KAISER FAMILY FOUNDATION

Program on Medicare Policy

Medigap Reforms
Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs

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Mark Merlis

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EXECUTIVE SUMMARY

Among the many proposals under consideration to control the growth in Medicare spending is one that attempts to achieve savings by restricting coverage under Medigap plans to require enrollees to pay a larger share of the costs of Medicare-covered services. In 2008, about one in six Medicare beneficiaries, over 7 million, had an individually purchased Medicare supplemental insurance policy, known as Medigap (and no other source of supplemental coverage).[1] Medicare by itself has relatively high deductibles, and imposes coinsurance for most covered services. Moreover, Medicare does not have any limit on total cost sharing, exposing some beneficiaries to large out-of-pocket (OOP) costs. Medigap policies help cover some or all of Medicare's cost-sharing requirements. Some analysts contend that comprehensive "first dollar" coverage from Medigap leads enrollees to obtain unnecessary services, which results in excess Medicare spending.[2]

Various approaches to Medigap reform have been proposed in recent years, although they all involve higher cost sharing for enrollees. The Congressional Budget Office (CBO) has described an option that would prohibit Medigap policies from paying the first $550 of enrollees' cost sharing and requiring that they cover no more than half of Medicare's additional required cost sharing up to a fixed out-of-pocket limit.[3] CBO estimates this would produce savings of $3.7 billion in 2013 and $53.4 billion over the nine-year period from 2013-2021. Senators Joe Lieberman and Tom Coburn recently proposed a set of Medicare reforms that included a similar version of this option[4], and the National Commission on Fiscal Responsibility and Reform, known as the Bowles-Simpson Commission, also included a similar proposal in its set of recommendations released late last year.[5] Another approach, suggested by the Medicare Payment Advisory Commission (MedPAC), would require Medigap enrollees to pay fixed copayments (rather than coinsurance) for office and emergency room (ER) visits.[6]

This brief examines the potential effects of three different Medigap reform proposals on Medicare program spending and on beneficiaries' out-of-pocket costs **(Exhibit ES1)**.

Exhibit ES1: Description of Medigap Reform Options in This Analysis

	AMOUNT ENROLLEE PAYS	AMOUNT MEDIGAP PAYS
OPTION 1 **Based on CBO option; similar to Bowles-Simpson**	First $550 of any required cost sharing for services covered under Parts A or B; 50% of additional required cost sharing up to $3,025 limit on out-of-pocket spending	50% of required cost sharing after the first $550 paid by enrollee up to $3,025 out-of-pocket spending limit; 100% of costs for Part A/B cost sharing above out-of-pocket limit
OPTION 2 **Similar to Medigap Plan L, but more generous than Option 1**	25% of Part A deductible ($1,132 in 2011); 100% of Part B deductible ($162 in 2011); 25% of required cost sharing for Part A/B services up to $2,070 limit on out-of-pocket spending	75% of Part A deductible; 75% of A/B coinsurance up to $2,070 out-of-pocket spending limit; 100% of costs for cost sharing above out-of-pocket spending limit
OPTION 3 **Similar to Medigap Plan N**	100% of Part B deductible; $20 per office visit; $50 per emergency room (ER) visit	100% of Part A deductible and cost sharing for all other Medicare-covered services

The analysis, based on data from the Medical Expenditure Panel Survey (MEPS) and other sources, takes into account expected changes in utilization, and the likely effects of Medigap reforms on insurers' costs for Medicare-covered services and on Medigap premiums. The analysis assumes full implementation of Medigap reforms in 2011 to better understand the likely effects on program and out-of-pocket spending once fully implemented, although in all likelihood such a policy would be phased in over the course of several years. The analysis assumes no additional changes in the underlying Medicare benefit design.

FINDINGS

Impact on Medicare Spending

Each of the three Medigap reform options would be expected to achieve Medicare savings – primarily by inducing Medigap enrollees to curtail their use of Medicare-covered services, which in turn reduces federal Medicare spending **(Exhibit ES2)**. These estimates rely on specific assumptions (detailed in **Appendix B)** about how beneficiaries will respond to requirements that they pay more of the costs of services themselves. If these predictions were wrong and beneficiaries continued to use services as they do today, there might be no savings for the Medicare program.

Exhibit ES2: Estimated Medicare Savings from Medigap Reform Options in This Analysis

	OPTION 1 Enrollees pay first $550 in cost sharing for covered A/B services and 50% of additional required cost sharing up to $3,025 OOP limit	OPTION 2 Enrollees pay 25% of Part A and 100% of Part B deductibles; 25% of required cost sharing up to $2,070 OOP limit	OPTION 3 Enrollees pay Part B deductible; copayments for physician visits and emergency room visits
Medicare Savings, FY2011	$4.6 billion	$2.3 billion	$1.5 billion
Savings as Share of Medicare Benefit Spending Under Parts A and B	0.9%	0.5%	0.3%

SOURCE: Medicare savings based on author's calculations, based on Part A and B spending for all Medicare beneficiaries.

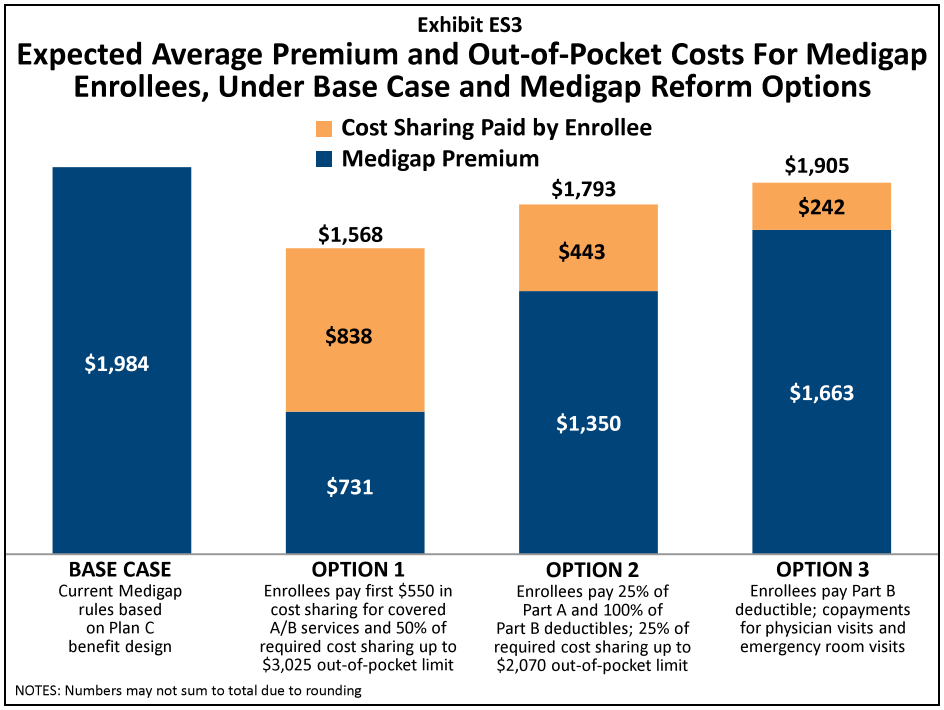
The first option, with a relatively high unified deductible for Parts A and B, and a limit on out-of-pocket spending, is estimated to reduce Medicare spending for Medigap enrollees by about 7 percent or $4.6 billion dollars in fiscal 2011, reducing by 0.9 percent total spending for Medicare benefit payments under Parts A and B. (CBO's somewhat lower estimate for this option is chiefly because of different assumptions about how enrollees will change their use of services in response to higher cost sharing.) The second option would save about half that amount, because of its lower annual deductible and the lower limit on out-of-pocket spending. The third option, with fixed cost sharing required for physician and ER visits, achieves smaller savings than the other two; it might deter some enrollees from initiating care, but would have little effect on use of services once care began.

Impact on Beneficiary Spending

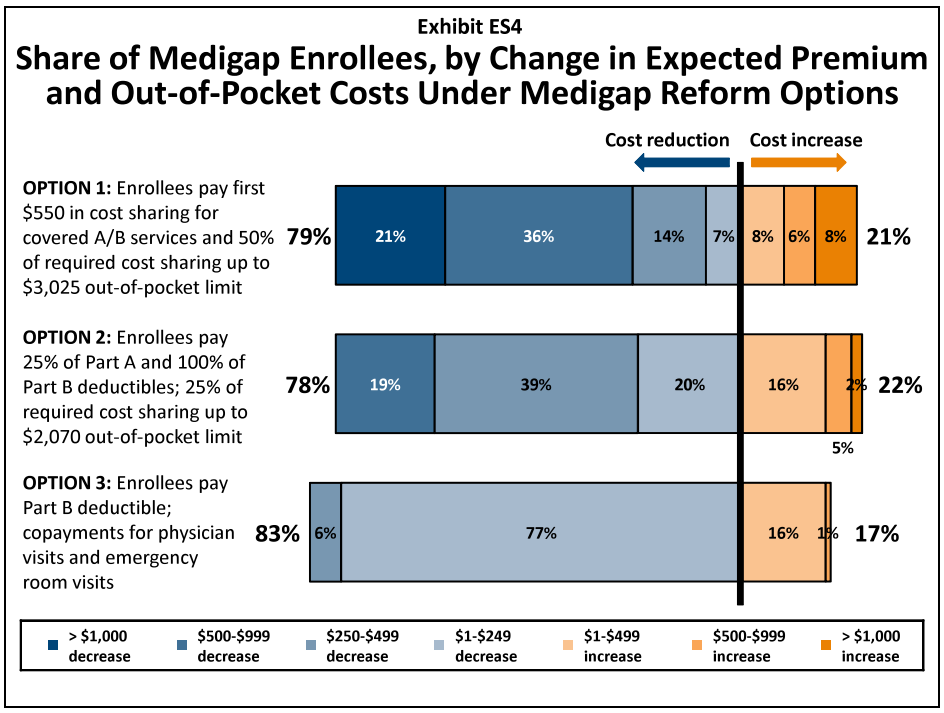
This analysis estimates the effects of the three Medigap reforms on enrollees' out-of-pocket costs, taking into account cost sharing for Medicare covered services (Parts A and B) and Medigap premiums. As **Exhibit ES3** shows, most Medigap enrollees could see their direct costs rise as their Medigap policies become less generous, imposing higher deductibles and cost-sharing requirements. Compared to the base case (with premiums and cost sharing based on Medigap Plan C benefit design), Medigap enrollees would face the largest average increase in their expected out-of-pocket costs for Medicare cost-sharing requirements under Option 1, as their cost sharing goes from $0 under the base case to $838 under Option 1. Cost sharing would be lower under Options 2 and 3 ($443 and $242, respectively).

