36.5% and 34.0%, respectively). This effect is essentially the result of

beneficiaries dropping their supplemental plans and saving the money spent on premiums. Savings among those with Medigap are driven by two main factors: beneficiaries bear the full price of these plans, and the plans have relatively high administrative costs. (In fact, out-of-pocket spending for those with Medigap drops more than their liability. Out-of-pocket expenses of those with ESI decrease less than their liability, because these individuals pay for only a portion of their premium.)



Savings due to the prescription drug plan (option 4) are more uniform across those with both types of additional insurance, as well as those with none. Under this option, we assume that Medigap policies ultimately would not cover drugs. The MCBS indicates that only 13 percent of beneficiaries with Medigap purchase the policies with drug coverage, and on average the coverage represents a very small part of Medigap payouts. Under this option, we adjust for Medigap drug coverage by subtracting drug-related costs of Medigap from the average out-of-pocket spending of beneficiaries with Medigap. Drug coverage is standard under many ESI plans. However, because of the decline in subsidies for ESI, we conservatively assume that beneficiaries with this coverage would see no change in their out-of-pocket burden, and that ESI sponsors instead would pocket any savings and reduce their overall subsidy for their retiree plans.²⁶

Overall, behavioral assumptions and methodological adjustments regarding supplemental insurance can substantially alter estimates of the impact of these (or any) options to reform the Medicare benefit package. Indeed, differences in the mix of insurance coverage across cohorts explain a considerable amount of variation in the impact of reform options on out-of-pocket spending.

Impact on Medicare Program Expenditures

The options simulated in this paper are designed in part to illustrate a modest benefit expansion relative to a larger one (option 1 versus option 2), and a larger expansion relative to a similar expansion that also is budget-neutral (option 2 versus option 3). As a result, the four options also have quite different impacts in terms of federal spending on Medicare. It is important to note, however, that these impacts are not formal cost estimates. Such estimates require calculation of the effects of behavior changes that would increase or decrease the use of services in response to benefit changes. Formal cost estimates, with behavioral adjustments, would affect both the absolute totals and the relative effects of the four illustrative options simulated here.

Option 1 would result in an estimated net increase of 1.3 percent in federal spending for Medicare (Table 3). This option produces liability and out-of-pocket savings mainly for very vulnerable, high-utilization beneficiaries (through the option's \$3,000 stop-loss element). Medicare's outlays for those individuals, however, are nearly netted out by the increased liability that some younger, healthier beneficiaries would owe through the option's \$400 combined premium. Option 2 substantially expands coverage and

²⁶ Employers with ESI plans could respond to a Medicare drug benefit by maintaining their level of plan contributions and covering retiree's Medicare drug copayments or other expenses. Because retiree benefits have been declining rather than improving, however, we think this assumption would be overly optimistic.

reduces liability across all beneficiaries. Consequently, this option, as designed, would increase federal spending on Medicare substantially, by 6.8 percent. Option 3, in contrast, practically eliminates beneficiary cost-sharing yet does not increase the federal Medicare budget at all. Instead, this option includes a new premium calculated at the amount that would offset federal outlays which would otherwise be necessary to cover the reduced beneficiary liability. Finally, the prescription drug benefit (option 4) would increase Medicare spending by 5.8 percent.

Table 3
Impact of Options on Federal Spending for Medicare, 2000

Option	Per Capita Medicare Spending	Aggregate Medicare Spending (in millions)	Percent Increase in Federal Spending Due to Option
Current Law	\$6,213	\$240,949	—
Option 1: Basic Catastrophic Coverage	6,295	244,117	1.3%
Option 2: Additional Catastrophic Coverage and Lower Cost-Sharing Rates	6,636	257,368	6.8
Option 3: Zero Coinsurance and Budget-Neutral Premium	6,213	240,949	0.0
Option 4: Medicare Prescription Drug Coverage	6,572	254,882	5.8

While only four options are detailed in this paper, numerous combinations of benefit elements and alternative benefit amounts can be considered. Furthermore, the combinations could be adjusted to be budget-neutral or nearly neutral. The level of federal costs associated with option 4 (prescription drug coverage), however, implies that it would be difficult to modernize Medicare's current cost-sharing requirements *and* introduce meaningful drug coverage in a fully budget-neutral manner.

