MEDICARE COST-SHARING AND MEDIGAP

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

MAY 1, 2003

Serial No. 108–8

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

88–643 WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

BILL THOMAS, California, *Chairman*

PHILIP M. CRANE, Illinois
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHIL ENGLISH, Pennsylvania
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY C. HULSHOF, Missouri
SCOTT McINNIS, Colorado
RON LEWIS, Kentucky
MARK FOLEY, Florida
KEVIN BRADY, Texas
PAUL RYAN, Wisconsin
ERIC CANTOR, Virginia

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. McNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida
LLOYD DOGGETT, Texas
EARL POMEROY, North Dakota
MAX SANDLIN, Texas
STEPHANIE TUBBS JONES, Ohio

Allison H. Giles, *Chief of Staff*
Janice Mays, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

NANCY L. JOHNSON, Connecticut, *Chairman*

JIM McCRERY, Louisiana
PHILIP M. CRANE, Illinois
SAM JOHNSON, Texas
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
PHIL ENGLISH, Pennsylvania
JENNIFER DUNN, Washington

FORTNEY PETE STARK, California
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
JIM McDERMOTT, Washington
LLOYD DOGGETT, Texas

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

	Page
Advisory of April 24, 2003, announcing the hearing	2

WITNESSES

Medicare Payment Advisory Commission, Glenn M. Hackbarth, Chairman	8
Blue Cross and Blue Shield Association, and Anthem Blue Cross and Blue Shield, Richard White	18
Rice, Thomas, UCLA School of Public Health and, Neuman, Patricia, Henry J. Kaiser Family Foundation	26
United American Insurance Company, Torchmark Corporation, and Maynard, Cooper & Gale, P.C., Stephen W. Still	22

SUBMISSIONS FOR THE RECORD

American Association for Homecare, statement	49
American Medical Association, statement	50
Coalition to Promote Choice for Seniors, statement	51
Health Insurance Association of America, statement and attachments	51
National Association of Health Underwriters, statement and attachment	61

MEDICARE COST-SHARING AND MEDIGAP

THURSDAY, MAY 1, 2003

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 12:12 p.m., in room 1100 Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 24, 2003
No. HL–4

CONTACT: (202) 225–1721

Johnson Announces Hearing on Medicare Cost-Sharing and Medigap

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on rationalizing Medicare cost-sharing and supplemental insurance policies. **The hearing will take place on Thursday, May 1, 2003, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 12:00 noon.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include program experts on beneficiary cost-sharing under the Medicare and Medigap supplementary insurance coverage. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The structure of Medicare beneficiary cost-sharing in the traditional fee-for-service program reflects the insurance practices prevalent when Medicare began in 1965. Today, Medicare's beneficiaries are confronted with irrational and confusing cost-sharing which does not reflect the current delivery of health care.

In 1965, employer-sponsored group plans had two sets of benefits—one for inpatient hospitalizations and the other for physician services. Employer plans long ago shed this distinction, and created a combined plan with a combined deductible. Medicare, in contrast, still has two different deductibles—an $840 deductible for Part A and a $100 deductible for Part B. This means that when a beneficiary is hospitalized for an inpatient procedure, and less likely to be sensitive to pricing issues, the beneficiary is faced with a significant deductible. In addition, after a beneficiary has been hospitalized for 60 days, the beneficiary must then pay $210 coinsurance per day for days 61 through 90, and even more when the hospital stay extends beyond 90 days. Moreover, Medicare pays nothing if a beneficiary is hospitalized more than 150 days.

In contrast, when a beneficiary receives outpatient care, and is arguably more sensitive to costs, the beneficiary must pay the separate $100 Part B deductible, which has not increased since 1991, while health costs have doubled. Part B has different coinsurance depending on the service—none for home health or lab tests, 20 percent for physician services and supplies, and close to 50 percent for hospital outpatient services.

Unlike 97 percent of private health policies, the Medicare fee-for-service program still lacks catastrophic insurance protection for those with serious health conditions. The other glaring omission is a lack of an outpatient prescription drug benefit.

In total, due to cost-sharing obligations and Medicare's limited benefit package, more than 40 percent of seniors' health care costs are not covered by Medicare. As a result, 9 out of 10 beneficiaries have some type of supplemental coverage. Those

with retiree coverage from their former employers generally receive generous benefits, including catastrophic protection and good prescription drug coverage. The poorest beneficiaries receive wrap-around coverage through Medicaid.

Medicare's confusing and irrational cost-sharing has led more than one-quarter of beneficiaries to purchase Medigap insurance in the individual, private insurance market. In 1990, Congress created 10 standardized Medigap policies. Nine out of 10 of those policies, which comprise more than 90 percent of the Medigap market, must cover the Part A deductible, and the most popular Medigap policy covers both deductibles. Numerous studies have demonstrated that covering the deductibles has led to markedly higher Medicare spending because beneficiaries become insensitive to costs. In addition, only the three most expensive Medigap plans cover prescription drugs, and that coverage is limited. Yet, 8 of the 10 plans are required to cover foreign travel insurance, while most beneficiaries never leave the country. Medicare coverage has changed since 1990, but Medigap plans have been frozen in time. Researchers have shown that Medigap policyholders sometimes pay more than $100 in premium to cover the Part B $100 deductible, illustrating the poor value of some Medigap plans.

In announcing the hearing, Chairman Johnson stated, "Seniors face a confusing hodge-podge of copayments and deductibles in Medicare. The system is irrational and difficult to navigate. Simplifying and modernizing cost-sharing will make coverage easier to understand and will strengthen the Medicare program over the long term. I believe we can better design both Medicare and Medigap so that seniors and people with disabilities get the most for the health care dollars they spend."

FOCUS OF THE HEARING:

Thursday's hearing will focus on improving Medicare's cost-sharing structure and reforming Medigap coverage.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by the close of business, Thursday, May 15, 2003. Those filing written statements that wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Good midday to you.

Today we continue our examination of the Medicare program and how we can strengthen and improve Medicare for seniors and the taxpayers financing the program.

Medicare's current beneficiary cost-sharing was enacted nearly 4 decades ago and has separate deductibles and cost-sharing rules for Medicare Part A and Part B. When Medicare was enacted, the Part B outpatient deductible accounted for about 45 percent of beneficiary expenditures. Today, because it has not been indexed, it accounts for less than 3 percent. In Medicare, we charge seniors two different deductibles, and make the deductible for inpatient hospitalization eight times higher than the outpatient deductible.

Why should the deductible be eight times higher for a health service that a patient desperately needs and can't avoid? Why would we impose new cost-sharing on a patient who has been lying on her back in a hospital bed for 2 months? While most private health plans provide catastrophic protection for their enrollees, why does Medicare expose the sickest patients to unlimited cost-sharing?

Medicare currently covers slightly more than half of all health-care services seniors consume when you include prescription drugs and long-term care. As a result, 90 percent, 9 out of 10 beneficiaries, feel compelled to carry supplemental insurance to fill in the holes that Medicare does not cover. Many receive retiree coverage through their former employer. The poor receive assistance through Medicaid. More than one-quarter of beneficiaries purchase Medigap insurance themselves.

In 1990, Congress created 10 standardized Medigap policies to assist beneficiaries in choosing plans. After 12 years, it's time to revisit the adequacy and structure of these plans. All 10 Medigap plans are required to cover the coinsurance that beneficiaries must pay under Medicare—for example, the 20 percent of the cost of a physician's visit. Nine out of 10 of these plans are required to cover the Part A inpatient hospital deductible, which is currently $840.

The most popular Medicare policy covers both the Part A hospital deductible and the $100 Part B deductible for physicians' services, and 8 of 10 policies are required to cover foreign travel insurance, just in case beneficiaries travel to France, though many never leave their home State.

At the same time, only the three most expensive Medigap policies cover prescription drugs, though prescription drugs are seniors' most pressing need. Numerous studies have demonstrated that Medigap's first dollar coverage of medical services has resulted in excessive Medicare spending because items and services appear to be free. Beneficiaries with Medigap consume $1,400 more in Medicare services than beneficiaries without supplemental coverage, and $500 more than beneficiaries with employer-sponsored insur-

ance. This higher utilization drives up costs for everyone, premiums for Medicare beneficiaries without Medigap coverage, and cost to taxpayers.

In addition, the prescription drug coverage mandated in Medigap is wholly inadequate. Yet, Medigap premiums continue to rise. From 1998 to 2000, average premiums rose 16 percent for plans without drug coverage, and more than twice as fast, 37 percent, for plans with drug coverage. In addition, premiums vary dramatically for identical plans in the same location.

Weis Ratings, Inc. analyzed Medigap premiums in 2001. A 65-year-old man living in Fort Myers, Florida would pay about $3,600 for Plan J from Physicians Mutual Insurance Company, but only $2,700 with United Health Insurance Company through American Association of Retired Persons (AARP). That's nearly a thousand dollars less for the same policy in the same location.

The same gentleman living in Las Vegas would spend about $1,500 for Plan C with United American Insurance Company, and about half that amount, $778, with the USAA Life Insurance Company for the same policy.

Much has changed in health care and health insurance over the past 12 years, but Medigap policies have remained the same. Medigap insurers have been unable to modify their offerings in response to market changes because the 10 standard Medigap policies are set in the statute.

I believe we can do better. We can do better for Medicare fee-for-service benefits and Medigap policies, so that seniors and people with disabilities can get the best health care and the most health care for the dollar they spend.

Mr. Stark.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Honorable Nancy L. Johnson, Chairman, and a Representative in Congress from the State of Connecticut

Today we continue our examination of the Medicare program and how we can strengthen and improve Medicare for seniors and the taxpayers financing the program.

Medicare's current beneficiary cost-sharing is a relic of the program that was enacted nearly four decades ago with separate deductibles and cost-sharing rules for Medicare Part A and Medicare Part B. After examining the Medicare's complex and irrational cost-sharing structure, I conclude that a fundamental restructuring is needed.

Why would we charge seniors two different deductibles, and make the deductible for inpatient hospitalization—when a patient is least price sensitive—eight times higher than the outpatient deductible, when health care is arguably more discretionary? And why would we impose new cost-sharing on a patient who has been lying on her back in a hospital bed for two months? While most private health plans provide catastrophic protection for their enrollees, why does Medicare expose the sickest patients to unlimited cost-sharing?

The answer, of course, is that Congress has not changed the law to modernize the Medicare program. Consider that when Medicare was enacted the Part B outpatient deductible accounted for about 45% of beneficiary expenditures. Today, because it has not been indexed it accounts for less than three percent.

Notwithstanding, Medicare currently covers slightly more than half of all health care services seniors consume, when including prescription drugs and long-term care. As a result, 90 percent—that's right 9 out of 10 beneficiaries—feel compelled to carry supplemental insurance to fill in the holes that Medicare does not cover. Many receive retiree coverage through their former employer. The poor receive assistance through Medicaid. But more than one-quarter of beneficiaries purchase Medigap insurance themselves.

In 1990, Congress created 10 standardized Medigap policies to assist beneficiaries in choosing plans. After 12 years, it's time to re-visit the adequacy and structure of these plans. All 10 Medigap plans are required to cover the coinsurance that beneficiaries must pay under Medicare, for example, the 20 percent of the costs of a physician visit. Nine out of 10 of these plans are required to cover the Part A inpatient hospital deductible, which is currently $840. The most popular Medigap policy covers both the Part A hospital deductible and the $100 Part B deductible for physician services. And 8 of the 10 policies are required to cover foreign travel insurance, just in case these beneficiaries travel to France, though many never leave their home State! At the same time, only the three most expensive Medigap policies cover prescription drugs, though prescription drugs are seniors' most pressing need.

Numerous studies have demonstrated that Medigap's first dollar coverage of medical services has resulted in excessive Medicare spending because items and services appear free to beneficiaries. Beneficiaries with Medigap consume $1,400 more in Medicare services than beneficiaries without supplemental coverage, and $500 more than beneficiaries with employer-sponsored insurance. This higher utilization drives up costs for everyone—premiums of Medicare beneficiaries without Medigap coverage and costs to taxpayers. In addition, the prescription drug coverage mandated in Medigap is wholly inadequate.

Yet Medigap premiums continue to rise. From 1998 to 2000, average premiums rose 16 percent for plans without drug coverage, and more than twice as fast, 37 percent, for plans with drug coverage. In addition, premiums vary dramatically for identical plans in the same location. Weiss Ratings, Inc. analyzed Medigap premiums in 2001. A 65-year-old man living in Ft. Myers, Florida would pay about $3,600 for Plan J from Physicians Mutual Insurance Company, but only $2,700 with United Healthcare Insurance Company through AARP. That's nearly $1,000 less for the same policy in the same location! The same gentleman living in Las Vegas would spend about $1,500 for Plan C with United American Insurance Company, but about half that amount—$778—with the USAA Life Insurance Company for the same policy.

Much has changed in health care and health insurance over the past 12 years. But Medigap insurers have been unable to modify their offerings in response to these market changes because the 10 standard Medigap policies are set by statute. I believe that we can better design both Medicare fee-for-service benefits and Medigap policies so that seniors and persons with disabilities get the most for the health care dollars they spend.

Mr. STARK. Well, thank you, Madam Chair.

This is the third year in a row that we have had this same hearing, and maybe at some point somebody will introduce some legislation and we can make the changes. If there's anything wrong, we only have ourselves to blame. Nobody else is doing this. So, our inaction is the root cause of any problems that do exist.

I hope that we can at least have one hearing on the forthcoming Chairman's mark to reform Medicare before that legislation. It's my understanding that we're going to be marking that up and finishing it by Memorial Day, and it would certainly be of much more benefit to have a hearing on those issues so that we can understand what will happen to Medicare in general.

Cost-sharing for Medicare could benefit from a fresh look and some adjustment. I think there's no question about that. We have made precious little change to Medicare in the last 9 years, and unlike the insurance companies who will testify today, they don't just set one policy and then never change their corporate policies over 10 years or they generally cease to exist. So, we might take a page from free enterprise and be a little bit more active in improving Medicare from day to day as we go along. There is also, of course, a gap due to the lack of coverage under prescription drugs and other important issues.

I would like to make sure that we don't blame—when you talked at length in your opening statement about the first dollar coverage driving up utilization, I would like to point out that the beneficiaries have nothing to do with this. The only choice that a beneficiary in Medicare has is basically whether or not to go to a primary care physician. They cannot, for the most part, go to a surgeon directly, because they have to have a referral. People don't go to take a test just for the hell of it. If I told you you could go down and have a pap smear at George Washington this afternoon, would you go down and have one? I wouldn't go have a colonoscopy just because it was cheap.

Chairman JOHNSON. Under Medicare, though, I would certainly have the right to.

Mr. STARK. People don't do that, and most specialists won't even give you the test unless you're referred. So, what I'm suggesting is that it is those benefits to which we are referred by our primary care physician, and we don't make those decisions as patients. We do what our primary care docs tell us, and as you're well aware, Medicare doesn't cover much primary care or preventative care. It only covers procedures to which we have been referred. So if, in fact, there is a lot of extra utilization, it is the physicians and/or other providers who cause this and not our beneficiaries. I hope we can keep that in mind.

I would like to note that I intend to introduce a catastrophic bill once again that would, in effect, put a limit on cost-sharing for the current Medicare beneficiaries. I hope the Chair would look forward to cosponsoring that with me, because if we intend to do it, we can improve Medicare. That would be, of course, for the beneficiaries, a great improvement, and we would then bring it up to what most policies that we enjoy as Members of Congress and provide that same protection for our senior citizens. I know the Chair would like to join with me in doing that, and I hope to have that in the hopper soon.

So, with that, I look forward to hearing the suggestions of our witnesses about how we might adjust the current Medigap coverage to be of more benefit to the beneficiaries. Thank you again for holding this hearing, and I hope we can make the changes before we have the fifth hearing.

[The opening statements of Mr. Stark and Mr. Ramstad follow:]

Opening Statement of the Honorable Fortney Pete Stark,* a Representative in Congress from the State of California

*As part of my opening remarks, I would like to submit the following statement on behalf of our Ways and Means colleague, Congresswoman Stephanie Tubbs Jones:

Thank you for hosting this very important hearing, and thank you for welcoming me to participate. I appreciate this opportunity to hear from our invited guest concerning the irrational and complex issues surrounding rationalizing Medicare cost-sharing and supplemental insurance policies.

As all of you are aware, Medicare plays a vital role in the lives of our Nation's seniors. However, while the program remains popular among seniors, it has several major limitations such as the lack of prescription drug coverage, and the lack of catastrophic insurance protection.

Most individuals cope with these problems by navigating a complex array of supplemental coverage programs, such as: employer coverage, Medigap programs and Medicaid. Currently, employer-based programs and State Medicaid spending are declining rapidly. Moreover, the cost of cost-sharing payments or of supplemental coverage premiums can be overwhelming for elderly individuals living on fixed incomes.

For example, according to the Kaiser Family Foundation, an elderly woman with the median income level of $1,400 per month would spend half of her monthly income on the Part A deductible alone. It is time for Medicare to eliminate disparities in supplemental coverage and provide health care services Americans can understand and depend on.

And, finally, many of my colleagues today have called for higher deductibles for outpatient expenses, since individuals are more likely to utilize fewer so-called discretionary services if they bear a higher percentage of the cost. Yet, as you will hear in testimony today, this change would raise the cost of preventative and diagnostic services, making such services prohibitively expensive for low-income populations, especially those who lack adequate supplemental coverage. By discouraging utilization of outpatient coverage, higher cost-sharing on outpatient care will force the most vulnerable Americans to wait until their health deteriorates further before seeking medical assistance. Seniors in my district cannot wait that long. Madam Chairwoman and Members of the Subcommittee, I look forward to working with all of you to iron out the irrational and complex issues that leave many seniors and disabled citizens at a disservice.

Opening Statement of the Honorable Jim Ramstad, a Representative in Congress from the State of Minnesota

Madame Chair, thank you for holding this important hearing today.

Medicare's confusing and counterintuitive cost-sharing system and the lack of a basic prescription drug benefit are unacceptable and must be changed. The status quo does not meet the needs of our seniors or reflect the realities of today's health care delivery.

The Medicare system is difficult to navigate and unfair to Medicare seniors. There is a high deductible for hospital services that are usually beyond the patient's control and a relatively low deductible for services that are more controllable. Many preventive services are difficult to obtain. Seniors face long delays before getting access to medical technology that could save or improve their lives. There is no catastrophic protection for high out-of-pocket costs, nor is there a basic prescription drug benefit in the traditional program. Employer-sponsored supplemental insurance is diminishing, States are cutting Medicaid funding, and Medigap policies are costly and incomplete.

Without a doubt, Medicare faces major challenges. But one thing is clear—we must keep our promise to our Nation's seniors to improve Medicare and preserve it for current and future beneficiaries.

Thank you, Madame Chair, for your leadership in examining these difficult issues and leading the charge on Medicare reform.

Chairman JOHNSON. Thank you, Mr. Stark. As we start this hearing, I do want to remind Members that David Walker, in his testimony before the full Committee on April 9th, did remind us that in just 10 years we will have to find new revenues to cover the outlays that we will be obliged to make just in the hospital trust fund. So, we will have to find those revenues from cutting other programs or increasing taxes. Ten years is not a long time away. So, we do have to be very conscious in the legislation we're going to write this year in how we make Medicare stronger, more financially secure, and of better service to our seniors.

Mr. Hackbarth, welcome.

STATEMENT OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you, Chairman Johnson, other Members of the Committee. I appreciate the opportunity. I know time is short, so I will just make a few brief points.

One, of course, the Medicare program has played a vital role in providing financial protection and access to care for millions of Americans. Having said that, if we were to start over today with a clean piece of paper, the benefit package that currently exists is probably not the one we would design. The package does not cover some important services like prescription drugs. Other services are covered inadequately—for example, hospital outpatient care—and there is no limit on cost-sharing, no catastrophic coverage.

We have depended on supplementation of various sorts to fix these problems, but depending on supplementation is, itself, problematic. About 10 percent of Medicare beneficiaries have no supplemental coverage; they're not eligible for Medicaid and they don't have employer-sponsored retiree coverage. They don't have Medigap coverage. These beneficiaries tend to be lower income beneficiaries, beneficiaries eligible by virtue of disability, rural beneficiaries, and they have somewhat more health problems than average.

In addition to that, employer-based coverage and coverage through the Medicare+Choice (M+C) program, and even Medicaid, are under pressure. Employers, as you well know, are increasingly stepping back from offering retiree coverage. The net effect of these developments is that, over time, we will become increasingly dependent on Medigap coverage as our primary source, our major source of supplementation.

Medigap coverage, of course, plays a vital role, and it's critical for many Medicare beneficiaries, but it's not without its problems. It is often inadequate, particularly in the area of prescription drug coverage. It can be expensive, in part because of the high cost associated with individual coverage, but also in part probably because of the design of the coverage. It is sold through individual markets primarily, insurers feel compelled to use underwriting and rating policies that tend to increase cost and reduce availability for beneficiaries with health problems. Finally, it can be very confusing for Medicare beneficiaries.

In our June 2002 report, Medicare Payment Advisory Commission (MedPAC) analyzed the Medicare benefit package and some possible improvements. I want to emphasize that in this instance we did not make any specific recommendations. Our purpose here was more analytic and educational. There were, however, some important themes on which there was a consensus among the Commissioners.

First of all, Medicare needs a better back-end coverage, if you will; that is, coverage for beneficiaries using the most services—for example, catastrophic coverage or better coverage for extended hospital and skilled nursing stays.

Reduced coinsurance for some services is important. As you know, the coinsurance is quite high currently for hospital outpatient and mental health services.

Third, it seemed to us that moving away from the separate Part A and Part B deductibles which, of course, are an artifact of the history of the program, toward a single combined deductible would make sense.

Finally, it seemed to us that if, in fact, we have constrained resources as, of course, we do, that having at least some cost-sharing on all services might be a reasonable thing to require.

So, those are my initial comments. I welcome the chance to discuss them.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission

Chairman Johnson, Congressman Stark, distinguished Subcommittee Members. I am Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss cost-sharing in the Medicare program and supplemental insurance.

Thank you for the opportunity to participate in this important discussion. MedPAC has considered the design of Medicare's benefit package and beneficiary cost-sharing over the past several years. We also have examined the different ways that beneficiaries supplement Medicare benefits, including Medigap; how various forms of supplementation affect access to care; and the costs of the health care services beneficiaries use. In my remarks today, I would like to draw on that work, and highlight several key points:

- The limitations of the Medicare benefit package and the characteristics of its cost-sharing cause beneficiaries to enroll in a variety of supplemental insurance programs. These include employer-sponsored retiree insurance, Medigap, and Medicaid.
- Beneficiaries' access to different forms of supplemental coverage vary by their characteristics (such as where they worked, their financial resources, and their health care preferences) and where they live.
- Supplemental coverage improves beneficiaries' access to care, their use of necessary services and reduces their cost-sharing on covered services. It also increases Medicare spending and total administrative costs.
- Medigap in particular may still leave beneficiaries with a significant degree of liability and its premium represents a major proportion of beneficiary out-of-pocket expense.

Limitations of the benefit package

As we discussed in our June 2002 Report to the Congress: Assessing Medicare Benefits, Medicare has provided tens of millions of older and disabled Americans with access to acute medical care—extending lives, improving health and functional status, and protecting families from impoverishment (MedPAC 2002). Changes in medical technology, as well as demographic changes, however, have drawn attention to the limitations of the basic Medicare benefit package.

By law, the Medicare benefit package is generally limited to acute care services needed for the diagnosis or treatment of illness or injury.[1] Medicare's covered services have been revised over its lifetime. These revisions have substantially expanded coverage, adding new technologies and procedures, more post-acute care, and other benefits such as selected preventive services and hospice care for those at the end of life. However, the basic structure of the benefit design has remained essentially unchanged since Medicare's inception.

