



**MEDICARE'S COST-SHARING:
IMPLICATIONS FOR BENEFICIARIES**

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Modernizing Beneficiary Cost-Sharing
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EXECUTIVE SUMMARY

Modernizing Medicare's benefits should be concerned with both adding prescription drugs and reducing burdensome deductibles and cost-sharing that lead nine out of ten Medicare beneficiaries to obtain supplemental insurance coverage. Medicare's cost-sharing has risen more rapidly than inflation and the incomes of beneficiaries since it was enacted in 1965, eroding the protection Medicare was designed to provide.

The attached testimony makes eight basic points:

Medicare Beneficiaries Spend a High Proportion of Income on Health Care

- In 2000 the average elderly Medicare beneficiary spent \$3,142 on their own health care expenses, or 21.7 percent of income
- By 2025 that will increase to \$5,248 (in constant 2000 dollars) or 29.9 percent of income.

Medicare Beneficiaries Are Disproportionately Poor and Sick

- Two out of three Medicare beneficiaries are either sick or poor with incomes below twice the federal poverty level.
- One-third of Medicare beneficiaries are either cognitively impaired, or have serious physical limitations. These beneficiaries account for 60 percent of all Medicare outlays. Nine million cognitively impaired beneficiaries alone account for 42 percent of Medicare outlays.

Medicare Beneficiary Cost-Sharing Is High

- If Medicare's 1966 cost-sharing had only risen with general inflation, today's Part A deductible would be \$218, not \$792; the Part B deductible would be \$272 not \$100; and the Part B annual premium would be \$196, not \$600.
- Half of beneficiary cost-sharing goes for cost-sharing for covered services or private supplemental insurance premiums; one-fifth is Part B premiums; and the remaining 30 percent goes for services not covered by Medicare, primarily prescription drugs.
- Beneficiaries who are the sickest or are without good supplemental insurance bear the heaviest brunt of out-of-pocket spending: the disabled ages 45–64 average out-of-pocket spending of \$3,870 per person; the elderly in poor health with no supplemental coverage average \$4,815, and low-income women over age 85 in poor health average \$5,969 per person.

Medicare Cost-Sharing Contributes to Beneficiary Access and Bill Problems

- Current cost-sharing contributes to difficulty obtaining needed care and paying medical bills, especially for lower-income beneficiaries. One-fourth of those with incomes below the poverty level report access problems, as do one-third of the disabled under age 65. Similar percentages report difficulty paying medical bills.
- Two in five of the most at risk beneficiaries report either problems obtaining needed services or medical bill problems. This includes 41% of those with incomes below the poverty level, 39% of those in fair or poor health, 47% of the disabled under age 65, and 40% of those needing help with one or more activities of daily living.
- Cost-sharing and absence of supplemental insurance contribute significantly to failure to obtain preventive services, and proper management of chronic conditions.

Medicare Cost-Sharing Is Higher than Typical Employer Plans

- Working families spend 8 percent of incomes on health care, compared with 22 percent of income spent by elderly Medicare beneficiaries.
- The average deductible in employer fee-for-service plans is \$239 for all services, compared with \$792 for Part A and \$100 for Part B.
- The median ceiling on patient out-of-pocket expenses is \$1,500 in conventional employer plans; Medicare has no catastrophic ceiling.
- Worker share of premiums for single coverage is \$28 per month, compared with Medicare's Part B premium of \$50 a month, plus MediGap premiums of over \$100 a month.
- Benefits in employer plans are more comprehensive: 71 percent of firms cover adult physical exams which Medicare does not; 87 percent cover prescription drugs; and 25 percent cover dental care.
- Despite the fact that Medicare's benefits do not compare favorably with employer coverage, Medicare beneficiaries report higher satisfaction with Medicare than do working families with employer coverage.

Medicare Beneficiaries Need Supplemental Insurance Coverage But It Is Increasingly Unaffordable or Unavailable

- Nine of ten Medicare beneficiaries obtain supplemental coverage to augment Medicare's benefits. About 38 percent have coverage from a current or former employer; 23 percent are covered by MediGap private coverage; 15 percent are enrolled in Medicare+Choice plans, and 13 percent are covered in part or in full by Medicaid.
- Among beneficiaries with incomes below \$10,000, 17 percent have no supplemental coverage, and only 14 percent have employer-sponsored supplemental coverage.

- MediGap premiums are expensive: Plan E premiums (moderate benefits, no prescription drugs) average \$1,320 for a 65-year old woman; Plan J premiums (comprehensive benefits, prescription drugs) average \$3,242. Increasingly, MediGap premiums are age-rated, leading to much higher premiums for older beneficiaries.
- Employers are cutting back on retiree coverage: 81% of employers report that they are planning to increase retiree health premiums and/or cost-sharing in the future; 40% are cutting back on prescription drugs; and 30% are planning to terminate coverage for future retirees.
- Medicare+Choice enrollment has dropped from 6.3 million beneficiaries in 1999 to 5.6 million in 2001 as plans have increased premiums, reduced prescription drug benefits, and withdrawn plans either nationally or from selected geographic areas.

There Are a Number of Options for Improving Medicare Benefits and Reducing Cost-Sharing

- In a report being released today by The Commonwealth Fund, a study by Marilyn Moon and colleagues at the Urban Institute simulates the impact on beneficiaries of improving Medicare benefits and cost-sharing:
 - Option 1 combines Part A and Part B with a single annual deductible of \$400 and a ceiling of \$3,000 on beneficiary cost-sharing. It would increase Medicare outlays by an estimated \$2.2 billion in 2000.
 - Option 2 has a Part A deductible of \$200 per spell of illness, a Part B annual deductible of \$200, 10 coinsurance on physician and home health services, and a \$2,000 ceiling on beneficiary cost-sharing. It would increase Medicare outlays by an estimated \$14.8 billion in 2000.
 - Option 3 eliminates all deductibles and coinsurance except for a \$200 Part B deductible. Part B premiums are increased to a budget-neutral \$105 per month. It would generate a small federal budget savings of \$1.7 billion in 2000.
 - Option 4 adds a prescription drug benefit with 50 percent coinsurance, \$2,500 limit on beneficiary cost-sharing, and a \$26 monthly premium.
- Under all four options both the elderly and the disabled would experience a reduction in total out-of-pocket expenses, including private insurance premiums. The elderly would save \$27 per capita under Option 1, \$240 under Option 2, and \$763 under Option 3. The disabled ages 45–65 would save \$103, \$280, and \$408 respectively under the three options. Option 4 would save the elderly \$181 per person, and the disabled ages 45–64 \$824 per person.
- Savings would be greatest for beneficiaries with serious health problems. For elderly beneficiaries in poor health without supplemental coverage the savings would be \$285, \$587, and \$1591 under the first three options, and \$415 under Option 4.

- On average out-of-pocket spending for elderly beneficiaries would decline from the current rate of 21.7 percent of income to 21.5 percent under Option 1, 20.0 percent under Option 2, 16.4 percent under Option 3, and 20.4 percent under Option 4.
- Option 3, by eliminating the need for private supplemental insurance is an important way to improve efficiency in coverage for Medicare beneficiaries.
- Option 1 would increase costs for the 80 percent of beneficiaries not experiencing a hospital stay from a Part B deductible of \$100 to a combined A/B deductible of \$400. This would have an immediate effect on beneficiaries without supplemental coverage.
- For retirees with employer-sponsored coverage the impact depends on whether employers use savings to pay beneficiary premiums and/or improve benefits such as prescription drugs, or use it as an opportunity to drop retiree coverage.
- State Medicaid programs would be expected to benefit from an improvement in Medicare benefits.

Medicare Beneficiaries Have a Claim to a Portion of the Budget Surplus

- Slow-down in Medicare and Medicaid outlays since 1995 accounts for \$1 trillion of the 10-year \$5.6 trillion federal budget surplus. A major portion of these savings came from the 1997 Balanced Budget Act.
- Ten percent of the Medicare BBA savings came from increased beneficiary Part B premiums. For example, the Part B premium in the year 2006 was increased by over 50 percent. Over \$50 billion of the 10-year budget surplus came from higher premiums charged to Medicare beneficiaries.

MEDICARE'S COST-SHARING: IMPLICATIONS FOR BENEFICIARIES

Karen Davis

Thank you, Madam Chairman, for this invitation to testify on Medicare's cost-sharing. Medicare provides health insurance for 40 million elderly and disabled beneficiaries. It was created in 1965 to provide financial protection for beneficiaries against the cost of medical expenses and to ensure access to quality health care. At the time, half of the elderly were uninsured since few had retiree coverage through work or could afford private coverage on their own. Today, nearly all of the elderly have basic coverage through Medicare.