However, as enrollees' costs increase, Medigap insurers' claims costs would drop, and insurers would be likely to reduce premiums. When compared to the base case, enrollees would face the largest average reduction in their Medigap premium under Option 1, from $1,984 to $731. If premium reductions were fully proportionate to the drop in expenses, the savings for the *average* beneficiary would be sufficient

to more than offset his or her new direct outlays for Medicare cost sharing. However, the magnitude of change varies across the three options, with average reductions in combined premiums and cost sharing ranging from $415 under Option 1 to $190 under Option 2 and $78 under Option 3.



Under all three options, the majority of Medigap enrollees are projected to see a reduction in net out-of-pocket costs (including premiums), but about one in five Medigap enrollees would pay more **(Exhibit ES4).**



Some Medigap policy holders are projected to have fairly substantial reductions in net out-of-pocket spending. In 2011, about one in five Medigap policy holders would see net out-of-pocket spending drop by $1,000 or more under Option 1 and by $500-$999 under Option 2, with more modest savings projected under Option 3.

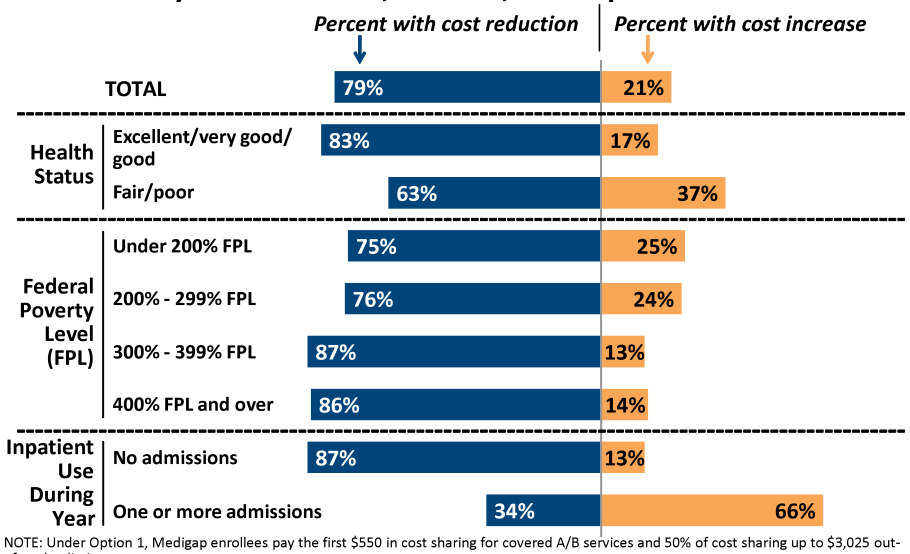
A small number of enrollees could see equally large increases in out-of-pocket spending attributable to these reforms. For example, net out-of-pocket costs would increase by $1,000 or more for 8 percent of Medigap enrollees under Option 1, and another 6 percent would see cost increases of between $500 and $999. Under Option 2, 7 percent of Medigap enrollees would have cost increases of $500 or more. With the third option, the majority of those with cost increases would see costs increase between $1 and $500.

Medigap reforms would have a disproportionately negative impact on enrollees with modest incomes, in relatively poor health, and those with any inpatient hospital utilization **(Exhibit ES5)**. Under all three options, a greater share of beneficiaries reporting fair or poor health than those in better health would experience an increase in total out-of-pocket costs, because their premium savings would not be enough to offset their new spending for direct cost-sharing. Under Options 1 and 2, more than one-third of all Medigap enrollees in fair or poor health would experience a net increase in premiums and other out-of-pocket costs for Medicare covered services, as compared to less than one-fifth of those in relatively good health. Because those in relatively poor health use more services than healthier enrollees, the increase in their direct cost-sharing expenses for Medicare-covered services would more than offset any premium reduction.

Similarly, a greater share of Medigap enrollees with incomes below 300 percent of the federal poverty level than of those with higher incomes would experience an increase in out-of-pocket spending. About one quarter of Medigap enrollees with incomes below 300 percent of poverty are projected to face higher costs under these options—a much higher share than among Medigap enrollees with higher incomes.

Exhibit ES5

Share of Medigap Enrollees By Change in Expected Premium and Out-of-Pocket Costs Under Medigap Reform Option 1, by Health Status, Income, and Inpatient Use



NOTE: Under Option 1, Medigap enrollees pay the first $550 in cost sharing for covered A/B services and 50% of cost sharing up to $3,025 out-of-pocket limit.

DISCUSSION

As policymakers consider Medigap reforms as part of a broader strategy to reduce the growth in Medicare spending, this analysis shows that restrictions on Medigap coverage can be expected to reduce both Medicare spending and net average out-of-pocket spending, including cost sharing and Medigap premiums, for most but not all Medigap enrollees. Whatever the possible role of comprehensive Medigap policies in encouraging higher utilization, they have also served to spread the risks for enrollees with chronic illness or high-cost events. Changes in Medigap could expose about one in five Medigap enrollees to higher out-of-pocket costs, and these increases would disproportionately affect policyholders in relatively poor heath and with modest incomes.

Moreover, the savings that could accrue to Medicare, and some of the net savings for Medigap enrollees, would result from reductions in medical service utilization, as beneficiaries have more "skin in the game". There is no way of ensuring that enrollees who might reduce their utilization would forgo only services of questionable value. On the contrary, at least one study suggests that enrollees with chronic conditions could defer necessary services—perhaps leading in the long run to even higher costs.[7] Thus, it is important to emphasize that this analysis does not assess the extent to which the likely reduction in service utilization could negatively affect patient outcomes or result in higher costs.

Beyond the distributional effects and the potential for adverse health outcomes, there are other questions that could arise if Medigap reforms are considered. Should similar rules be applied to other sources of supplemental coverage, such as employer-sponsored benefits for Medicare-eligible retirees or Medicare Advantage plans? How does increased cost sharing work with proposals to move away from fee-for-service payment under Medicare, such as bundled payments or shared savings with accountable care organizations? Changes in Medigap plan designs should be considered in the context of a broader reevaluation of the structure of Medicare benefits and a possible realignment of overall financial incentives for both providers and beneficiaries.

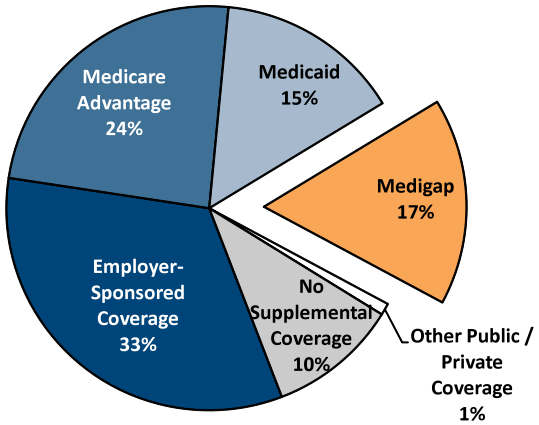
INTRODUCTION

Medicare beneficiaries are subject to cost sharing—deductibles or coinsurance payments—for most covered services, but unlike most private insurance plans for the nonelderly, Medicare does not have an "out-of-pocket limit." Under typical employer plans, once the enrollee's cost-sharing liability has exceeded a specified threshold, the plan usually pays the full cost of covered services. Medicare beneficiaries have no such protection; if they have a costly medical problem, they can be exposed to very large out-of-pocket expenditures. In 2008, six percent of Medicare beneficiaries incurred cost sharing of $5,000 or more for their Medicare-covered services.[8]

As a result, most beneficiaries obtain additional coverage to help with some or all of Medicare's required cost sharing **(Exhibit 1)**. In 2008, 90 percent of Medicare beneficiaries had some form of supplemental coverage.[9] Employer-sponsored retiree health plans are the primary source of supplemental coverage, providing additional coverage to one-third of all Medicare beneficiaries, typically those with relatively high incomes. Medicaid is an important source of supplemental coverage for beneficiaries with very low-incomes. Others get additional benefits by enrolling in Medicare Advantage (MA) plans, which provide basic Medicare benefits and typically some amount of supplemental coverage. Roughly one in six beneficiaries has an individually-purchased Medicare supplemental policy, known as Medigap.[10]

Exhibit 1

Sources of Supplemental Coverage Among Medicare Beneficiaries, 2008



Total Medicare Beneficiaries, 2008 = 41.8 Million

NOTES: Supplemental coverage was assigned in the following order: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage. Individuals with more than one source of coverage were assigned to the category that appears highest in the ordering.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Access to Care File, 2008.

Medigap plans vary in the extent to which they fill in Medicare's cost-sharing requirements. In 2011, beneficiaries could choose from among 10 standard Medigap policies to supplement their coverage under fee-for-service Medicare. The most popular Medigap plans, C and F, cover virtually all required Medicare cost sharing for Medicare-covered services, including deductibles, meaning that covered services are essentially free to the enrollee. **(See Appendix Exhibits A1 and A2 for standard Medigap plans and distribution of Medigap policyholders by plan type.)**

Several studies have found that beneficiaries with comprehensive Medigap plans ("first dollar" coverage) use more Medicare services than those who have to pay some or all of Medicare's cost sharing on their own.[11] Estimates of the size of this spending gap vary, and analysts disagree about why Medicare spending for Medigap enrollees is higher than for other beneficiaries, after controlling for health status and other factors. Some analysts suggest that people who expect to incur large expenses are more likely to buy a Medigap plan than to go without a Medicare supplement. Others say that Medigap encourages people to obtain services of marginal utility because they do not have to bear the cost out of their own pockets. (Physicians may also consider patients' supplemental coverage when ordering services.) To the extent it occurs, higher use may be attributable to both factors.