Medicare beneficiaries may receive covered services in the traditional program or they may enroll in a private health insurance plan under the Medicare+Choice (M+C) program. Traditional Medicare covers health care services—furnished on a fee-for-service basis—through its two parts, the Hospital Insurance and Supplementary Medical Insurance programs, known as Parts A and B, respectively. My discussion today will focus on the benefit design and cost-sharing structure of the traditional program.

There are three serious limitations of the Medicare benefit package:

- It does not cover some important health care products and services. For example, the program does not cover outpatient prescription drugs (with limited exceptions), many preventive services (such as annual physical exams), and routine eye and dental care.

[1] Section 1862(a)(1)(A) of the Social Security Act prohibits Medicare payment for items or services that are "... not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

- It has high cost-sharing on some covered services such as outpatient care and none on others.
- It has no limit on total cost-sharing (catastrophic cap).

Cost-sharing structure. Medicare's cost-sharing structure has several weaknesses (see Table 1). Insurance theory suggests that random, non-discretionary events should be covered more fully than events that are within the insured person's discretion. In Medicare, however, the Part A hospital inpatient deductible is large ($840 in 2003), while that for physician services or other ambulatory care under Part B is small ($100) even though inpatient care is generally believed to be less discretionary and more difficult to predict than ambulatory care. Further, the low Part B deductible provides little incentive to use covered services judiciously, while the high hospital inpatient deductible may contribute to beneficiaries' perceived need for supplemental insurance.[2]

Medicare's cost-sharing provisions vary considerably among covered services and these variations may lead to inefficient choices by beneficiaries and providers. For instance, the coinsurance liability for hospital outpatient services (20–55 percent) is often substantially higher than the coinsurance that applies for ambulatory surgery centers or physicians' offices (20 percent). These discrepancies could inappropriately affect patients' or providers' decisions about the setting for care. The high (50 percent) copayment for outpatient mental health services and high coinsurance for many outpatient hospital services may create barriers to the use of these services. On the other hand, no cost-sharing on home health and lab services may increase use of those services, either because beneficiaries are more likely to demand them or providers are more likely to order them.

Limited financial protection. Medicare's benefit design and cost-sharing structure taken together determine how well beneficiaries are protected from the cost of acute illness. Medicare seeks to ensure access to clinically appropriate care and to insulate beneficiaries and their families from the risk of impoverishment associated with serious illness.

Medicare provides considerable financial protection to its enrollees; most would be much worse off without its benefits. On average, beneficiaries consumed $7,500 in health care services in 1999, of which Medicare covered 58 percent (Table 2). Moreover, Medicare covered a substantially larger share of the total for beneficiaries with the highest spending (Figure 1). For instance, on average, Medicare covered about 73 percent of the total for the 10 percent of beneficiaries with the highest total spending.

Nevertheless, Medicare's benefit design—with substantial cost-sharing for many covered services, no catastrophic cap, and no coverage for some important health care products and services—leaves beneficiaries at risk for large out-of-pocket expenses. For example, the 27 percent of total spending that Medicare did not cover for beneficiaries with the highest total spending in 1999 averaged $11,000 per person. The potential for high out-of-pocket spending is a serious problem if it reduces beneficiaries' abilities to seek needed care or comply with care recommendations. It is equally serious if the burden of out-of-pocket spending forces beneficiaries to forego or cut back on other necessities.

Supplemental coverage options

About 90 percent of Medicare beneficiaries obtain some type of additional coverage. Supplements have been available from Medicare's beginning in 1966, when it looked quite similar to the private sector insurance packages offered to the general population. Beneficiaries may obtain supplemental coverage for a variety of reasons. Many—particularly those with relatively low incomes—may prefer the known cost of a premium to the unknown costs that may be associated with an unexpected illness, and even to the predictable costs of routine medical services. Also, large employers in certain industries historically have provided retiree coverage that provides supplemental insurance at low cost to some beneficiaries. Moreover, as non-covered services, such as prescription drugs, have accounted for a growing share of beneficiaries' health care, obtaining additional coverage has become more important as one means of limiting financial risk.

Sources of additional coverage include supplements sponsored by former or current employers, individually purchased Medigap plans, and Medicaid coverage provided for low-income individuals. Also, for purposes of this discussion, additional

[2] At $100, the Part B deductible is unchanged since it was raised in 1991 and only about one-half as high as ambulatory care deductibles commonly required by PPOs for services furnished by favored (in-network) providers (Gold 2002).

benefits offered by some M+C or other Medicare managed care plans are also considered.

About one-third of all Medicare beneficiaries have **employer-sponsored** supplemental insurance (Figure 2).[3] Currently, benefits provided by employer-sponsored plans tend to be comprehensive. For example, almost all retiree plans provide some coverage of prescription drugs, and the average retiree has an out-of-pocket cap of $1,500 per year for all covered services.

Medigap—private health insurance specifically designed to wrap around Medicare's benefit design—is the second most common form of additional coverage. Twenty-seven percent of beneficiaries held Medigap policies in 2000. All policies issued since 1992, except those sold in three waiver States, have been limited to 10 standard benefit packages. The plans beneficiaries most commonly choose cover Medicare deductibles and coinsurance, but not prescription drugs.

State **Medicaid** programs provide additional coverage for certain low-income, sick, and disabled Medicare beneficiaries—about 12 percent of community-dwelling beneficiaries in 2000. People with full dual eligibility receive Medicare benefits, coverage of Medicare cost-sharing, and full Medicaid benefits, including some health care products and services—notably prescription drugs and long-term care—not covered by Medicare. Other Medicaid programs pay for Medicare premiums and/or cost-sharing, but not for Medicare's noncovered benefits.

Medicare managed care plans may offer reduced cost-sharing requirements or other benefits beyond those covered in the traditional program, such as some coverage for outpatient prescription drugs. Medicare's managed care options consist primarily of private managed care plans that participate in the M+C program, but also include plans paid on a cost basis, and those participating in various demonstration projects. About 18 percent of Medicare beneficiaries were enrolled in some form of Medicare managed care in 2000—although this share has declined to about 15 percent in 2002. Using enrollment data from M+C managed care plans as a proportion of all beneficiaries (not just community-dwelling as in Figure 2) enrollment peaked in 2000 at 15.8 percent.

Other sources of additional coverage, held by about 2 percent of beneficiaries, include benefits obtained through the Department of Veterans Affairs (VA) or the TRICARE program for military retirees.

Availability of options vary

The options for supplementing Medicare actually available to beneficiaries vary considerably because of significant differences in local market circumstances, as well as differences in beneficiaries' resources and preferences. MedPAC has investigated the factors accounting for relatively low rates of supplementation in some States. We find some States have about twice the national average of Medicare beneficiaries who lack any supplemental coverage, and this was generally true in both urban and rural areas in the State. Beneficiaries living in rural areas are more likely to be in the traditional Medicare FFS program without any supplemental coverage or to be enrolled in Medigap than those in urban areas.

We also find, however, that coverage patterns can vary among metropolitan areas—even in the same State. Tampa and Miami, for example, look very different in regard to each type of coverage. An explanation for some of the difference lies in the respective proportion of people on Medicaid, the availability of Medicare managed care, and the employment structure. Because 21 percent of Miami's senior population is living under the poverty level and Tampa's rate is 11 percent, more people in Miami may have supplementation through Medicaid.

In summary, we find that Federal and State oversight of Medicare products influence the availability and design of Medigap, employer-sponsored, and M+C options (as well as supplementation available through Medicaid). For example, some of the variation among States in Medigap enrollment may be a result of differing State regulation of those products. Nonetheless, even though State characteristics have an important influence over health insurance markets, local factors such as income and employment history are also important. All of these factors will need to be considered in the design of reforms.

Recent trends suggest that the availability of these sources of additional coverage may be declining, leaving more people with only the basic Medicare benefit package:

[3] The distributional numbers presented here come from MedPAC analyses of the 2000 Medicare Current Beneficiary Survey (MCBS) Cost and Use file and include only community-dwelling individuals.

- the number of beneficiaries enrolled in Medicare managed care has fallen, as have the number of plans participating and, in many areas, the value of the benefits offered;
- employers have scaled back on coverage for future retirees and increased premium contributions and cost-sharing for current retirees, and state that they will continue to do so in the future;
- Medigap premiums have continued to increase, raising questions about the affordability of this form of supplemental coverage; and
- fiscal pressures at the State level may cause reductions in Medicaid coverage.

Increasing numbers of beneficiaries could face greater financial risks and may experience access problems if the current sources of additional coverage are diminished and not replaced.

Effects of supplemental coverage

Access and use. Beneficiaries with additional coverage have consistently reported better access to health care than those without (MedPAC 2000). In 2000, beneficiaries with only fee-for-service Medicare compared to those with employer-sponsored or Medigap insurance were more than four times as likely to report trouble getting care; nearly five times as likely to have delayed care due to cost; and about three times as likely to lack a usual source of care. The type of additional coverage also leads to differences in access; those with coverage from public programs (Medicaid, DOD, and the VA) are less likely to report access problems than those without any supplemental coverage, but more likely to report problems than those with private supplemental coverage (MedPAC 2002).

Other research has shown that people with supplemental drug coverage also have higher use of medically appropriate therapies for conditions such as hypertension and coronary heart disease. These studies have focused particularly on use of prescription drugs (Blustein 2000, Federman 2001, Seddon 2001, Adams 2001). Our research has shown that beneficiaries without a supplemental source of coverage use fewer services deemed clinically necessary than those with a supplement (MedPAC 2002). On the other hand, some increased use may not be appropriate, as is discussed in a later section.

Out-of-pocket costs. Although the vast majority of beneficiaries obtain some type of additional insurance, they still face potentially large out-of-pocket spending (Figure 3). Beneficiaries' out-of-pocket spending includes their direct spending on services—or the associated cost-sharing—and their payments for insurance premiums, including those for Medicare Part B and any amounts for additional insurance.

Per capita out-of-pocket spending varies widely among groups with different types of supplemental coverage (Figure 4). These spending differences primarily reflect differences in premium payments for supplemental coverage and direct payments for noncovered services as opposed to cost-sharing for covered services. As might be expected, the roughly 4 million people who qualify for Medicaid benefits have relatively low out-of-pocket spending and most of what they spend goes toward services not covered by Medicare or Medicaid. About 10 million people buy Medigap policies. On average, these beneficiaries annually spend about $1,400 for noncovered services and cost-sharing, and about $1,700 for Medigap premiums. Even those who have employer-sponsored supplemental insurance, which usually provides generous benefits, still have relatively high spending for noncovered services. Beneficiaries who report being in fair or poor health spend more out-of-pocket for health coverage and for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare. These findings suggest that supplemental coverage does not fully address the limitations of Medicare's benefits.

High out-of-pocket spending may push some Medicare beneficiaries into poverty. Our analysis shows that about 11 percent with total incomes above poverty have out-of-pocket spending large enough to push them into poverty. Those with incomes just above the poverty line (100 to 110 percent) clearly have a much greater likelihood of falling into poverty than those with higher incomes.

Implications of first-dollar coverage. All of the Medigap plans, Medicaid, and some employer-sponsored plans provide generous coverage of Medicare's cost-sharing requirements. This so-called first-dollar coverage often protects beneficiaries from financial liability from the first dollar of expenditure beyond their premium.

First-dollar coverage may respond to beneficiaries' desire for convenience and to limit financial risk to the maximum extent possible, but it may not be the most efficient policy. For the Medicare program, extensive coverage of deductibles and coinsurance diminishes many of the incentives embedded in the cost-sharing structures

that are meant to encourage people to be judicious in their use of services. Therefore, coinsurance or deductibles may not affect use as expected or desired. First-dollar coverage also raises the premiums for supplemental coverage. In addition, the costs of predictable expenditures, such as the Part B deductible, are automatically included in the premium, along with insurers' administrative markup.

Medicare beneficiaries with supplemental insurance use more services and thus generate higher program expenditures than those without such coverage. This in turn increases beneficiaries' Part B premiums and the burden on tax payers. A MedPAC analysis of the 1998 MCBS found that Medicaid dual-eligible beneficiaries have the highest Medicare program expenditures, followed by beneficiaries with Medigap coverage, and then by those with employer-sponsored coverage. Medicare beneficiaries without any supplemental coverage have the lowest Medicare program expenditures. Researchers have not successfully isolated the extent to which the differences in use of care reflect people with supplemental coverage getting unnecessary care or those without supplemental coverage going without needed care (Atherly 2001).

Increased administrative costs. Multiple sources of coverage also increase administrative costs for providers and insurers. Administrative costs for insurers may include marketing, claims processing, reserves, and profit. Administrative costs for Medigap plans average about 20 percent; in comparison, administrative costs are about 11 percent for M+C plans and about 2 percent for program management of traditional Medicare—although the administrative costs for the Medicare program are thought to be both understated and insufficient. For example, the administrative budget for CMS does not include the costs of collecting payroll taxes for the Part A trust fund or of withholding Part B premiums from Social Security checks. The National Academy of Social Insurance recommended more resources for CMS to better manage the program (King 2002).

Confusion among beneficiaries. The multiple sources of supplemental coverage create a maze of options for beneficiaries. Beneficiaries have a difficult time navigating the choices, in part because they lack a basic understanding of the Medicare program (of course, understanding of the health care system by the general population is also limited). For example, only about half knew that they have health plan choices available (Stevens 2000). Beneficiaries are frequently unclear about the differences between traditional Medicare and Medicare managed care, often not knowing whether they are enrolled in a health maintenance organization or in traditional Medicare.

Beneficiaries also have difficulty understanding their Medigap insurance options, not knowing, for example, that if they drop a Medigap policy they may only be able to purchase another one under certain conditions. Confusion about Medigap was one of the reasons for the standardization of Medigap policies. Before standardization, some beneficiaries bought multiple policies, not understanding that the coverage was duplicative.

Some research suggests that many Medicare beneficiaries are not highly motivated to make choices about their insurance coverage. A recent survey found that most beneficiaries (in both FFS and M+C plans) did not give serious thought to options for insurance coverage. Only 14 percent thought seriously about options or actually changed plans, and, of those, more than one-third were either new beneficiaries (who had to make a choice) or beneficiaries who switched from one M+C plan to another (Gold 2001).

Conclusion

Uneven cost-sharing, lack of a catastrophic cap, and omission of certain services—most notably prescription drugs—have called into question the health security promised by the Medicare program. To fill the gaps in the benefit package, most beneficiaries obtain supplemental coverage, but this coverage is often costly and, for Medigap in particular, only partly effective in addressing the limitation of the Medicare benefits package. It also may contribute to inefficiency in providing health care for Medicare beneficiaries because of first-dollar coverage. The availability and affordability of supplemental coverage is, moreover, uneven across different markets, and increasingly unstable.

Although beneficiaries value their Medicare and supplemental coverage, the problems with the current Medicare benefit package and the resultant supplemental coverage system leave policymakers with difficult choices. It might be possible to improve beneficiary financial protection through adjustments to the supplemental market, however, it would be more fruitful to first directly address the limitations in the Medicare benefit package and its cost-sharing provisions.

1. Section 1862(a)(1)(A) of the Social Security Act prohibits Medicare payment for items or services that are ". . . not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

2. At $100, the Part B deductible is unchanged since it was raised in 1991 and only about one-half as high as ambulatory care deductibles commonly required by PPOs for services furnished by favored (in-network) providers (Gold 2002).

3. The distributional numbers presented here come from MedPAC analyses of the 2000 Medicare Current Beneficiary Survey (MCBS) Cost and Use file and include only community-dwelling individuals.

References

Medicare Payment Advisory Commission. Report to the Congress: assessing Medicare benefits. Washington (DC), MedPAC. June 2002.

Gold M. Trends in medical coverage that active employers receive from employers: implications for reforming the Medicare benefit package. Washington (DC), Mathematica Policy Research, Inc. April 2002.

Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC). March 2000.

Blustein J. Drug coverage and drug purchases by Medicare beneficiaries with hypertension, Health Affairs. March/April 2000, Vol. 9, p. 219–30.

Federman AD, Adams AS, Ross-Degnan D, Soumerai SB, Ayananian JZ. Supplemental insurance and the use of effective cardiovascular drugs among elderly medicare beneficiaries with coronary heart disease, Journal of the American Medical Association, October 10, 2001, Vol. 286, No. 14, p. 1762–1763.

Seddon M, Ayanian JZ, Landrum MB, et al. Quality of ambulatory care after myocardial infarction among Medicare patients by type of insurance and region, American Journal of Medicine, 2001. Vol. 111, p. 24–32.

Adams, AS, Soumerai, SB, Ross-Degnan D. Use of antihypertensive drugs by Medicare enrollees: does type of drug coverage matter? Health Affairs. 2001, Vol. 20, No. 1, p. 276–286.

Atherly A. Supplemental insurance: Medicare's accidental stepchild, Medical Care Research and Review. June 2001, Vol. 58, No. 2, p. 131–161.

King, K, Burke, S and Docteur, E., eds., Final report of the study panel on Medicare's governance and management—matching problems with solutions. Washington (DC) National Academy of Social Insurance, July 2002.

Stevens B, Mittler J. Making Medicare+Choice real: Understanding and meeting the information needs of beneficiaries at the local level. Princeton (NJ), Mathematica Policy Research, Inc. November 2000.

Gold M, Justh N. How salient is choice to Medicare beneficiaries? Monitoring Medicare+Choice: Fast Facts. Washington (DC), Mathematica Policy Research, Inc. January 2001, No. 5.

Table 1. Medicare benefits and cost-sharing requirements, 2003 *

Services	Beneficiary cost-sharing
Part A	
Inpatient hospital (up to 90 days per benefit period plus 60 lifetime reserve days)**	$840 for the first stay in a benefit period Days 1–60; fully covered Days 61–90; $210 per day coinsurance 60 lifetime reserve days: $420 per day
Skilled nursing facility (up to 100 days per benefit period)	Days 1–20; no coinsurance Days 21–100: $105 per day
Hospice care: for terminally ill beneficiaries	Nominal coinsurance for drugs and respite care
Part B	
Premium	$58.70 per month
Deductible	$100 annually
Physician and other medical amount services (including supplies, durable medical equipment, and physical and speech therapy)	20 percent of Medicare-approved
Outpatient hospital care	20 percent of 1996 national median charge updated to 2000
Ambulatory surgical services	20 percent of Medicare-approved amount
Laboratory services	None
Outpatient mental health services	50 percent of Medicare-approved amount
Preventive services	20 percent of approved amount (none for Pap smear, pneumococcal vaccine, flu shot, prostate specific antigen (PSA) test)

Table 1. Medicare benefits and cost-sharing requirements, 2003 *— Continued

Services	Beneficiary cost-sharing
Both Part A and Part B	
Home health care for homebound beneficiaries needing skilled care	None

* These benefits and cost-sharing requirements apply to traditional Medicare. Medicare+Choice plans can deviate from these requirements, but they must cover the same services, cost-sharing cannot be higher on average, and CMS must approve each plan's cost-sharing and benefit package.

**A benefit period begins when a patient is admitted to the hospital for inpatient care and ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days.

Source: Centers for Medicare & Medicaid Services.

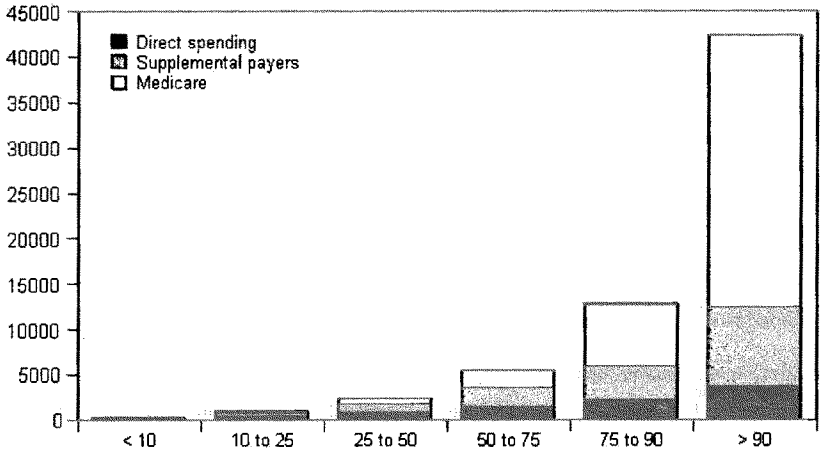
Table 2. Total spending on health services for Medicare beneficiaries, by source of payment, 1999

Source	Amount per capita	Percent of total
Medicare	$4,370	58%
Supplemental payers	1,984	26
Beneficiaries' direct spending	1,158	15
Total	7,512	100

Note: Sample of 9,647 includes community-dwelling beneficiaries who participated in traditional Medicare in 1999. Supplemental payers include all public-sector and private-sector supplemental coverage. Beneficiaries' direct spending includes their out-of-pocket spending on covered and non-covered acute care services. It excludes premiums and long-term care services. Percentage do not sum to 100 because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 1999.

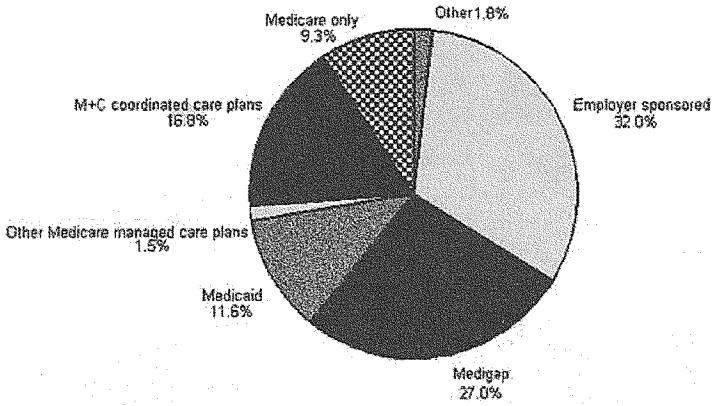
Figure 1. Per capita spending on health services, by source of payment, 2000



Note: Analysis includes fee-for-services beneficiaries living in the community.

Source: MedPAC analysis of 2000 Medicare Current Beneficiary Survey, Cost and Use file.

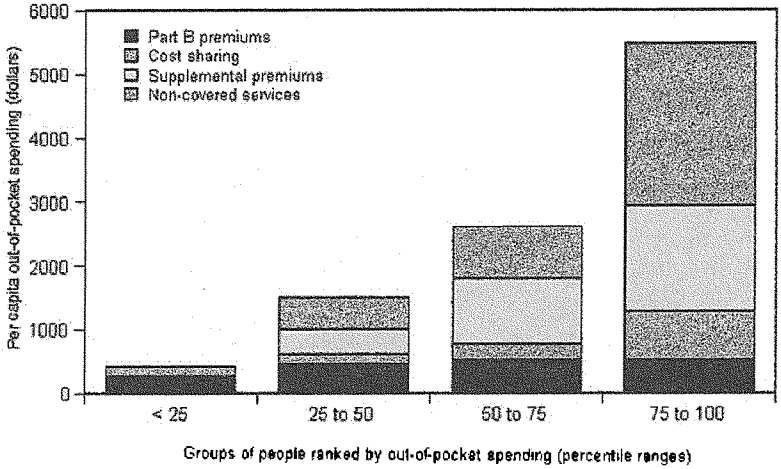
Figure 2. Sources of supplemental coverage among beneficiaries living in the community, 2000



Note: M+C (Medicare+Choice). Other includes federal and state programs not included in other categories. Analysis includes beneficiaries living in the community. The share of all beneficiaries (community-dwelling and institutionalized) in M+C coordinated care plans was 15.8% in 2000.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2000; Medicare managed care plans monthly summary report, CMS, December 2000.