However, Medicare's cost-sharing has risen more rapidly than inflation and the incomes of beneficiaries, eroding the protection Medicare was designed to provide. In 2000 the average elderly Medicare beneficiary spent \$3,142 on their own health care expenses, or 21.7 percent of income.¹ By the year 2025 that will increase to \$5,248 (in constant 2000 dollars) or 29.9 percent of income. Financial burdens on beneficiaries need to be reduced, not increased.

Medicare Beneficiaries Are Disproportionately Poor and Sick

Some argue that Medicare cost-sharing is necessary to encourage cost-conscious choices about health care on the part of beneficiaries. Any discussion of restructuring Medicare cost-sharing should be firmly rooted in an understanding of the characteristics of beneficiaries, their current financial contributions for care, and their current difficulties in obtaining access to care and paying medical bills.

Unlike working families, two out of three Medicare beneficiaries are either sick or poor.² They are the least well-positioned to "help the market work" by making cost-conscious choices. Eleven million beneficiaries have less than a high school education. One-third of Medicare beneficiaries are either cognitively impaired, or have serious physical limitations.³ These beneficiaries account for 60 percent of all Medicare outlays. Included are over 9 million beneficiaries who are cognitively impaired, accounting for 42 percent of Medicare outlays. One and a half million Medicare beneficiaries are in nursing

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

² Patricia Neuman, Cathy Schoen, Diane Rowland, Karen Davis, Michelle Kitchman, Elaine Puleo, and Drew Altman, "Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform," *Journal of Aging and Social Policy*, 10(4), pp. 25–30, 1999.

³ Marilyn Moon and Matthew Storeygard, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems*, The Commonwealth Fund, May 2001.

homes.⁴ Terminal illness affects 2.4 million beneficiaries each year. The majority of beneficiaries suffer from a chronic condition such as diabetes, arthritis, heart disease, cancer, or stroke. Three-fourths require on-going prescription drugs.⁵

Those with the lowest incomes are also the sickest. Over half of those with incomes below the poverty level (\$8,259 for a single elderly person in 2000; \$10,409 for a couple) are in fair or poor health. One-fourth of the poor need assistance with at least one activity of daily living.

Medicare Beneficiary Cost-Sharing Is High

When Medicare began in 1966, the major expenses for which beneficiaries were responsible were the average cost of the first day of hospital care under Part A, a deductible for Part B physician and other ambulatory services, 20 percent coinsurance for Part B services (plus any physician charges over the allowed fees), and a Part B premium. Even adjusting for inflation, today's Part A hospital deductible and Part B premium are 3 to 4 times higher than they were in 1966. The rapid growth in the Part A deductible reflects changes in health care technology that have led to shorter but more intensive hospital stays, driving up the average daily cost. Only the Part B deductible is lower today in real terms than it was in 1966. If these cost-sharing amounts had remained constant adjusted for inflation, today's Part A deductible would be \$218, not \$792; the Part B deductible would be \$272 not \$100; and the Part B annual premium would be \$196 (or \$16 a month), not \$600 a year.⁶

These cost-sharing amounts or the supplemental insurance premiums required to cover them represent significant financial burdens on Medicare beneficiaries. In 2000, elderly Medicare beneficiaries spent on average \$3,142 out-of-pocket on health care. About half of this amount comes from cost-sharing for covered services or private supplemental insurance premiums to pick up costs not covered by Medicare, about one-fifth is Part B premiums, and the remaining 30 percent is for services not covered by Medicare, primarily prescription drugs.

Despite Medicaid and other programs to subsidize Medicare cost-sharing and premiums for low-income beneficiaries, burdens on low-income beneficiaries are particularly heavy. The poorest beneficiaries spend thirty percent of income on health care. Only 40 percent of low-income beneficiaries eligible for Medicaid and other programs (Qualified Medicare Beneficiaries (OMB), Supplemental Low Income

⁴ National Center for Health Statistics, *Health, United States, 2000*, HHS/CDC/NCHS, July 2000.

⁵ Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, Kaiser/Commonwealth Fund, December 1998.

⁶ Author's calculations based on average inflation rates applied to the original deductibles and premium.

Medicare Beneficiaries (SLMB), Qualified Individuals) participate.⁷ Outreach efforts to inform and enroll eligible beneficiaries have been limited.

A study by Marilyn Moon and colleagues at the Urban Institute supported by the Commonwealth Fund modeled average out-of-pocket costs for six cohorts of beneficiaries to illustrate how widely costs vary depending on health and income. For each group, the estimates provide averages given the groups' likely health expenses. The six groups include:

- All elderly
- Elderly with physical or cognitive health problems with no supplemental coverage
- Disabled beneficiaries ages 45–64
- Beneficiaries ages 65–74 with incomes above \$50,000 and employer-sponsored supplemental coverage
- Women with QMB coverage
- Women age 85 and older with physical or cognitive health problems and incomes between \$5,000 and \$20,000.⁸

Out-of-pocket spending as a percent of income ranges from 6% for younger higher income beneficiaries with employer supplemental coverage to 52% for older women in poor health with limited incomes. It averages 22 percent for all elderly, and 29% for disabled ages 45–64. On a per capita basis, expenses average \$3,142 for all elderly, and \$3,870 for disabled ages 45–64. They reach as high as \$4,815 for those elderly in poor health with no supplemental coverage and \$5,969 for older low-income women in poor health. These are staggering amounts for a retired population with little income and limited savings.

Medicare Cost-Sharing Contributes to Beneficiary Access and Bill Problems

Not surprisingly, Medicare's cost-sharing affects access to care. This is particularly true for lower-income beneficiaries and for those with serious health problems. The Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries found that about 15 percent of Medicare beneficiaries experience difficulty obtaining needed care.⁹ Almost one-fourth of those with incomes below the poverty level report access problems, as do one-third of the disabled under age 65. Problems paying medical bills are reported by 14

⁷ Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

⁸ Stephanie Maxwell, Marilyn Moon, and Misha Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.

⁹ Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.

percent of all beneficiaries, by one-fourth of those below poverty, and by almost one-third of the disabled under age 65.

About two in five of the most at risk beneficiaries report either problems obtaining needed services or medical bill problems. This includes 41% of those with incomes below the poverty level, 39% of those in fair or poor health, 47% of the disabled under age 65, and 40% of those needing help with one or more activities of daily living.

Financial barriers to health care particularly affect use of preventive care. A 1995 study supported by the Commonwealth Fund reported that elderly women were less likely to receive mammogram screening if they did not have supplemental health insurance coverage.¹⁰ Medicare has since covered mammograms without subjecting services to the Part B deductible.

The absence of coverage for prescription drugs, however, continues to lead to underutilization of services, and inadequate maintenance of chronic conditions. A 2000 study supported by the Commonwealth Fund found that absence of supplemental coverage for prescription drugs was a significant cause of failure of Medicare beneficiaries with hypertension to receive appropriate medication.¹¹

Rates of ambulatory sensitive hospital admissions that could have been prevented with better preventive or primary care are particularly high for poor and minority elderly—indicating inadequate access to primary care. In sum, poor and near-poor elderly are more likely to experience health problems that require medical services than elderly people who are economically better off. Yet, they are less able to afford needed care because of their lower incomes.

Medicare Cost-Sharing Is Higher than Typical Employer Plans

Working families spend about 8 percent of their incomes on health care—a much lower percent than do the elderly.¹² In large part this reflects extensive employer-sponsored health insurance with lower cost-sharing, and better benefits. Most employer plans include a ceiling on out-of-pocket expenses; Medicare does not. In the generosity of its benefit package, Medicare ranks in the bottom decile of insurance plans.

The average deductible for all services—including hospital, physician, and other services—is \$239 in conventional fee-for-service plans offered by employers.¹³ Deductibles are even lower in managed care plans including preferred provider option (PPO) plans and point of service (POS) plans, and virtually non-existent in health

¹⁰ Janice Blustein, “Medicare Coverage, Supplemental Insurance, and the Use of Mammography by Older Women,” *New England Journal of Medicine* 332:1138–1143, April 27, 1995.

¹¹ Jan Blustein, “Drug Coverage and Drug Purchases by Medicare Beneficiaries with Hypertension,” *Health Affairs*, 19 (March/April), pp. 219–230, 2000.

¹² AARP, based on 1994 data.