Discussion

An expanded Medicare benefit package clearly would reduce the out-of-pocket burdens of many beneficiaries. Although average reductions in spending would be small in some cases, several vulnerable categories of beneficiaries would be aided substantially under most options. In terms of health status, sicker (and older) beneficiaries would benefit the most,

particularly if their expenses exceed the stop-loss threshold of a catastrophic benefit. Regarding income, low- and moderate-income beneficiaries would benefit the most, because their out-of-pocket expenses can quickly consume an inordinate share of their income. (These beneficiaries also are less likely than higher-income ones to have ESI.)

In terms of insurance status, those currently with Medigap policies or no additional coverage would benefit more than those with ESI. However, because the level and availability of ESI is declining, the results described in this paper underestimate the positive impacts over time of expanding the Medicare benefit package. In particular, because most employers who offer ESI to their current retirees will not do so for future ones, the share of all beneficiaries with this type of coverage will diminish over time. The expansion would also create a much more stable alternative source of additional benefits for those currently enrolled in Medicare's managed care program.

Some may argue that Medicare cannot afford to expand its benefit package, because health care costs and the number of beneficiaries are growing more rapidly than the nation's ability to fund the program. However, most expansion options can be designed in a budget-neutral or near-neutral manner by restructuring the program's cost-sharing requirements or by adding such requirements to services currently paid fully by the program. Further, an expanded and redesigned benefit package could actually reduce some types of Medicare utilization, by reducing the excess demand associated with "first-dollar coverage." Several studies, such as the classic RAND Health Insurance Experiment, have documented what insurance experts argue: First-dollar coverage increases demand for services of often marginal value. Indeed, to the extent that an expanded benefit package results in beneficiaries dropping their supplemental coverage, beneficiaries would trade a system of first-dollar (yet still limited) coverage for a more cost-effective system of catastrophic coverage.

The beneficiary cohorts and expenditure model used in this paper were developed as part of a larger study that also projects beneficiaries' out-of-pocket spending. Our prior analyses indicate that without any policy changes, liability will increase as a share of total Medicare expenditures from 24 percent in 2000 to almost 27 percent by 2025, and out-of-pocket spending will rise as a share of income from 22 percent to 30 percent. The benefit reform options presented here likely would reduce out-of-pocket burdens over time, assuming the current erosion of supplemental coverage continues. That trend is not factored into our projection model, however, and thus our estimates of the impacts of the options between 2000 and 2025 are very similar.

In general, assuming beneficiary out-of-pocket spending continues to rise over time, the protections generated by the benefit options described here would have the same relative impact in 2025—assuming inflation adjustments are incorporated in the benefit reform. For example, the current Part B deductible has remained at \$100 for several years, but in a reformed benefit package, the premium, stop-loss amount, and deductibles could rise periodically with the rate of consumer inflation or the rate of Medicare expenditure growth. A benefit such as prescription drug coverage could rise with the rate of Medicare’s expenditures for that specific item. Pegging these items to inflation would prevent the federal government’s share of expenditures from rising over time (and the beneficiary share from decreasing). For example, the government’s projected share of total Medicare expenditures in 2025 (74%) would not increase under option 1 if the deductible and stop-loss amounts rose with Medicare’s total rate of spending. The federal share would rise to 79 percent in 2025 if the option’s benefit amounts did not change over time. Indeed, this illustrates an important issue in evaluating any policy change: the method by which automatic adjustments to specific policy provisions change over time.