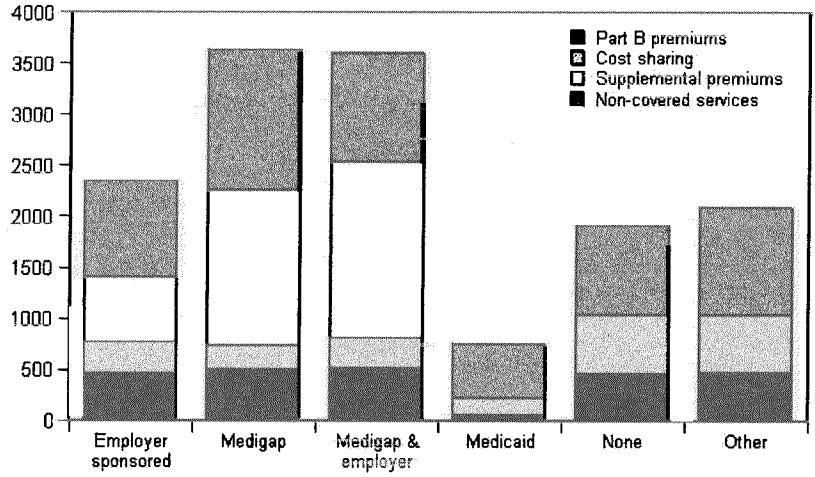
Figure 3. Composition of out-of-pocket spending, by out-of-pocket spending level, 2000



Note: Sample of 9,577 includes community-dwelling beneficiaries who participated in traditional Medicare in 2000. Out-of-pocket spending includes beneficiaries' direct spending in four categories: the Part B premium, cost sharing for covered services, supplemental premiums, and non-covered services. The vertical bars represent per capita out-of-pocket spending, divided into the four categories, for each group. For example, the < 25 group illustrates per capita out-of-pocket spending for beneficiaries with the 25 percent smallest values (the lowest quartile). Likewise, the 75 to 100 group illustrates per capita out-of-pocket spending for beneficiaries with the 25 percent largest values (the highest quartile).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use File, 2000.

Figure 4. Variation and composition of out-of-pocket spending, by type of supplemental insurance, 2000



Note: Analysis includes fee-for-services beneficiaries living in the community.

Source: MedPAC analysis of 2000 Medicare Current Beneficiary Survey, Cost and Use file.

Chairman JOHNSON. Thank you very much.
Mr. White.

STATEMENT OF RICHARD WHITE, VICE PRESIDENT, INDIVIDUAL PRODUCT MANAGEMENT, ANTHEM BLUE CROSS AND BLUE SHIELD, ON BEHALF OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. WHITE. Madam Chairman and Members of the Subcommittee, I am Richard White, Vice President of Individual Product Management for the Southeast Region of Anthem Blue Cross and Blue Shield. Thank you for the opportunity to testify today on behalf of the Blue Cross and Blue Shield Association.

All Blue Cross and Blue Shield plans offer Medigap insurance, and collectively, we are the largest Medigap issuer in the Nation. Blue Cross and Blue Shield plans support comprehensive Medicare reform and believe that, with an increasing reliance on private competitive markets, Medicare can achieve the value, choice, and innovation that has been realized in the private sector.

Medicare's deductibles and cost-sharing requirements leave significant gaps that expose beneficiaries to sizeable financial risk. These cost-sharing requirements are much higher than those in most employer-sponsored plans today, and do not protect beneficiaries from the open-ended financial burdens of catastrophic illness.

To protect themselves against high, out-of-pocket costs and fill Medicare's coverage gaps, U.S. General Accounting Office has estimated that more than one-fourth of Medicare beneficiaries rely on

Medigap; that is, private, individually purchased supplemental insurance. Blue Cross and Blue Shield plans believe that the Medigap market is working well. An overwhelming majority of Medicare beneficiaries express satisfaction with their Medigap coverage and consider their policies a good or excellent value. Beneficiaries particularly value the peace of mind of predictable monthly expenses and knowing that they do not have to hassle with the medical bills from their providers.

Plans are widely available and there are many insurers to choose from.

Finally, Medigap policies are required to meet stringent consumer protection rules that were put in place as a result of legislation passed by Congress.

I would like to make three points regarding potential changes to Medigap. First, we applaud the Administration's recent effort to encourage States to take advantage of a provision in existing law that allows for approval of innovative benefits in addition to the standardized benefits of Medigap.

Standardization of Medigap policies, in effect since 1992, has simplified the purchasing decision for beneficiaries and made it easier for beneficiaries to compare benefits and premiums. At the same time, standardization means that benefit packages have been frozen in time and do not reflect many of the design features typical in today's private market. This has significantly limited plans' ability to innovate to keep Medigap premiums affordable.

For example, Medigap carriers offering prescription drug coverage have not been able to introduce formularies or tiered copayments, create incentives for use of generic drugs, or use other incentives and methods that we typically apply in the private market. Similarly, we cannot provide disease management programs with our Medicare supplement products.

Until recently, many States have been reluctant to approve innovative benefits. Examples of innovative benefits proposed in previous years, but not approved, include generic prescription drug benefits, vision care benefits, and cost-sharing changes such as a $5 copayment for physicians' services. The Administration's initiative is a very promising development and we believe it will help assure that Medigap continues to provide valuable benefits to Medicare beneficiaries.

Second, we believe the legislative changes to Medigap should be made in the context of comprehensive Medicare reform. Medigap policies will need to be revised in order to be consistent with a restructured Medicare program. Multiple rounds of Medigap redesign would increase costs for insurers that ultimately are borne by the consumer, and would increase the potential for confusion among seniors. This could result in three or four different types of Medigap programs out there.

Third, we believe that beneficiaries should continue to have the option to purchase varying degrees of financial protection, including "first dollar" coverage, that covers all of the required Medicare deductibles and cost-sharing. It is critical to remember that beneficiaries want "first dollar" coverage. Many older Americans live on fixed incomes and fear that unpredictable medical bills would make it difficult to meet their monthly expenses. Medigap law already re-

quires all insurers to offer Plan A, which does not cover the Part A and B deductibles, in addition to the other policies they may choose to carry. Yet, it represents only 3 to 4 percent of the plans sold. So, consumers aren't picking that option.

It would also be inappropriate to eliminate "first dollar" coverage solely for people who choose to purchase Medigap coverage while others continue to have this option through their employer-based coverage, including the Federal Government and military retirees through the new TRICARE For Life program.

Finally, "first dollar" coverage helps assure that beneficiaries get the medical services they need.

Thank you for the opportunity to submit this testimony on behalf of the Blue Cross and Blue Shield Association.

[The prepared statement of Mr. White follows:]

Statement of Richard White, Vice President, Individual Project Management, Anthem Blue Cross and Blue Shield, on behalf of the Blue Cross and Blue Shield Association

Good afternoon, Madame Chairwoman and Members of the House Ways and Means Health Subcommittee. I am Richard White, Vice President of Individual Product Management for the Southeast Region of Anthem Blue Cross and Blue Shield. I am here today representing the Blue Cross and Blue Shield Association (BCBSA). BCBSA represents 42 independent Blue Cross and Blue Shield Plans throughout the nation that together provide health coverage to 84.9 million—nearly thirty percent—of all Americans. We appreciate the opportunity to testify before you today on Medicare cost-sharing and Medigap.

All Blue Cross and Blue Shield (BCBS) Plans offer Medigap insurance, and collectively we are the largest Medigap issuer in the nation. BCBS Plans have a unique point of view because we are a major presence in all aspects of the Medicare program. BCBS Plans process 90 percent of all Medicare Part A claims and about 67 percent of all Part B claims. Collectively, BCBS Plans are also the largest Medicare+Choice (M+C) provider in the country, providing comprehensive coverage to close to 1 million beneficiaries.

We are pleased that the Committee is examining ways to modernize Medicare and bring Medicare beneficiaries the types of choices and innovations that working Americans now enjoy. BCBSA supports comprehensive Medicare reform that will assure that the program remains financially stable and secure so that it can successfully serve both current and future beneficiaries. We believe that with an increasing reliance on private competitive markets, Medicare can achieve the value, choice and innovation that have been realized in the private sector.

My testimony focuses on two areas:

I. An overview of today's Medigap marketplace; and
II. BCBSA's Comments Regarding Potential Changes to Medigap

I. Overview

While Medicare provides valuable coverage for the health care needs of over 40 million elderly and disabled beneficiaries, its deductibles and cost-sharing requirements leave significant gaps that may expose beneficiaries to sizeable financial risk. For example, according to MedPAC, in 1999 Medicare beneficiaries consumed on average $7,500 in health care services—of which Medicare covered only 58 percent.

Traditional Medicare's cost-sharing requirements are much higher than those in most employer-sponsored plans today, and do not protect beneficiaries from the open-ended financial burdens of catastrophic illness. Features of Medicare cost-sharing include:

- Two separate deductibles: a high deductible for Part A ($840 in 2003) for a hospital admission, which can be charged more than once a year and a separate $100 deductible for Part B;
- No cap on beneficiary out-of-pocket spending; and
- Little financial protection against the cost of very long hospital stays (e.g., no coverage after 150 days).

In addition, Medicare does not provide coverage for many services such as prescription drugs, dental care, vision care, and hearing aids.

To protect themselves against high out-of-pocket costs and fill Medicare's coverage gaps, roughly 90 percent of Medicare beneficiaries acquire some form of supplemental coverage, either through employer-sponsored plans, Medicaid, a Medicare+Choice plan, or Medigap—individually purchased private policies.

According to the General Accounting Office (GAO), more than one-fourth of Medicare beneficiaries relied on private Medigap policies in 1999 for supplemental insurance.

The Medigap Market Provides Valuable Benefits

The Medigap market is working well:

- **Beneficiaries are extremely satisfied:** Medicare beneficiaries express overwhelming satisfaction with their Medigap coverage. A 2000 survey conducted by American Viewpoint, an opinion research firm, found that 89 percent of Medigap policy holders are satisfied with their coverage. A strong majority—76 percent—also said that, considering the premiums they pay, their policies were a good or excellent value. American Viewpoint found beneficiaries particularly value the peace of mind of knowing that they can afford their medical bills and do not have to hassle with medical bills.
- **Wide availability of plans:** In 2001, GAO found that Medigap plans are widely available, and beneficiaries have many insurers to choose from. In fact, on average, 28 insurers in each State offered Plan F, the most popular Medigap plan.
- **All seniors are guaranteed the opportunity to choose any plan, regardless of their health conditions.** Current law requires that seniors are given a 6-month open enrollment period to purchase any Medigap policy they choose when they first enroll in Medicare Part B. During this period, Medigap insurers may not deny coverage to applicants or adjust premiums based on health status. There are also other open enrollment opportunities for beneficiaries under certain circumstances (e.g., those who lose employer-sponsored coverage, or Medicare+Choice).

Medigap Policies Are Required to Meet Stringent Consumer Protection Rules Today

Medigap policies are required to meet stringent Federal and State consumer protection requirements. States are responsible for assuring that Medigap policies comply with these rules. The Department of Health and Human Services (HHS) has the authority to review State enforcement policies. Federal and State Medigap laws apply only to individually sold Medigap policies; employer-sponsored policies are not subject to these rules.

The major Federal rules that all Medigap policies must meet include:

- **Standard Packages:** Since 1992, Medigap policies have been required to conform to 10 standardized sets of benefits, referred to as A to J. Medigap insurers can offer some or all of these benefit packages, but are not allowed to vary the benefit configurations (except in 3 waiver States: Massachusetts, Minnesota, and Wisconsin).
- **Initial Open Enrollment:** As mentioned above, insurers are required to accept all seniors—regardless of their health status—during a 6-month open enrollment period when they first enroll in Medicare Part B. Open enrollment is also available under certain circumstances to beneficiaries whose plans have left the Medicare+Choice program or to those who lose employer-based coverage.
- **Prohibition on Duplication of Coverage:** Insurers cannot sell a Medigap policy to someone who already owns one.
- **Guaranteed Renewal:** Beneficiaries are guaranteed the right to renew their current policy at their option. If a beneficiary moves to another State, he or she simply takes the coverage with them—the policy is totally portable.
- **Limits on Preexisting Conditions:** Waiting periods are limited to 6 months; however, if a continuously insured Medigap subscriber switches policies, new preexisting periods may not be imposed.

II. BCBSA Comments on Potential Changes to Medigap

I would like to make three points regarding potential changes to Medigap:

1. Medigap Policies Can Provide Even More Valuable Benefits

Standardization of Medigap policies—in effect since 1992—has simplified the purchasing decision for beneficiaries and made it easier for beneficiaries to compare benefits and premiums. At the same time, standardization means that benefit packages have been frozen, and do not reflect many of the design features typical in to-

day's private market. This has significantly limited plans' ability to innovate to keep beneficiary premiums affordable.

For example, Medigap carriers offering prescription drug coverage have not been able to introduce formularies or tiered co-payments, create incentives for use of generic drugs, require additional cost-sharing, or use other management techniques typically applied to drug coverage for those under 65. Similarly, insurers are not able to provide disease management programs.

BCBSA applauds the Administration's recent efforts to address this problem by encouraging State Insurance Commissioners to take advantage of a provision in existing law that allows for approval of "innovative benefits."

Current law gives States the authority to approve "new or innovative benefits" in addition to the standard Medigap benefits (Section 1882 (p)(4)(B)). However, until recently, many States have been reluctant to use this authority because of concern that it would undermine Federal intent to standardize products. Examples of innovative benefits proposed, but not approved, in previous years include:

- Generic prescription drug benefit (with pharmacy network)
- Vision care benefits
- Cost-sharing changes, e.g., a $5 copayment for physician services

BCBSA believes the Administration's initiative is a very promising development; while it is too soon to evaluate results, we believe it will help assure that Medigap provides valuable benefits to Medicare beneficiaries.

2. Legislative Changes to Medigap Should Be in the Context of Comprehensive Reform

BCBSA believes that any legislative changes to Medigap should be made in the context of overall Medicare reform. Medigap policies will need to be revised in order to be consistent with a restructured Medicare program. We believe multiple rounds of Medigap redesign would increase costs and confusion for beneficiaries.

3. Continue to Allow First-Dollar Coverage

BCBSA believes that beneficiaries should continue to have the option to purchase varying degrees of financial protection, including policies that cover all of Medicare's required deductibles and cost-sharing, because:

- **Beneficiaries want first-dollar coverage.** Older Americans, many of whom live on fixed incomes, are particularly risk averse. One reason many purchase Medigap coverage is that they want predictable monthly expenses. Medigap law already requires all insurers to offer Plan A—which does not cover the Part A and Part B deductibles—in addition to any other policy they offer. Less than 3 percent of beneficiaries choose to purchase Plan A, according to the GAO.
- **It would be inappropriate to eliminate first-dollar coverage solely for people who choose to purchase Medigap coverage** while others continue to have this option through their employers, including the Federal Government.
- **"First-dollar" coverage helps assure beneficiaries get needed services.**

The available literature is unambiguously clear that beneficiaries with supplemental coverage report better access to health care services. For example, in its report in June 2002, MedPAC noted that: *"Beneficiaries without supplemental coverage were nearly six times as likely to have delayed care due to cost and about four times as likely to lack a usual source of care, compared to those with employer-sponsored or Medigap insurance."*

Thank you for the opportunity to submit this testimony on behalf of the Blue Cross and Blue Shield Association.

Chairman JOHNSON. Thank you very much, Mr. White.

Mr. Still.

STATEMENT OF STEPHEN W. STILL, ESQ., MAYNARD, COOPER & GALE, P.C., BIRMINGHAM, ALABAMA, ON BEHALF OF TORCHMARK CORPORATION, BIRMINGHAM, ALABAMA AND UNITED AMERICAN INSURANCE COMPANY, McKINNEY, TEXAS

Mr. STILL. Madam Chairman and Mr. Stark, Members of the Committee, thank you for having me here today. I am representing

Torchmark and its subsidiary, United American Insurance Company.

In your opening remarks you said you believe we could do better, and we agree with you on that. We hope to have a suggestion for you to improve that.

We believe that the Medicare program should remain viable and solvent in order to continue to provide meaningful health insurance coverage for senior Americans. We have supported efforts in the past to reform the Medicare program in order to meet this goal, and we continue to support such efforts.

We have worked with Members of this Committee and other Members of Congress to help you achieve the outpatient co-insurance reductions that you have seen in the 1999 and 2000 bills, and we applaud you for your efforts on that. It's been very meaningful for beneficiaries.

Medicare supplement insurance is specifically designed to cover the gaps in coverage that the Medicare program does not cover. For that reason, Medigap is extremely important to the beneficiaries. Medigap is probably the most regulated commercial insurance product that I'm aware of. I'm not aware of any product that is more regulated than this product.

One of the criticisms of Medigap is that the products do reimburse policyholders for "first dollar" health care expenses that they incur, and that they cause over-utilization. Under current law, Medigap insurers have absolutely no freedom to offer products beyond what has been spelled out in Federal law. So, if there's a problem with overutilization, then the root of the problem lies with the underlying law itself, and we believe the law should be changed.

We would support an amendment to the law that would incorporate reasonable notions of cost-sharing in the Medigap law. We believe that this can be done in such a way to benefit the Medicare beneficiaries as well as the Medicare program. Unlike Rich, we believe it should be done immediately within the context of Medicare reform or outside of the context of that Medicare reform.

Our legislative proposal would be as follows—and this can be done in different ways. There are different ways to address cost-sharing, and we realize that. We would suggest that the Medicare law be amended to create a new, optional Medigap plan, so it would be a new stand-alone plan in addition to the 10 existing plans. You could include the core benefits that are found in Plan F, and under this plan, a beneficiary would share 50 percent or one-half of the incurred "first dollar" Part B expenses up to a preselected cap. The cap would be selected by the beneficiary. The caps could be established at a minimum of $1,000 and then going up to $3,000. They could be in increments of $250. Again, the beneficiary could select their own cap.

The premium would be set accordingly—using actuarial principles, the premiums would be set accordingly, and if Rich selected a cap of $3,000, he would obviously pay a lower premium than I would pay if I selected a $1,000 cap.

We believe that such a change in the law would be a good thing for beneficiaries and for the program. We believe that this would help bring the premiums down for this new product, and it would

be available and affordable for Medicare beneficiaries. We are very concerned about the affordability of these products and we think this would help make these affordable. Similarly, we believe it would be good for the program because we think it does address the utilization issue, and it helps to address that issue and control costs for the Medicare program.

As I said, we think these changes should be made immediately. We don't think this is radical, invasive surgery. We think it is simply fine-tuning and a good improvement to the plans that you described as having been adopted 13 years ago. We think it offers consumer choice, much like a homeowners or automobile policy would offer on such cost-sharing.

Thank you very much for your consideration.

[The prepared statement of Mr. Still follows:]

Statement of Stephen W. Still, Esq., Maynard, Cooper & Gale, P.C., Birmingham, Alabama, on behalf of Torchmark Corporation, Birmingham, Alabama, and United American Insurance Company, McKinney, Texas

I am Stephen Still, an attorney with the law firm of Maynard, Cooper & Gale, P.C. in Birmingham, Alabama. I represent Torchmark Corp. and its subsidiary, United American Insurance Company. Torchmark is a publicly held company; it is traded on the New York Stock Exchange, and headquartered in Birmingham, Alabama. United American, based in McKinney, Texas, is one of the oldest suppliers of Medigap insurance. United American started selling Medicare supplement insurance shortly after the Medicare program was created in 1966. By 1981, the company was nationally recognized as a preeminent writer of individually sold Medigap insurance. Today, United American is known to be one of the most cost-efficient Medicare supplement insurers. Annually, it processes over 9 million claim transactions that result in over 3 million claim checks being issued to policyholders. United American does not sell any products such as Medicare+Choice. Furthermore, the company does not act as a Medicare intermediary as some other competitors in the industry do. It is strictly a Medicare supplement insurer.

United American strongly believes that the Medicare program should remain viable and solvent in order to continue to provide meaningful health insurance coverage for senior Americans. We have supported efforts in the past to reform the Medicare program in order to meet this goal, and we continue to support such efforts. In fact, we have worked closely with members of this Committee and other Members of Congress to amend the Medicare law to achieve reductions in the outpatient coinsurance amounts that beneficiaries are charged under Part B. We applaud you for the reductions you have achieved thus far. As you know, beneficiaries continue to be overcharged for these amounts, and we continue to seek legislative changes to correct this problem.

Under the current Medicare program, approximately 85% of beneficiaries receive their health care service through the traditional fee-for-service Medicare delivery system. With that in mind, we are especially aware of the fact that the supplemental products that we offer are invaluable to Medicare beneficiaries. Why? Because the Medicare program, as valuable and important as it is to seniors, does not cover 100% of the health care costs that are incurred by policyholders. As you know, the Medicare program is designed in such a way that it does not cover items such as the deductibles under Part A and B, co-payment amounts under Part B, and, importantly, Medicare coverage is not unlimited. It is subject to specific limited amounts. I might add that the Part B coinsurance amounts and the Medicare caps on hospital reimbursement can expose beneficiaries to significant medical expenditures.

Medicare supplement insurance is specifically designed to cover these gaps in coverage that the Medicare program does not cover. I don't need to remind you that most seniors are very risk averse. Whether dealing with medical expenses or any other financial risks, most seniors abhor the idea of unknown and unlimited financial exposure. **For this reason, Medicare supplement insurance is extremely important to Medicare beneficiaries.** The primary benefit of Medicare supplement insurance is that it does provide protection against unlimited financial exposure. Thus, United American is proud of this service that it offers and the supplemental products that provides. Does that mean that everything about the system is perfect? No. As we all know, as important as these programs are to senior citi-

zens, neither the Medicare program nor the Medigap products are perfect. In fact, United American believes that improvements need to be made to the standardized Medigap plans.

To put my remarks in perspective, please keep in mind that Medicare supplement is the most regulated commercial insurance product that I am aware of. It is regulated by Federal and State laws. These laws dictate specifically what products can be sold, the loss ratio that must be achieved and the amount of profit that can be earned. It mandates that these insurance products must be offered without underwriting for coverage, and insurers must guarantee renewal of coverage to policyholders. Although most successful Medigap insurers have learned to operate subject to these restrictions, keep in mind that constraints such as these are foreign to other commercial insurance products. I am not aware of any other commercial insurance product that is subject to legal requirements remotely similar to these.

One of the criticisms of Medicare supplement insurance is that the products reimburse policyholders for "first dollar" health care expenses that they incur. These would include expenses such as deductibles and copays. The argument is made that this practice leads to "over utilization" of health care services by beneficiaries, because there is no disincentive to use these services. I am not the appropriate party to address the validity of that argument; however, I can provide the following observation. Medicare supplement insurers only offer the Medigap products that Federal law requires them to offer. Under current law, Medigap insurers have absolutely no freedom to offer anything beyond what you, in Congress, have told them to sell. If, in fact, there is a problem with "over utilization" and "first dollar coverage," then the root of the problem lies with the underlying law itself. Does the underlying law need to be changed? Yes. United American believes that it should be changed.

United American began selling the standardized plans in 1992 pursuant to the *Omnibus Budget Reconciliation Act of 1990*. The design of these plans may have made sense a decade ago, but health insurance and health care delivery have changed dramatically over the past decade. The standardized Medigap plans offered today are distant ancestors to other commercial health insurance plans offered today to the under 65 market. One of the principal differences is that other commercial health insurance products contain more up-to-date elements of "cost-sharing" by policyholders. Since Medicare supplement products are required by law to cover deductibles and co-payment amounts, they avoid cost-sharing and, as previously pointed out, may contribute to over utilization of services. Accordingly, United American believes that the Federal law should be changed to incorporate reasonable notions of cost-sharing. We believe that this can be done in such a way as to benefit Medicare beneficiaries as well as the Medicare program. How would this work?