¹³ Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits, 2000 Annual Survey*.

maintenance organizations (HMOs). The typical ceiling on out-of-pocket expenses in conventional employer plans is \$1500. Benefits are substantially more comprehensive: 71 percent of firms cover adult physical exams which Medicare does not, 87 percent cover prescription drugs, and 25 percent cover dental care. Employers on average pick up 86% of the premium for single coverage for workers, leaving the worker share of the premium at \$28 per month, compared with Medicare's \$50 a month (plus Medigap premiums that average over \$100 a month).

Over an individual's lifetime health care expenses are greatest after reaching retirement—when incomes are lower and savings are being drawn down. Improving Medicare benefits, even if financed by greater contributions during the working years, would smooth lifetime health spending patterns and afford greater economic security in older age.

Despite the fact that Medicare's benefits do not compare favorably with employer coverage, it is noteworthy that Medicare beneficiaries report higher satisfaction with Medicare than do working families with their own coverage. Fifty-seven percent of Medicare beneficiaries say that are very satisfied with Medicare, compared with 46 percent of working families covered by employer health insurance.¹⁴

A Commonwealth Fund survey of 50–70 year old adults finds strong support for Medicare.¹⁵ Older adults trust Medicare, and value its reliability. Almost two-thirds of all adults 50–64 would like the option of buying into Medicare early, and 86 percent of uninsured older adults would like that option. Preference for Medicare may reflect the predominance of the fee-for-service option in Medicare, while most employer plans are limited to one or more managed care plans. Or it may reflect an appreciation for the fact that Medicare will be there over time, and a concern that as serious illness or disability strikes, and older adults are unable to continue working, private coverage may be unavailable or unaffordable.

Supplemental Coverage Needed by Medicare Beneficiaries

Unlike employer coverage where workers rarely purchase supplemental coverage, nine of ten Medicare beneficiaries obtain supplemental coverage to augment Medicare's benefits. About 38 percent of Medicare beneficiaries have coverage from a current or former employer.¹⁶ About 23 percent are covered by individually-purchased private supplemental insurance (Medigap), 15 percent are enrolled in Medicare+Choice plans, and 13 percent are covered in part or in full by Medicaid. About one in ten Medicare

¹⁴ Kaiser/Commonwealth, *Working Families at Risk: Coverage, Access, Costs, and Worries*, Kaiser/Commonwealth 1997 National Survey of Health Insurance, December 1997.

¹⁵ Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis, *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70*, The Commonwealth Fund, July 2000.

¹⁶ Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

beneficiaries are covered by traditional Medicare only. The ability of Medicare beneficiaries to supplement Medicare's benefit with additional coverage is undoubtedly a factor in the high satisfaction with Medicare reported by beneficiaries. On the other hand, the extent of supplemental coverage attests to the perceived inadequacy of the Medicare benefit package.

Not all Medicare beneficiaries are able to afford supplemental coverage, nor is coverage with prescription drug benefits available to those with serious health problems. A recent study by a team of investigators at the University of California, Los Angeles, supported by The Commonwealth Fund reported that 17 percent of beneficiaries with incomes below \$10,000 had no supplemental coverage, compared with 5 percent of those with incomes above \$25,000.¹⁷ Similarly, employer-sponsored supplemental coverage is much lower as is Medigap coverage for lower income beneficiaries.

Nor does supplemental coverage always include prescription drug benefits. Only about half of Medicare beneficiaries have year-long supplemental prescription drug coverage.¹⁸ Prescription drug coverage is quite expensive, and Medigap plans that cover prescription drugs (Plans H-J) are subject to underwriting and exclude poor health risks. In 2000 Medigap annual premiums for Plan J including prescription drugs averaged \$3,252 for a 65-year old woman.¹⁹ Even Plan E plans that exclude prescription drugs average annual premiums of \$1,320—\$110 a month, on top of Medicare Part B premiums that are now \$600 a year. While standardization of Medigap policies has reduced confusion, not all plans are in compliance with federal standards on minimum loss ratios, and many plans offer poor value at high cost.²⁰

Most disturbing is the trend in future coverage. Eighty-one percent of employers report that they are planning to increase retiree health premiums and/or cost-sharing in the future, and 40 percent are cutting back on prescription drugs.²¹ Thirty percent are planning to terminate coverage for future retirees.

Medicare+Choice plans have enrolled about 6 million beneficiaries. Better benefits and lower cost-sharing are major reasons why beneficiaries choose managed care plans. But instability in the managed care market and the withdrawal of plans either nationally or from selected geographic areas raise questions about the long-term future of this option. Medicare+Choice plans are increasing monthly premiums, and reducing

¹⁷ Nadereh Pourat, Thomas Rice, Gerald Kominsky, and Rani E. Snyder, "Socioeconomic Differences in Medicare Supplemental Coverage," *Health Affairs*, 19:5, Sept/Oct 2000.

¹⁸ Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, The Commonwealth Fund, January 2000.

¹⁹ Quotesmith.com as cited in Marilyn Moon, *Assessing the President's Proposal to Modernize and Strengthen Medicare*, Commonwealth Fund, January 2000.

²⁰ General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards, 1988-93*, August 12, 1995.

²¹ McArdle, Coppock, Yamamoto, and Zebrak, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, Hewitt Associates, October 1999.

benefits especially prescription drug benefits.²² As a result the number of beneficiaries enrolled in Medicare+Choice peaked in 1999 at 6.3 million; such plans now cover 5.6 million people.

If private market trends continue, Medicare beneficiaries will be increasingly reliant on the individual, Medigap market to supplement Medicare's basic benefits. Without the advantage of pooling risk through employer groups or managed care health plans, this market has shown signs of spiraling premium costs for options that include prescription drugs on top of already high administrative costs. Further increases may well expand the proportion of beneficiaries who can afford only basic Medicare benefits.

Options to Improve Medicare Benefits and Reduce Cost-Sharing

Given the serious financial burdens and barriers to needed care for Medicare beneficiaries and the increasing unreliability of supplemental coverage, consideration should be given to improving Medicare's benefits. In a Commonwealth Fund-supported study by Marilyn Moon and colleagues at the Urban Institute being released today,²³ four options for improving Medicare's benefit package are simulated:

- Option 1 combines Part A and Part B, replaces the current deductibles with a single combined annual deductible of \$400, and introduces a \$3,000 annual beneficiary limit on cost-sharing and deductible expenses. It would increase Medicare outlays by an estimated \$2.2 billion in 2000.
- Option 2 reduces the Part A deductible to \$200 per spell of illness, and increases the Part B deductible to \$200; Part B coinsurance is reduced to 10 percent, a new 10 percent coinsurance on home health services is introduced; and all cost-sharing and deductible expenses are subject to a \$2,000 annual beneficiary limit. It would increase Medicare outlays by an estimated \$14.8 billion in 2000.
- Option 3 eliminates the Part A deductible and all Part A cost-sharing, and increases the Part B deductible to \$200 but eliminates Part B coinsurance. This improved coverage is financed by increasing the Part B premium to \$105 per month, achieving near budget-neutrality (estimated budget savings of \$1.7 billion in 2000).
- Option 4 adds a prescription drug benefit with 50 percent coinsurance, a \$2,500 limit on beneficiary cost-sharing, and a \$26 monthly premium.

The first three options reduce out-of-pocket spending by improving covered Medicare benefits and/or reducing or eliminating the need to purchase costly Medigap coverage. The fourth option introduces coverage for a currently uncovered benefit, prescription drugs, and could be combined with any one of the first three options.

²² Marsha Gold and Lori Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001*, The Commonwealth Fund, April 2001.

²³ Stephanie Maxwell, Marilyn Moon, and Matthew Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.

Under all four options both the elderly and the disabled would experience a reduction in total out-of-pocket expenses, including private insurance premiums, cost-sharing for covered services, and expenses of noncovered services. The elderly would save \$27 per capita under Option 1, \$240 under Option 2, and \$763 under Option 3. The disabled ages 45–64 would save \$103, \$280, and \$408 respectively under Options 1, 2 and 3. The disabled would particularly benefit from a prescription drug benefit. Option 4 would save the elderly \$181 per person, and the disabled ages 45–64 \$824 per person.

Savings would be greater for beneficiaries with serious health problems. The Urban Institute team estimates that elderly beneficiaries in poor health without supplemental coverage would save \$285, \$587, and \$1591 under Options 1, 2, and 3. For low-income women over age 85 in poor health, savings would be even greater at \$495, \$753, and \$2092.

On average, out-of-pocket spending for elderly beneficiaries would decline from the current rate of 21.7 percent of income to 21.5 percent under Option 1, 20.0 percent under Option 2, and 16.4 percent under Option 3. Option 4 if enacted alone would reduce spending to 20.4 percent of income.