The current debate about how to control the growth in Medicare spending has brought renewed attention to the possible role of Medigap in driving program costs. A number of recent deficit reduction plans have included proposals to restrict Medigap coverage. For example, the National Commission on Fiscal Responsibility and Reform, also known as the Bowles-Simpson Commission, would prohibit Medigap policies from covering the first $500 of cost sharing, and impose 50 percent coinsurance on the next $5,000 in total spending, before providing a catastrophic benefit.[12] In general, these proposals would prohibit first-dollar coverage, requiring policyholders to pay at least some of Medicare's usual cost sharing for covered services.[13] Proponents of this approach suggest that enrollees would use fewer services, producing measurable savings for the Medicare program. At the same time, most enrollees could benefit, because first-dollar coverage is not a good bargain for many beneficiaries.

This brief reviews the potential effects of imposing restrictions on Medigap coverage, using a simplified model based on data from the 2006 Medicare Expenditure Panel Survey and other sources. Three different options for benefit redesign are considered, including two that require substantial cost sharing for most inpatient and outpatient services and one that requires more limited cost sharing for ambulatory care only. For each option, the modeling estimates how the policy changes might affect beneficiary behavior, federal Medicare spending, and Medigap enrollees' out-of-pocket costs for Medicare-covered services and Medigap premiums, and which beneficiaries are likely to face higher or lower total out-of-pocket-costs than under their current plans.

Medicare Cost Sharing and Medigap Plans

This section provides a brief overview of Medicare cost-sharing requirements and an overview of benefits and other provisions pertaining to Medigap plans.

Medicare Cost Sharing

Medicare benefits are subject to deductibles and cost sharing. Beneficiaries are subject to a deductible ($1,132 in 2011) before receiving Medicare payment for inpatient hospital care under Part A and a separate $162 deductible for the physician and outpatient services covered under Part B. They must pay a daily coinsurance amount for long inpatient stays and a fixed daily copayment for days 21 through 100 in skilled nursing facilities. In addition, they are required to pay coinsurance for most Part B services, usually 20 percent of Medicare's total approved amount for those services.[14] More detailed information about Medicare benefits and cost sharing is included in **Appendix Exhibit A3.**

Medigap Plans

About one in six people on Medicare is covered by a Medigap policy that supplements the fee-for-service Medicare program. All Medigap plans offered by insurance carriers must conform to one of the standardized designs developed by the National Association of Insurance Commissioners (NAIC).[15] The list of standard plans has been modified several times, most recently in 2010. Currently, there are 10 standard plans, designated as Plan A through Plan N (some letters are no longer in use). All of these packages provide a minimum set of basic benefits, including coverage of some or all of Medicare's inpatient hospital coinsurance and Part B coinsurance. In 2009, 88 percent of people covered by standardized plans were in plans that covered 100 percent of Medicare's required deductibles and coinsurance, or all except the Part B deductible.[16]

Medigap Premiums and Loss Ratios

Insurers set premiums for Medigap plans in one of three ways:

- ***Attained age:*** The premium rises as the policyholder gets older.
- ***Issue age:*** The premium is based on the policyholder's age when he or she first buys coverage. Any increases for rising medical costs or other factors are applied equally to all policyholders.
- ***Community rating:*** All policyholders pay the same amount, again subject to increases for group-wide cost increases.

Under attained age rating, purchasers may have a low premium rate when they first buy the coverage, but the rate can rise steeply as they age. Under issue age or community rating, purchasers will pay a higher initial rate, but are shielded to some extent from rate increases later on. Although a few states require issue age or community rating, attained age rating is much more common. The modeling for this brief therefore assumes attained age rates for all participants.

Medigap plans must meet minimum "loss ratio" tests or provide rebates to enrollees. The loss ratio is the proportion of premium revenues that is spent for medical claims. For example, a plan with an 80 percent loss ratio pays out 80 cents of every premium dollar for medical services and retains 20 cents for administrative costs and profit. Medigap plans sold to individuals must have at least a 65 percent loss ratio, while those sold to employer groups (for retiree coverage) must have a 75 percent ratio. This rule applies to all the purchasers of a given policy combined, and over the lifetime of the policy—not to any particular purchaser or any one year.

Medigap Reform Options

Most of the discussion of Medigap in the context of deficit reduction has focused on proposals that would require all enrollees in Medigap plans to pay at least some deductible and coinsurance on their own, up to a specified out-of-pocket (OOP) limit, and would prohibit first-dollar coverage. There have also been suggestions that enrollees should pay copayments, instead of coinsurance, for some ambulatory services, as is common in most private non-Medicare plans. This brief considers both of these approaches to prohibiting first-dollar coverage, along with a third option that would prohibit first-dollar coverage for Part B services only and impose less stringent deductible and coinsurance requirements than those commonly suggested.

OPTION 1: Require Medigap enrollees to pay the first $550 in cost sharing for services covered under Medicare Parts A and B, and then 50 percent of required cost sharing up to an out-of-pocket limit of $3,025

The Congressional Budget Office (CBO), in its periodic compendium of options for reducing the federal deficit, has described one possible redesign of Medigap benefits to achieve Medicare/federal savings. Under this proposal, beginning in 2013, Medigap policies would be prohibited from covering the first $550 in Medicare cost sharing. Once this threshold was reached, enrollees would pay 50 percent of required cost sharing and their Medigap plan would pay 50 percent until total costs reached $5,500. At that point, the Medigap plan would pay any additional cost sharing in full. The most an enrollee would be required to pay out-of-pocket would be $3,025. For later years, the threshold and out-of-pocket limit would be increased in proportion to growth in per capita Medicare spending.

CBO estimates that this plan would reduce Medicare spending by $3.7 billion in 2013 and $53.4 billion in the nine-year period from 2013 to 2021.[17] MedPAC has estimated that applying these same rules to employer-provided retiree coverage, in addition to Medigap, would more than double these savings.[18]

A similar plan is included in the Medicare reform proposal from Senators Joe Lieberman and Tom Coburn, but in this plan the catastrophic limit would be $7,500 rather than $5,500.[19] A similar approach is also included in the Bowles-Simpson Commission final report and in a separate Medicare/Medicaid redesign proposal presented by two of the commission members, Rep. Paul Ryan and former CBO director Alice Rivlin.[20] The Medigap rules suggested in both plans are the same as those in the CBO plan, except that enrollees would pay the first $500 in cost sharing and then pay 50 percent of total costs up to a catastrophic limit of $5,000. (In the Rivlin-Ryan plan, these rules would apply to beneficiaries enrolling in Medicare before 2021; new beneficiaries beginning in 2021 would not receive traditional Medicare, but would be enrolled in a voucher or premium support system.)

OPTION 2: Require Medigap enrollees to pay 25 percent of the Part A deductible, 100 percent of the Part B deductible, and 25 percent of required cost sharing up to an out-of-pocket limit of $2,070

Under this option, Medigap enrollees would be shifted to a plan resembling Medigap Plan L, one of the standard benefit designs currently available. Enrollees would pay 25 percent of the inpatient (Part A) deductible, 100 percent of the Part B deductible, and 25 percent of all required coinsurance, up to an annual out of-pocket limit of $2,070. This option is presented to illustrate a midpoint between current comprehensive Medigap benefits and the sharply reduced benefits under Option 1.

OPTION 3: Require Medigap enrollees to pay the Part B deductible (but not Part A deductible), plus $20 copayments for physician office visits and $50 emergency room visits

The 2010 health reform law, the Patient and Protection and Affordable Care Act (ACA), requires that the Department of Health and Human Services (HHS) request NAIC to update the standards for the most popular Medigap plans, C and F, "to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under Part B."[21] The new standards would apply to policies sold in 2015 or later.

The copayment approach is already included in one of the new Medigap options first offered in 2010, Plan N. This plan covers all cost sharing except the Part B deductible, but requires copayments for office visits with physicians or other practitioners and for emergency room visits. Copayments are set at the lesser of the coinsurance that would ordinarily apply for these services or $20 per office visit and $50 per emergency room visit. MedPAC has suggested that all Medigap plans could be required to include similar copayments, except that the office visit copayment would be $10 for primary care and $25 for specialist visits.

The modeling in this brief assumes that under Option 3, all Medigap enrollees shift to a plan comparable to Medigap Plan N, without a distinction between primary care and specialist visits.[22]

METHODOLOGY

Data and Assumptions

Data used in the modeling for this brief are derived from the 2006 Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Healthcare Research and Quality. The MEPS interviews a nationally representative sample of households and collects information on demographic characteristics, health status, use of medical services, charges and payments for care, health insurance coverage, and other characteristics. The MEPS data have been adjusted using information from several other sources. The following is a summary of a few key assumptions used in the modeling. A fuller explanation of the model is provided in **Appendix B**.

- The population includes all Medicare beneficiaries who had individually purchased Medigap in 2006 and who were not enrolled in Medicaid, an employer plan, or a Medicare Advantage plan during the year. It is assumed that none of the Medigap subscribers drop coverage or change to some other form of supplement.
- Medicare-approved amounts and Medicare payments are updated to fiscal year 2011, using data from the Centers for Medicare & Medicaid Services (CMS) and CBO.
- The model measures the effects of policy options relative to a "base case." In the base case, all beneficiaries with Medigap coverage have at least Plan C, which provides first dollar coverage for services provided under Parts A and B and covers coinsurance for virtually all services.
- Estimated premiums for Medigap coverage, in the base case and under each of the policy options, are equal to expected claims costs for the cost sharing covered by the policy, plus an administrative add-on. For all options, the plan is assumed to have a medical loss ratio of 77.5 percent, the national average for established policies in the individual market in 2009. As is common in the Medigap market, premiums are based on attained age, with older beneficiaries paying more.
- Estimates of spending by Medicare, Medigap carriers, and beneficiaries include only spending for services under Parts A and B; spending for Part D (prescription drug) benefits is omitted.