There may actually be more than one way to accomplish this, but United American would offer the following legislative proposal. United American would propose amending the Medicare law to create a new optional Medigap plan. Under this plan, a beneficiary would share one half of the incurred, first dollar expenses up to a preselected, optional cap. These caps could be established at $1,000, $1,250, and so on, in increments of $250, up to a maximum cap of $3,000. This approach would operate like a homeowner's policy or personal automobile policy in that the policyholder could select the out-of-pocket amount that he or she is comfortable with, and the premium for that policy would be set accordingly. Thus, a policyholder with a $3,000 cap would pay a lower premium than a policyholder who selects a $1,500 cap. The Medicare supplement insurers would price their products accordingly using actuarial principles in order to reflect these cost-sharing amounts and other risks normally associated with such coverage. As with other commercial insurance products, different Medigap insurers would price these products differently. Likewise, beneficiaries could select premium amounts that they were comfortable with. How would such a change affect the Medicare program and Medicare beneficiaries?

United American believes that a change in the law along these lines would be a good thing for beneficiaries and for the Medicare program. One of the biggest concerns that United American has had in recent years is the premium rate increases that it and other Medigap insurers have experienced. These increases are the result of increases in health care costs, and they are also the result of the regulatory constraints of the current law. Medigap insurers do not like premium rate increases. Over time, such increases will cause these valuable supplemental products to become unaffordable for the very senior citizens who demand these products. I can assure you that United American would much rather sell more policies at lower premiums, than lose policyholders because its products are unaffordable. United American believes that changing the law along the lines that I have outlined would cause premiums for such modified Medicare supplement products to be reduced and, over time, remain more stable.

Similarly, we believe that this change would be good for the Medicare program. If reasonable cost-sharing concepts, such as those that I have mentioned, were incorporated into the law, then we believe that utilization could be decreased and there could be substantial savings to the Medicare program. Such savings could be used by the Medicare program to reduce expenses, or even partially provide for a prescription drug benefit for seniors. Would a change such as this solve all of the problems for the Medicare program, or could it completely offset a drug benefit? No. However, I would suggest that this is a step in the right direction, and it may provide one piece of the puzzle that you, as policy makers need to have in order to best serve the Medicare program and beneficiaries.

Chairman JOHNSON. Thank you, Mr. Still.

Dr. Neuman.

STATEMENT OF PATRICIA NEUMAN, SC.D., VICE PRESIDENT AND DIRECTOR, MEDICARE POLICY PROJECT, THE HENRY J. KAISER FAMILY FOUNDATION, ON BEHALF OF THOMAS RICE, PH.D., PROFESSOR AND VICE CHAIR, DEPARTMENT OF HEALTH SERVICES, UCLA SCHOOL OF PUBLIC HEALTH

Dr. NEUMAN. Thank you, Mrs. Johnson, and Mr. Stark and Members of the Subcommittee. I am going to summarize my written remarks, with your permission.

Medicare offers 41 million elderly and disabled Americans reliable health insurance at a time in their lives when they are most likely to need medical care. Medicare helps pay for basic services, but has high cost-sharing requirements and a limit on catastrophic expenses, and no outpatient drug coverage. As a result, it is substantially less generous today than typical employer plans.

Gaps in the benefit package are problematic for many, particularly those who lack supplemental coverage or who have modest incomes. Four in 10 people on Medicare today live on incomes below twice the poverty level, or less than $18,000 for an individual. The same share has less than $12,000 in countable assets. Thus, the risk of incurring unaffordable medical expenses is very real. For an older woman with a median monthly income of $1,400, the Part A deductible alone would consume more than half of her monthly income.

To help fill Medicare's gaps, nearly 9 in 10 beneficiaries have some form of supplemental insurance, but access to supplemental coverage is on the decline. Our own surveys find that fewer employers are offering retiree health benefits, and many are considering eliminating these benefits in the future. In addition, the number of people with Medigap policies has declined by one-and-a-half million in the late nineties, and the number covered by M+C plans has dropped by about the same amount. Given State budget problems, Medicaid coverage may also be in jeopardy as a supplement to Medicare.

Modifying Medicare's cost-sharing could be one approach to reduce the growth in Medicare spending while addressing concerns related to supplemental insurance. Some have suggested the beneficiaries should bear more of their health care costs to deter use of services that are not really needed. The RAND Health Insurance Experiment, which is the largest and most prominent study to date on cost-sharing, offers some important insights on this issue.

It found that, as cost-sharing increases, utilization decreases, along with total spending. It also found that cost-sharing lowers the use of both medically necessary services as well as less essential care. Subsequent studies of people 65 and older indicate that cost-sharing, or the lack of supplemental coverage, deters people from seeking diagnostic and preventive care, such as mammograms, as well as routine care for chronic illnesses.

Lack of supplemental coverage also affects utilization of treatments that are not covered by Medicare, particularly prescription drugs. A recent study found that seniors with conditions such as congestive heart failure and diabetes but no drug coverage were far more likely than those with drug coverage to forego their prescriptions or to skip doses to make their medicines last longer.

Cost-sharing makes consumers more price-sensitive, but there's a limit to how much influence patients have on the care they get when they're sick. Cost-sharing tends to affect whether people decide to seek care in the first place, but has far less influence on the number and types of medical services they receive after they initiate care. This is because physicians generally guide these decisions about follow-up treatment and care.

In summary, bringing Medicare coverage more into line with benefits typically offered by large employers would help achieve multiple goals. It would lower seniors' out-of-pocket costs, remove financial barriers to care, reduce the need for supplemental insurance and, in so doing, would produce some administrative savings. Clearly, these enhancements would come at a cost and, thus, would compete with other national spending priorities.

The evidence shows that cost-sharing lowers utilization of both necessary and potentially nonessential care. Lower utilization may reduce spending in the short term, but could ultimately result in poorer health outcomes, hitting those with limited incomes the hardest, including older women, the oldest old, racial and ethnic minority beneficiaries, and the under 65 disabled.

If, for example, restructuring results in a lower deductible for people using hospital services, but is a significantly higher deductible for those using only physician care, then beneficiaries with modest incomes could face a difficult choice: they could pay more out of pocket to get physician care if they have a health concern, or risk going without it to save money. If they end up in the ER as a result of going without needed care, Medicare spending could actually rise.

Over the course of its nearly 40-year history, Medicare has done much to improve the lives of people it serves. Despite its limited benefit package, the program continues to enjoy broad public support. Efforts to modify cost-sharing should address the need to contain program spending without creating new financial barriers to care. Adding drug coverage and limiting catastrophic expenses are a top priority for seniors. In the absence of such changes, people on Medicare will continue to seek supplemental insurance, such as Medigap, and shoulder these costs themselves.

Thank you, Mrs. Chairman.

[The prepared statement of Dr. Neuman follows:]

Statement of Patricia Neuman, Sc.D., Vice President and Director, Medicare Policy Project, Kaiser Medicare Policy Project, Henry J. Kaiser Family Foundation, on behalf of Thomas Rice, Ph.D., Professor and Vice Chair, Department of Health Services, UCLA School of Public Health

Thank you, Madam Chairman and Members of the Committee, for the opportunity to testify on the issue of Medicare's cost-sharing structure and Medigap supplemental coverage. I am Patricia Neuman, a Vice President of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project. I am testifying today on behalf of myself and Thomas Rice, Ph.D., Professor and Vice Chair of the Department of Health Services at the UCLA School of Public Health. This testimony reviews the evidence on the effects of cost-sharing on health care utilization, and the implications for proposals that would modify Medicare's cost-sharing structure.

Medicare Today

Medicare plays a critical role in the lives of 41 million elderly and disabled Americans, offering a reliable source of health insurance at a time in their lives when they are most likely to need medical care. Medicare pays for much-needed basic medical services, such as physician and hospital care. However, with high cost-sharing requirements and no outpatient prescription drug coverage, Medicare is substantially less generous than plans typically offered by large employers (Figure 1).

Figure 1

Comparison of Benefits Covered Under Medicare, the FEHBP BlueCross/BlueShield Standard Plan, and a Typical Large Employer Plan, 2003

Plan Feature	Medicare	FEHBP BC/BS Standard Option PPO Benefit	Typical Large Employer Plan
Deductible	Inpatient: $840/benefit period Outpatient: $100/year for Part B services	$250/individual	$250/individual
Out-of-Pocket Limit	None	$4,000	$1,500
Cost-Sharing for Hospital Inpatient Care	Days 1-60: No coinsurance Days 61-90: $210/day Days 91-150: $420/day After 150 days: No benefits	$100 per admission Unlimited inpatient days	Subject to deductible; 15% coinsurance up to out-of-pocket limit
Cost-Sharing for Physician Visits	Typically 20% coinsurance, after deductible is met	$15 per visit, with no deductible	Subject to deductible; 15% coinsurance up to out-of-pocket limit
Outpatient Prescription Drugs	Not generally covered	No Rx deductible; 25% coinsurance (retail) and $10 generics/$35 brand copayment (mail order)	No Rx deductible; $8 generic/$20 brand-name (30-day retail); $15 generic/$40 brand-name (90-day mail order)

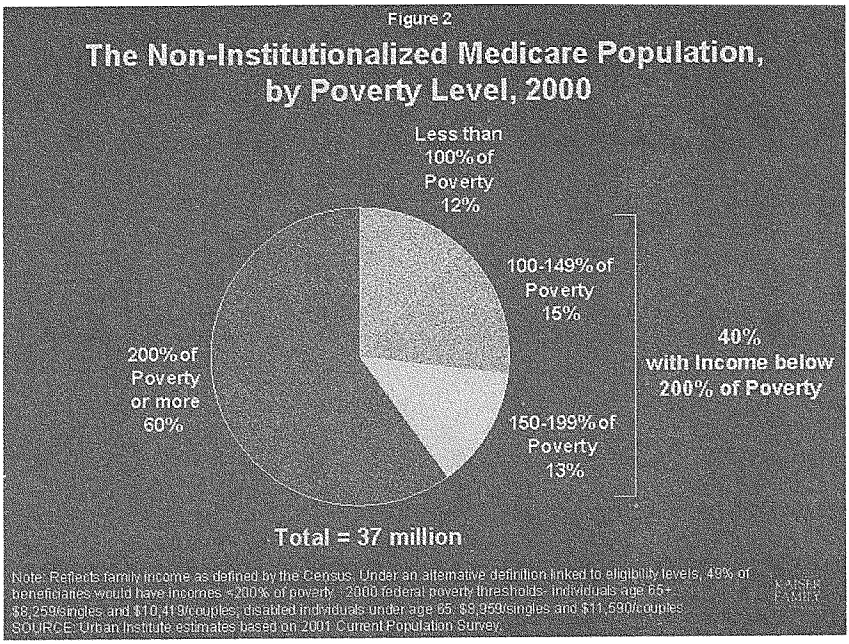
SOURCE: CMS, Medicare and You, 2003; BlueCross/BlueShield Federal Employees Program http://www.fepblue.org/benefits/03/03ccs012.html; Hewitt Associates

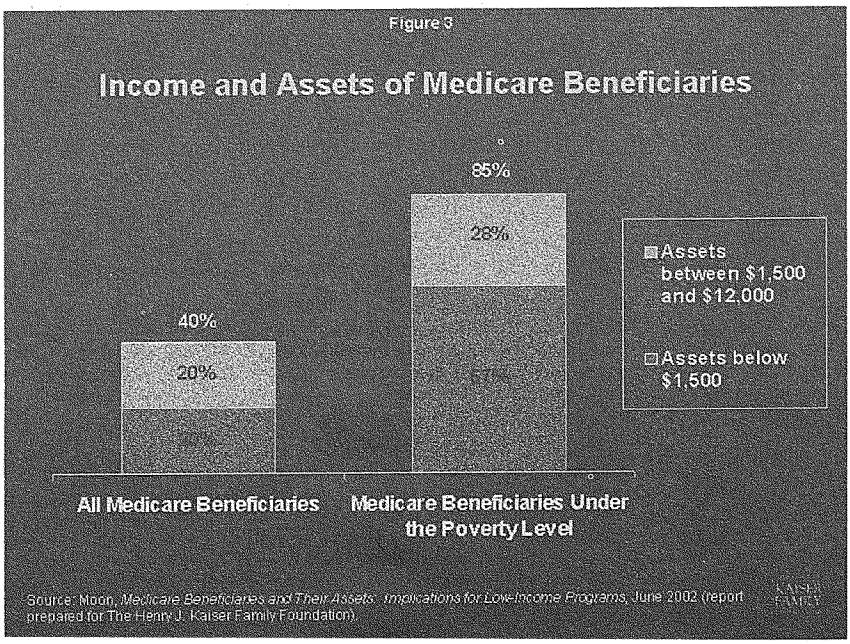
KAISER FAMILY

Medicare's Part A deductible, for example, now $840 per benefit period, is more than three times as high as the deductible typically imposed by large employer plans. It is also considerably higher than the FEHBP Blue Cross/Blue Shield Standard Plan, which has a $250 deductible and a $100 inpatient admission fee. Medicare has no limit on beneficiaries' out-of-pocket expenses, while the typical large employer plan has a $1,500 limit and the FEHBP Blue Cross/Blue Shield Standard Plan has a $4,000 limit on out-of-pocket spending.[1] And, virtually all large employer plans, including FEHBP plans, cover prescription drugs—typically without a separate drug deductible or cap on covered drug benefits.

Gaps in Medicare's benefit package are increasingly problematic for beneficiaries given that many have relatively modest incomes and limited assets, and face declining access to affordable supplemental coverage. Four in ten Medicare beneficiaries live on incomes below twice the Federal poverty level—about $18,000 per person and $24,000 per couple in 2003 (Figure 2), and the same number have less than $12,000 in countable assets, leaving them with little capacity to pay for unexpected medical expenses (Figure 3).[2] On average, Medicare beneficiaries spend more than

a fifth of their income on health expenses, including Part B premiums; Medicare cost-sharing; non-covered services, such as prescription drugs; and premiums for supplemental insurance.[3]

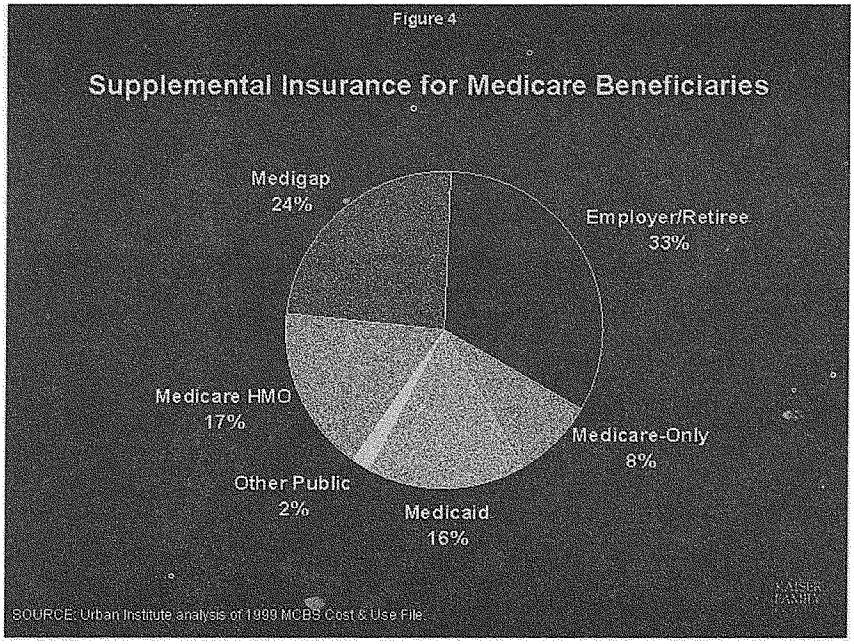




With many living on fixed incomes, the risk of incurring unaffordable medical expenses is very real. For an elderly woman at the median income level of $1,400 per month, the Part A deductible alone would consume more than half of her monthly income. Those with serious health problems are particularly at risk. A recent study of out-of-pocket spending among beneficiaries with various medical problems found that a chronically ill, frail 80-year-old woman could pay more than $10,000 within a year for her health care, supplies, and prescriptions, if she had no supplemental insurance.[4]

Gaps in Medicare and Supplemental Coverage

The majority of beneficiaries—9 in 10—rely on supplemental insurance to help fill the gaps in Medicare's benefit package and to protect themselves from large, unanticipated health care expenses (Figure 4). Employer-sponsored retiree coverage is the primary source of supplemental insurance, assisting one-third of all beneficiaries. Seniors with health benefits from a former employer typically have relatively generous benefits, and tend to have higher incomes and more years of education than do other beneficiaries.[5]



Medigap is the second leading source of supplemental coverage, providing coverage to a quarter of all beneficiaries. Beneficiaries who elect to stay in traditional Medicare have a choice of purchasing one of ten standard Medigap benefit packages (Figure 5). Those who buy Medigap policies are typically female, white, older, and more educated. They also tend to have higher-than-average incomes, although more often lower incomes than retirees with employer-sponsored coverage. They are also more likely to live in rural areas, where they are less apt to be offered retiree coverage from a former employer or a Medicare+Choice plan that offers supplemental benefits.

Figure 5

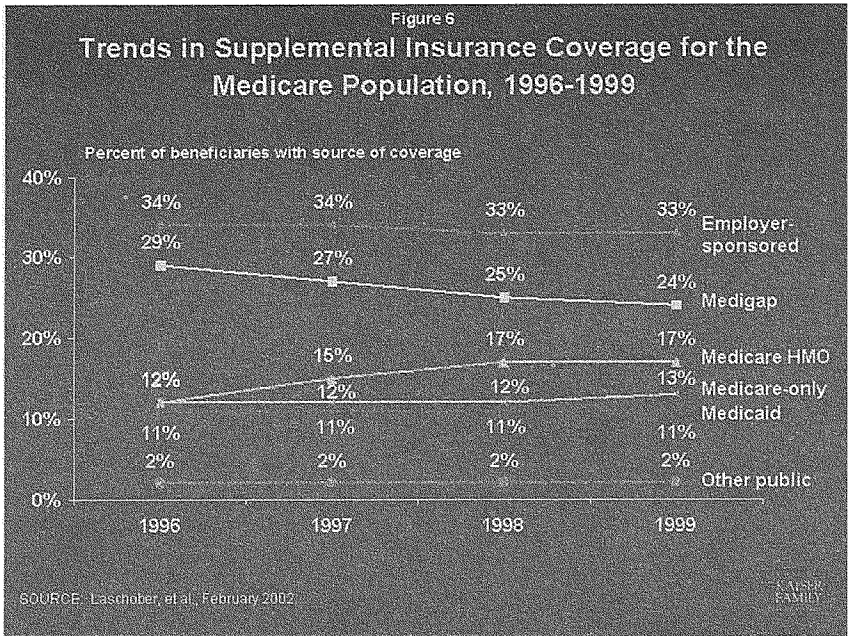
Benefits Offered Under Standardized Medigap Plans

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F [a]	Plan G	Plan H	Plan I	Plan J [a]
Coverage for: - Part A coinsurance - 365 additional hospital days during lifetime - Part B coinsurance - Blood products	X	X	X	X	X	X	X	X	X	X
Skilled Nursing Facility Coinsurance			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Balance Billing [b]						X	X		X	X
Foreign Travel Emergency			X	X	X	X	X	X	X	X
Home Health Care				X			X		X	X
Prescription Drugs								X [c]	X [c]	X [c]
Preventive Medical Care				X						X

[a] Plans F and J also have a high-deductible option that requires the beneficiary to pay $1,550 before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs ($250/year for plan J) and foreign travel emergency ($250/year for plans F and J), which are required in these plans with or without the high-deductible option.
[b] Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15% higher than the Medicare payment rate. Plan G pays 80% of balance billing; plans F, I, and J cover 100% of these charges.
[c] Plan H and I pay 50% of drug charges up to $1,250/year and have a $250 annual deductible. Plan J pays 50% of drug charges up to $3,000/year and has a $250 annual deductible.
SOURCE: General Accounting Office analysis of NAIC data, July 2001.

Finally, Medicaid is a critical source of supplemental coverage for low-income Medicare beneficiaries. Medicaid helps relieve the financial burdens facing low-income Medicare beneficiaries in several ways. First, it pays their monthly Medicare Part B premium, which now amounts to over $700 per year. Second, Medicaid pays the cost-sharing charged for many Medicare-covered services. Finally, Medicaid covers a range of important benefits excluded from Medicare, such as prescription drugs.

Together, these various supplemental insurance options have helped to shield seniors from the full effects of Medicare's high cost-sharing requirements and limited benefit package. The evidence now suggests that access to supplemental coverage is on the decline, however. Between 1996 and 1999, while the share of beneficiaries with supplemental coverage remained stable due to the increase in Medicare+Choice enrollment, the number of beneficiaries with Medigap policies declined by 1.5 million, bringing the share of all Medicare beneficiaries with Medigap coverage from 29% to 24% (Figure 6).[6] Since then, enrollment in Medicare+Choice plans has also dropped by roughly the same number.



In addition, results from several surveys point to an erosion of employer-sponsored retiree health benefits. Between 1988 and 2002, the share of large employers offering retiree health benefits dropped from 66 percent to 34 percent.[17] And, according to the recent Kaiser/Hewitt survey, 22% of large employers say they are likely to terminate health benefits for future retirees in the next few years.[18] Finally, the adequacy of Medicaid benefits is likely to be jeopardized by acute budgetary problems at the State level.

The erosion of supplemental coverage raises questions about how best to protect beneficiaries from high out-of-pocket costs in the future, from improving Medicare's benefit package to changing cost-sharing structures under Medicare and supplemental sources.

COST-SHARING: IMPLICATIONS FOR BENEFICIARIES

One key consideration in redesigning Medicare's benefit package is an understanding of the effects of cost-sharing on beneficiaries' access to care. Some have suggested, for example, that beneficiaries should bear a greater share of their health care costs to deter use of non-essential services. A review of the literature, however, identifies several concerns associated with proposals that would raise cost-sharing under Medicare: (1) higher cost-sharing requirements are likely to lower use of medically necessary services and may have a negative impact on beneficiaries' health status; (2) higher cost-sharing is inequitable, hitting the most financially vulnerable beneficiaries the hardest; and (3) many if not most seniors do not appear to have sufficient information and knowledge to navigate the health care system and assess their options when faced with high cost-sharing requirements.