Option 3, by eliminating the need for private supplemental insurance is an important way to improve efficiency in coverage for Medicare beneficiaries. Consolidating coverage under Medicare produces savings through reduced administrative costs by eliminating the need to coordinate two sources of coverage. Medicare administrative costs are also lower than private insurance plans since it doesn't need to maintain reserves to protect against adverse risk selection, nor are marketing or sales commissions needed.

Some beneficiaries, however, could face higher costs. About 20 percent of Medicare beneficiaries are hospitalized in a given year.²⁴ Under Option 1 replacing the current Medicare Part B \$100 deductible with a combined A/B deductible of \$400 would result in higher costs for the 80 percent of beneficiaries without a hospital episode during the year. For beneficiaries without supplemental coverage, the immediate effect would be a substantially higher overall deductible.

Similarly, for retirees with employer-sponsored coverage much depends on how employers respond to improved Medicare benefits. If employers pick up the higher Part B premiums under Option 3, most beneficiaries with retiree coverage would gain. If any savings to employers were devoted to improving other benefits (such as prescription drugs), beneficiaries would gain further. But employers could use the improvement in Medicare benefits as an opportunity to drop retiree coverage even more rapidly than is currently anticipated.

²⁴ U.S. House of Representatives, Committee on Ways and Means, *2000 Green Book*, October 6, 2000.

State Medicaid programs would also be expected to benefit from an improvement in Medicare benefits. This is particularly true under Option 4 with the addition of prescription drugs to Medicare, a benefit now covered by most Medicaid programs. But the reduced cost-sharing under Options 1, 2, and 3 would also provide fiscal relief to state governments. Improved Medicare benefits might be coupled with increased state responsibility for coverage of low-income families under Medicaid or the Children's Health Insurance Plan.

Conclusion

For more than 35 years, the Medicare program has assured health and economic security for older and disabled Americans. Understanding the strengths of the program and its contributions to improving health outcomes and access to health services is an important foundation on which to build.

Medicare beneficiaries are heterogeneous. Some fit the stereotype of vigorous and well-to-do seniors. But others are older widows living alone, some are in nursing homes, some are terminally ill, and some live on quite modest incomes. These are the faces of Medicare, and they should be kept foremost in mind as new ideas for modernizing Medicare's benefits are developed and considered. Improving Medicare's benefits—not just looking for savings or shifting costs to beneficiaries—should be an important priority.

Reducing the financial burden beneficiaries already bear, and the increasing burden they are expected to face over the next 25 years, should be a priority for use of federal budgetary outlays. We should remember that a considerable portion of the federal budgetary surplus was generated by the Balanced Budget Act. An estimated \$1 trillion of the \$5.6 trillion 10-year surplus came from a slow-down in Medicare outlays, in large part as a result of BBA, and the slow-down in Medicaid outlays, an unintended consequence of welfare reform.²⁵

Ten percent of the Medicare BBA savings came from increased beneficiary premiums, as home health services were moved from Part A to Part B and subject to 25 percent beneficiary premium contributions.²⁶ For example, the Part B premium in 2006 was raised by over 50 percent by the BBA. As a result of the BBA, over \$50 billion of the 10-year budget surplus came from higher premiums charged to Medicare beneficiaries. Returning this contribution to beneficiaries in the form of improved benefits and reduced cost-sharing is worthy of consideration.

Thank you for this opportunity to testify. I would be pleased to answer any questions.

²⁵ Karen Davis, Cathy Schoen, and Stephen C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine*, 260, December 11/25, 2000.

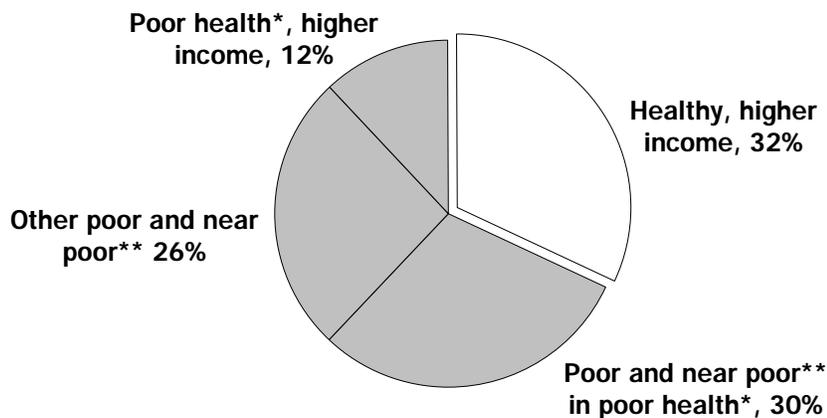
²⁶ Marilyn Moon, Barbara Gage, and Alison Evans, *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997*, The Commonwealth Fund, September 1997.

Medicare and Beneficiary Protection

- **Primary source of health insurance for 39.5 million elderly and disabled beneficiaries in 2000; 70 million beneficiaries projected in 2025**
- **Medicare was designed to ensure financial protection to beneficiaries and access to care**
 - **Despite this, out-of-pocket spending for elderly beneficiaries will increase from \$3,142 in 2000 to \$5,248 in 2025 in constant 2000 dollars**
 - **Out-of-pocket spending will increase as a percent of income from 21.7% in 2000 to 29.9% in 2025**



Two in Three Medicare Beneficiaries have Health Problems* or Live on Low Incomes



*In fair or poor health or disabled, under age 65.

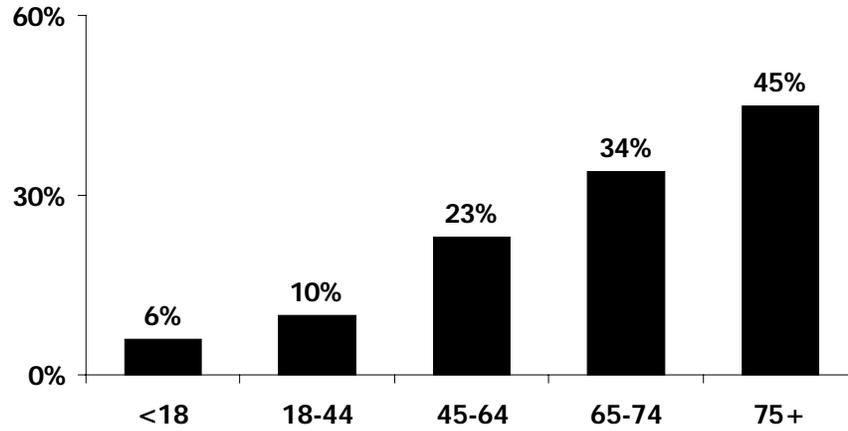
**Near poor include those with incomes between 100 and 199% of the Federal Poverty Level.

Source: Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.



Likelihood of Chronic Conditions Increases with Age

Percent limited in activities because of chronic conditions

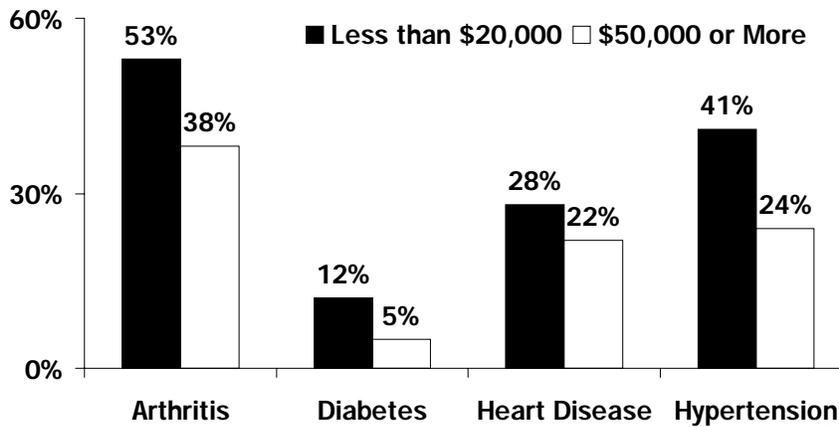


Source: Laura Trupin and Dorothy Rice, *Health Status, Medical Care Use, and Number of Disabling Conditions in the United States*, Disability Statistics Abstract Number 9 (June 1995), National Institute on Disability and Rehabilitation Research.