APPENDIX: MEDICARE BENEFIT SIMULATIONS

After reviewing literature on private comprehensive policies as well as the Medicare prescription drug plans proposed in 1999, we modeled options that represent alternatives along a spectrum of benefit comprehensiveness. Three options reduce beneficiary liability for Medicare's current package of covered services. The fourth option adds outpatient prescription drugs to the list of covered services and items. The outpatient drug option would increase beneficiaries' Medicare liability (cost-sharing requirements and premiums), but would decrease out-of-pocket spending. Because supplemental coverage is a critical factor affecting out-of-pocket spending, we adjusted the impact of our options on the out-of-pocket burdens by the presence and type of beneficiaries' supplemental insurance plans.

Option 1: Basic Catastrophic Coverage and Restructured Deductible

This option introduces basic coverage for catastrophic Medicare liability. Beneficiaries are responsible for up to \$3,000 of liability annually, and the Medicare program is responsible for annual spending exceeding that amount.

This option also eliminates the current Part A and Part B deductibles and replaces them with a combined (Part A and B) annual deductible of \$400. The deductible in this option increases beneficiaries' average deductible liabilities. It is also designed, though, to spread the existing amount of deductible liability across a broader spectrum of beneficiaries. For example, this design effectively eliminates the inpatient hospital deductible of \$768 per spell of illness, and increases the \$100 annual Part B deductible to \$400. The combined deductible results in decreased spending required by the Medicare program, and offsets roughly half of the increased spending required by the program to pay for the catastrophic coverage benefit.

Simulating this option required that we first calculate current law liability for each beneficiary, based on the amount of Medicare payments for each type of service used. We then decreased the deductible amount for those beneficiaries with hospital stays (we assumed that beneficiaries with one or more inpatient stays would meet the new deductible), and, correspondingly, increased the program payments associated with these beneficiaries. Of those hospitalized in a year, over 66 percent incur only one stay. For these beneficiaries, we subtracted the difference between one hospital deductible and the combined deductible from their liability. Using the average hospital liability paid and the frequency distribution of the number of hospital stays per beneficiary, we estimated the liability paid by those with multiple hospital stays, and subtracted the difference between those amounts and the combined deductible from beneficiaries' liabilities.

We increased the liability (and decreased program payments) for those beneficiaries who used Medicare services but were not hospitalized during the year. New deductible amounts were estimated and liability was increased up to \$400, depending on the amount of Medicare Part B payments associated with each beneficiary.

After finalizing the new liability amounts, we then simulated the \$3,000 stop-loss mechanism. For those with liability over that amount, we subtracted the proper amount from their liability and added that amount to the program payments associated with each beneficiary.

Option 2: Additional Catastrophic Coverage and Lower Cost-Sharing Rates

This option introduces additional coverage for catastrophic Medicare liability. Beneficiaries are responsible for a maximum of \$2,000 of liability annually, and the Medicare program is responsible for annual spending in excess of \$2,000.

This option also redesigns the deductible amounts and coinsurance rates. The Part B deductible is increased from \$100 to \$200, and the Part A deductible is reduced to \$200 per spell of illness. The coinsurance rate is reduced from 20 percent to 10 percent. In addition, however, home health services are subject to the 10 percent coinsurance requirement under this option.

Simulating this option entailed the same steps as the option above, with one straightforward additional step regarding home health users: For those beneficiaries, we moved 10 percent of their Medicare home health spending to their liability amount.

Option 3: Zero Coinsurance and Budget-Neutral Premium

This option is designed to reduce greatly the need for supplemental health insurance policies, but to do so in a manner that is budget-neutral for the Medicare program. This option eliminates most cost-sharing requirements—the Part A deductible, Part A coinsurance (which is used mainly by hospital and skilled nursing facility patients with extremely long stays), and Part B coinsurance.

To pay for these changes, the option increases the Part B deductible to \$200 annually, and replaces the current Part B premium (almost \$46 per month in 2000) with a combined Part A and B premium of \$105 per month (in 2000 dollars). The combined premium amount was identified by simulating the option first without the premium alteration, identifying the resulting average liability change, and then calculating a new premium to offset what otherwise would be an increase in Medicare program payments.

By essentially spreading the cost-sharing expenses across all beneficiaries in the form of a higher premium, this option has the effect of providing *community-rated* additional insurance to beneficiaries with a minimum of administrative overhead.