Impact of Cost-Sharing on Use of Services

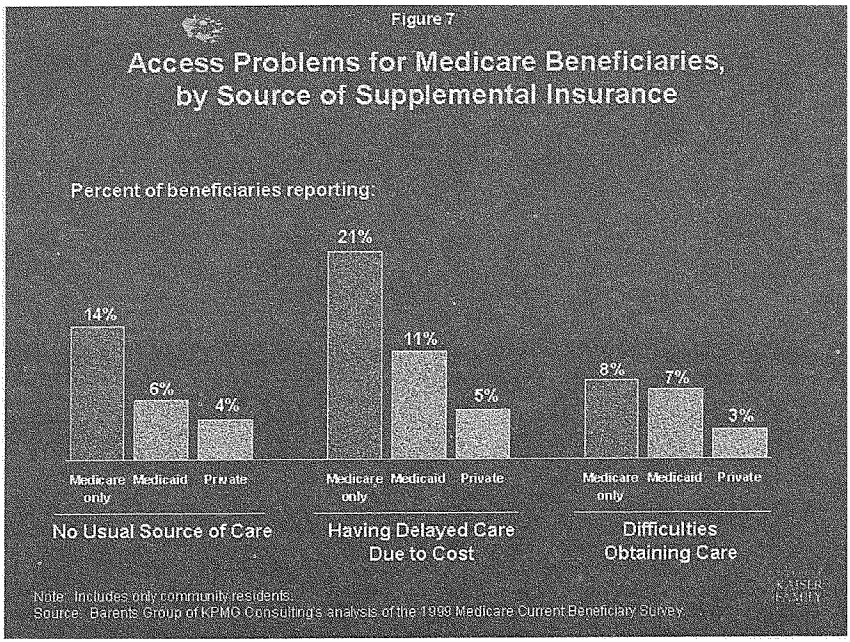
It is clear that increased cost-sharing reduces service utilization and total spending. The most notable study on the topic was the RAND Health Insurance Experiment. Conducted in the 1970s and early 1980s, the study remains the only large-scale, randomized controlled trial to compare use of services and total spending across different cost-sharing arrangements. The study examined the effects of four coinsurance groups: 0% (free care), 25%, 50%, and 95%. All participants were protected by an annual limit on out-of-pocket costs. The study demonstrated that coinsurance had a considerable impact on both use and spending, finding that people in the highest cost-sharing group, who had to pay 95% of charges, had total annual expenditures that were 31% lower than those of the no-coinsurance group. From a policy standpoint, perhaps more relevant is the finding that those facing a 25% coin-

surance rate had expenditures that were 19% lower than those of the participants in the free-care group.[9]

One would hope that, as people cut back on utilization as their cost-sharing increases, they would be selective in doing so—forgoing services of little value, while continuing to receive the most useful services. However, the RAND study found that cost-sharing is as likely to lower use of services judged by medical experts to be medically effective as it is to lower use of those deemed less effective or ineffective.[10] The authors of this evaluation concluded that, "[C]ost-sharing did not lead to rates of care seeking that were more 'appropriate' from a clinical perspective." That is, cost-sharing did not seem to have a selective effect in prompting people to forgo only care that would likely be of little or no value.[11]

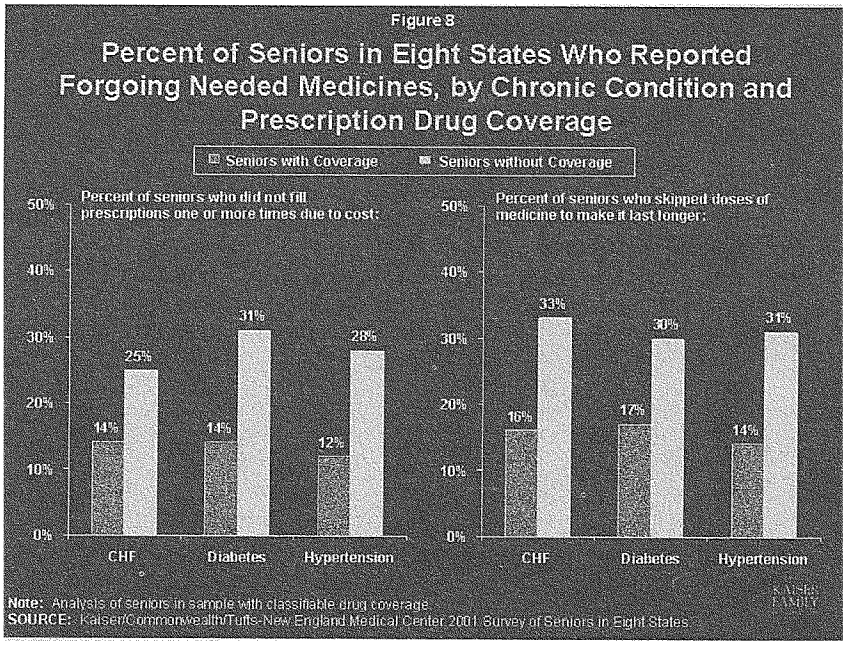
Although the RAND experiment did not include seniors, subsequent studies that have show similar results. A recent review of studies that included people ages 65 and older confirmed these results, with nearly all studies showing that higher patient cost-sharing resulted in use of fewer services.[12] Rice and Matsuoka examined 18 studies that measured the impact of cost-sharing or the possession of supplemental insurance on clinically appropriate utilization.[13] Of the 18 studies, 14 found that higher cost-sharing or lack of supplemental coverage had a negative effect on appropriate utilization of health services, whereas just 4 found that it had no effect or a positive effect. For example, one of the studies found that women on Medicare without supplemental coverage were far less likely than those with some form of coverage to have a mammogram.[14] Together, these findings strongly suggest that those having to pay Medicare's cost-sharing requirements out of their own resources (i.e., without supplementation) use far fewer preventive and medically necessary services than recommended.

Surveys of beneficiaries themselves confirm these results. Beneficiaries who are exposed to Medicare's cost-sharing requirements because they lack supplemental coverage report greater access problems than do those with supplemental coverage. Data from the Medicare Current Beneficiary Survey show that while 21% of those with only traditional Medicare reported having delayed care due to cost, just 11% of those with Medicaid and 5% of those with private supplemental coverage had done so in 1999. In addition, while 14% of those without supplemental coverage had no usual source of care in 1999, this was the case for only 6% of those with Medicaid and 4% of those with private coverage to fill in Medicare's gaps (Figure 7).



Beneficiaries without supplemental coverage—including those with serious health concerns—are also less likely to receive treatments not covered by Medicare, par-

ticularly where prescription drugs are concerned. A 2002 study by Safran and others found, for example, that seniors with chronic conditions, such as congestive heart failure, diabetes, and hypertension, but no drug coverage, were far likelier than those with drug coverage to forgo filling their prescriptions due to costs, or to skip doses to make their medicines last longer. Among seniors with diabetes, for example, nearly a third of those without drug coverage skipped doses (30%) or didn't fill a prescription (31%); among diabetics with drug coverage, the comparable figures were 17% and 14%, respectively (Figure 8).[15]

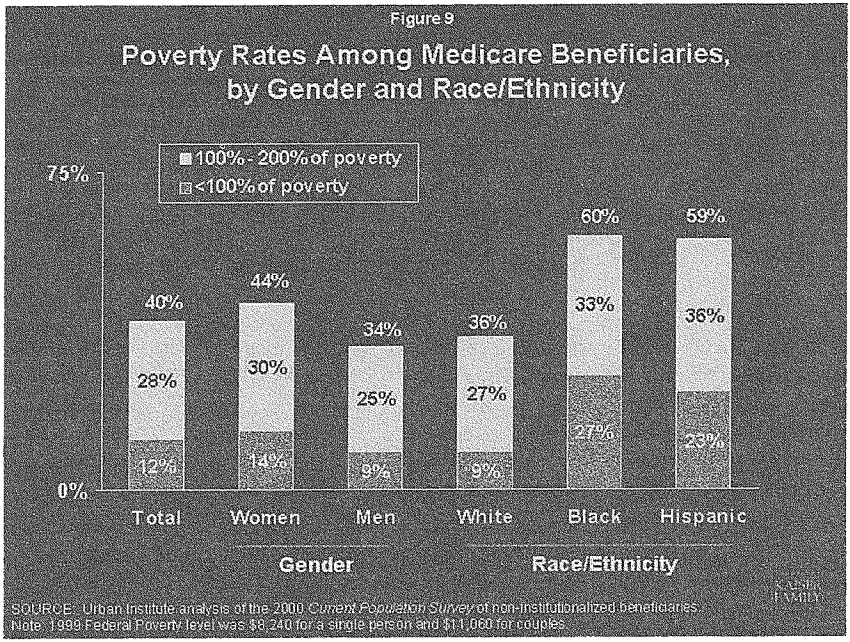


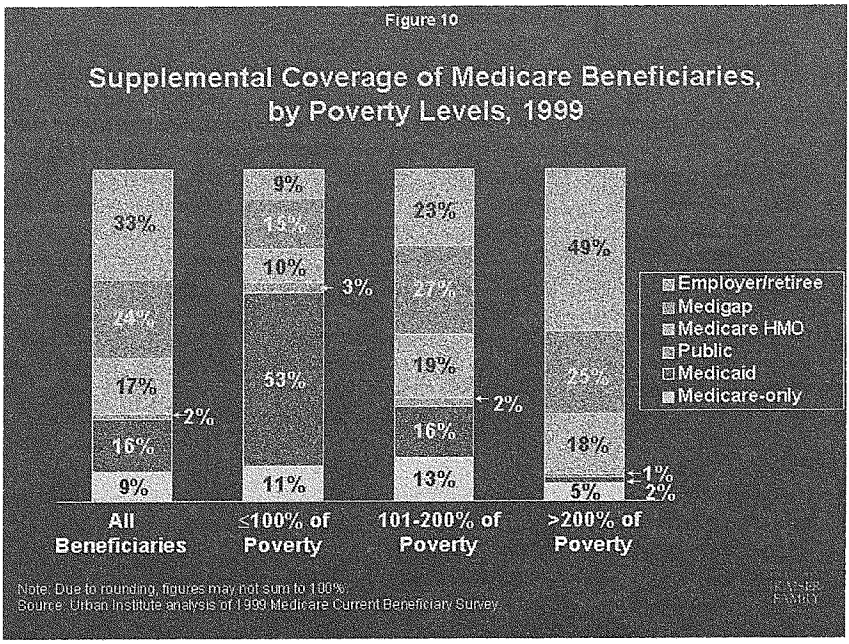
Along with potential implications for beneficiaries' health, lower use of prescription drugs stemming from lack of coverage may raise overall spending due to increased demand for other services, such as inpatient hospital care (Lichtenberg, 2001).[16]

Impact on Equity

By its nature, increased patient cost-sharing hurts the financially vulnerable the most. This is because of three interrelated issues: cost-sharing accounts for a greater proportion of their incomes; those with lower incomes tend to be sicker; and, because they are sicker, they generally require more services.

Families with lower incomes who seek medical care will likely spend a greater proportion of their income on cost-sharing requirements than will wealthier families, unless they have relatively comprehensive private supplemental insurance or Medicaid. Higher cost-sharing requirements disproportionately affect Medicare beneficiaries with incomes below twice the poverty level (about $18,000 for an individual), including: women (44%), seniors ages 85 and over (52%), African American (60%) and Hispanic (59%) beneficiaries, and under-65 beneficiaries with permanent disabilities (59%) (Figure 9).[17] Adding to the obvious challenge of living on modest incomes, low-income beneficiaries are less likely than those with higher incomes to have any form of supplemental coverage (Figure 10). They are also more likely to be in fair or poor health and therefore have a greater need for medical services.





Increased cost-sharing can therefore be viewed, colloquially speaking, as a "triple jeopardy" for elderly and disabled beneficiaries with modest incomes:

- Those with low incomes are more likely to be without any form of supplemental insurance that covers Medicare's cost-sharing requirements;[18]

- Since those with low incomes also tend to be in poorer health and need more medical services, Medicare's cost-sharing requirements will account for a greater portion of their limited incomes if they use the necessary additional services; and
- If they do not use the additional services they need, their health is likely to suffer as a result.

Seniors and Health Care Decisions

One of the arguments for maintaining cost-sharing under Medicare is that it gives consumers an incentive to "think twice" before using services. The idea is that, if beneficiaries are made more price-sensitive, they will forgo potentially unnecessary services, which in turn, will help contain health care spending. There are other factors that drive treatment decisions for patients, including whether they have control over the medical services they get, and sufficient information to make such decisions for themselves.

There is a limit to how much decision-making power is vested, or even should be vested in beneficiaries when it comes to health care utilization. The RAND experiment suggested that patient cost-sharing has a considerable impact on whether or not beneficiaries seek care when they are sick, but far less influence on the intensity of service use after they initiate care.[19] This is likely because physicians, not patients, generally guide decisions about follow-up care and testing.

Even when patients are more actively involved in decisions about their own care, they need to be able to review information from a variety of sources to determine whether medical treatment is not only affordable, but also whether it is clinically necessary. This is challenging as it requires: (a) knowing what the out-of-pocket costs of a service will be, and (b) understanding both the health implications of obtaining the service and the medical (and financial) consequences of not obtaining the service. This would likely be extremely difficult for people of all ages.

Summary and Policy Considerations

In summary, there is substantial evidence showing that cost-sharing leads to lower utilization of health care services—both necessary and potentially non-essential services. A number of studies show that cost-sharing (or lack of supplemental coverage) deters people from seeking diagnostic and preventive services, as well as services that are often used to treat chronic illness. Lower utilization may reduce health care spending in the short term, but could ultimately result in poorer health outcomes for seniors and younger beneficiaries with disabilities.

This body of evidence has direct bearing on efforts to modify Medicare's current cost-sharing structure, and has implications for low-income and otherwise vulnerable beneficiaries. If, for example, restructuring results in a lower deductible for people using hospital services, but a higher deductible for those who use only physician care, then beneficiaries with modest incomes would face a difficult choice. They could decide to pay the higher deductible out of their limited incomes to get physician care or they could decide to take a risk and go without care in order to save money, which could potentially increase Medicare spending if they end up in the hospital.

As noted earlier, Medicare is substantially less generous than typical large employer plans. Bringing Medicare coverage more in line with typical employer benefits would go a long way toward removing financial barriers to care. Benefit improvements could also reduce the need for supplemental insurance, and produce some administrative savings as well. At the same time, these changes would increase Medicare spending, by shifting costs now incurred by beneficiaries onto the program.

It is important to note that changes in Medicare's cost-sharing requirements and benefit package would also impact State budgets, in that Medicaid fills in Medicare's gaps for low-income beneficiaries also covered by Medicaid. This can play both ways for States. Benefit improvements such as a prescription drug benefit or stop-loss protection could significantly reduce Medicaid spending, while passing increases in Medicare premiums and deductibles on to Medicaid could have the opposite effect.

Over the course of its nearly 40-year history, Medicare has done much to improve the lives of its beneficiaries. Despite a limited benefit package, Medicare remains a popular program and enjoys broad public support. Efforts to modify cost-sharing should balance the need to reduce program spending without creating new and unintended financial barriers to care. From the perspective of people served by the program, adding a prescription drug benefit and limiting catastrophic expenses are especially important. These benefit enhancements would come at a cost, and compete

with other national spending priorities. In the absence of such changes, beneficiaries will continue to shoulder these costs.

REFERENCES

[1] Blue Cross Blue Shield Federal Employee Program. Accessed on April 28, 2003. *http://www.fepblue.org/benefits/benefits03/soaag03.html.*
[2] Moon, M., R. Friedland, and L. Shirey. Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs. Prepared for The Kaiser Family Foundation, June 2002.
[3] Maxwell, S., M. Moon, and M. Storeygard. Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures. Prepared for The Commonwealth Fund, May 2001.
[4] Snyder, R., T. Rice, and M. Kitchman. Paying for Choice: The Cost Implications of Health Plan Options for People on Medicare, January 2003.
[5] Pourat, N., et al. "Socioeconomic Differences in Medicare Supplemental Coverage," *Health Affairs* 19(5), September/October 2000: 186–196.
[6] Laschober, M.A., M. Kitchman, P. Neuman, and A.A. Strabic. "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996–1999." *Health Affairs* Web Exclusive, 27 February 2002.
[7] Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2002; KPMG Survey of Employer-Sponsored Health Benefits: 1988.
[8] Kaiser/Hewitt 2002 Survey on Retiree Health Benefits, December 2002.
[9] Newhouse, J.P., et al. *Free for All? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press, 1993.
[10] Lohr, K.N., et al. 1986. "Effect of Cost-Sharing on Use of Medically Effective and Less Effective Care." *Medical Care* 24 (Supplement): S31–S38.
[11] Lohr, K.N., et al. 1986. "Effect of Cost Sharing on Use of Medically Effective and Less Effective Care." *Medical Care* 24 (Supplement): S31–S38.
[12] Rice, T., and K.Y. Matsuoka. "The Impact of Cost-Sharing on Utilization and Health Status: A Review of the Literature on Seniors," Submitted for publication. Available as working paper from the Department of Health Services, UCLA School of Public Health, 2003.
[13] Ibid.
[14] Blustein, J. 1995. Medicare Coverage, Supplemental Insurance, and the Use of Mammography by Older Women. *New England Journal of Medicine* 332(17): 1138–1143.
[15] Safran, D.G., et al. "Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap? Findings from a 2001 Survey of Seniors in Eight States," *Health Affairs* Web Exclusive, July 31, 2002.
[16] Lichtenberg, F. "Are the Benefits of Newer Drugs Worth Their Cost? Evidence from the 1996 MEPS." *Health Affairs* 20(5), September/October 2001: 241–251.
[17] The Urban Institute analysis of 2000 Current Population Survey prepared for The Kaiser Family Foundation.
[18] Pourat, N., et al. "Socioeconomic Differences in Medicare Supplemental Coverage," *Health Affairs* 19(5), September/October 2000: 186–196.
[19] Newhouse, J.P., et al. *Free for All? Lessons from the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press, 1993.

Chairman JOHNSON. I thank the panel for their comments. Mr. Still, that's an interesting option that you proposed. Have you done any runs to see what the premiums would be for various deductibles? I assume that once you reach the deductible, that you would have catastrophic coverage then?

Mr. STILL. What kind of coverage?

Chairman JOHNSON. Once you met the cap you were describing, 50 percent of the cost up to a cap——

Mr. STILL. Yes.

Chairman JOHNSON. —after the cap, the policy would provide complete coverage?

Mr. STILL. Yes, that's correct.

Chairman JOHNSON. Do you have any idea what the premium would be?

Mr. STILL. We've done some rough estimates on that. Of course, this would have to be priced once the product was offered and you knew how many policyholders you had, and every company would have to price it accordingly. We're estimating, if you assume that Plan F currently costs $2,300 a year—and that's on the high side——

Chairman JOHNSON. The cap would be?

Mr. STILL. With a $1,000 cap, we think the annual savings would be $480. That's an estimate. We think there would be a $480 savings on Plan F, with a $1,000 cap.

Chairman JOHNSON. So, for a $1,000 cap, the premiums would amount to about $520 a year?

Mr. STILL. No, $1,820 a year. We believe—The other thing is we believe it would help keep the increases in check in the future, which is also important. The initial——

Chairman JOHNSON. For a $1,000 cap, the premium would be $850 a year?

Mr. STILL. It would be $1,820 a year. You have the same coverage as in Plan F. You would have all the benefits under Plan F, the core benefits of Plan F, but what you would be doing is you would have an annual savings of $480.

I just did an example. If you had a $2,000 Part B expenditure, the policyholder would incur a $100 Part B deductible, and then 20 percent of that $2,000 is $400, for a total incurred amount of $500. If the beneficiary pays 50 percent of that, then the beneficiary would pay $250 out of pocket and would still have saved $230. It still has all the other coverage that they have under Plan F.

Chairman JOHNSON. That's interesting. All right.

The issue of "first dollar" coverage is, of course, a very important issue. I would like each of you to enlarge on that a little bit more. It is certainly true that it discourages buying, buying both needed services and unneeded services.

Are there structures in the real world that allow a differentiation between those things, at least at the preventive level? Are there other comments that you might have on how to structure a "first dollar" responsibility, or do you think having a "first dollar" responsibility is just something we shouldn't do?

Mr. Hackbarth.

Mr. HACKBARTH. A couple of quick reactions.

One, there is two different sets of reasons for having some front-end cost-sharing. One is to try to effect the utilization pattern. The other is just as a matter of allocating resources.

I mentioned in my comments that in our thinking about the issue there did seem to be a consensus among Commissioners that we ought to have better coverage at the back end for the patients using the most services, and in exchange for that, have some front-end cost-sharing for all services. So, that's a decision based primarily on how we make the best use of limited resources. That's a good, general trade consistent with insurance principles from our perspective.

In terms of the effect of cost-sharing on use of services, I basically agree with Tricia's summary of the available evidence, with

a couple of additional points. One, with regard to the RAND Health Insurance Experiment, which, by the way, did not include seniors—the oldest people included were 62, as I recall—there was a decline in utilization. As Tricia said, it was a mixture of both effective and ineffective services that were foregone as a result of cost-sharing.

The RAND experiment found no effect on the general population of foregoing the services, no effect on their health status, with the important exception of some health effects for low-income people and people with some particular conditions. So, in general, there was no negative health status effect. It did only apply to a non-Medicare population.

Whether we could extrapolate that finding to Medicare is very much in doubt. It's a question because of the differences in the populations.

With regard to other research that's been done, there have been a fair number of studies specifically directed at cost-sharing and its effect on seniors, but none of them have been experimental like the RAND Health Insurance Experiment. So, even though they're done by very capable researchers, they are always plagued by not having an experimental design and there are questions about whether you're appropriately controlling for all of the variables, what's the cause, what's the effect and all that.

In most of them, the vast majority of them focus on prescription drug cost-sharing as opposed to cost-sharing for other services.

The last point, as Tricia said, cost-sharing does tend to work on the decision to enter the system, and it would effect most powerfully the initial decision to seek services, as opposed to the services delivered to a patient once they are in the system. So, it would have the greatest effect on ambulatory services. This is one reason why many people recommend that there be reduced or no cost-sharing for preventive services, for services that you really want to encourage.

Chairman JOHNSON. Thank you. Would anyone else care to comment?

Mr. White.

Mr. WHITE. Yes. We believe that consumers should have the ability to choose what they want, and right now it appears that the consumers are choosing in the Medicare supplement market "first dollar" coverage. Sixty-seven percent of the policies being sold are plans that offer coverage for the Part A and B deductibles.

Persons that are purchasing Medicare supplements should also have the same options that are available to other people. The Federal employees program, if you choose the Blue Cross option, it covers everything with a complete wrap-around. The TRICARE For Life was recently introduced. It's a complete wrap-around. A lot of employer-based plans are complete wrap-arounds, along with Medicaid, which the reason there is obvious.

If you look at how much impact does Medicare supplement "first dollar" coverage have, it's really only going to be—If it's 67 percent of the people purchasing those plans, and then only 25 percent of the people buy Medicare supplements, we're only talking about a small fraction of Medicare beneficiaries.

Why do people choose these plans? One, it's financial. It makes it predictable. The second is the billing. Personally, I'm dealing

with my mother, who recently passed away, and it makes it much simpler to know that if she is balanced billed, I don't need to worry. I don't need to talk to Medicare and talk to the insurance company. I can stay out of it. I'm fortunate because I know the system. It makes it much simpler for consumers.

On the effect of cost-sharing, I tend to agree with what Tricia is saying. I do not see, in the data I look at, that the cost-sharing would have that much benefit. I offer certain plans and I compare the cost between plans. I do look for anti-selection—drug plans have higher medical costs, versus the non-drug plans. When you look at the plans that have the Part B deductible and those that don't, there is not a radical difference in the claims cost once you adjust for the benefits. So, I'm not saying that utilization is——

Chairman JOHNSON. However, the choices under Medigap really don't give you any information on that point, because if you look at the benefits offered by the plans, in addition to copayments for A and B, foreign travel—How big an issue is this? Under coinsurance, most people don't realize how exposed they are, and that's not a big item. In other words, we don't have any experience in offering a supplemental that has variable copayments and offers variable opportunities to participate. So, seniors can't see what the impact would be for them on their premiums.

We do have seniors paying extraordinary premiums under Medigap now. That really concerns me, because I sit with seniors who are very upset about the premium cost and, honestly, they're never going to use their premium. So, I am concerned that there's a very narrow range of choice for seniors.

There are two series of questions the Subcommittee will have to look at. One is, do we simply outright require everybody to carry some "first dollar" responsibility for the Medicare program, certainly exempting preventive care services? Do we make some similar exception for chronic care patients, so that, in a sense, everybody knows that they are part of the action?

Then the other issue is, how much can you vary those so that you can vary premiums? Then, if they want almost 100 percent coverage, they pay a higher premium. If they're willing to pay 50 percent of their copayments or 100 percent of their copayments, they pay a lower premium. So, we need for seniors to have choices that will—We need them to have a choice of benefits that will more deeply affect the premium. Foreign travel is not going to affect the premium much, truthfully, and even at-home recovery is not going to affect the premium much.