Low-Income Elderly Face Higher Risk of Chronic Conditions

Percent of adults age 65 and over with a chronic condition

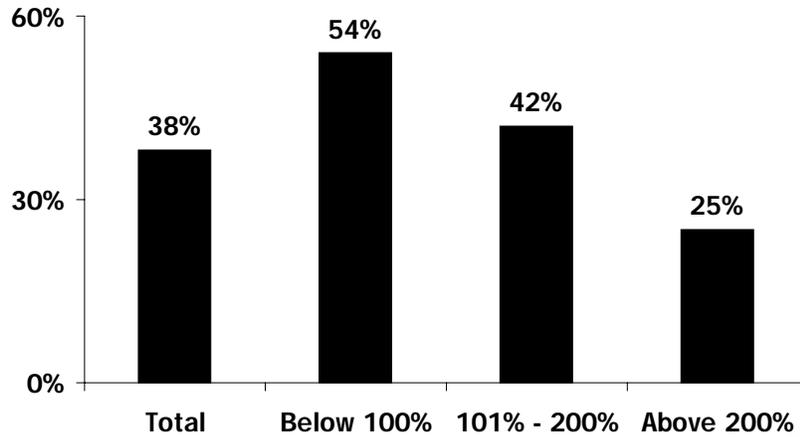


Source: National Academy on an Aging Society analysis of 1994 National Health Interview Survey data.



Medicare Beneficiaries in Fair or Poor Health, by Poverty Status, 1997

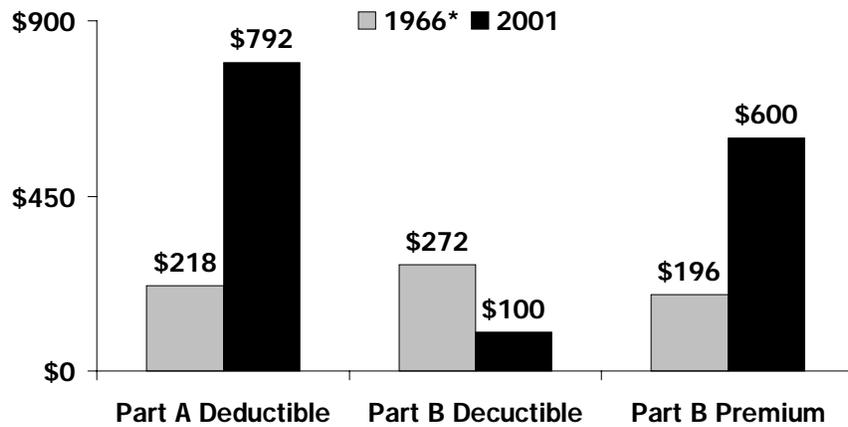
Percent of beneficiaries in fair or poor health



Source: Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.



Medicare Cost Sharing, 1966 and 2001



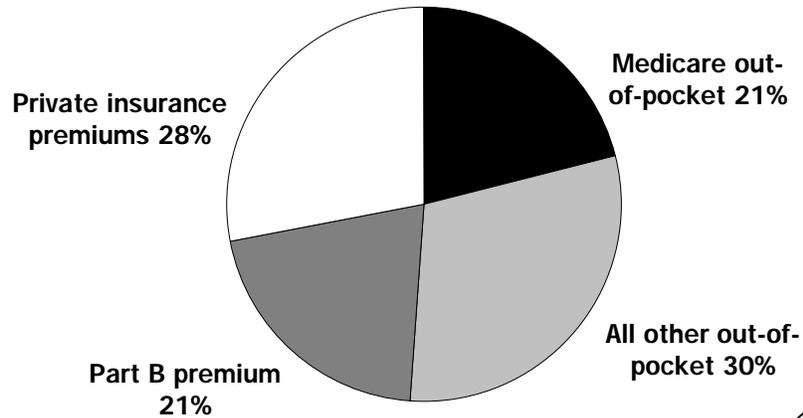
*1966 figures are in 2001 dollars.

Calculated by Karen Davis based on Bureau of Labor Statistics CPI data and HCFA, Office of the Actuary.



Out-of-Pocket Health Expenditures for the Non-Institutionalized Elderly, 2000

\$3,142 per beneficiary

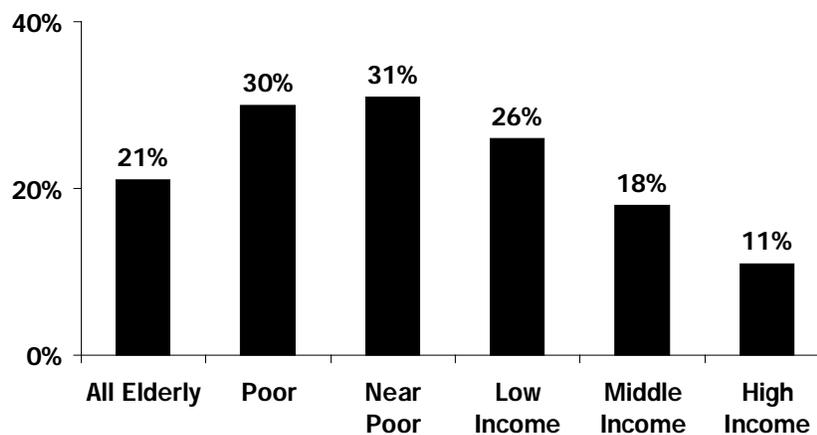


Source: Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.



Medicare Beneficiaries Pay a High Percentage of Income for Health Care, 1996

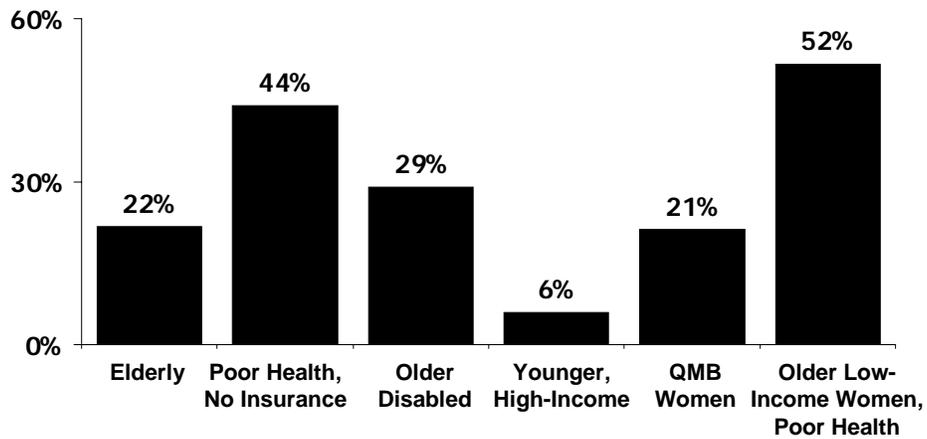
Total health spending as a percent of family income



Source: M. Moon, C. Kuntz, and L. Pounder, *Protecting Low-Income Medicare Beneficiaries*, The Commonwealth Fund, December 1996.



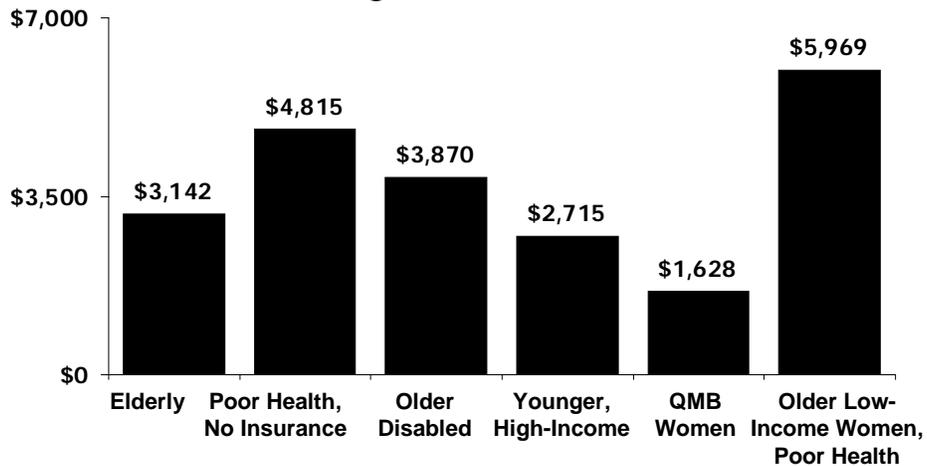
Out-of-Pocket Spending as a Share of Income Among Cohorts, 2000



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



Per Capita Out-of-Pocket Spending Among Cohorts, 2000

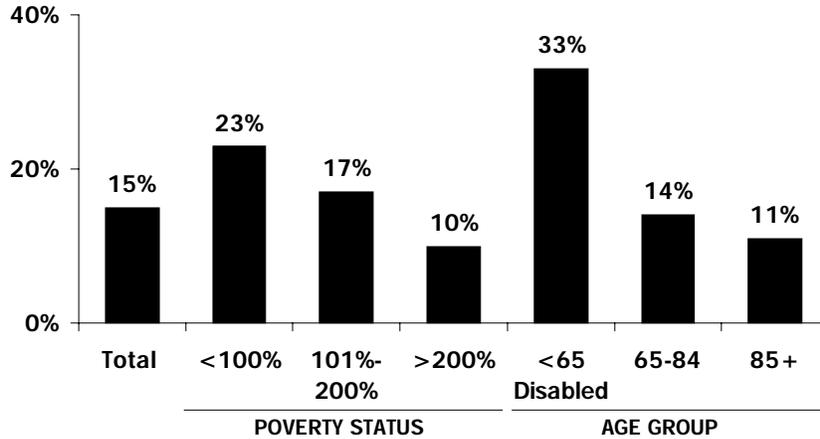


Source: Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001.