Option 4: Medicare Prescription Drug Coverage

This option furnishes a community-rated outpatient drug benefit as part of the basic (required) Medicare benefit package. The option is designed to help beneficiaries with modest drug expenses as well as those with catastrophic drug outlays.

The option consists of a 50 percent coinsurance requirement, a maximum beneficiary liability of \$2,500 in annual drug expenses, and a \$26 monthly drug benefit premium (in 2000 dollars). The Medicare program would pay for drug expenses in excess of \$2,500. "Annual drug expenses" include drug expenses paid out-of-pocket, the shares of supplemental premiums attributable to drug benefits, and drug expenses paid by supplemental insurers.

Finally, this option also includes a premium subsidy for low-income beneficiaries. The premium is fully subsidized for those up to 135 percent of the federal poverty level (which in 2000 is \$8,350 for single households and \$11,250 for households with two members). The premium is subsidized in a linear sliding scale fashion for those above 135 percent and at or below 150 percent of the poverty level. (For example, 69 percent of the premium is subsidized for those at 140 percent of the poverty level, and 6 percent of the premium is subsidized for those at 150 percent of the poverty level.)

Adjusting Effects of Options for Supplemental Insurance Coverage

Simulations of these four options identify changes in beneficiary liability and in Medicare program requirements. To accurately estimate the impact of these options on beneficiary spending out-of-pocket, however, expenditure adjustments are necessary for those with supplemental insurance coverage. The exact adjustments vary by type of additional coverage (employer-sponsored or individually purchased), since the level of administrative overhead included in premiums and the share of premiums typically paid by beneficiaries differs by type of coverage.

Under options 1 and 2, we assume that insurers would modify their policy premiums to reflect the new (and on average, lower) levels of beneficiary liability, and that beneficiaries who have supplemental insurance coverage would keep their policies. We first calculated changes in out-of-pocket spending assuming no supplemental coverage, and then adjusted the change to account for the coverage by multiplying the change by

the product of a plan's overhead loading factor and the share of the plan premium paid by the beneficiary. Through literature reviews, we found that the average administrative overhead factor is 1.23 for individually purchased plans and 1.05 for employer-purchased plans.²⁷ The average share of premiums paid by beneficiaries is 100 percent for those with individually purchased plans and 20 percent for those with employer-purchased plans.²⁸

The upshot of this adjustment for options 1 and 2 is that, given an average reduction in Medicare liability, the out-of-pocket spending of an average beneficiary with an individually purchased plan will decrease by 20 percent more than the average liability reduction, because that plan's premium will be reduced by both the average liability amount and by its sizable loading factor. The out-of-pocket spending of an average beneficiary with an employer-sponsored plan, however, will decrease by less than the average liability reduction, largely because the typical individual pays for only 23 percent of the policy. (In this case, the plan sponsor reaps most of the savings due to the reduced liability.) Finally, the out-of-pocket expenses of beneficiaries without supplemental insurance are decreased simply by the amount of their liability reduction.

The coverage policy simulated under option 3 is so comprehensive that we assume beneficiaries would drop their supplemental coverage. Thus, we subtracted the cost of supplemental policies (the premiums) from the out-of-pocket spending of beneficiaries with such coverage. Among elderly beneficiaries, the average individually purchased policy premium (in 2000 dollars) is \$1,264, and the average amount that beneficiaries contributed toward their employer-sponsored policies is \$761.

If Medicare were to cover outpatient prescription drugs (option 4), supplemental insurers could choose to cover the remaining drug coinsurance requirements or they could eliminate their drug benefits altogether. Most individually purchased policies do not include a drug benefit, while most employer-sponsored plans do. Drug coverage is more common in the employer-sponsored plans partly because the plans typically are limited versions of the health plans already sponsored for current employees. The MCBS indicates that, among elderly beneficiaries with individual supplemental plans, the average payout per beneficiary for drugs by these plans is \$62 (in 2000 terms). In contrast, among elderly beneficiaries with employer-sponsored supplemental plans, the average drug payout by these plans is \$521.