I hear what you're saying about the disadvantages of requiring that everyone carry some "first dollar" coverage, although my jury is still out on whether that isn't good public policy. I don't think you can make the case that our current structure of Medigap benefits demonstrates to us that seniors want to have 100 percent coverage. Yes, they like the predictability; yes, they like the simplicity. They don't like the premiums and they have no way of seeing that, if they take some responsibility, then their premiums might be radically lower.

Mr. WHITE. I would agree. In fact, the important point is choice. We don't want this choice to be taken away. The Torchmark proposal, our only concern would be about timing and is there a better

approach perhaps—could we modify the high deductible plans F and J, offer different options, just so we keep the market simple. We would be interested in working with you on that, if you all decided to——

Chairman JOHNSON. I think we have to be rather more creative than perhaps your testimony indicated.

I'm not going to allow the other panelists to comment because this issue will come up, I'm sure, over and over again. I think I will let Mr. Stark have his chance and other people a chance to comment before they have to leave.

Mr. STARK. Let me just see if I can review how we got where we are.

First of all—and I would direct this to Mr. Still and Mr. White—the insurance industry, in the best tradition of free enterprise and free markets, basically wrote the various Medigap plans, did they not? The designed them. When the bill came into effect, they met with the Secretary of U.S. Department of Health and Human Services (HHS) and came up, as an industry, with the various plans, A through J or whatever they are.

Mr. WHITE. Actually, I believe that was deferred to the National Association of Insurance Commissioners.

Mr. STARK. Well, in conjunction with these various State insurance commissioners, yeah. In other words, the industry and the industry State regulators agreed, maybe compromised, for a set of benefits.

Mr. WHITE. Consumer representatives, also.

Mr. STARK. We basically had nothing to do with it. Yeah, that's right, and the consumers protecting them overly aggressive insurance companies, which is what actually triggered the legislation in the first place. There was confusion among the seniors, who were unable really to discern what very aggressive salespeople might tell them were the benefits, and there was no way to really compare prices when you had a variety of benefits, as the Chairman has suggested, what is the value of a foreign travel benefit, and I suspect you could oversell that.

To change Medigap offerings today would be done by the same procedures, as I read the law—I happened to write it, so I think I recall this—and you would once again meet with the insurance commissioners and the Secretary of HHS and redesign the benefits. I'm sure the Chair would join with me in encouraging you to do that.

I think both of your testimonies have indicated that you would just as soon wait until Medicare is reformed or not reformed, as we may decide, so that you don't have to do it a couple of times, that once there is a new Medicare, or if there is a new Medicare design, that it might be time then for the industry, who doesn't have to offer this policy—we're not directing you to; it's a private, free enterprise issue—would get together. Is that not correct, Mr. Still, and meet once again and negotiate with the insurance commissioners in denying new benefits?

Mr. STILL. That's not our proposal. Our proposal is to——

Mr. STARK. I know that's not your proposal, but that's what the law is.

Mr. STILL. We would propose for Congress to actually write the bill.

Mr. STARK. I would suggest to you that that's a formula for disaster. You all did a pretty good job when you did it early on. Now times have changed. There wasn't as much demand for drug benefits when this bill was first written. That has changed.

I'm perfectly willing—and we did decide and that's why the insurance industry cooperated with us in the bill in the first place, to say, look, this is your business, you decide what—you know the market. Mr. White is an expert in that, in marketing to seniors, is that not correct? I think you mentioned that what seniors like most is the predictable premium. They don't want to worry about whether they're going to pay 50 percent of this and how much of that because most live on very fixed incomes, and to know that this set monthly premium takes care of their problems as they see it, is what makes them decide. Was that a fair assessment, Mr. White, of what your research finds?

Mr. WHITE. Yes. Well, for 67 percent of the people perhaps. Yes, they do—and this is consistent with when we did research back before standardization when we started offering the standardized plans and asked them, what were they interested in.

Mr. STARK. You wanted to sell them a plan.

So, what I'm suggesting is that I think we have a lot of faith in the free enterprise system here, and I think we would encourage you to go back with the insurance commissioners, who do regulate you, and all we look for was a standardized set, whether it was 10 or 12 or 20, was pretty much up to you, even leaving some creative loophole in there that said, if a State found a special policy, if you needed it for ice fishermen who had hyperthermia a lot, like in Wisconsin, where if they fall through the ice they could have a special benefit——

Mr. KLECZKA. Or sunstroke like California.

Mr. STARK. Or sunstroke like in California, all right. I think that this has worked well. I think it served the public. They've been able to identify the various costs. It may not today, particularly in the pharmaceutical benefits, have all of the desired features the public would like, but that's up to you guys to decide. I have a great deal of faith in your doing that.

If I could, Madam Chair, for an additional second, just on another issue. I gather that you, Mr. Still and Mr. White, would agree with that. That's what the law would call for as it's currently written.

Mr. STILL. What we would propose under the McCarren-Ferguson Act, of course, if Congress speaks, then it preempts the State law. So, there is a way that Congress can define the plan——

Mr. STARK. We spoke.

Mr. STILL. If Congress were to define a new plan——

Mr. STARK. We speak again? The plan is yours. You guys have to decide. We can't tell a private industry what they have to sell or not sell. You guys could back out. I could say to Torchmark, you've got to offer a policy like this, and you would say huh-uh, I ain't going to do that. There's nothing we could do to force you. So, for us to have coverage available to beneficiaries, you guys have to

come up with something that arguably you can sell and make a profit, and that the seniors want.

I just want to hear from Mr. Hackbarth and Dr. Neuman. My sense is that the research, such as it is, would indicate that there are not great savings available to any insurance system by increasing a huge copay. As I recall, Kaiser Permanente, not the Kaiser Foundation, found that after a certain level of copay—$5 or $10—you didn't get much change in behavior, or when you dropped it a certain level. In other words, for $5, you got as much people withholding as you did if you went to 15, and if you got too high, people didn't come at all. If we're looking for cost savings, I guess my question to Dr. Neuman and Mr. Hackbarth is, looking at limiting "first dollar" coverage would probably do more harm than it would be worth for the same savings we would get. Is that a fair assessment of what the research tells us so far?

Mr. HACKBARTH. On the first piece, on how large is the effect, again we're handicapped because we don't have Medicare-specific research. In the case of the RAND Health Insurance Experiment, for the plan that had 25 percent coinsurance basically across the board, the effect was large. It was like a 20-percent reduction in utilization of services. So, the effect can be substantial. That's fairly significant cost-sharing, of course, but the effect can be substantial.

The real issue is around again, what is the impact on necessary care and ultimately on health status. Cost-sharing can make a difference in utilization.

Mr. STARK. Trish?

Dr. NEUMAN. I would agree with that. I think the real issue, though, is setting the right amount, what level should the deductible be, what level should the cost-sharing be, if there's going to be cost-sharing under Medicare or under any of these policies.

Actually, employer plans, while they're really generous in wrapping around Medicare, many of them do maintain some smaller, a $200 deductible, so they don't fully shield seniors from the $840 deductible, but they partially do. So, I think I would agree completely with Glenn on his comments about this level of savings, because they are real, but the concern is savings at what cost. So, you might want to give greater thought to how high the cost-sharing responsibility should be, so that you don't really penalize people with modest incomes who can't really deal with the calculus of making a decision of when they're avoiding care that's less essential, versus care that might be necessary. There's lots of evidence to show that they do both.

Mr. STARK. Thank you, Madam Chair.

Chairman JOHNSON. Mr. McCrery.

Mr. McCRERY. I'll just address this to anyone on the panel who can answer it. If we were to decide that we wanted to allow Medigap plans more flexibility, in terms of their design, would that have to be done by legislation, or could it be done by referral to the same group that Mr. Stark referred to?

Mr. STILL. I believe it would have to be done by legislation. What I proposed to Mr. Stark, would be to have a new plan and just create that legislatively. That would be the most efficient and cleanest way to do it, and Congress has the authority to do that.

Mr. McCRERY. Thank you. Madam Chair, I have no further questions.

Chairman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair. Dr. Neuman, it's good seeing you again. In your testimony, I thought you indicated—and correct me if I'm wrong—that currently in the Medicare program there is some high cost-sharing; however, you went on to say that we could probably look at cost-sharing for what you term "nonessential care."

Could you give me a feel for what we're talking about when you talk about "nonessential care"? What type of procedures are——

Dr. NEUMAN. Well, first I would like to say that this would not be my view of what nonessential care is. The RAND Health Insurance Experiment had a group of clinical advisers that looked at people with different conditions. They made determinations of what would be clinically indicated and what might not be clinically indicated for a person with a specific health problem under certain circumstances.

Mr. KLECZKA. So, you're not willing to give me a specific procedure that that bad study called "nonessential care"?

Dr. NEUMAN. Well——

Mr. KLECZKA. If it's nonessential care, it's probably not covered by Medicare, or I hope it's not.

Dr. NEUMAN. Glenn, perhaps your work at MedPAC speaks to this question.

Chairman JOHNSON. Medicare covers you whenever you go to the doctor, whether you needed to or not.

Mr. KLECZKA. I can give you some examples.

Dr. NEUMAN. The point is, if you have a health problem, if you don't have symptoms related to a condition like diabetes, you may not need to have tests that diagnose diabetes. There are some things that are appropriate and some things that are not appropriate for people, given their conditions.

Mr. KLECZKA. Bad example. I don't buy that one.

Dr. NEUMAN. Glenn.

Mr. HACKBARTH. I can't speak specifically to what the RAND Health Insurance Experiment considered unnecessary care, but an example of where front-end cost-sharing might have a significant effect is in terms of ambulatory visits to a physician. Again, there will be arguments about whether this is a loss or not in terms of beneficiary welfare, but that's an area where you would probably expect to see a decline in utilization.

In my experience in talking to physicians, they will talk about beneficiaries who are non-Medicare patients who require extra visits, often for reassurance. Sometimes physicians talk about the "worried well." That's a type of visit that might decline in the face of cost-sharing.

Again, whether we want that to happen or not is another question. It's effect on health status of the beneficiary may be minimal of losing that sort of visit.

Mr. KLECZKA. Is the Medicare program rampant with these types of office visits you just cited?

Mr. HACKBARTH. I can't answer that. I don't know the answer to that. I don't know how frequent they are.

Now, by definition, we would be talking about patients that have some medical problem, because Medicare doesn't cover——

Mr. KLECZKA. Trish, do you have any——

Dr. NEUMAN. I don't think there's any evidence that the program is rampant with people using services willy nilly that they don't need.

Mr. KLECZKA. Well, my two colleagues on the right here indicated that yeah, it does happen in Medicare. From the discussion here, it's not a real big abusive problem that I'm aware of. I stay away from the doctor——

Chairman JOHNSON. Would the gentleman yield?

Mr. KLECZKA. Sure.

Chairman JOHNSON. Frankly, we don't know the dimensions of the problem, nor is anyone suggesting we try to find out. I don't think the Medicare program is structured, nor do we want the Federal Government trying to evaluate whether any particular item of care was necessary or not necessary. I think the statistics that I gave in my opening comments do give us some reason to believe that there is overuse. Beneficiaries with Medigap insurance policies consume $1,400 more in Medicare services than beneficiaries without supplemental coverage. So, that's——

Mr. KLECZKA. Maybe those buying supplemental coverage are sicker. If I'm a healthy senior, I'm not going to buy a supplemental because I have the basic plan and I'll go bare, and once I turn 73 and start creaking around——

Chairman JOHNSON. Mr. Kleczka, can I just finish my sentence?

Mr. KLECZKA. Sure. —and I start creaking around, then I'm going to start looking for a Medigap policy. That's wise consumerism.

Chairman JOHNSON. Miss Tubbs Jones.

Ms. TUBBS JONES. Thank you, Madam Chairman, for the opportunity——

Mr. KLECZKA. I wasn't done yet, but go ahead.

Chairman JOHNSON. Ms. Tubbs Jones.

Ms. TUBBS JONES. Thank you, Madam Chairman, for the opportunity to inquire. Dr. Neuman, I'm interested, because a significant number of my constituents are low-income persons, about, from your perspective, what basic provisions Medicare covers and what are they missing out of without the ability to purchase a Medigap policy?

Dr. NEUMAN. Well, Medicare does provide a pretty good range of basic services. The big gap in Medicare from the perspective of seniors is prescription drugs. That's the real issue. Some, but not all, are able to get prescription drugs through other sources, like the M+C plans, depending on where they live, or Medigap, if they're able to find a policy and don't have health problems that would exclude them, or from Medicaid if they're very low income. That's really the number one concern.

Ms. TUBBS JONES. Now, if they're very low income and they can get—Let me ask another question.

The way the Federal Government figures out how you are able to access assistance, there is probably a group of folks—and I'm not speculating; I'm asking this question of you—that fall above what

Medicaid covers and below what these supplemental programs, if I were able to afford one, would cover.

Dr. NEUMAN. You're absolutely right. Medicaid does not cover everybody up to the poverty level, so if you think of poverty being around $9,000 for a single person, and if you think you're low income if you're maybe earning less, or have an income of less than $20,000, you probably have more than a third of all people on Medicare in that group right there who would be low income but wouldn't qualify for Medicaid.

Ms. TUBBS JONES. I find this very interesting because earlier today I was participating in a Subcommittee on Social Security hearing, where we were talking about the government pension offset and a husband and a wife both having participated in Social Security, and when one spouse dies the other one doesn't get the full income but gets a portion of it, we were looking at the—The person who testified said to me that, in order for me to get $1,000 a month income, I would have had to have made $36,000 annually in order to get $1,000 a month in Social Security.

When you contemplate that this group we're talking about probably made no where near $36,000, we have a significant number of folk out there who are not receiving Medicaid and can't afford Medigap.

I'm going to ask Mr. White this question as well. We are paying for these people at some point, at some time, either in more serious, acute care down the line, or in chronic illnesses that they have, even without this type of coverage. What would you suggest as a policy person, each of you, what do we do to cover that group that can't afford Medigap and make too much money to be in Medicaid? That's our dilemma, at least from my perspective.

Dr. NEUMAN. Well, I'll get it started, and I'm sure the other panelists will have some comments.

Today, Medicaid helps some people, and there is some discussion about—there had been discussions before the current fiscal crisis facing States, of either federalizing some of the benefits that are available to low-income people through Medicaid, or expanding the role of Medicaid. I think Medicaid expansions appear a more difficult proposal now, with States facing large deficits. So, then the real issues involve expanding Medicare directly, to provide the benefits directly, or provide more affordable coverage in the supplemental market. Supplemental coverage is available, but for many people it's quite expensive.

Maybe the others would have some comments about how to make it more affordable.

Ms. TUBBS JONES. I'm sorry. I didn't mean to leave you, Mr. Still. My father is a graduate of Parker High School, Birmingham, Alabama, or Mr. Hackbarth. Please join in.

Mr. STILL. Trish has some connections to Birmingham, too. She had grandparents there.

Ms. TUBBS JONES. Okay. Good.

Chairman JOHNSON. We're going to have a vote, so let's focus on your comments.

Mr. STILL. We are trying to make the products more affordable. We are trying to do that. Our suggestion would be to try to make these more affordable. I'm not sure we could take care of everyone

who falls between Medicaid eligible and someone who can afford a Medicare supplement. We're trying to reduce the prices of these products to make them more affordable.

Ms. TUBBS JONES. Mr. White, I apologize. We're about to have a vote, so I'm going to terminate my questioning—only to say this. Clearly, if we didn't have the tax cut that's being proposed, we might be able to pay for some of the health care benefits that many of the people that are left out of this process can afford.

Thank you, Madam Chairman, for the opportunity to be heard.

Chairman JOHNSON. I thank my colleague. I think if you attended the full Committee hearing, you would have heard from all of the experts, that there is no way, even with the tax cut, under any other circumstances, that we're going to buy ourselves out of this problem. We've got a big problem looming, and the tax cut, eliminating the tax cut, does not solve the problem. So——

Ms. TUBBS JONES. Madam Chairman, I'm thankful that you brought out to the attention of the world that I wasn't at the whole hearing, but there are other issues going on that I'm required to pay attention to.

Chairman JOHNSON. Thank you. I do want to return to the issue of overuse, and if Mr. Kleczka would like to comment, he is welcome to do so.

I think it is significant, or at least I would like to better understand, why people with Medigap insurance do consume $1,400 more on average for Medicare patient, when employer-covered people only consume about $900 more. So, there is a difference between the structure of the employer plans. Generally, they have more copayments and "first dollar" responsibilities, and people get better coverage with Medicare and the employer, and yet they're only consuming, on average, $500 more per patient. So, you would assume that they're not able to have health care that they need, as Mr. Kleczka clearly pointed out some people without Medigap, and Ms. Tubbs Jones clearly was concerned about—and that's a group we've been concerned about—don't have the resources to get into the system. Nonetheless, that difference between $1,400 and $500 is significant and does suggest, in my mind, overuse. Is that a conclusion that is illogical?

Mr. HACKBARTH. Cost-sharing clearly matters. It affects utilization of services. I think that's pretty much beyond dispute, and it may help explain the numbers that you're talking about.

The issues tend to be about whether the reduced utilization has an adverse effect on health or not, and there the questions are more complicated.

Chairman JOHNSON. It's likely, with the employer provided plans, that it doesn't deny access that is needed. It suggests to me that the difference between the $500—so you have a difference between the $1,400 level of usage and the $500 below that, so one could suggest that you may have about a $500 on average overuse.

Mr. HACKBARTH. I'm not familiar with all the details of the studies you're citing, but as I understand what's happening with employer-provided retiree coverage, there is now a tendency to move toward means of coordinating the benefits, the result in people continuing to face some front-end cost-sharing, as opposed to the employer picking up all of the Medicare cost-sharing. To the ex-

tent that they are facing some cost-sharing as opposed to Medigap beneficiaries, who have basically "first dollar" coverage, that might help explain the utilization difference.

Chairman JOHNSON. Dr. Neuman, would you care to comment?

Dr. NEUMAN. I would just concur with that. Our work with Hewitt Associates has found that employers are maintaining some level of cost-sharing through deductibles, so many people with employer coverage don't have "first dollar" coverage.

Chairman JOHNSON. Thank you.

Dr. NEUMAN. However, let me just add that they are not required to pay the full Part A deductible. The amount that's required is generally in the $200–$300 range.

Chairman JOHNSON. We are looking into that, what exactly is the general shape of the employer provided coverage.

The gentleman from California, would you care to——

Mr. STARK. Thank you.

I was just going to ask Mr. White and Mr. Still if they were familiar with the previous Medicare plan that the majority introduced that had a $250 deducible and a 20 percent cost-sharing for the next $750, and then a 50-percent cost-sharing for the next $1,000, and then 100 percent cost-sharing for the next $2,800 and so forth.

Have you ever come across a similarly structured drug benefit in your experience in the medical insurance world that has the "donut hole," as it was called, and is that something that is used in any other insurance program that you know of?

Mr. WHITE. I think I've heard of one or two very limited uses of that. It's called a "corridor" deductible, which is the technical term for it.

Mr. STARK. A which?

Mr. WHITE. Corridor deductible is the standard term.

Mr. STARK. Mr. Still.

Mr. STILL. I'm not the best witness on this point.

Mr. STARK. Thank you, Madam Chair.

Chairman JOHNSON. I thank the panel, and appreciate your——

Ms. TUBBS JONES. Madam Chairman, just briefly, could I have unanimous consent to submit an opening statement for the record on this issue?

Chairman JOHNSON. I would prefer not to set that precedent, just because you're not a Member of the Subcommittee.

Ms. TUBBS JONES. I'm a Member of the full Committee, ma'am.

Chairman JOHNSON. I appreciate that.

Mr. STARK. Madam Chair, I——

Chairman JOHNSON. There is a Subcommittee structure that I think is responsible—I have tried to be welcoming and respectful to——

Mr. STARK. Madam Chair, could I ask permission to submit an extended opening statement?

Chairman JOHNSON. You certainly may.

Mr. STARK. Thank you.

Chairman JOHNSON. The meeting is adjourned.

[Whereupon, at 1:23 p.m., the hearing adjourned.]

[Submissions for the Record follow:]

Statement of the American Association for Homecare

The American Association for Homecare (AAHomecare) would like to thank Chairwoman Johnson, Ranking Member Stark and the Ways and Means Health Subcommittee, for the opportunity to provide testimony on rationalizing Medicare cost-sharing. We appreciate the Subcommittees work to strengthen and preserve Medicare and look forward to continuing to work with the Subcommittee.

AAHomecare is a national association representing a continuum of home health care including home health agencies, suppliers of durable medical equipment (DME), orthotics and prosthetics, and suppliers of re/hab and assistive technology. As a representative of home health agencies, our members are very concerned about proposals to add a copayment to the Medicare home health benefit.

BACKGROUND

The typical Medicare home health patient is female, older, poorer, more likely to live alone, and more likely to have three or more impairments in activities of daily living (ADLs) than the average Medicare beneficiary.

As you know, last year the House of Representatives rejected the inclusion of a home health copayment in the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954). This legislation also included an elimination of the 15% cut and an extension of the 10% rural add on for home health services provided to beneficiaries living in rural areas. Unfortunately, since the bill was not approved by the Senate, the 15% cut went into effect on October 1, 2002 and the rural add on expired on April 1 of this year. While the true impact of these recent reimbursement cuts has yet to be determined, home health agencies have closed since the enactment of the 15% cut and many of the remaining providers are finding it extremely difficult to continue providing medically necessary health care services to beneficiaries in the home. The home health industry desperately needs a period of stability to enable providers of home health services to continue to provide services to the most vulnerable medically complex patients.

CONGRESS SHOULD NOT ENACT COPAYMENTS FOR HOME HEALTH

Copayments Would Have Disproportionate Impact on Frail Elderly

AAHomecare strongly opposes adding a copayment to the home health benefit for many reasons outlined throughout the testimony. A copayment would fall heaviest on the sickest Medicare home health patients, those having multiple episodes of care. Home health patients are typically older, sicker, poorer, and are the least likely to have disposable incomes. 70 percent of beneficiaries are over age 75, and 25 percent are over 85. Most have incomes of less than $15,000 per year, while 43 percent have less than $10,000 per year. They are confined to home, unlikely to ever return to work, and unable to earn money to offset the cost of an additional copayment.

Home health beneficiaries are already subject to copayments and assume responsibility for many of their health care costs, including the 20% copayment for physicians' services which is an essential part of covered home health services. In addition, home health beneficiaries pay for more of their health care costs than beneficiaries in other treatment settings, as well as their food, shelter, and other costs necessary to remain at home. Copayments would increase beneficiaries' costs without improving the Medicare home health benefit.

Copayments Will Undermine The Patient Caregiver Relationship and Increase Administrative Burdens on Home Health Agencies

AAHomecare also has concerns regarding the change in the relationship between the beneficiary and the caregiver implementation of a copay would bring. If home health agencies are required to collect a copayment the beneficiaries in many cases will refuse care. In addition, implementing a copayment would add new administrative burdens to home health agencies when they can least afford it. Agencies would be forced to set up new billing and collection systems at the very time they are still trying to master the intricacies of the new prospective payment system and OASIS, as well as preparing for implementation of the Outcome Based Quality Improvement system and HIPAA privacy and transaction standards. These new administrative costs are being imposed upon home health providers in the wake of reimbursement reductions of over 50% stemming from the Balanced Budget Act of 1997.