Difficulties with Access to Health Care, by Poverty Status and Age Group

Percent of beneficiaries reporting difficulties with access to health care*



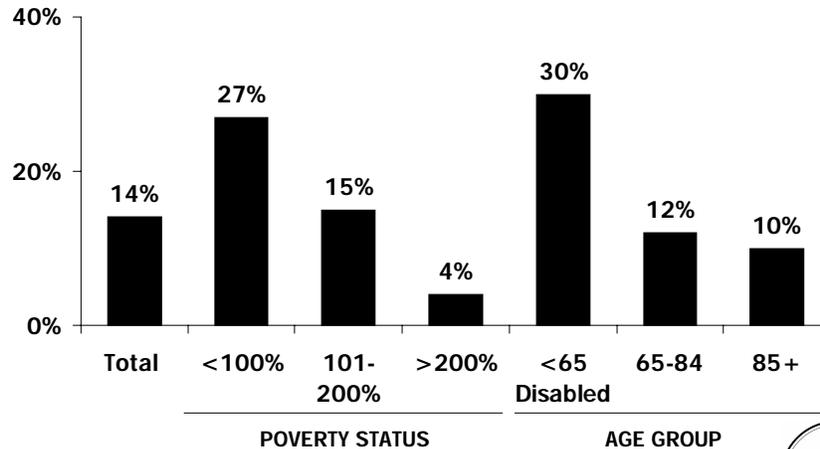
* Difficulties with access to health care refers to beneficiaries who either needed medical care but didn't get it, put off or postponed care, were unable to see a specialist when needed, or reported that it was extremely, very, or somewhat difficult to get care.

Source: Schoen, et al., *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.



Problems Paying Medical Bills, by Poverty Status and Age Group

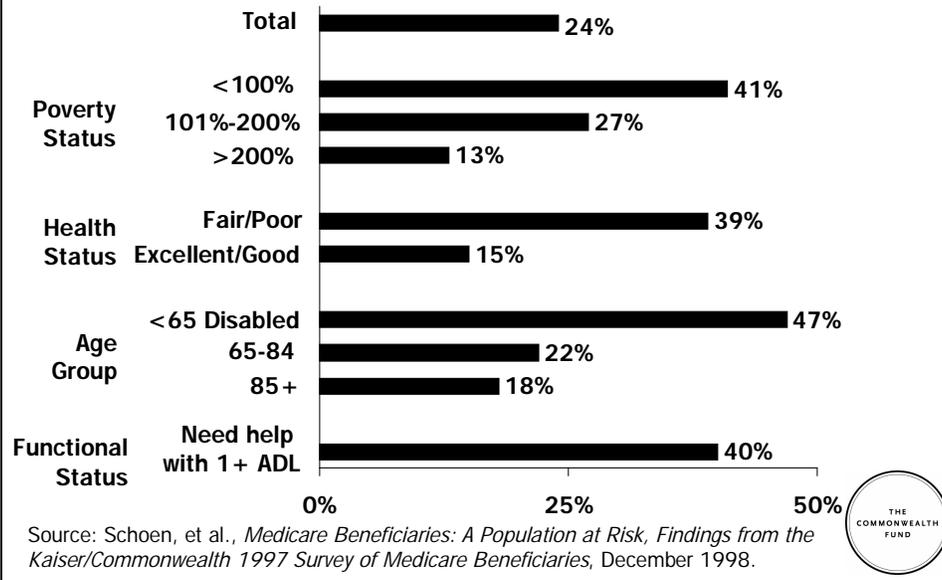
Percent of beneficiaries saying it was "very difficult" to pay medical bills or that they had spent all savings as a result of medical bills



Source: Schoen, et al., *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998.



Medicare Beneficiaries Experiencing Access or Cost Difficulties, by Poverty Status, Health Status, Age Group, and Functional Status



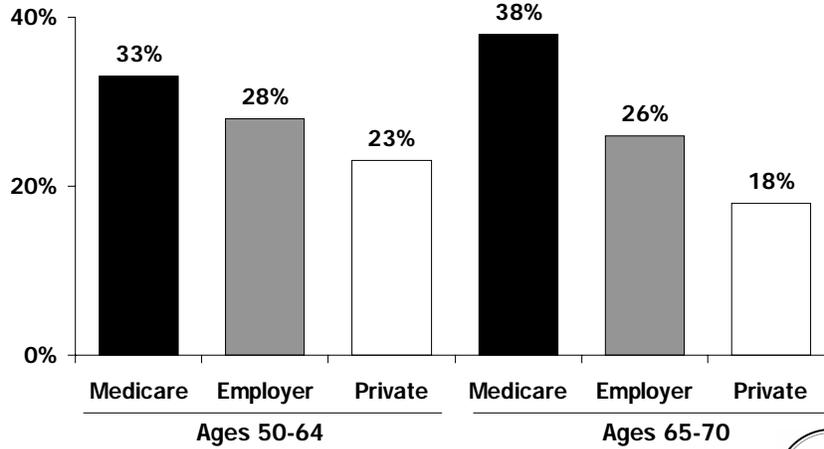
Cost-Sharing in Employer Health Plans

- The average deductible for all services in employer conventional fee-for-service plans is \$239; \$187 in PPO plans, and \$79 in Point of Service plans
- The median maximum out-of-pocket ceiling in conventional employer plans is \$1,500
- Physical exams are covered by 71% of firms; prescription drugs by 87%; dental by 25%
- The average monthly premium paid by workers for single coverage is \$28, or \$336 a year

Source: Kaiser/HRET, *Employer Health Benefits: 2000 Annual Survey*.

Which Would You Trust More to Insure Adults Age 50-64?

Percent of adults who said they would trust...

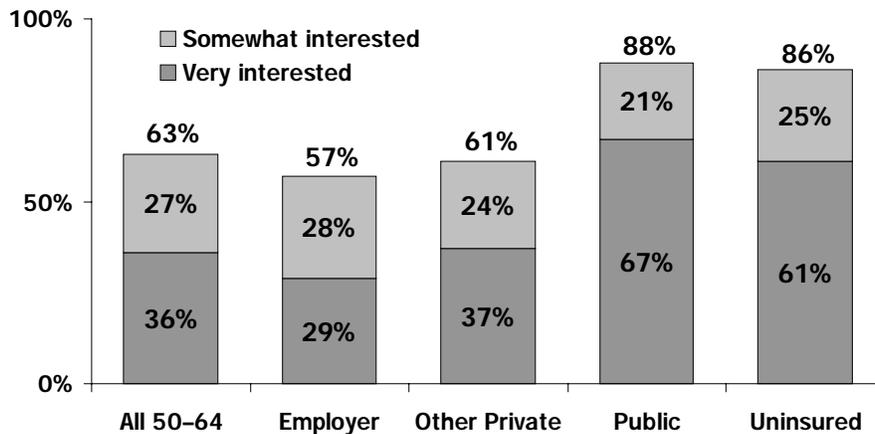


Source: Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.