²⁷ Estimates of the administrative overhead, or loading factors, are from the U.S. General Accounting Office, *Medigap Insurance: Compliance with Federal Standards Has Increased*, GAO/HEHS-98-66, Washington, DC, March 1998.

²⁸ Estimates of the share of premiums paid by individuals with employer-sponsored plans are from Levit et al. and Gabel et al., op. cit.

Because of the limited nature of drug benefits in the individual plan market and the relatively high administrative expense of tracking drug purchases, we assume that, ultimately, sellers of individual policies with a drug benefit would remove the benefit and re-price their policies, and that beneficiaries would keep the plans because of the other coverage furnished by the plan. For these beneficiaries, we simulate this assumption by subtracting from their out-of-pocket drug spending the share of their individual plan premiums attributable to prescription drug coverage. Because prescription drug coverage is common in the current employer and retiree insurance market, however, we assume that the drug benefit in the retiree plans would continue in some modified form to wrap around the Medicare drug benefit. Our initial analyses indicated that the amount currently contributed to drug expenses by employer-sponsored plans would not be sufficient, on average, to wrap around the Medicare benefit and *fully* cover beneficiaries' 50 percent coinsurance requirements. Given this circumstance, employer-sponsored plans would face three possible opportunities for response. Under the most generous approach, plans could increase their outlays related to prescription drugs and fully insure beneficiaries' drug liabilities under option 4. Under a middle-of-the road response, plans could contribute the same amount to beneficiaries' drug expenses, on average, as they did without the Medicare drug benefit. This response would decrease the drug-related out-of-pocket expenses of the elderly with employer-sponsored plans by roughly one-half, according to our simulations. Under the least generous response, plans could structure their drug benefit so that their enrollees incurred no out-of-pocket change. Although this might be marketed to enrollees as a positive response, on average this option would result in savings to the plan sponsors. We simulated each of these responses. Because of the recent trend of declines in levels of employer-sponsored supplemental coverage,²⁹ however, we report and discuss the most conservative response—that these beneficiaries would see no change in their out-of-pocket burden, and that plan sponsors would contribute less to drug outlays than they did before the Medicare drug benefit was in place.³⁰

²⁹ Hewitt Associates LLC, op. cit.

³⁰ In general, we keep our Medicare Projections Model as straightforward as possible with a minimum of assumptions. Where assumptions are required and a range of possible values exists, we use conservative estimates to generate projections that represent a minimum bound on spending by beneficiaries.

Table A-1
Impact of Options on Beneficiary Liability and Out-of-Pocket Spending, by Cohort, 2000

Cohort	Beneficiary Liability	Out-of-Pocket Spending	Total Drug Spending	Out-of-Pocket Drug Spending	Option 1		Option 2		Option 3		Option 4	
					Beneficiary Liability	Out-of-Pocket Spending						
Age 65+	\$1,498	\$3,142	\$1,006	\$565	\$1,454	\$3,115	\$1,123	\$2,902	\$1,543	\$2,379	\$1,882	\$2,961
Age 65+, Poor Health	2,343	4,815	1,514	859	1,905	4,530	1,443	4,228	1,609	3,224	2,786	4,400
Age 45–64, Disabled	1,509	3,870	2,445	1,181	1,366	3,767	1,119	3,590	1,541	3,462	1,867	3,046
Age 65–74, High-Income, ESI	1,335	2,715	896	314	1,276	2,703	997	2,647	1,431	2,144	1,625	2,691
QMB Women	2,051	1,628	473	473	1,659	2,322	1,309	2,030	1,574	1,981	2,545	2,625
Age 85+, Low-Income Women, Poor Health	2,632	5,969	1,223	795	1,940	5,474	1,578	5,216	1,601	3,877	3,033	5,575

Note: ESI is employer-sponsored supplemental insurance; QMB is qualified Medicare beneficiary.

Source: The Urban Institute's Medicare Simulation Model, 2000.