Copayments Not Needed To Reduce Home Health Rate of Growth

One argument in favor of copayments is that they would help contain the rate of growth in the industry. AAHomecare does not believe that copayments are nec-

essary in order to control the rate of growth in home health. Since 1997, approximately 1.2 million Medicare beneficiaries have been lost from the home health benefit, payments have been cut by more than 50%, and the number of home health providers has been cut by 36%. MedPAC concluded in its March 2003 report that following the implementation of home health PPS, there continues to be a decline in the number of beneficiaries receiving home health services. Simply stated, there is no reliable evidence to show that the home health benefit is growing at an inappropriate rate.

One other misunderstanding is that home health is the only benefit under Medicare that does not currently have a copayment. This is not true. The Medicare program does not impose a copayment on the first 60 days of inpatient hospital services or on outpatient clinical laboratory services.

In 1997, when Congress created the prospective payment system for home health it was done in part as an alternative to copayments. At the time, Congress supported PPS over copayments because PPS promotes efficiency and appropriate care, while copayments restrict utilization by penalizing the sick. If given time to stabilize, the PPS system currently in place can be refined to address issues with the Medicare home health benefit.

CONCLUSION

In closing AAHomecare would like to reiterate its recommendation that the Subcommittee reject the idea of adding a copayment to the home health benefit. Congress should follow the recommendations of the Polisher Research Institute by giving the home health benefit a chance to stabilize.

Statement of the American Medical Association

The American Medical Association (AMA) appreciates the opportunity to present to the Ways and Means Subcommittee on Health our views on Medicare cost-sharing and Medigap, and we applaud the efforts of the Chairman and Members of the Subcommittee for focusing on this important issue.

For years the AMA has been a strong advocate of basic, essential reforms of Medigap and the cost-sharing aspects of the Medicare program, and AMA policy supports the following modifications in this regard.

Medicare Beneficiary Cost-Sharing

The AMA recommends that the Medicare fee-for-service program implement a single combined deductible for beneficiaries, instead of the existing, separate Part A and B deductibles, and, in addition, we recommend a cap on beneficiaries' total out-of-pocket spending.

Beneficiary cost-sharing in the traditional Medicare fee-for-service program is a key contributor to the bleak outlook for the Medicare program's long-term finances. Because patient copayments are not capped and hospital benefits diminish and eventually expire if patients have to stay in the hospital for a lengthy period, beneficiaries annually face potential out-of-pocket costs for covered Medicare services of as much as $34,000. Beneficiaries also face additional and exorbitant out-of-pocket costs for non-covered medical services. These enormous potential costs generate a huge demand for supplemental insurance, or medigap, policies. Far from being a solution, however, medigap is part of the problem.

The Medigap Problem

As the General Accounting Office (GAO) recently testified, Medigap coverage is expensive and its costs are increasing rapidly. Fewer employers now offer retiree health benefits (34% in 2001, down from 66% in 1988) and even fewer offer supplemental coverage to their Medicare-age retirees (23% of firms in 2001, down 10% since 1999). More beneficiaries must, therefore, buy medigap policies themselves, and annual premiums averaged $1,300 (but the range could exceed $5,500) in 1999 and rose by up to 34% in 2000.

Medigap policies also encourage inappropriate utilization of services since they offer first-dollar coverage that completely insulates patients from the costs of covered services. The current system is designed so that the beneficiary's rational response is to obtain supplemental coverage, which the majority of beneficiaries do as a hedge against economic catastrophe. The risk of paying

tens of thousands of dollars out-of-pocket is not one that most beneficiaries want to take.

Further, government studies have shown that beneficiaries with Medigap utilize 28% more medical services than they would otherwise. While Medigap plans cover about 20% of the cost of this increased utilization, the Medicare program pays 80%. Besides adding to the strain on Federal resources, the 80% that Medicare pays increases Medicare premiums for all beneficiaries, whether or not they have Medigap.

The AMA would like to work with Congress and the Administration to design enhancements for both traditional Medicare and new private plan options, including restructuring Medicare's cost-sharing policies, as discussed above, to reduce potential beneficiary liability in a manner that eliminates the need for private Medigap insurance.

As an example of the benefits of a more sensible cost-sharing structure, PriceWaterhouseCoopers has estimated that a system with a combined refundable deductible of $500 and no additional cost-sharing would reduce Medicare spending by about 4.0% for each enrollee who selected this type of plan.

The Baby Boomers will begin aging into Medicare in just a few years, and it is imperative that we take steps now to improve and secure the program for this generation of older and disabled Americans and the generations to come.

We again thank the Subcommittee for your leadership on these important matters and for the opportunity to provide our views.

Statement of the Coalition to Promote Choice for Seniors

The Coalition to Promote Choice for Seniors represents the vast majority of companies who provide supplemental Medicare coverage to over 10 million Medicare beneficiaries. Numerous public and private sector studies have demonstrated that Medicare beneficiaries express overwhelming satisfaction with Medicare supplemental insurance, including Medigap plans.

When considering issues related to Medicare cost-sharing and Medigap, we would recommend that the Committee consider the following principles:

- The overwhelming majority of senior Medicare beneficiaries currently elect to obtain their Medicare health care services through the traditional fee-for-service delivery system. Policymakers should take no action that endangers the delivery of health care service to senior Medicare beneficiaries.
- Private, voluntary Medigap coverage can continue to provide older Americans with a valuable Medicare drug benefit that might not otherwise be available to them.
- To help keep Medigap coverage affordable for older Americans who choose to purchase private insurance, a one-time open enrollment option should be retained to avoid adverse selection and higher costs.
- Seniors should continue to have access to existing Medigap products. Further, insurers should have the flexibility to continue offering existing products, but must be able to discontinue failed products if necessary.
- In order to provide the most appropriate level of benefits to seniors, insurers should have the ability to employ tools used in the commercial market to manage the benefits.
- Seniors should be afforded the option of first dollar insurance coverage that is consistent with many employer-provided retiree offerings.

The Coalition to Promote Choice for Seniors consists of the following companies and associations: Blue Cross Blue Shield Association; Health Insurance Association of America; Highmark Blue Cross Blue Shield; Monumental Life Insurance Company; Mutual of Omaha; National Association of Health Underwriters; Torchmark Corp.; WellPoint.

Statement of the Health Insurance Association of America

Introduction

The Health Insurance Association of America (HIAA) greatly appreciates the opportunity to submit written testimony for your May 1, 2003 hearing from the standpoint of our member companies (Medigap policy issuers) and their customers (Medicare beneficiaries). HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 mil-

lion Americans. Many of HIAA's members provide Medicare supplemental insurance products, including individual Medigap policies.

Need for Medicare Supplemental Benefits

Medicare beneficiaries are at risk of incurring major out-of-pocket costs for medical care. The Medicare Part A deductible for each episode of inpatient hospitalization in a year is $840 in 2003. There is a $100 annual deductible for physician and other outpatient benefits covered by Part B. In addition, once the deductibles have been met, beneficiaries may incur substantial cost-sharing obligations for covered services. Medicare places no limit on out-of-pocket expenditures for these payments. In addition, Medicare beneficiaries are fully at risk for benefits that Medicare does not cover at all, such as most outpatient prescription drugs. Attachment A lists the major health care expenses not covered by Medicare. The Secretary of the U.S. Department of Health and Human Services, in April 2002 testimony to the House Ways and Means Committee, noted: "Because of the major gaps in the benefit package in the fee-for-service [Medicare] program, supplemental coverage—often called Medigap—is an essential part of Medicare coverage for millions of our nation's elderly and disabled." [1]

Beneficiaries Value Supplemental Coverage

Because of the cost-sharing requirements on covered services, and limits on what services are covered, as noted above, Medicare is estimated to cover only about half of the health care costs incurred by seniors and other beneficiaries. It is little surprise then that nine out of ten Medicare beneficiaries obtain additional coverage to supplement their Medicare benefits and protect themselves from these substantial costs. In 2000, the major sources of coverage supplementing Medicare were employer-sponsored coverage (32 percent of beneficiaries) and individually purchased insurance policies, i.e., Medigap plans (27 percent of beneficiaries). This 27 percent translates to over 10 million Medicare beneficiaries enrolled in a Medigap plan in 2000.[2] Estimates of the number of Medigap enrollees for a sampling of States in 2001 include: California, 584,000 Medigap enrollees; Connecticut, 138,000; Florida, 663,000; New York, 382,000; Pennsylvania, 664,000; and Texas, 500,000.[3] Attachment C shows Medigap enrollment in 2001 for each State.

Medicare beneficiaries overwhelmingly value and express satisfaction with Medicare supplemental insurance, including Medigap plans. Annual surveys of Medicare supplemental insurance policyholders conducted by the U.S. Department of Health and Human Services consistently show a high level of satisfaction with supplemental coverage. In a 2001 survey conducted by American Viewpoint, 89 percent of beneficiaries were satisfied or very satisfied with their Medigap coverage, while 76 percent said that, considering the premiums they pay, the policies are a good or excellent value. What they value most is peace of mind from knowing what their medical costs will be and the lack of paperwork—they don't have to hassle with medical bills. The vast majority (81 percent) would recommend Medigap coverage to a friend or relative when they become Medicare eligible.

Another indication of the value beneficiaries ascribe to their Medigap coverage is policy renewal and retention rates. While standardized Medigap plans have been available since 1992, the Medicare Payment Advisory Commission (MedPAC) recently pointed out that "[a]bout 25 percent of Medigap enrollees have stayed in their prestandardized plans that have been closed to new enrollment since 1992." [4] In other words, many Medicare beneficiaries retain Medigap policies they originally purchased more than 10 years ago. MedPAC went on to observe that the "benefits in nonstandardized plans tend to be similar to those found in the standardized plans." MedPAC also noted recently that there are a large number of beneficiaries in standardized Medigap plans that have been closed to new members for at least three years.[5] Clearly these beneficiaries value their current coverage.

---

[1] Testimony of Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services, before the House Committee on Ways and Means, April 17, 2002.

[2] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2003, p. 206.

[3] U.S. Census Bureau, Analysis of 2001 coverage data from the March 2002 Current Population Survey. Posted at http://ferret.bls.census.gov/macro/032002/health/h05_000.htm.

[4] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2003, p. 199.

[5] Transcript of MedPAC March 20, 2003 meeting on health insurance markets for Medicare beneficiaries.

We would argue that yet another indication of value is the fact that a number of associations serving senior citizens have chosen to offer Medigap coverage as a benefit of membership. This includes AARP. Cheryl Matheis, AARP Director of State Affairs, said the following in December 3, 2002 testimony to the NAIC Medicare Supplement Working Group:

> "Because Medicare benefits cover only a portion of a typical Medicare beneficiary's spending on health care, supplemental coverage can provide financial protection against out-of-pocket costs for many of the beneficiaries who are enrolled in original fee-for-service Medicare. Therefore, the availability of adequate, affordable insurance coverage to help supplement Medicare remains vitally important. To help make financial protection available to our members, AARP contracts with United HealthCare to offer Medicare Supplement policies to our members."

At the outset, then, we should all be mindful of the fact that seniors satisfied with their current health care coverage would likely oppose major changes to a product that already works well for them. We say this as a representative of dozens of companies whose customers include millions of Medicare beneficiaries.

In the remainder of this testimony, we will briefly describe current Medigap coverage options, review several burning Medigap issues, and provide a few recommendations for your consideration.

Medigap Benefit Design

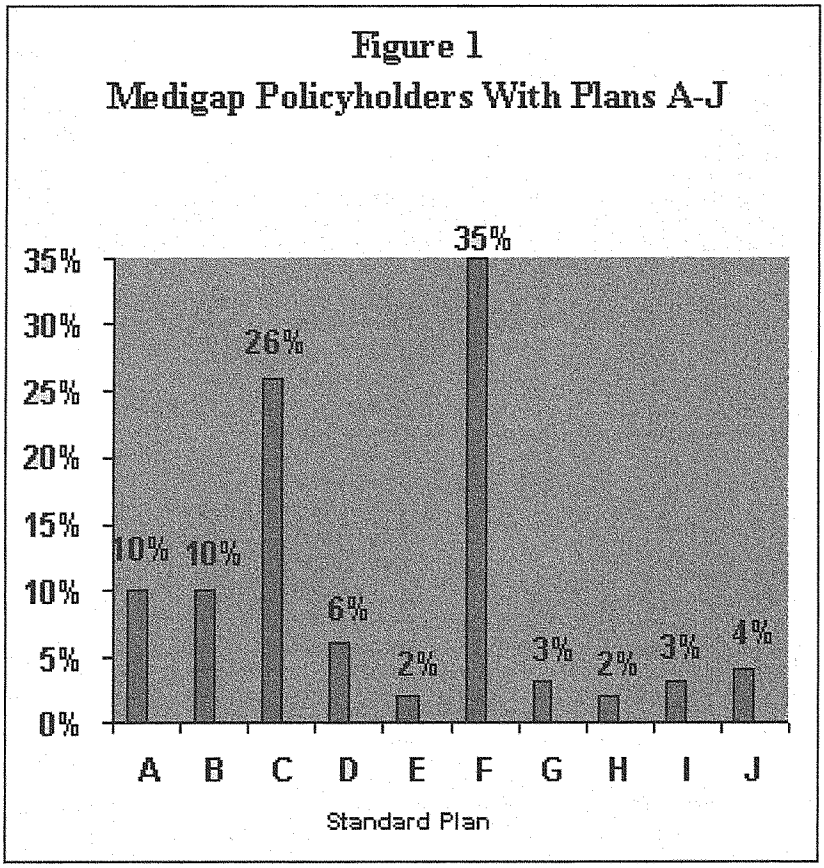
The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) limits Medigap policies to ten standard plans labeled A through J. In 1997 Congress added a high-deductible version of plans F and J.[6] Each standard plan contains a core benefit package. Plan A consists of the core benefits alone; Plans B–J contain additional benefits such as coverage of copayments for care in a skilled nursing facility, benefits for at-home help, coverage of physician charges in excess of Medicare's approved amount, and limited coverage for prescription drugs. Attachment B shows the core benefit package and the additional benefits covered by each standard plan. All Medigap policies currently issued must conform to one of the ten standard plans, although beneficiaries may renew non-standard plans issued before July 1992.[7]

Some standard plans are considerably more popular than others. Figure 1 shows the percentage of Medigap policyholders enrolled in each standard plan. As explained below, plans H, I, and J, which provide some coverage for outpatient prescription drugs, have seen low enrollment because of the effects of adverse selection.

---

[6] The high deductible plans were added under P.L. 105–033, the Balanced Budget Act of 1997. For 2003, the high deductible amount is $1,650.

[7] Three states (Massachusetts, Minnesota, and Wisconsin) kept the system of standard plans they developed prior to OBRA 90.



Source: Medicare Payment Advisory Commission, "Report to Congress: Assessing Medicare Benefits." (June 2002).

Prescription Drug Coverage

Three of the standard Medigap plans (plans H, I, and J) provide limited coverage for outpatient prescription drugs. Plans H and I contain a $250 deductible for drug benefits and pay 50 percent of drug costs up to a maximum payment of $1,250 in a year. Plan J has the same deductible but pays 50 percent of drug costs up to a maximum annual payment of $3,000. None of these plans, nor any other standard Medigap plan, provides catastrophic coverage for prescription drug costs.

Offering affordable Medigap coverage that covers prescription drugs has proven extremely difficult, especially as drug utilization and spending have increased at a rapid pace over the last decade. The 2002 average annual expenditure for prescription drugs by a Medicare beneficiary was estimated to be $1,912.[8] And during the last decade prescription drug spending has outpaced increases in other health expenditures by a wide margin, so that prescription drugs have come to account for a larger and larger portion of total health care expenditures.

In addition to the rising cost of prescription drugs, adverse selection against plans H, I, and J has driven premiums for these plans to a level where they are a reasonable purchase only for persons who have extremely high annual drug expenses. The term "adverse selection" refers to the tendency of individuals to purchase health

[8] Marilyn Moon and Matthew Storeygard, "Stretching Federal Dollars: Policy Trade-offs in Designing a Medicare Drug Benefit with Limited Resources," *The Commonwealth Fund Policy Brief.* (August 2002).

benefits only when they expect to need them. Prescription drug benefits are particularly susceptible to adverse selection in the senior market because drug expenditures for seniors tend to be more predictable (for example, because of high utilization of maintenance drugs) and are much higher than they are for younger individuals.

Over time, adverse selection has caused premiums for the Medigap plans with drug coverage to spiral upwards as the pool of persons with these plans has come to include, to a greater and greater extent, just those who have a substantial and ongoing need for prescription drug benefits. Because of this problem, many insurers no longer offer these plans.

Non-Standard Medigap Coverage

While a great deal of attention is paid to standardized Medigap policies, it needs to be remembered that a large number of Medigap policyholders actually have non-standardized policies. In its June 2002 report to the Congress, MedPAC noted that in 2000, about 400,000 Medicare beneficiaries with private Medicare Supplement insurance lived in the three States not subject to the national Medigap benefit standards (Massachusetts, Minnesota, and Wisconsin). And, more importantly, another 3.1 million beneficiaries were still enrolled in pre-standardized plans.[9] Many of these non-standard Medigap plans offer some coverage for outpatient prescription drugs.

Federal Requirements Relating to Open Enrollment and Premium Rates

In addition to standardizing Medigap policies, OBRA 90 established a six-month open enrollment period for Medigap coverage beginning when a beneficiary is age 65 or older and enrolls in Part B. A beneficiary applying for a Medigap plan during this period may not be denied coverage and cannot be charged a higher premium because of poor health. OBRA 90 also requires that all Medigap policies be guaranteed renewable regardless of when the policy is issued and increased other regulatory standards.[10]

Recent Federal laws have expanded open enrollment for Medigap plans to include certain additional circumstances—for example, certain cases where a beneficiary terminates or loses coverage in a Medicare+Choice plan or loses coverage under an employer-sponsored plan.[11] Additional proposals to expand open enrollment are presented in nearly every Congressional session. It is important for Congress to evaluate these proposals carefully. Additional open enrollment opportunities may prompt Medicare beneficiaries to delay purchasing Medigap coverage or even game the system. This can disadvantage the majority of Medicare beneficiaries who obtained supplemental coverage at the first opportunity, by driving up the costs of coverage.

State Regulation

Although Federal law establishes a wide range of requirements for Medigap coverage, the States have primary enforcement jurisdiction over Medigap insurers and policies. State regulatory authority includes review and approval of premium rates, regulation of rating practices and rules of enrollment, review and approval of policy forms, and all other aspects of insurance regulation. States may expand open enrollment and other guaranteed rights to Medigap coverage beyond the requirements established by Federal law, and, in fact, many have done so.

The Issue of First-Dollar Coverage

It is clear from Figure 1 above that the most popular standardized Medigap plans are Plans C and F—the only two non-drug plans that cover both Medicare Part A and Part B deductibles as well as Part A copayment and Part B coinsurance amounts. This benefit design is typically referred to as first-dollar coverage. Some

---

[9] Medicare Payment Advisory Commission, *Report to the Congress: Assessing Medicare Benefits*, June 2002, pp. 76–77.

[10] A guaranteed renewable policy may not be cancelled or have its benefits changed, although the premium may increase, subject to State limitations. Other requirements on Medigap plans established by OBRA 90 include requiring State approval of premium rates and reporting of the proportion of premiums paid as benefits.

[11] The Balanced Budget Act of 1997 (BBA), the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) each expanded Medigap open enrollment opportunities.

policymakers have expressed concern that first-dollar coverage, by lessening beneficiary price sensitivity, may increase Medicare spending, perhaps inappropriately.

This is not a new issue, and things are not as simple as they might first appear. To begin with, Medigap plans that do not provide full first-dollar coverage are available to beneficiaries. However, the plans that do are far and away the most popular plans among the nation's seniors. Despite the fact that less expensive plans are available, over half of Medigap purchasers select plans C or F. This popularity is likely due to the fact that Medicare beneficiaries are risk averse and derive a great deal of financial and personal security from their supplemental insurance policies.

Moreover, as mentioned above, under the Balanced Budget Act of 1997, Congress provided for two new high-deductible Medigap products. However, few such plans have actually been sold, and there are reports that the biggest hurdle to the sale of these products is overcoming beneficiary expectations that a Medigap plan will provide first-dollar coverage.

Second, if Medicare spending is higher for beneficiaries who purchase a Medigap plan with first-dollar coverage, it cannot automatically be assumed that such spending is for medically inappropriate or unnecessary services. Medicare's existing coverage and utilization review mechanisms are specifically designed to assure that Medicare pays only for items and services that are reasonable and necessary. Medicare supplemental insurers do not make independent coverage decisions. Thus, attempts to move away from first-dollar coverage might in fact impose barriers to the receipt of necessary care. A special study performed a few years ago for HIAA by Gerard Anderson and his colleagues at Johns Hopkins noted that the burden of Medicare cost-sharing is distributed unequally across beneficiaries, increasing as they become older, develop chronic illnesses, or have catastrophic illnesses.[12] Supplemental insurance spreads this risk, thereby reducing the financial burden on older beneficiaries and those with chronic or catastrophic illnesses.

Dr. Anderson's study also noted that the available literature suggested that Medicare beneficiaries' price sensitivity is greatest for preventive and physician services. According to Dr. Anderson's study, Medicare beneficiaries without supplemental insurance were much less likely to have flu shots, mammograms, and pap smears. For this and other reasons, Dr. Anderson cautioned that comparisons of the Medicare expenditures incurred by beneficiaries with supplemental coverage and those who do not overestimate the effect of supplemental insurance on Medicare spending.

Even the celebrated RAND Health Insurance Experiment, which investigated the impact of cost-sharing on health care utilization by a non-elderly population, found that when faced with cost-sharing, individuals were just as likely to limit the use of "highly effective" care as "less effective" care. Thus, as far as we can determine, the Medicare savings predicted from restrictions on first-dollar coverage of Medicare deductible and coinsurance amounts would, at least to some extent, be due to the fact that beneficiaries would be discouraged from seeking medically appropriate care. In a report last year, the Congressional Budget Office acknowledged that "the decrease in use of services by Medigap policyholders" produced by restrictions on first-dollar coverage "might not be limited to unnecessary care, so the health of some policyholders might be adversely affected."[13]

A more recent study provides actual evidence of continuing underutilization by Medicare beneficiaries. In a paper published in the Journal of the American Medical Association early this year, Federal officials noted that a large number of Medicare beneficiaries enrolled in Medicare's fee-for-service program failed to receive the amount of recommended care.[14] For example, during 2000–2001, 29 percent of Medicare beneficiaries failed to obtain a yearly flu shot, and 36 percent had never received the recommended pneumococcal vaccine. Similarly, 23 percent of female Medicare beneficiaries aged 52 to 69 failed to receive recommended mammographic screening. And, in the case of Medicare beneficiaries with diabetes, large numbers failed to receive recommended eye exams and lab tests.

The level of underutilization documented by this report was even more profound in some States. For example, 48 percent of female Medicare beneficiaries in the District of Columbia, 44 percent of those in California, and 42 percent of those living in New York did not receive the recommended level of mammographic screening in 2000–2001. In the case of annual flu shots, more than a third of the Medicare beneficiaries in Alabama, Florida, Kentucky, Louisiana, Nevada and the District of Co-

---

[12] Anderson, GF; Wiest, A; Shaffer, T; Hussey, P; and Bilenker, J. *Concerns About the Theory of Increased Cost-Sharing for Medicare Beneficiaries and Its Policy Implications for the Medicare Program*. Washington, DC: Health Insurance Association of America, 1999.

[13] Congressional Budget Office, *Budget Options*, February 2001.

[14] S.F. Jencks, E.D. Huff and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 and 2000–2001," *JAMA*, January 15, 2003, 289(3): 305–312.

lumbia did not get them. And, during this same period, 35 percent or more of the Medicare beneficiaries with diabetes living in 14 States (Alabama, Alaska, Arizona, Georgia, Indiana, Kentucky, Louisiana, Missouri, Nevada, New Mexico, Oklahoma, Tennessee, Texas, and West Virginia) did not get the recommended eye exams. In short, while some see the higher health care utilization rates of Medicare beneficiaries with supplemental coverage as a problem, the real problem may be that many beneficiaries are not getting the care they need. That may well explain why Medicare expenditures vary for beneficiaries with and without supplemental coverage.