Many Older Adults Are Interested in Getting Medicare Before Age 65

Percent of adults ages 50 to 64* interested in coming into Medicare early

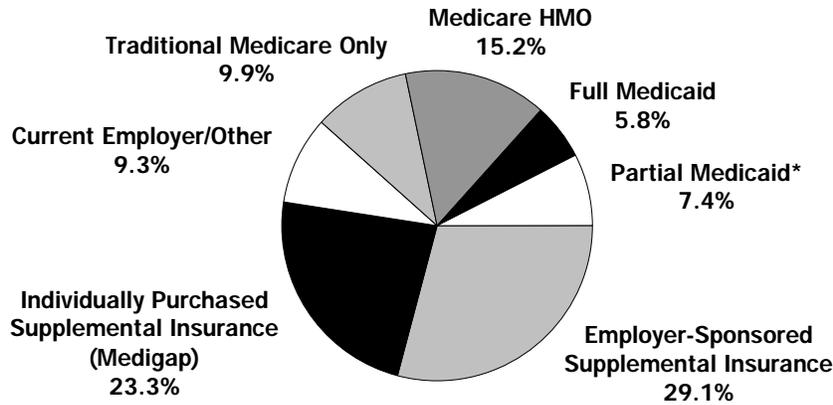


* Not currently on Medicare.

Source: Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70.



Distribution of Insurance Coverage Among Medicare Beneficiaries, 1997

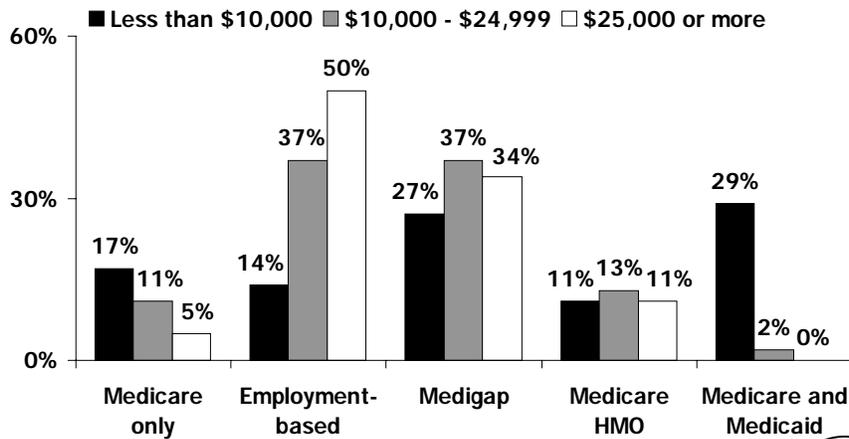


*Partial Medicaid refers to qualified Medicare beneficiaries and specified low-income Medicare beneficiaries.

Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.



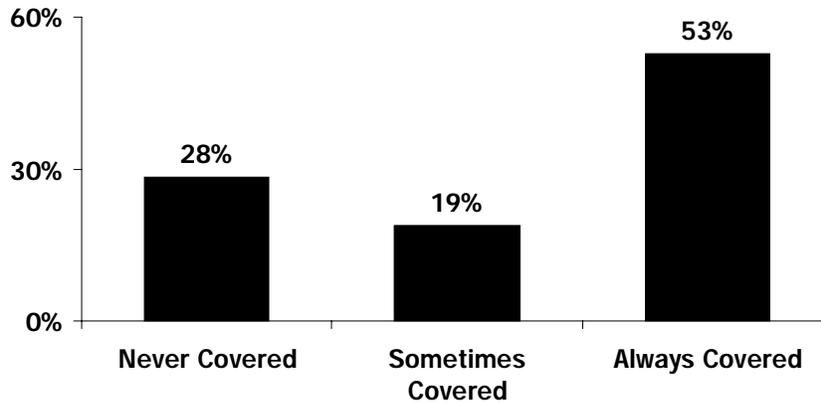
Percentage of Medicare Beneficiaries with Different Types of Supplemental Coverage, by Income, 1996



Source: Pourat, Rice, Kominski, and Snyder, "Socioeconomic Differences in Medicare Supplemental Coverage," *Health Affairs*, Vol. 19, No. 5, September/October 2000, p. 186-196.



Prescription Drug Coverage of Medicare Beneficiaries in 1996*

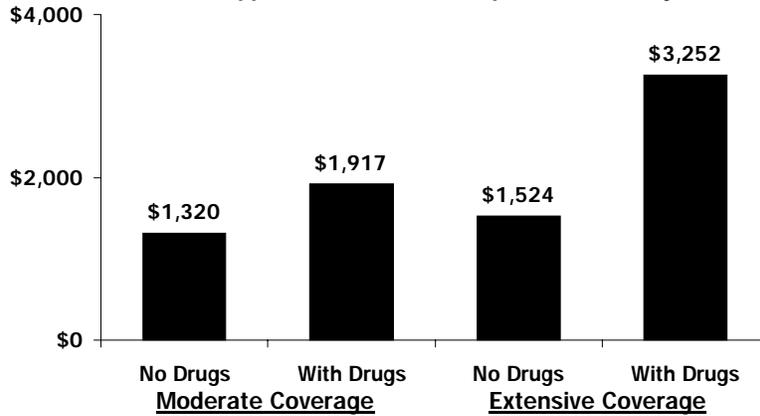


*Noninstitutionalized beneficiaries enrolled in Medicare throughout 1996.
 Source: Bruce Stuart, Dennis Shea, and Becky Briesacher, *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*, The Commonwealth Fund, January 2000.



Supplemental Medigap Coverage Expensive With or Without Prescription Drugs

Average annual Medicare supplemental insurance quotes for a 65-year old woman*

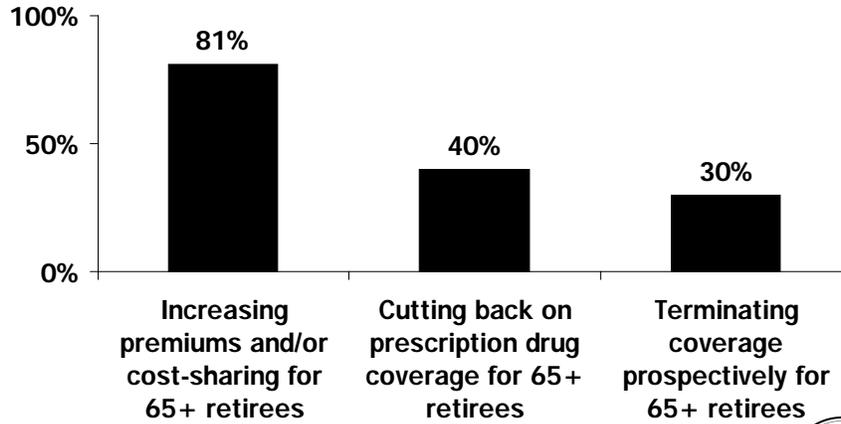


*Average of quotes from five counties: Butler County, KS, Multnomah County, OR, Sacramento County, CA, Dade County, FL, New York County, NY.
 Note: Moderate coverage without drugs is Option E, with drugs it's Option H. Extensive coverage without drugs is Option F, with drugs it's Option J.
 Source: Quotesmith.com as cited in Marilyn Moon, *Assessing the President's Proposal to Modernize and Strengthen Medicare*, prepared for the Commonwealth Fund, January 2000.



Large Employers Are Considering Restricting Retiree Drug Benefits

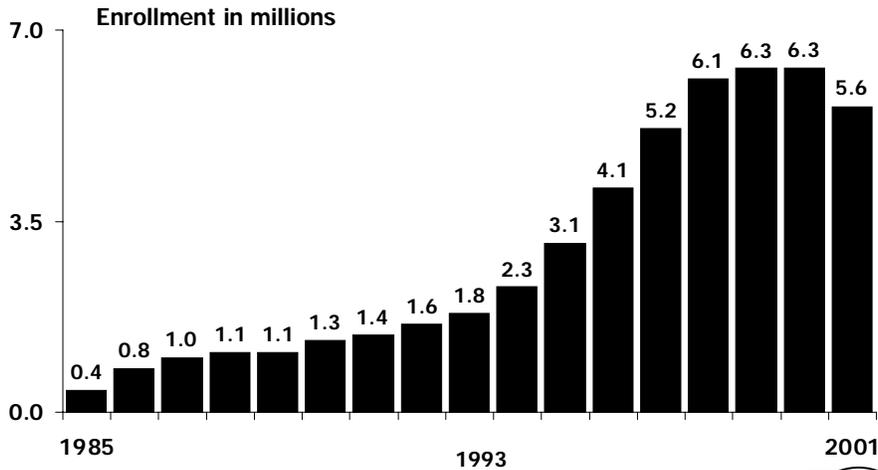
Percent of large employers who would seriously consider...



Note: Based on a survey of 600 companies with more than 1000 employees.
 Source: McArdle, Coppock, Yamamoto, and Zembrak, *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits*, Hewitt Associates, October 1999.