Changes in Medigap rules would affect Medicare spending only if beneficiaries responded to these changes by using fewer covered services or less costly services. Unfortunately, there is no reliable way of estimating how a given policy will affect care-seeking behavior. Instead, analysis must rely on more or less arbitrary guesses. Different behavioral assumptions would affect estimated per beneficiary costs for Medicare and for enrollees. The analysis here uses a set of factors that assumes that lower-income

beneficiaries would be more likely to curtail their utilization than higher-income ones. How the results might be affected by different behavioral assumptions is discussed later in this paper.

In addition, the analysis assumes: (1) full implementation of the policy in 2011 to assess the full effect, although most proposals would allow for a longer transition; (2) no increase or decrease in the number of Medigap policyholders (which would potentially increase or decrease the Medicare savings); and (3) no change in the underlying structure of the Medicare benefit (although several current proposals would couple Medigap reform with benefit restructuring under the fee-for-service program).

FINDINGS

Effects on Aggregate Medicare and Beneficiary Costs

Exhibits 2 and 3 compare the effects of the three policy options on Medicare spending and beneficiary costs. To allow for comparison of the different options, all of the estimates in this and the next section are based on the assumption of income-based behavioral changes in response to the Medigap changes. These should be regarded as high-end estimates of potential Medicare savings and of net gains for typical beneficiaries.

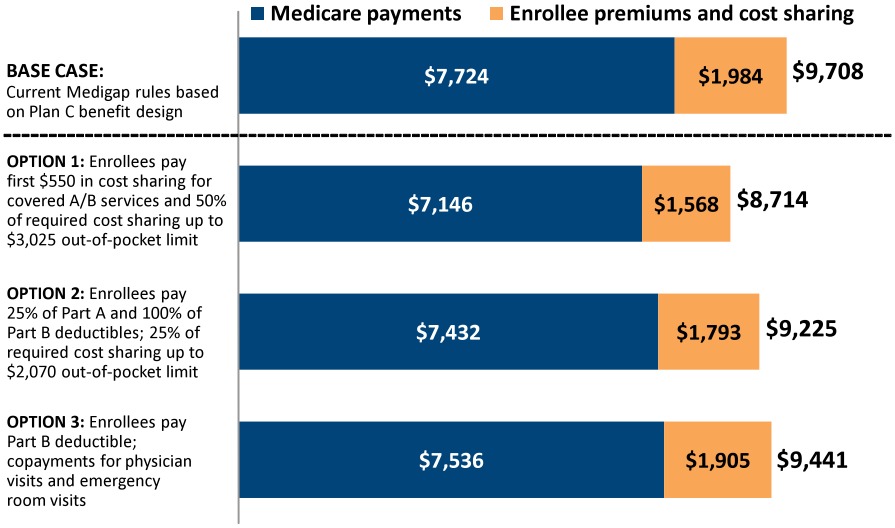
Option 1 provides the largest savings for Medicare and for the average enrollee, while Option 3 has much less impact **(Exhibit 3)**. Under Option 3, enrollees would have to pay only the $162 Part B deductible and fixed copayments for office and emergency room visits. While these cost-sharing requirements might deter initiation of an episode of care, they would not have much effect on use of services once care began. Option 2—the Medigap Plan L package—falls midway between the other two. Its cost-sharing requirements are less stringent than under Option 1, and its out-of-pocket limit is lower. Unlike Option 3, it requires some cost sharing for all services subject to cost sharing under ordinary Medicare rules.

Exhibit 2: Changes in Medicare Spending Per Beneficiary and Average Beneficiary Costs under Three Medigap Benefit Options

	BASE CASE	OPTION 1 First $550 in cost sharing for covered A/B services; 50% of additional required cost sharing up to $3,025 OOP limit	OPTION 2 25% of Part A and 100% of Part B deductibles; 25% of required cost sharing up to $2,070 OOP limit	OPTION 3 Part B deductible; copayments for physician visits and ER visits
(a) Medicare-approved amounts (=b+c)	$9,262	$8,550	$8,922	$9,066
(b) Medicare payments	$7,724	$7,146	$7,432	$7,536
(c) Required cost sharing (=d+e)	$1,537	$1,404	$1,490	$1,531
(d) Paid by Medigap	$1,537	$566	$1,047	$1,289
(e) Paid by enrollee	$0	$838	$443	$242
(f) Medigap premium (=d/.775)	$1,984	$731	$1,350	$1,663
(e) Combined premium and OOP cost (=e+f)	$1,984	$1,568	$1,793	$1,905
(g) Average enrollee savings from base case	n/a	$415	$190	$78
Medicare savings in FY 2011 (in billions)	**n/a**	**-$4.60**	**-$2.32**	**-$1.50**
As percent of Part A and Part B benefit spending (including spending for non-Medigap beneficiaries)	**n/a**	**0.9%**	**0.5%**	**0.3%**

Exhibit 3

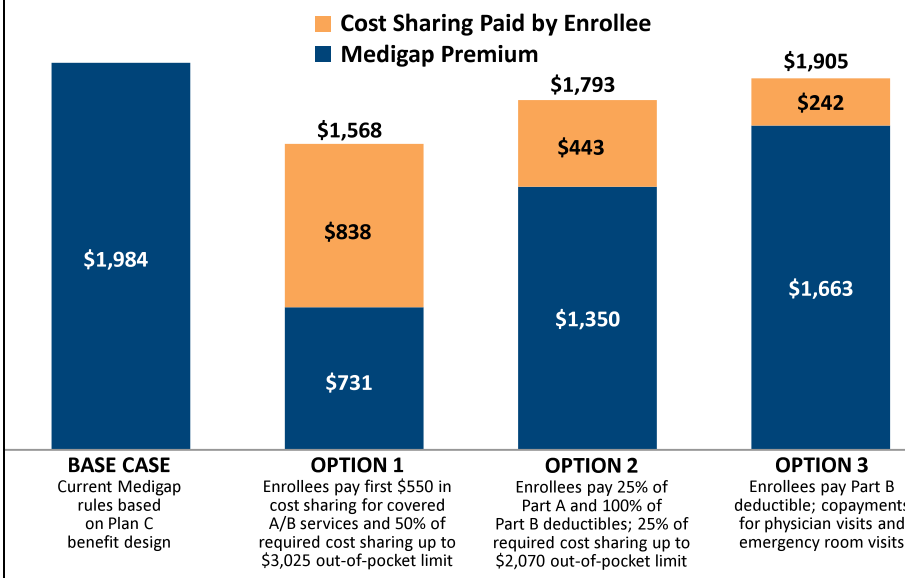
Estimated Medicare and Enrollee Payments Under Medigap Reform Options



As **Exhibit 4** shows, most Medigap enrollees could see their direct costs rise as their Medigap policies become less generous, imposing higher deductibles and cost-sharing requirements. Compared to the base case (with premiums and cost sharing based on Medigap Plan C benefit design), Medigap enrollees would face the largest average increase in their expected out-of-pocket costs for Medicare cost-sharing requirements under Option 1, as their cost sharing goes from $0 under the base case to $838 under Option 1. Cost sharing would be lower under Options 2 and 3 ($443 and $242, respectively).

Exhibit 4

Expected Average Premium and Out-of-Pocket Costs For Medigap Enrollees, Under Base Case and Medigap Reform Options



NOTES: Numbers may not sum to total due to rounding.

However, as enrollees' costs rise, Medigap insurers' claims costs would drop, and insurers would be likely to reduce premiums. When compared to the base case, enrollees would face the largest average reduction in their Medigap premium under Option 1, from $1,984 to $731. If premium reductions were fully proportionate to the drop in expenses, the savings for the *average* beneficiary would be sufficient to more than offset his or her new direct outlays for Medicare cost sharing. However, the magnitude of change varies across the three options, with average reductions in combined premiums and cost sharing ranging from $415 under Option 1 to $190 under Option 2 and $78 under Option 3.

As noted earlier, the premium estimates here assume that policies under both the base case and Option 1 have a loss ratio of 77.5 percent, which is substantially higher than the 65 percent required by law. This analysis assumes that insurers would pass their savings from reduced claims costs to enrollees to retain market share. However, the impact of reduced claims on premiums could be limited by other factors. Many enrollees are effectively locked into their current carrier because they might not pass medical underwriting tests for a new policy. Carriers could hold onto these enrollees even if they did not share savings. Moreover, it is unlikely that insurers' administrative costs would drop in direct proportion to reduced utilization. There might be somewhat fewer individual claims from enrollees, reducing claims processing costs. But other components of administration, such as marketing and premium collection, would not be affected at all.