With respect to first-dollar coverage, we would make only one additional point. The HIAA member companies that sell Medigap insurance have made it clear to me that Medicare beneficiaries—their customers—greatly prefer Medigap plans that provide full protection against Medicare deductibles and other cost-sharing amounts. They predict that any Congressional plan to restrict Medigap first-dollar coverage of such deductibles and cost-sharing obligations will, at best, be difficult for Medicare beneficiaries to understand, and could even risk producing a great deal of anger and hostility. HIAA's member companies vividly recall beneficiary reactions to the Medicare catastrophic protections passed by Congress in 1988 and repealed soon after. They wish to avoid a repeat of this kind of public relations disaster.

The Foreign Travel Benefit

Some policymakers have questioned the value of one of the prescribed benefits for most Medigap policies, foreign travel insurance, asserting that most beneficiaries never leave their home country. This benefit covers 80 percent of the medically necessary emergency care received in a foreign country, after a $250 deductible, up to a lifetime maximum of $50,000. Based on conversations with our member companies, we can make several interesting observations about this benefit.

The first thing to recognize is that consumer groups had an active role in deciding what benefits would be included in the standardized plans. During the 2000 National Association of Insurance Commissioners (NAIC) winter meetings, consumer representative Bonnie Burns spoke about the foreign travel benefit at a public hearing on Medigap reform. Ms. Burns said:

> "The benefit for foreign travel is often criticized for being included in most of the packages. Let me explain the genesis of this benefit. Before OBRA 90, the Blues and AARP, representing over half the Medigap market, routinely covered foreign travel but few beneficiaries knew that they had that benefit. When people traveled out of the U.S. they bought travel policies to cover their medical expenses. Those policies then as now seldom covered medical care in the way seniors expected. In fact, they were much more like accidental injury, death or dismemberment policies.
>
> "During the formation of these standardized packages it became apparent that the major insurers automatically provided this benefit and that the cost of doing so was extremely low, and the benefit was included in most of the packages. Since 1992 this benefit has been so obviously covered by a Medigap policy there has been no need for seniors to buy a separate, but woefully insufficient travel policy when they travel outside the country. And, it isn't just the wealthy who travel and can potentially take advantage of this benefit, but many people of modest means who now take cruises or travel to Mexico or Canada. If the medical benefits in travel policies were reformed there might be much less need for this benefit in a Medigap policy. But over the years powerful interests have beaten back efforts to reform various types of low value policies and that shows no sign of changing." [15]

One of our member companies sells Medigap policies to seniors in the Southwestern States. They make the following observations:

> "Many of our members tell us that the foreign travel benefit is perceived as a valuable benefit to them and those who have had to use the benefit have communicated to us how grateful they were that the benefit existed.
>
> "The number of foreign travel claims paid is small in relation to other Medigap benefits paid. In 2002, we paid 162 foreign travel claims on over 72,000 Medicare Supplement policies in force. However, those 162 policyholders are all glad that this benefit was part of their Medicare supplement from our company—it paid off when they found themselves in the position to need it. One

[15] 2000 Proceedings of the NAIC, 4th Quarter.

of our claims, that ran up to the lifetime $50,000 maximum, was for an insured who was in an extreme life-threatening situation."

While the foreign travel benefit may be used fairly infrequently, it adds no more than a few dollars per year to the premium. Given that Medicare covers nothing when seniors travel abroad, the foreign travel benefit provides considerable peace of mind to seniors who do travel.

We should also keep in mind that, for purposes of this benefit, "emergency care" means "care needed immediately because of an injury or illness of sudden and unexpected onset." [16] So coverage is not limited to life-threatening conditions, and immediate treatment abroad may well provide savings to Medicare if, without it, individuals might have required treatment for complications or more severe problems when they returned to the States.

Ideally, any redesign of Medigap benefits in the context of Medicare reform would take account of the needs and preferences of today's seniors. In this regard, it also needs to be remembered that current law requires that Medigap products be guaranteed renewable. This means that a Medigap policy may not be cancelled or have its benefits changed. Thus, any revisions to current Medigap benefits would raise very important transition issues, which are likely to be complex and difficult to resolve.

HIAA's Recommendations to the Congress

What we have tried to do in this statement is to provide a context for the understandable desire to reform not only the basic Medicare program, but Medigap coverage options as well. We hope it is apparent that even the most tempting Medigap reforms would need to navigate some difficult ground. The design of any new or revised Medigap plans would, of course, be heavily dependent upon the features of a modernized Medicare program. Thus, it seems to us that the Congress should first make decisions about the Medicare program itself, and then proceed to address corresponding Medigap issues.

HIAA also believes that changes to Medigap policies should be done in conjunction with comprehensive changes in Medicare benefits, and not before that time. Further, changes affecting Medigap should be made at one time and not in an incremental or piecemeal fashion. Making Medigap changes in two or more "rounds of reform" would add significantly more administrative costs to the system than making such changes at one time, and would likely increase beneficiary confusion.

We would also suggest that Congress provide as much flexibility as possible for any mandated redesign of Medigap benefits. As you know, under the Omnibus Budget Reconciliation Act of 1990, the Congress did not specify the contents of the 10 standardized Medigap plans we have today, but instead allowed for a process where consumer representatives, State regulators, and insurers worked together to design Medigap benefit options. Similarly, we believe that it would be extremely risky for Congress to mandate by statute the contents of insurance products intended for voluntary sale and purchase in the private marketplace.

In the case of the elderly, many of whom suffer from chronic illnesses, treatment costs for such things as prescription drugs and regular physician office visits can be more or less predictable. This relative predictability certainly permits each beneficiary to make a reasoned economic judgment about the expected near-term value of an insurance product. In other words, beneficiaries can be expected to do the math, comparing anticipated benefits with known premium costs. This raises the potential that healthier Medicare beneficiaries will seek out lower cost Medigap products or even decide to self-insure, thereby further driving up the average costs of coverage for those remaining behind. As insurers know only too well, benefit redesign, if not very carefully done, can lead to adverse selection and ultimately make the re-designed insurance product simply unaffordable for the average citizen.

Finally, to state the obvious, when it comes to Medigap, Medicare beneficiaries are the customers, and they are free to buy—or not buy—available products. In the end, whatever we do must be viewed as beneficial, not harmful, to the interests of the typical Medicare beneficiary, and result in Medigap products that are affordable.

Conclusion

Given budgetary realities, it seems almost certain that even a modernized Medicare will leave substantial out-of-pocket expenses for many Medicare beneficiaries, who will continue to want and need Medicare supplemental insurance. Thus, any Medicare modernization plan will need to provide a reasonable roadmap for

[16] See NAIC Medicare Supplement Model Regulation section 8(c)(8).

transitioning from "old" to "new" Medicare, and from current Medigap and other supplemental coverage to any new Medicare supplemental insurance options.

In considering such a transition, it is extremely important to understand that the States, not the Federal Government, have primary enforcement jurisdiction over Medigap insurers and policies. As a result, any Federal legislation affecting Medigap insurance products will need to be mindful of the interplay between Federal and State requirements.

We hope that this testimony helps elucidate the many issues that arise in any consideration of changes to Medigap. HIAA is open to considering Medigap reforms in the context of broader reform of Medicare covered benefits. However, without knowing how the core Medicare benefit package is structured, it is difficult, if not impossible to properly evaluate the merit of individual Medigap reform suggestions. In addition, some suggestions may not be well received by Medicare beneficiaries, could risk subjecting Medigap plans to adverse selection, or might otherwise endanger the important goal of maintaining affordable Medigap products. In any case, HIAA and its member companies look forward to working with this Committee to craft feasible Medicare and Medigap policies that will meet the needs and expectations of Medicare beneficiaries.

Attachment A

Costs Not Covered By Medicare Traditional Fee-For-Service Program

Part A	**2003 Beneficiary Costs**
Inpatient	
Deductible for each hospital stay of 1–60 days	$840
Copayments for days 61–90	$210 per day
Copayments for lifetime reserve days 91–150	$420 per day
Beyond 90 days after exhausting lifetime reserve days	All costs
Skilled Nursing Facility Care	
Days 21–100	Up to $105 per day
Beyond 100 days	All costs
Home Health Care	
Durable Medical Equipment	20% of approved amount
Hospice Care	
Outpatient drugs and inpatient respite care	Limited costs
Blood	
First three pints	All costs
Part B	
Medical expenses	$100 annual deductible
Physician costs	20% of allowable charges
Physician not accepting assignment	20% of allowable charges plus 100% of the difference between allowable charges and an additional capped amount
Outpatient hospital services	Variable copay amounts determined by formula*
Outpatient mental health services	50% of approved charges
Monthly premium	$58.70

Costs Not Covered By Medicare Traditional Fee-For-Service Program—Continued

Part A	2003 Beneficiary Costs
Other Costs Not Covered By Medicare	
Routine exams and podiatric care	All costs
Long-term care	All costs
Care outside United States	All costs
All costs that are not medically necessary	All costs
Dental, hearing, and vision care	All costs
Outpatient prescription drugs	All costs**

* Under current law, copayments exceeding 20% are being phased down gradually to 20%.
** Medicare covers a limited number of drugs and antigens that cannot be self-administered.

Attachment B

Benefits Covered By Standard Medigap Plans

Covered Benefits	Standard Medigap Plans									
	A	B	C	D	E	F**	G	H	I	J**
Core Benefits*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
SNF Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓			✓
Part B Deductible			✓			✓				✓
Part B Excess Charges						✓	a		✓	✓
Prescription Drugs								b	b	c
Preventive Medical Care					✓					✓

* Core benefits include Part A copayment for days 61–90 in the hospital, Part A copayment for each lifetime reserve day in the hospital, up to 365 additional days of hospital coverage after Medicare coverage is depleted, the first three pints of blood used under Part A or Part B, and the 20-percent coinsurance for Part B services after the Part B deductible has been met.
** Plans F and J also have a high deductible option. The high deductible, which is adjusted for inflation, is $1,620 in 2002.
a. Medigap policy pays 80 percent of balance billing charges.
b. After $250 deductible, policy covers 50 percent of prescription drug costs to a maximum of $1,250.
c. After $250 deductible, policy covers 50 percent of prescription drug costs to a maximum of $3,000.

Attachment C

Number of Beneficiaries in Medigap Plans by State, 2001 *

(000's)

	Total population 65 and over	Covered by private health insurance—65 and over	Employment based—65 and over	Individually purchased health insurance—65 and over	Percent covered by private health insurance—65 and over	Percent of employment based—65 and over	Percent of individually purchased health insurance—65 and over
United States	33,769	20,751	11,645	9,106	62%	35%	27%
Alabama	552	332	194	138	60%	35%	25%
Alaska	37	19	14	5	50%	39%	14%
Arizona	607	336	188	148	55%	31%	24%

Number of Beneficiaries in Medigap Plans by State, 2001 *—Continued

(000's)

	Total population 65 and over	Covered by private health insurance—65 and over	Employment based—65 and over	Individually purchased health insurance—65 and over	Percent covered by private health insurance—65 and over	Percent of employment based—65 and over	Percent of individually purchased health insurance—65 and over
Arkansas	394	202	90	112	51%	23%	28%
California	3,243	1,658	1,074	584	51%	33%	18%
Colorado	413	249	120	129	60%	29%	31%
Connecticut	481	326	188	138	68%	39%	29%
Delaware	100	73	51	22	73%	51%	22%
District of Columbia	64	35	28	7	55%	44%	11%
Florida	2,660	1,447	784	663	54%	30%	25%
Georgia	724	333	211	122	46%	29%	17%
Hawaii	158	99	74	25	63%	47%	16%
Idaho	149	108	55	53	72%	37%	36%
Illinois	1,428	905	453	452	63%	32%	32%
Indiana	831	555	273	282	67%	33%	34%
Iowa	382	313	92	221	82%	24%	58%
Kansas	413	289	119	170	70%	29%	41%
Kentucky	507	339	200	139	67%	40%	27%
Louisiana	522	283	164	119	54%	31%	23%
Maine	211	126	61	65	60%	29%	31%
Maryland	616	387	247	140	63%	40%	23%
Massachusetts	807	455	253	202	56%	31%	25%
Michigan	1,184	852	586	266	72%	50%	22%
Minnesota	460	338	150	188	74%	33%	41%
Mississippi	306	147	75	72	48%	25%	24%
Missouri	664	461	201	260	69%	30%	39%
Montana	132	96	35	61	72%	27%	46%
Nebraska	202	159	46	113	79%	23%	56%
Nevada	230	121	80	41	53%	35%	18%
New Hampshire	179	125	64	61	69%	36%	34%
New Jersey	1,204	780	453	327	65%	38%	27%
New Mexico	246	134	90	44	55%	37%	18%
New York	2,414	1,397	1,015	382	58%	42%	16%
North Carolina	969	567	299	268	59%	31%	28%
North Dakota	84	61	15	46	73%	18%	55%
Ohio	1,465	1,043	724	319	71%	49%	22%
Oklahoma	423	284	151	133	67%	36%	31%
Oregon	359	221	85	136	62%	24%	38%
Pennsylvania	1,639	1,198	1534	664	73%	33%	41%
Rhode Island	163	92	40	52	56%	25%	32%
South Carolina	528	344	188	156	65%	36%	30%
South Dakota	106	75	17	58	71%	16%	55%
Tennessee	610	348	209	139	57%	34%	23%
Texas	2,082	1,163	663	500	56%	32%	24%
Utah	168	108	57	51	65%	34%	30%
Vermont	69	33	22	11	48%	32%	16%
Virginia	834	543	297	246	65%	36%	29%
Washington	701	492	239	253	70%	34%	36%
West Virginia	299	178	117	61	60%	39%	20%
Wisconsin	692	487	246	241	70%	36%	35%
Wyoming	60	37	13	24	61%	22%	40%

* Source: U.S. Census Bureau, Current Population Survey, March 2002, posted at http://ferret.bls.gov/macro/032002/health/h05_000.htm.

Statement of the National Association of Health Underwriters

The National Association of Health Underwriters (NAHU) is an organization of over 17,000 insurance professionals specializing in the sale and service of health insurance and related products. Many of our members who specialize in the senior market regularly counsel and work with Medicare beneficiaries on Medicare, Medigap, and Medicare+Choice options as well as other types of products. We are pleased to offer comments and suggestions regarding the current options and enroll-

ment procedures for supplemental health insurance coverage for Medicare beneficiaries.

NAHU believes that there are a number of inherent problems within the Medicare program that can only be addressed through comprehensive Medicare reform. The current Medicare programs A and B present an antiquated approach to the financing of health care reminiscent of 1960, when the greatest fear for most seniors was an extended hospital stay. Now, with many services provided on an outpatient basis and the availability of stronger and more effective prescription drugs, many beneficiaries are able to avoid hospitalization. In addition, Medicare hasn't kept up with advances in technology and treatments, and the level of coverage provided under traditional Medicare alone is inadequate protection for most seniors. A number of solutions have been offered that would improve the current system, and many proposals include new options for Medicare beneficiaries that would provide a choice of comprehensive coverage more like that found in the individual market. Depending on the ultimate structure of the new comprehensive coverage, Medicare supplemental coverage as we know it would need substantial changes to conform to the new comprehensive form of Medicare.

Most current proposals for reform retain the option for beneficiaries to continue to participate in traditional Medicare. A number of improvements could be made to the currently mandated Medicare supplemental offerings to ensure that consumers have a variety of choices to allow them to select the type of plan most suitable for their personal situation. The first step in ensuring these choices will be to look at the plans that are already in existence and ascertain that Medicare+Choice plans and Medicare supplement providers have adequate incentives to participate in health plans for Medicare beneficiaries. It is essential that the current regulatory requirements for Medicare+Choice plans be eased and that they be compensated fairly. The current instability in the Medicare+Choice program obviously has a significant impact on increasing demand for Medigap coverage on a guaranteed issue basis. This increased demand may significantly alter both the availability and the cost of Medigap policies. Action by Congress to address this urgent situation will only have a positive impact on beneficiaries purchasing Medigap policies.

Our members report the following regarding market experience and beneficiary preferences concerning current Medigap policies:

- The most popular benefit is coverage of the Part A deductible. Coverage of the Part B deductible is sometimes purchased, but often because some other benefit in the plan is desired.
- The skilled nursing benefit isn't used often, because of the difficulty in meeting the requirements for skilled care due to the mandatory 3-day hospital requirement, and because most care quickly falls into a custodial category not covered by Medicare.
- Coverage of Part B excess charges is becoming more and more important, especially in rural areas where physicians may not feel compelled to accept Medicare assignment. In the absence of any stop loss provision being added to the basic Medicare program, coverage of these excess charges should remain available.
- The most popular plans sold by our members are C, F, H, and I. Although some employers offer this benefit plan for their retirees, very few people want to pay the premium associated with plan J.
- The benefits beneficiaries request most often, that are not currently covered by Medigap, are for coverage of dental care, vision services, hearing aids, and of course, prescription drugs.

BENEFICIARY REACTION TO MEDICARE

Based on what Medicare beneficiaries tell our members, the most significant problem facing them today is the cost of health care. Many Americans approaching retirement age believe that when they become eligible for Medicare, all of their health care needs should and will be taken care of. Their first step into the Medicare maze comes when they discover that they must purchase Part B to cover outpatient and other physician care. Many of these beneficiaries believe that Part B is a supplement especially since the Medicare supplements are alpha labeled, and they don't understand that they will still have significant financial exposure for the cost of their medical care even after they purchase Part B. Often beneficiaries first become aware of the gaps in coverage after they have passed open enrollment for Medigap. Unfortunately, by that time some have developed health problems, limiting or eliminating their choices for supplemental coverage. Having been participants in low copay drug cards as employees for many years, they are amazed to find out how much

coverage for prescription drugs will cost them, if it is available at all, and many of them seek supplemental coverage for prescription drugs at this time. They are even more amazed to learn the extent of the other medical services not covered under the traditional Medicare program. Many of these same individuals who may have sought supplemental coverage in order to secure insurance for prescription drugs end up buying plan C or F (which doesn't cover outpatient prescription drugs) primarily to cover hospital and physician charges not covered by the Medicare program. Since the benefit under a Medigap policy that includes limited coverage for prescription drugs is often equal to or less than the extra premium charged, many beneficiaries choose not to purchase prescription drug coverage under Medigap. Many of these Medicare beneficiaries have low incomes limited to little beyond their Social Security benefit, but for a variety of reasons, they may not be eligible for Medicaid or other low-income programs. Additionally, the Medicare+Choice plans, which they might have been able to afford, may no longer be available in their area.

RECOMMENDATIONS

So, how could Medigap be structured to make it more meaningful as well as more affordable? Again, in the absence of basic in depth changes to the Medicare program, our first recommendation would be that no Medigap plan subsidize the Part B deductible. This is not about saving $100 a year, but about changing consumer behavior regarding consumption of health care. There are numerous statistics that show that individuals with Medigap coverage utilize medical services at a significantly higher rate than Medicare beneficiaries without supplemental coverage. Their utilization rate is also higher than that of retirees with supplemental coverage through their former employers. We believe the reason for this is that there is typically some cost-sharing for beneficiaries covered under employer plans, and that plan utilization can be safely reduced if there is some financial incentive, however small, that causes a person to think before they seek medical care for even the most minor illnesses.

In terms of prescription drug coverage, we are very skeptical of any sort of mandate on Medicare supplemental plans to provide drug coverage, and we are pleased to see that most proposals have not included this requirement. Insurance carriers report that plan utilization is significantly higher on Medigap plans H, I, and J, the plans that include coverage for prescription drugs, and based on their experience, they have consistently maintained that drug only policies or mandatory drug coverage on all policies is simply not an insurable risk. Although some pharmacy benefit managers have expressed interest in being providers in a Medicare prescription drug program, they have not indicated a desire to take on all of the risk for the program.

On a positive note, some insurance carriers as well as some of our member agents routinely provide Medicare beneficiaries with a prescription drug discount card, often at no cost to the beneficiary. Some Blue Cross organizations have begun to extend the discounts they have negotiated through the pharmacy benefit managers with whom they contract for their under-65 insureds, to their Medicare Supplement policyholders. *This allows policyholders to purchase their outpatient prescription drugs at significantly discounted rates, as much as 15 to 30%, even though outpatient drugs are not specifically covered by their Medigap policy.* This provides no risk for the insurance carrier, but is an excellent way for beneficiaries to reduce their cost by using their numbers to negotiate discounts. For this reason, we're extremely pleased with the Administration's proposal for a prescription drug discount program for Medicare beneficiaries. We believe the discounts that could be provided by these programs will be greater than the Administration's estimates, based on the experience of employer plans in the under 65 market, and that beneficiaries would greatly value the assistance the discounts would provide.

NAHU additionally recommends that additional study be given to the very complicated coordination between COBRA and Medicare, and between individual health plans and Medicare. It is very difficult for beneficiaries, agents, and employers to navigate through the landmines associated with these benefits. Many beneficiaries discover too late that they should have made different decisions on applying for Part B after they prematurely trigger Medigap open enrollment rights, or when they are forced to go without Part B for an extended period of time due to late enrollment time penalties. Many others retain individual health insurance policies for years because they believe the policy will serve as a Medicare supplement only to find that their individual policy will actually pay little beyond what Medicare pays due to language on guaranteed renewability found in HIPAA. This is not the fault of the carriers, agents or employers but rather the complexity of several overlapping Federal

laws that don't coordinate adequately or provide for adequate notice to insureds of their rights and responsibilities.

Disabled Medicare beneficiaries need better access to Medigap coverage. Due to cost considerations, we are not suggesting that disabled beneficiaries have the same purchase rights and plans as those age 65, since doing so may mean increases to Medicare beneficiaries' already escalating Medicare supplement premiums. We do believe that creative options should be explored for extending coverage that won't increase costs for other beneficiaries, such as offering coverage for disabled beneficiaries through State high-risk pools. Currently eight States allow disabled beneficiaries to purchase coverage through high-risk pools. This allows these less healthy individuals to be pooled with other individuals in the same category, provides a place to purchase supplemental coverage, and keeps the costs down in the regular Medigap pool. We've included a chart for Members of the Committee illustrating the type of supplemental coverage currently available through high-risk pools.

Medigap policies are highly valued by Medigap beneficiaries and provide a great sense of security for millions of Medicare beneficiaries. Although changes need to be made to Medigap coverage, it may be difficult to implement broad reform without knowledge of the end result of reforms in the Medicare program itself, and any changes undertaken should be done with careful consideration of any impact they may have on current market availability.

High Risk Pools That Include Medicare Supplements

State	Is Medicare Disabled Covered?	Standardized Plans Offered?	If No Standardized Plans, What Is Offered?	Are Prescription Drugs Covered?
Alaska	Yes	Plans A & I. Medicare "carve-out" offered to those under age 65.		Yes
Minnesota	Yes	No	Two plans, Basic Plan and Extended Basic plan.	Yes, but only from Extended Basic plan.
Mississippi	Yes	No	An individual under age 65 that becomes eligible for Medicare after purchasing a high-risk pool plan may keep the plan as a Medicare "carve-out."	Yes, prescription benefits are covered under the high-risk pool.
Montana	Yes	No	Medicare "carve-out" offered.	Yes
North Dakota	Yes	Plan F		No
Washington	Yes	No	Medicare "carve-out" offered.	Yes
Wisconsin	Yes	No	Individuals under age 65 are offered Medicare disability plan.	Yes
Wyoming	Yes	No	High-risk pool is secondary to Medicare.	Yes

○