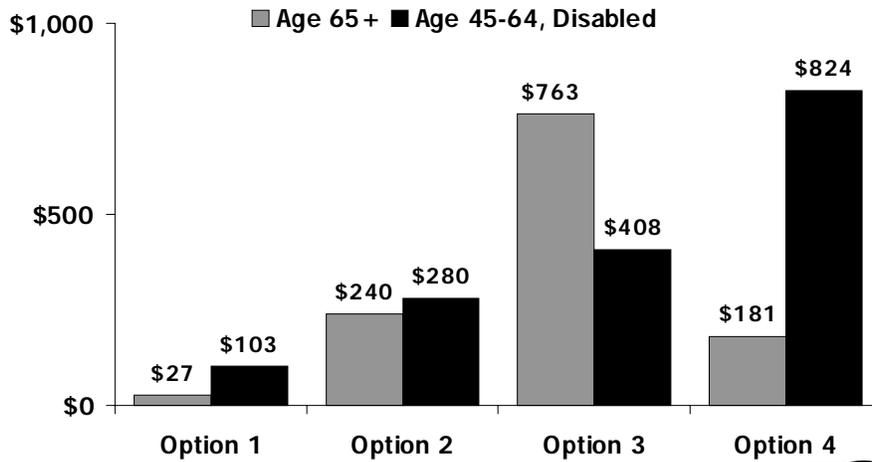
Medicare Risk/Medicare+Choice Enrollment, 1885-2001



Source: Gold and Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare + Choice Health Plans, 1999-2001*, The Commonwealth Fund, April 2001.
 Note: All data are for December of the year indicated except 2001 which is for January.



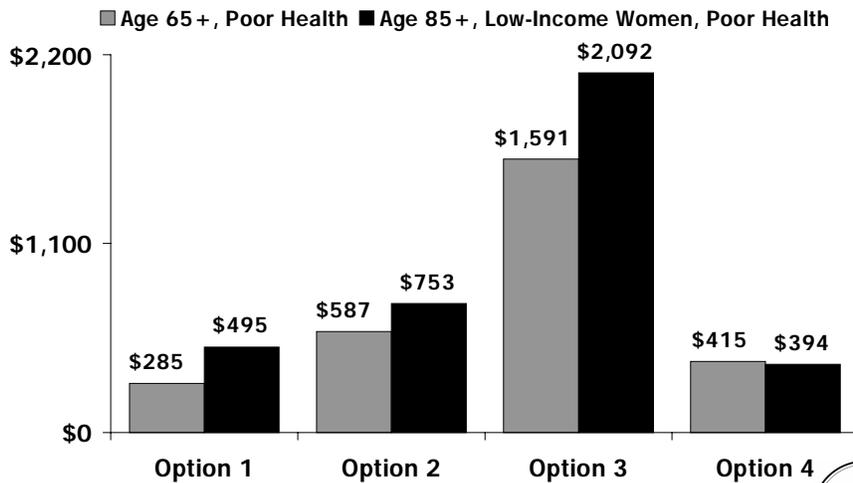
Savings in Out-of-Pocket Spending Under Four Options for the Elderly and the Disabled, 2000



Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.



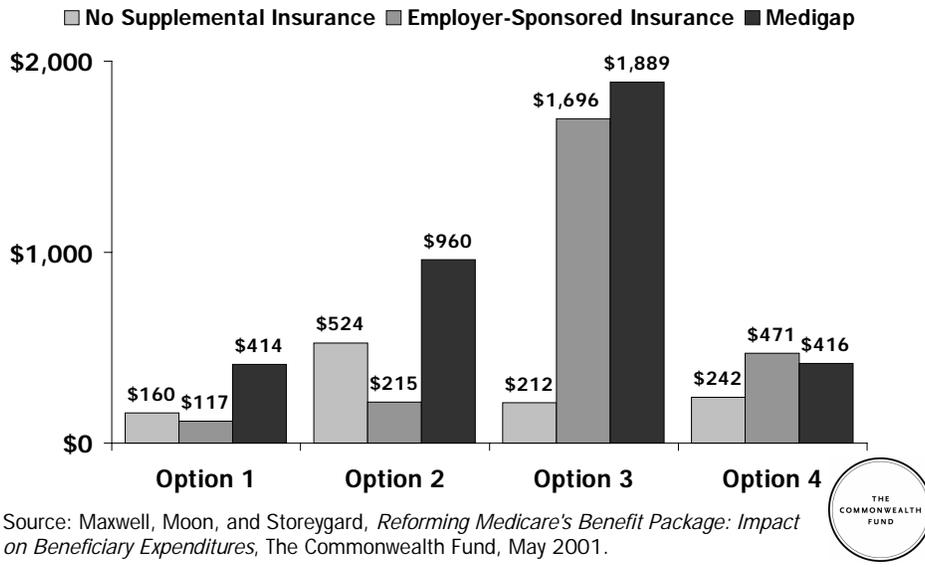
Savings in Out-of-Pocket Spending Under Four Options for the Sick Elderly and Sick, Aged, Low-Income Women, 2000



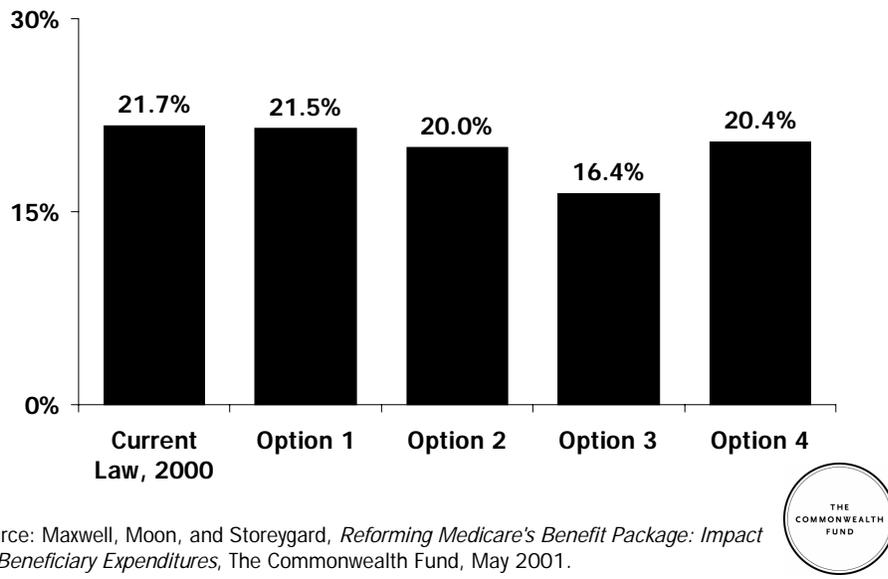
Source: Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001.



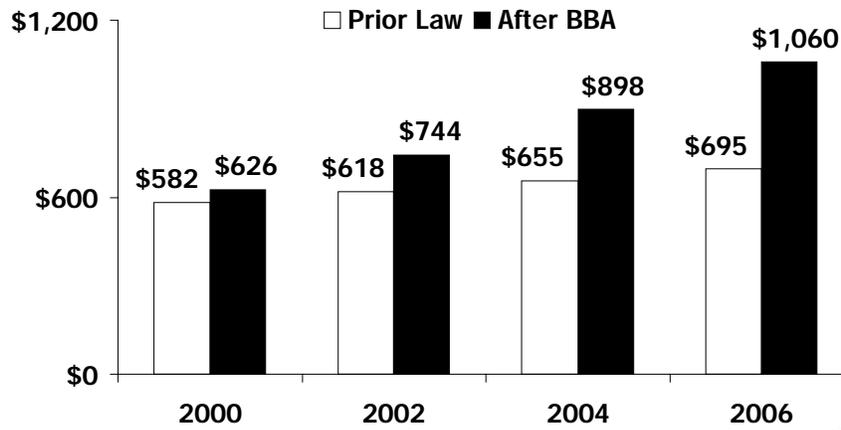
Savings in Out-of-Pocket Spending Under Four Options for Elderly Beneficiaries in Poor Health, by Type of Supplemental Coverage, 2000



Out-of-Pocket Spending as a Share of Income Among Elderly Beneficiaries, by Option, 2000



Projected Annual Medicare Part B Premiums, 2000-2006



Source: Sandy Christensen, "Memorandum on Medicare+Choice Provisions in the Balanced Budget Act of 1997", Congressional Budget Office, November 12, 1997 and the 1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.



Acknowledgements

- Maxwell, Moon, and Storeygard, *Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures*, The Commonwealth Fund, May 2001
- Maxwell, Moon, and Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001
- Schoen, Neuman, Kitchman, Davis, and Rowland, *Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries*, December 1998
- Erin Strumpf: research and production
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