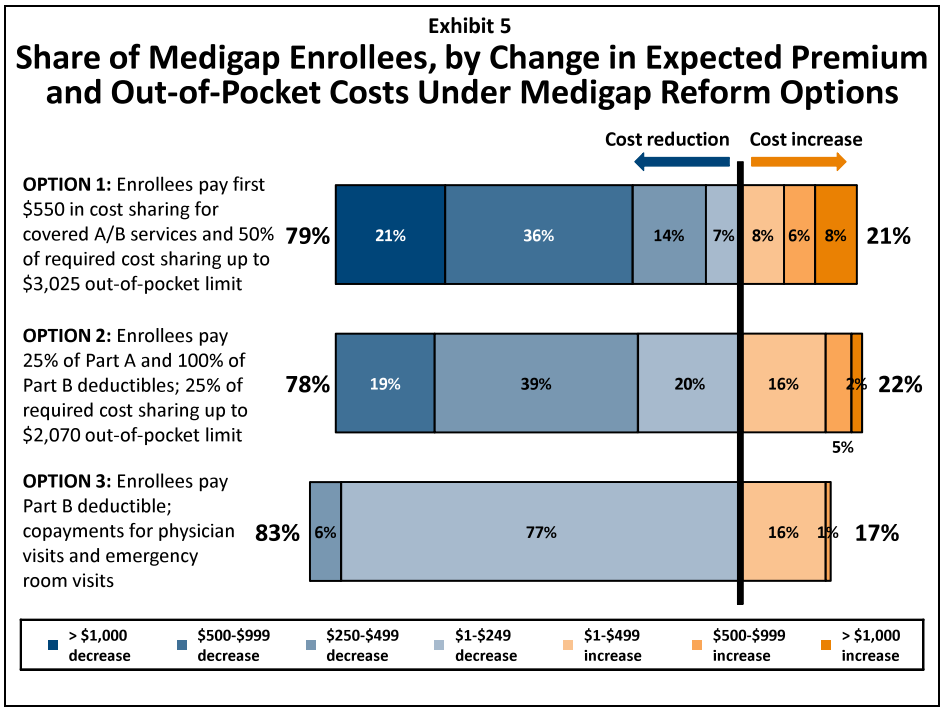
In sum, the premium estimates presented here may be optimistic. But even in the worst case, with loss ratios dropping to the minimum required 65 percent, most enrollees would still see a net savings. Under Option 1, for example, the average premium would go from $731 to $871 with the lower loss ratio. But this would still translate into average premium savings of $1,113 from the base-case premium ($1,984), more than enough to offset the increased cost sharing.

Average Cost Increases and Reductions Among Medigap Enrollees

Under all three options, the average beneficiary would see some cost savings. But there are winners and losers under each option, as **Exhibits 5 and 6** show.

Exhibit 5

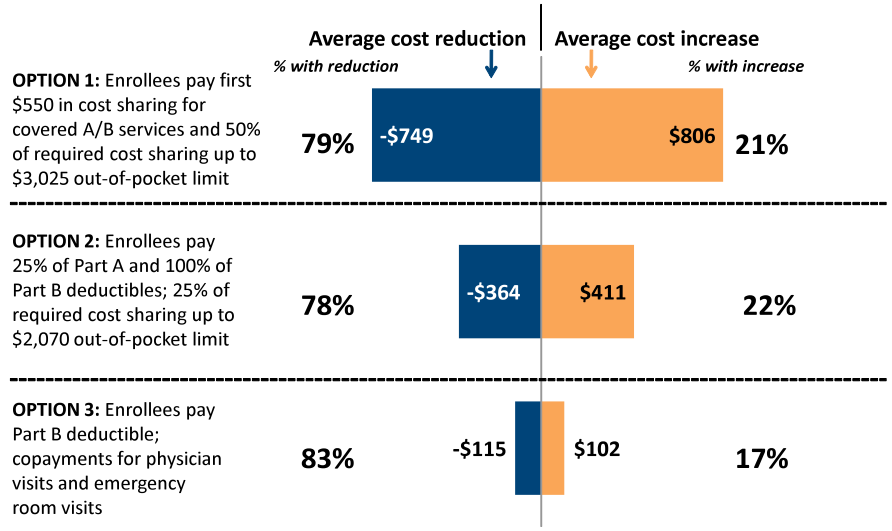
Share of Medigap Enrollees, by Change in Expected Premium and Out-of-Pocket Costs Under Medigap Reform Options



About 4 out of 5 enrollees would have lower combined premium and out-of-pocket costs under each option than under the base case, while 1 in 5 would see higher costs. But the magnitude of the effects is very different under Option 1 than under the other two. Under Option 1, 14 percent of enrollees would see their costs increase by $500 or more, while 57 percent would have cost reductions of $500 or more. Under Options 2 and 3, on the other hand, most enrollees have more modest gains or losses.

Exhibit 6

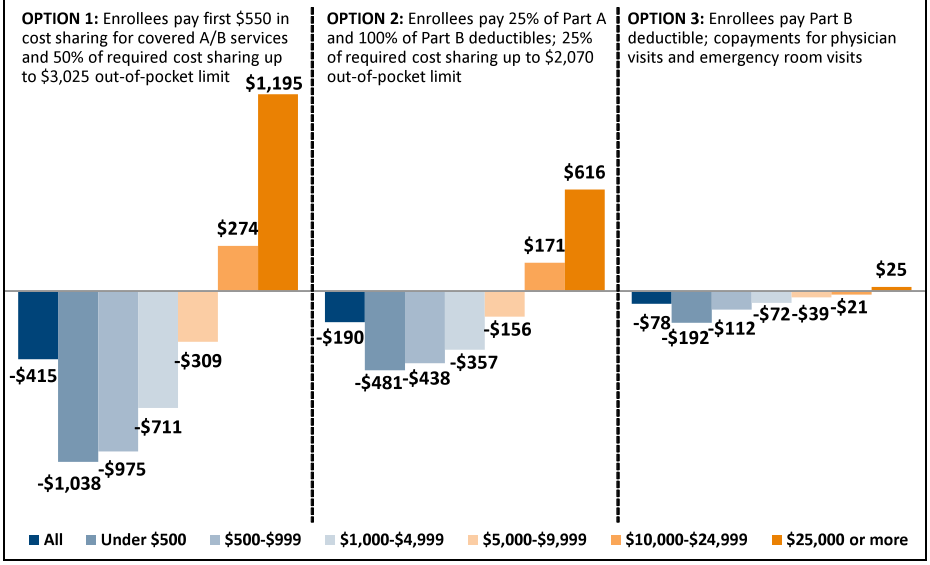
Average Change in Expected Premium and Out-of-Pocket Costs For Medigap Enrollees Under Medigap Reform Options



Many beneficiaries use comparatively few Medicare services during a year and thus would pay little or no cost sharing under any of the options, but they would benefit from Medigap premium reductions. Enrollees with lower Medicare spending are expected to see average net savings, while those with higher Medicare spending would face higher average net costs under these reform options **(Exhibit 7)**.

Exhibit 7

Average Change in Expected Premium and Out-of-Pocket Costs For Medigap Enrollees Under Medigap Reform Options, by Enrollees' Medicare Spending Level Before Reform

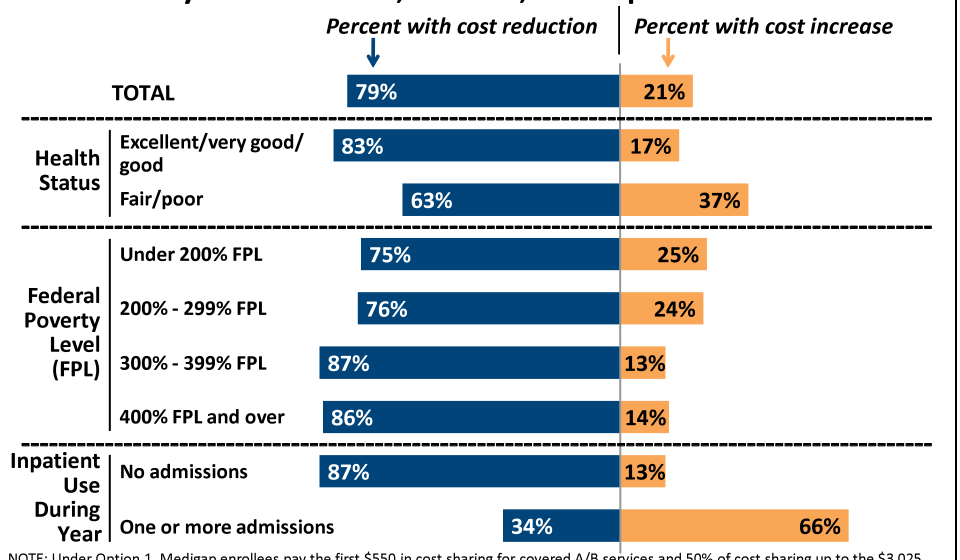


Effects on Medigap Enrollees by Beneficiary Characteristics

Exhibits 8 and 9 show Medigap enrollees who would experience changes in cost under the three different reform options by enrollee characteristics, including health status, age, income, and use of inpatient hospital services.

Exhibit 8

Share of Medigap Enrollees By Change in Expected Premium and Out-of-Pocket Costs Under Medigap Reform Option 1, by Health Status, Income, and Inpatient Use



NOTE: Under Option 1, Medigap enrollees pay the first $550 in cost sharing for covered A/B services and 50% of cost sharing up to the $3,025 out-of-pocket limit.

A greater share of Medigap enrollees reporting fair or poor health would see their costs increase under each option. Because they tend to have higher spending, they would pay more under the new cost-sharing rules. On the other hand, for those in the same age bracket, while their premiums would go down, the reductions would be the same for everyone, regardless of health status or utilization. For sicker enrollees, the uniform premium changes would be less likely to offset the new cost sharing.

A greater share of enrollees with low incomes than those with higher incomes would see cost increases under each of the options. This may be related to, but not primarily a function of, health status, since enrollees' reported health is not strongly correlated with income. It is possible that low-income beneficiaries who choose to devote some of their more limited resources to purchase Medigap have a higher propensity to use services than higher-income enrollees. Whatever the explanation, it appears that any Medigap restrictions would be somewhat more burdensome for lower-income Medigap purchasers.[23]

Finally, enrollees who receive inpatient hospital care would be far more likely than others to see net cost increases under Options 1 and 2, because they would have to pay part of the inpatient deductible, the most costly single component of Medicare cost sharing. This would not be true if cost sharing led some of these enrollees to decline an elective hospital admission. (The analysis here models changes in overall spending, but not in use of specific types of services.)

Exhibit 9: Percent of Medigap Enrollees with a Net Cost Increase under Medigap Benefit Options, by Beneficiary Characteristics

	OPTION 1 Enrollees pay first $550 in cost sharing for covered A/B services and 50% of additional required cost sharing up to $3,025 OOP limit	OPTION 2 Enrollees pay 25% of Part A and 100% of Part B deductibles; 25% of required cost sharing up to $2,070 OOP limit	OPTION 3 Enrollees pay Part B deductible; copayments for physician visits and emergency room visits
Reported health status			
Good, very good, or excellent	17%	18%	14%
Fair or poor	37%	39%	26%
Age*			
65-74	21%	21%	18%
75-84	22%	22%	16%
85 and older	21%	25%	14%
Family income as a percent of poverty			
Under 200%	25%	28%	16%
200%-299%	24%	23%	25%
300%-399%	13%	15%	10%
400% and over	14%	13%	12%
Inpatient hospital use during year			
No inpatient admission	13%	13%	14%
One or more inpatient admissions	66%	72%	31%
Total	**21%**	**22%**	**17%**

NOTE: *Only about 275,000 people with individual Medigap were under age 65. This sample is too small for meaningful analysis. However, nonelderly enrollees are included in the numbers for health status and income and in the totals

Are the Medicare Savings Real?

The modeling here assumes that Medigap enrollees would reduce their use of services in response to changes in Medigap coverage, and that the Medicare program would therefore realize savings. Because the size of the estimated savings is directly related to specific assumptions about likely enrollee behavior, an important question is what would happen if different assumptions were used.

Exhibit 10 shows how three different behavioral assumptions would affect estimated per beneficiary costs for Medicare and for enrollees under Option 1, the plan that requires the enrollee to pay the first $550 in cost sharing and 50 percent of additional required cost sharing up to an out-of-pocket limit. The three sets of assumptions are:

- ***No change in behavior:*** Beneficiaries continue using the same services, regardless of the changes in cost sharing.
- ***A 5 percent reduction in use and spending:*** This is roughly the change CBO has predicted in modeling similar options.[24]
- ***Income-based reductions in spending:*** According to this assumption, upon which the estimates in this paper are based, lower-income enrollees would be more likely to curtail use of services than higher-income enrollees. Under Option 1, the third of enrollees with the lowest incomes reduce spending by 9.2 percent, while the third of enrollees with the highest incomes reduce spending by 6.4 percent. (The source of these assumptions is discussed in **Appendix A**.)

Exhibit 10: Changes in Medicare Spending Per Beneficiary and Beneficiary Costs for Option 1, Using Different Behavioral Assumptions

		OPTION 1 results with--		
	Base case (A)	No change in behavior (B)	5% reduction in spending (C)	Income-based reductions in spending (D)
(a) Medicare-approved amounts (=b+c)	$9,262	$9,262	$8,799	$8,550
(b) Medicare payments	$7,724	$7,724	$7,358	$7,146
(c) Required cost sharing (=d+e)	$1,537	$1,537	$1,440	$1,404
(d) Paid by Medigap	$1,537	$648	$588	$566
(e) Paid by enrollee	$0	$889	$852	$838
(f) Medigap premium (=d/.775)	$1,984	$836	$759	$731
(e) Combined premium and OOP cost (=e+f)	$1,984	$1,725	$1,611	$1,568
(g) Average enrollee savings from base case	n/a	$258	$372	$415
Medicare savings in FY 2011 (in billions)	**n/a**	**$0.00**	**-$2.91**	**-$4.60**
As percent of Part A and Part B benefit spending (including spending for non-Medigap beneficiaries)	**n/a**	**0.0%**	**0.6%**	**0.9%**

SOURCE: Medicare savings based on author's calculations, based on spending under Parts A and B for all Medicare beneficiaries.

If Medigap enrollees made no change in their behavior at all (Column B results), there would be no savings to the Medicare program; it would still be paying for the same mix of services as before. But the average enrollee would still have net savings, because the new cost-sharing expense of $889 (Column B, Row d) would be more than offset by the premium reduction ($1,984 - $836).[25] As suggested earlier, the exact size of the offset depends on the extent to which insurers pass on their own claims savings. But most consumers are likely to see at least some savings. This fact is important when thinking about how enrollees might respond to Medigap policy changes and how total Medicare spending might be affected.

Many studies have shown that increasing cost sharing in any kind of health insurance plan deters enrollees from obtaining some services.[26] Two recent studies have focused specifically on Medicare beneficiaries. In each study, the beneficiaries started out with supplemental plans that required low copayments for covered ambulatory services. When the plans changed their benefits, requiring much higher copayments for ambulatory care, the enrollees' utilization dropped sharply.[27] But there is a key difference between the situation faced by these enrollees and the one that would be faced by Medigap policyholders under the options considered here.

In the studies cited, and in most similar analyses, the enrollees were faced with a *new cost.* They either had to reduce their utilization, spend money that they were previously using for other household expenses, or draw on savings. But the Medigap changes modeled here would merely retarget money that Medigap enrollees *are already spending for medical care.* In effect, each enrollee is being handed a lump sum, in the form of a premium reduction. The enrollee then has a choice of using this money to cover the new cost-sharing expenses or reducing use of medical services and spending the amount they saved on something else. Certainly, many enrollees might choose to use their premium savings to meet other needs. But others may not, and expectations of large Medicare savings resulting from Medigap restrictions may not be entirely realistic. The estimates here, with savings ranging from 0.3 percent to 0.9 percent of aggregate Part A and B spending, should probably be regarded as at the upper limit of possible savings.

Treatment of Employer Plans and Medicare Advantage Plans

If the rationale for restrictions on Medigap coverage is that first-dollar coverage leads to inappropriate utilization, it would seem equitable to set the same rules for beneficiaries with other forms of supplemental coverage. The Bowles-Simpson commission Medigap proposal would also apply to all employer-provided supplements, including the federal health programs for civilian and military retirees. As noted earlier, MedPAC has suggested that extending Option 1 to employer plans could double the Medicare savings. It would also be conceivable to impose similar restrictions on Medicare Advantage plans. But there are also arguments against restrictions on employer plans or MA plans.

For retirees with employer-provided benefits (as opposed to Medicare-eligible active workers), Medicare is the primary payer: it pays the amount it would normally pay on any claim, leaving any required cost sharing to be paid by the employer, the beneficiary, or both. Different employer plans have different ways of calculating what they will pay toward cost sharing. Some usually pay cost sharing in full; this is the rule, for example, for Medicare-eligible annuitants under the Federal Employees Health Benefits program. Others contribute only the difference, if any, between Medicare's payment and what the plan would have paid for the same service if the enrollee had not had Medicare. Because these plans have their own cost-sharing requirements, they may pay nothing toward a Medicare-covered service. The enrollee is left to pay the full Medicare cost sharing until he or she reaches the employer plan's out-of-pocket limit. While there do not appear to be any reliable data on how many employers use which method, benefits consultants indicate that the second approach is the more common one.[28]

This has a number of consequences. First, many beneficiaries already have something less than first-dollar coverage from their employer plans. This is reflected in the MedPAC study cited earlier, which shows that employer-provided supplemental coverage has less apparent effect on utilization than Medigap. And the number of retirees with very generous coverage is likely to drop as employers continue to look for ways of controlling the costs of benefits for current or future retirees.

Second, setting uniform benefit rules for retiree plans is likely to be very complex. Nearly everyone with Medigap is already getting one of a limited set of standardized plans, and tweaking the rules for these plans is fairly straightforward. But applying, for example, the CBO option to employer plans would be much more complex. What if a plan has a lower deductible than the proposal requires but a higher out-of-pocket limit? What if a plan's rules for coordinating its benefits with Medicare mean that it helps pay for some Medicare-covered services and not for others? It is hard to see how one could fairly regulate employer plans without moving toward standardization. An alternative might be some sort of actuarial equivalency test, under which the employer would show that retirees were paying at least as much of their own cost sharing as they would under the reformed Medigap plans. But this would still be complicated and burdensome to administer.

Finally, many retirees with generous Medicare supplemental coverage bargained for that coverage in lieu of other compensation. This argument is often raised in the context of discussions of possible changes in the tax treatment of employer-sponsored coverage. It is also one of the criticisms leveled at the excise tax on high-cost employer plans included in the ACA. But a key difference is that, if employers respond to the new excise tax by curtailing health benefits, active workers can negotiate other compensation—an offsetting wage increase or improvements in other benefits. Retirees, on the other hand, can no longer negotiate. If benefits under their Medicare supplement are reduced, they cannot make this up in some other way.

Imposing benefit restrictions on Medicare Advantage plans might seem fair, but would have little direct effect on federal spending. Most Medicare Advantage plans do offer reduced cost sharing for basic Medicare benefits. However, if the reduced cost sharing offered by an Medicare Advantage plan leads to higher utilization of these benefits, it is the plan and not the federal government that bears the cost. (In fact, plans that waive cost sharing are required to adjust their bids to assure that Medicare does not pay for any resulting induced demand.) Moreover, most plans are supposed to have some way of managing costs other than simply deterring utilization through cost sharing. So it may be more sensible to go on letting the market determine the mix of supplemental benefits that MA plans offer.

CONCLUSION

Restrictions on first-dollar coverage under Medigap plans could produce some savings for the Medicare program by deterring some beneficiaries from accessing medical care. For the most restrictive option, the savings could approach 1 percent of total Part A and B spending. This finding should be viewed with caution. As was suggested earlier, projections of utilization changes in response to benefit redesigns are highly speculative. And it is unclear whether changes in care-seeking behavior would produce one-time savings for Medicare or have an ongoing effect on spending growth. To the extent that Medicare spending growth is driven by the adoption of costly new medical technologies, physicians' decision-making may be at least as important as consumers' choices.

Policy changes must also be considered in the light of potential effects on beneficiaries. The analysis here suggests that most beneficiaries would gain financially from more restrictive coverage, because their increased cost sharing for covered services would be offset by Medigap premium reductions. But as many as one in five enrollees could see cost increases—in some cases $1,000 or more per year. Enrollees facing higher net costs are disproportionately those in fair or poor health, those requiring inpatient hospital care, and those with modest incomes. Even enrollees who do not actually see an increase in their total costs could be thought of as suffering a "welfare loss." Beneficiaries buy comprehensive insurance in part for the peace of mind of knowing that they are fully protected against unpredictable events. They may see the loss of this protection as outweighing any potential premium savings.

Perhaps more important, there is no way of ensuring that enrollees who might reduce their utilization would forgo only services of questionable value. The RAND Health Insurance Experiment, which randomly assigned participants to insurance plans with different levels of cost sharing, found that those facing higher cost sharing did indeed use fewer services. But they were as likely to go without services that experts deemed highly effective as services deemed ineffective.[29] The RAND experiment was conducted many years ago and did not include the elderly. However, more recent studies of the effects of cost-sharing on elderly people have shown reduced use of necessary services and poorer health outcomes. Most of these studies have focused on cost-sharing for prescription drugs, which is not affected by the proposals analyzed here.[30] But at least one study focusing on ambulatory care suggests that enrollees with chronic conditions could defer necessary services—perhaps leading to even higher costs in the long run.[31] More research is needed before it can be concluded that Medigap changes will not adversely affect the health of beneficiaries.

In the coming years, Medicare will be experimenting with new payment mechanisms meant to change financial incentives for providers and encourage reforms in the way medical care is organized and delivered. One option is bundled payment, a single payment to a provider for all services related to a

specific disease or condition during some fixed period. Another is to encourage development of accountable care organizations (ACOs), networks of physicians and other providers that would accept responsibility for overall care of a population of Medicare patients. The ACO program will begin with an arrangement under which ACOs and Medicare will share in any savings resulting from more cost-effective care, but many expect that it will eventually evolve into a capitated system.

None of these options work well with a cost-sharing structure that is designed for an entirely fee-for-service system. If a doctor/hospital team receives a single bundled payment for total care of a heart attack, does the beneficiary pay 20 percent of this amount? If ACOs are going to be capitated to provide total care for a beneficiary for a month, what is the beneficiary going to pay? New payment systems are meant to give the providers incentives to avoid delivering unnecessary services. Using cost sharing to induce beneficiaries to reduce utilization still further could jeopardize quality. Policymakers considering changes in Medigap rules will need to consider how Medigap fits into broader efforts to control the growth of Medicare spending.

Medigap enrollment is likely to grow in the coming years, for at least two reasons. First, the Affordable Care Act changed the payment formulas for Medicare Advantage (MA) plans; future payment reductions may mean that some beneficiaries will lose access to MA options. Or MA plans may curtail supplemental benefits or raise premiums, reducing their competitive advantage over conventional Medigap. In addition, while many current Medicare beneficiaries have retiree benefits from their former employers, this coverage is likely to erode. Fewer employers are promising future benefits to their active workers, and rising costs may lead some employers to abandon coverage even for current retirees, perhaps replacing their plans with subsidies for individual purchase of Medigap and Part D plans.

These trends may mean that a steadily growing share of beneficiaries will be relying on Medigap for their supplemental coverage. If these new purchasers, like existing Medigap enrollees, prefer the more comprehensive plans, this could mean some upward pressure on utilization. Potential Medicare savings from restricting benefits might be higher than suggested in CBO's projections or in this brief. But increasing reliance on Medigap also makes it all the more pressing that redesign of Medigap benefits be coordinated with other Medicare reforms. Medigap issues should be considered in the context of a broader reevaluation of the structure of Medicare benefits and a possible realignment of overall financial incentives for both providers and beneficiaries.

APPENDIX A: INFORMATION ON MEDICARE BENEFITS AND MEDIGAP PLANS

Exhibit A1

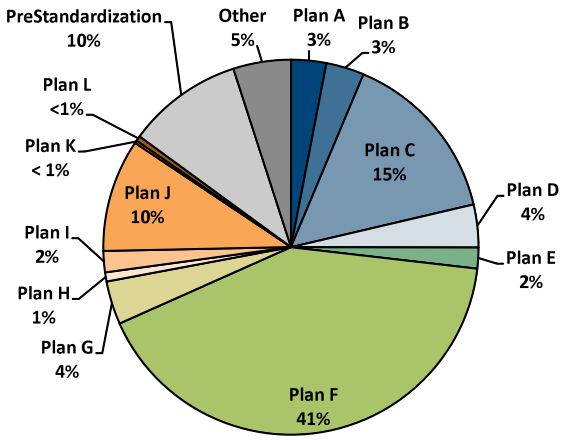
Standard Medigap Plan Benefits, 2011

BENEFITS	MEDIGAP POLICY									
	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance and all costs after hospital benefits are exhausted	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment for other than preventive services	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓*
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance or Copayment				✓		✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)*			✓	✓	✓	✓			✓	✓
Out-of-Pocket Limit							$4,620	$2,310		

NOTES: Check marks indicate 100 percent benefit coverage. Amount in table is the plan's coinsurance amount for each covered benefit after beneficiary pays deductibles or cost-sharing amounts, where applicable. *Plan N pays 100% of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits.
SOURCE: Centers for Medicare & Medicaid Services, 2011 Guide to Health Insurance, March 2011.

Exhibit A2

Distribution of Medigap Policyholders by All Plan Types, 2009



Total Number of Medigap Policyholders, 2009 = 8.5 million

NOTE: Analysis includes standardized plans A-L, policies existing prior to federal standardization, and plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program; does not include companies and plans that identified as Medicare Select; excludes companies and plans where sum of premiums or number of covered lives was less than or equal to zero; negative claims set at 0. Although plans H, I, and J are no longer offered, enrollees who had purchased these plans can remain in them.
SOURCE: K. Desmond and Kaiser Family Foundation analysis of 2009 National Association of Insurance Commissioners (NAIC) Medicare Supplement data; unpublished. CMS Medicare and Medicaid Statistical Supplement: Medicare Enrollment 2009, released September 30, 2010

Exhibit A3: Medicare Benefits* and Cost-Sharing Requirements, 2011

PART A	
Deductible	$1,132 per benefit period
Inpatient hospital	
Days 1-60	No coinsurance
Days 61-90	$283 per day
Days 91-150	$566 per day (for up to 60 lifetime reserve days)
After 150 Days	Not covered
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$141.50 per day
After 100 Days	Not covered
Home Health	No coinsurance; no limit on number of visits
Hospice	No coinsurance for hospice care; copayment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care
Inpatient psychiatric hospital	Up to 190 days in a lifetime
PART B	
Deductible	$162
Premium	$115.40/month; higher for those with incomes above $85,000/single or $170,000/couple; $96.40/month for those held harmless from the premium increase since 2009; $110.50/month for those held harmless from the premium increase since 2010.
Physician and other medical services	
MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance, plus up to 15% above the Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
Diagnostic tests, X-rays, and lab services	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance; certain limits may apply
Clinical laboratory services	No coinsurance
Home health care	No coinsurance; no limit on number of visits
Outpatient mental health services	45% coinsurance (phasing down to 20% in 2014)
One-time "Welcome to Medicare" physical exam	20% coinsurance; covered within first 12 months of Part B enrollment; Part B deductible does not apply
Preventive services*	
Flu shot, Pneumococcal shot	No coinsurance; limit of one flu shot per flu season
Hepatitis B shot, colorectal and prostate cancer screening, pap smear, mammogram, cardiovascular screening, abdominal aortic aneurysm (AAA) screening, bone mass measurement, diabetes screening and monitoring, glaucoma screening, smoking cessation	20% coinsurance after annual Part B deductible is met; however, Part B deductible and coinsurance are waived for some preventive services
PART D	
Information below applies to the standard Part D benefit; benefits and cost-sharing requirements typically vary across plans. Beneficiaries receiving low-income subsidies pay reduced cost-sharing amounts.	
Deductible	$310
Premium	$32.34 national average monthly premium *(unweighted PDP and MA-PD plan average)*
Initial coverage *(up to $2,840 in total drug costs)*	25% coinsurance
Coverage gap *(between $2,840 and $6,448 in total drug costs)*	50% coinsurance for brand-name drugs, 93% coinsurance for generic drugs, phasing down to 25% in 2020
Catastrophic coverage *(above $4,550 in out-of-pocket spending)*	Minimum of $2.50/generic, $6.30/brand; or 5% coinsurance

NOTES: *This table does not include all Medicare-covered benefits or preventive services; for a complete listing, see http://www.medicare.gov/Coverage/Home.asp and http://www.medicare.gov/Health/Overview.asp.

SOURCES: CMS, www.medicare.gov, Medicare & You 2011, Your Guide to Medicare's Preventive Services.

APPENDIX B: DATA AND METHODS

Data used in the modeling for this brief are derived from the 2006 Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Healthcare Research and Quality (AHRQ), adjusted using information from several other sources (discussed below).[32] The MEPS interviews a nationally representative sample of households and collects information on demographic characteristics, health status, use of medical services, charges and payments for care, health insurance coverage, and other characteristics.

Spending and Cost Sharing

The MEPS understates Medicare utilization and spending for certain categories of service. Data were adjusted using AHRQ's own reconciliation of MEPS and the National Health Expenditure Accounts and further corrected to match 2006 CMS administrative data.[33] The MEPS contains no information on the use of skilled nursing facility (SNF) services. SNF use and spending by enrollees with inpatient hospital admissions have been imputed using odds ratios derived from a CMS study of post-acute care use.[34] Medicare payment estimates were converted to allowable amounts using cost-sharing estimates developed by CMS for use in the 2006 Medicare Advantage bidding process.[35] All amounts were updated to FY 2011 using the CBO's benchmark estimates from March 2007 and March 2011.

Enrollment

Comparison with data from the Medicare Current Beneficiary Survey (MCBS) and other sources indicates that there is some under- or misreporting of Medicare beneficiaries' supplemental coverage. To correct for this, participants reporting individual Medigap were reweighted to match distributions of Medigap enrollees by age, income, health status, and Medicare spending in the 2006 MCBS. Enrollment estimates have *not* been updated to 2011, because there is no information on recent changes in supplemental coverage. The model therefore reflects estimated 2011 spending and cost sharing for the 2006 Medigap population. Characteristics of this population are shown in Exhibit B1.

Exhibit B1: Characteristics of Medigap Enrollees, 2006

		Number of enrollees (weighted)	Percent of total
Age	Under 65	274,745	3%
	65-74	3,546,764	45%
	75-84	2,907,148	37%
	85+	1,215,257	15%
Reported health status	Excellent	1,463,955	18%
	Very good	2,383,195	30%
	Good	2,582,861	33%
	Fair	1,119,257	14%
	Poor	337,539	4%
Family income as a percent of poverty	Under 200%	3,635,552	46%
	200%-299%	2,002,642	25%
	300%-399%	897,151	11%
	400% and over	1,408,569	18%
Total		**7,943,915**	**100%**

SOURCE: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2006. Family income estimates from reweighted 2006 Medical Expenditure Panel Survey data.
NOTE: Includes all Medicare beneficiaries who had individually purchased Medigap at any time in 2006 and who were not also enrolled in Medicaid, an employer plan, or a Medicare Advantage plan during the year.

Premiums

Premiums for Medigap coverage in the base case are estimated on the assumption that the plan covers all required cost sharing for Medicare Part A and B services. (Some components of cost sharing, such as coinsurance for very long hospital stays, are omitted from the estimates, because these events are too rare in the MEPS sample. As a result, premiums are somewhat understated.) For the base case and all options, it is assumed that every policy has a loss ratio of 77.5 percent. This is the average ratio reported to the NAIC in 2009 for individual policies that had been in force since 2006 or earlier.[36] (Newly issued policies tend to have much higher loss ratios at the outset.) Premiums are established on an attained age basis for four age groups. Base case premiums are shown in Exhibit B2. Note that because MEPS public use data include almost no geographic information, these premiums are based on national weighted averages for beneficiaries in the age group. Of course, actual Medigap premiums vary by geography. This would not likely affect the estimates of overall average Medicare and individual savings under the reform options in the analysis, but would affect the classification of individual cases as "winners" and "losers"—those whose cost sharing is or is not fully offset by premium reductions.

Exhibit B2: Estimated Base Case Premiums, by Age

Age	Base premium, FY 2011
Under age 65	$1,201
65-74	$1,600
75-84	$2,276
85 and older	$2,579

Behavioral Factors

Policy options that reduce coverage, exposing participants to higher OOP costs, are assumed to reduce the likelihood that enrollees will use any Medicare-covered services during the year, as well as the amount of services obtained by those who do use services. Estimates of these effects use factors derived from the Health Insurance Experiment (HIE) conducted by the RAND Corporation in the 1970s. HIE participants were randomly assigned to a full, first-dollar plan and to plans that imposed various levels of copayment—including one that required participants to pay nearly all their expenses until they reached an OOP limit. Random assignment meant that the researchers could set aside people's preference about what kind of insurance to buy and look directly at how different levels of coverage affected use. As expected, higher cost sharing did deter people from obtaining care. However, it made the greatest difference to poor people, especially poor children; higher-income participants were not much affected.[37]

Much has changed in insurance and in medical care since the 1970s. Moreover, the HIE did not include elderly people, and some analysts think they might behave differently from the nonelderly. Still, there appears to be no other source for income-based estimates of changes in demand in response to changes in cost sharing. For the estimates in this brief it is assumed that, for each 1 percent increase in the *share of Medicare allowed amounts* paid by the enrollee under the different options, the allowed amounts are reduced as shown in Exhibit B3.[38]

Exhibit B3: Estimated Spending Reduction for Each One Percent Increase in Share of Costs Paid by Beneficiaries

Income class	Spending reduction
Lowest third of Medicare households	0.961%
Middle third	0.764%
Highest third	0.666%

ENDNOTES

[1] Another 3 million Medicare beneficiaries had Medigap plus another source of supplemental coverage (such as Medicaid, Medicare Advantage, or employer-sponsored insurance). Estimates from Kaiser Family Foundation analysis of the 2008 Medicare Current Beneficiary Survey Access to Care file.
[2] For a recent review of the evidence, see MedPAC, *Report to the Congress: Aligning Incentives in Medicare,* June 2010.
[3] CBO, *Reducing the Deficit: Spending and Revenue Options*, March 2011.
[4] The Lieberman/Coburn Proposal, *A Bipartisan Plan to Save Medicare & Reduce Debt*, June 2011, http://lieberman.senate.gov/assets/pdf/LiebermanCoburn.pdf.
[5] The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010.
[6] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Aligning Incentives in Medicare,* June 2010, Chapter 2; *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011, Chapter 3.
[7] Amal N. Trivedi, Husein Maloo, and Vincent Mor, "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," *N Engl J Med* 362:320-8, Jan. 28, 2010.
[8] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011, Chapter 3..
[9] Kaiser Family Foundation analysis of 2008 Medicare Current Beneficiary Survey Access to Care file.
[10] Approximately 7 million Medicare beneficiaries have Medigap policies only and no other source of supplemental coverage; another 3 million beneficiaries have Medigap along with another source of supplemental coverage (Medicaid, Medicare Advantage, or employer-sponsored insurance).
[11] For a recent review of the evidence, see MedPAC, *Report to the Congress: Aligning Incentives in Medicare,* June 2010.
[12] Kaiser Family Foundation, *Comparison of Medicare Provisions in Deficit Reduction Proposals*, April 2011, http://www.kff.org/medicare/8124.cfm.
[13] Another approach, not considered here, would to impose some form of financial penalty, such as an excise tax, to encourage beneficiaries to shift to less comprehensive coverage and to offset some of the added Medicare spending beneficiaries with Medigap incur. This option is discussed in MedPAC's June 2011 report to Congress.
[14] Beneficiaries may also have to pay "excess charges" if they use a provider who does not accept Medicare-approved amounts as payment in full. Some Medigap plans cover these charges.
[15] Some policies purchased before the rules took effect are still in force, and three states, Massachusetts, Minnesota, and Wisconsin, have waivers to use their own rules for Medigap.
[16] America's Health Insurance Plans (AHIP), *Characteristics of Medigap Policies, December 2009,* Washington, Sep. 2010.
[17] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options,* March 2011.
[18] MedPAC 2010.
[19] The Lieberman/Coburn Proposal, *A Bipartisan Plan to Save Medicare & Reduce Debt*, June 2011, http://lieberman.senate.gov/assets/pdf/LiebermanCoburn.pdf.
[20] The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth,* December 2010. The Rivlin/Ryan plan is outlined in a set of supplemental statements by commission members, http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/MemberStatements.pdf.
[21] Section 3210.
[22] MedPAC (2011) notes that NAIC/CMS guidance on Plan N excludes from the definition of "office visit" some kinds of visits that may be subject to copayments under private plans, such as physical therapy visits and visits solely to obtain an x-ray. The model does not distinguish these types of encounters.
[23] Note that the behavioral factors used in the modeling already assume that lower-income participants will be slightly more likely to reduce their use of services. For many, however, even forgoing services will not be sufficient to protect them against cost increases.
[24] Congressional Budget Office, *Budget Options Volume 1: Health Care*, December 2008.
[25] As in the earlier premium example, there would still be a net saving even if the insurer charged the maximum permissible premium with a loss ratio of 65 percent, $997 in this case.
[26] For a review of past studies, see Jeanne S. Ringel, et al., *The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System,* Santa Monica, CA, RAND Center for Military Health Policy, 2005.
[27] Both studies found that resulting savings were more than offset by increases in inpatient hospital admissions. This might not be as true for Options 1 and 2 in this brief, because both also impose cost sharing for inpatient stays. Amal N. Trivedi, Husein Maloo, and Vincent Mor, "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," *N Engl J Med* 362:320-8, Jan. 28, 2010. Amitabh Chandra, Jonathan Gruber, and Robin McKnight, *Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly*, National Bureau of Economic Research Working Paper No. 12972, March 2007. Note that the latter study included prescription drug as well as ambulatory copayments.
[28] Michael Morfe, Aon Consulting, "Design Your Retiree Medical Plan for Maximum Flexibility," available at http://www.aon.com/about-aon/intellectual-capital/attachments/human-capital-consulting/Retiree_Medical_FINAL.pdf.
[29] Kathleen Lohr, et al., *Use of Medical Care in the RAND Health Insurance Experiment Diagnosis- and Service-specific Analyses in a Randomized Controlled Trial,* RAND Corporation, 1986, available at http://www.rand.org/pubs/reports/R3469.html.

[30] For a review of these studies, see Thomas Rice and Karen Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review,* December 2004; vol. 61, 4: pp. 415-452.
[31] Trivedi, Maloo, and Mor, "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly."
[32] MEPS data are available for more recent years, but some of the data used for adjustment were only available through 2006 when the modeling was being developed, so this year was selected as the starting point for the analysis.
[33] Available at http://www.cms.gov/MedicareFeeforSvcPartsAB/.
[34] Andrew Shatto, "Comparing Medicare Beneficiaries, by Type of Post-Acute Care Received: 1999," Health Care Financing Review, v. 24, n. 2 (Winter 2002), p. 137-142.
[35] Available at http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/costsharing2006.zip.
[36] National Association of Insurance Commissioners, *2009 Medicare Supplement Loss Ratios.* Sample data available at http://www.naic.org/documents/research_stats_medsup_sample.pdf .
[37] Willard G. Manning, et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, v. 77, n. 3 (June 1987), p. 251-277.
[38] The spending estimates in the HIE are affected by the use of income-based OOP limits; the factors developed here attempt to address this by giving greater weight to likelihood of any use than to total spending.

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