Section 3

Supplemental Insurance Coverage and Medicare Advantage

SECTION 3: SUPPLEMENTAL INSURANCE COVERAGE AND MEDICARE ADVANTAGE

Most Medicare beneficiaries (88 percent) have some type of supplemental insurance coverage to help pay for Medicare's cost-sharing requirements and for benefits currently not covered by Medicare. Employer-sponsored coverage is the most common source of supplemental insurance (held by 35 percent of all non-institutionalized beneficiaries in 2002), followed by individually-purchased Medigap policies (21 percent), and Medicaid (17 percent) for those with extremely low incomes.

These sources of coverage vary by beneficiaries' income. More than half (56 percent) of beneficiaries with incomes of $10,000 or less have Medicaid coverage, while only 8 percent of this group has employer-sponsored coverage. Poorer beneficiaries are also among those most likely to have no coverage beyond traditional fee-for-service Medicare. Thirteen percent of beneficiaries with incomes of $10,000 or less and 17 percent of beneficiaries with incomes between $10,001 and $20,000 rely solely on Medicare, while only 6 percent of those with incomes of more than $40,000 lack supplemental insurance coverage.

Employer-Sponsored Retiree Health Coverage. In recent years, employer-sponsored retiree health coverage has eroded as health care costs have climbed, particularly costs for prescription drugs. Between 1988 and 2004, the share of large employers offering retiree health benefits fell from 66 percent to 36 percent. Employers that continue to provide coverage have made changes in the benefits they offer to limit their liability, including increasing retiree contributions to premiums, raising copayments or coinsurance for drugs and other health care services, providing access-only to health benefits with retirees paying 100 percent of costs, and eliminating coverage for *future* retirees. Most large employers predict continued cutbacks in the future, particularly if retiree health costs continue to rise at double-digit rates.

Medicaid. For more than 6 million Medicare beneficiaries with extremely low incomes, Medicaid pays Medicare's premiums and cost-sharing requirements and covers benefits, such as long-term care and prescription drugs (until Medicare Part D drug coverage begins in 2006). These beneficiaries are known as "full-benefit dual eligibles." While dual eligibles are a fairly small share of the Medicare and Medicaid populations, they account for a sizeable share of the dollars spent on benefits in each program because they tend to be sicker and require more costly health care than non-dual eligible beneficiaries. Through the Medicare Savings Programs, other Medicare beneficiaries with limited income and resources who do not qualify for full Medicaid benefits may be eligible for financial assistance from Medicaid with Medicare's Part B premium and cost-sharing requirements.

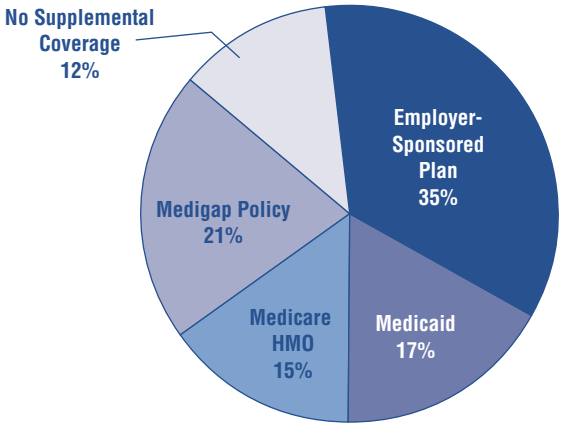
Medigap. Medicare beneficiaries can purchase a Medigap policy to supplement Medicare's traditional benefits, but these policies vary widely in the services they cover. Although federal legislation in 1990 limited Medigap coverage to 10 standard policies, one-third of all policies currently held are non-standard because they were issued prior to the reform. Among standard policies, Plans C and F are the most common, accounting for 23 percent and 37 percent of all standard Medigap policies held in 2001, respectively. Plans H, I, and J are the only Medigap policies that include prescription drug coverage, but only 9 percent of beneficiaries with a Medigap policy have one of these plans. Beginning in 2006, Medigap insurers will not be allowed to issue any new policies that include drug coverage, but two new packages of benefits (Plans K and L) will be available that provide coverage for catastrophic medical expenses.

Medicare Advantage. In 2005, 13 percent of Medicare beneficiaries are covered under a Medicare Advantage (MA) (formerly Medicare+Choice) plan, primarily health maintenance organizations (HMOs). Although HMOs have been an option under Medicare since the 1970s, the Balanced Budget Act (BBA) of 1997 expanded the role of private plans to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. To date, HMOs remain the most prevalent option in the Medicare Advantage program. Enrollment in MA plans varies widely across states. Less than 1 percent of Medicare beneficiaries are enrolled in MA plans in 17 states, while at least 20 percent are enrolled in Arizona, California, Colorado, Oregon, Pennsylvania, and Rhode Island. Nationwide, more than one in four Medicare Advantage enrollees live in California.

Overall MA plan participation and beneficiary enrollment have fluctuated in recent years. After a period of rapid growth between 1992 and 1998, the number of participating plans declined by half. In 2005, there are 179 Medicare HMOs with 4.8 million enrollees, down from a high of 6.3 million enrollees in 2000. Declining plan participation has been largely attributed to limited increases in Medicare payments to plans, increased administrative responsibilities, provider turnover in managed care networks, and other business concerns.

The Medicare Modernization Act (MMA) of 2003 made a number of changes to the MA program including increasing aggregate payments to plans, creating new regional PPOs that can operate in any of the 26 Medicare Advantage regions, and establishing a $10 billion stabilization fund that may be drawn upon to promote PPO participation on a regional basis. Private plans are expected to play a greater role in Medicare in the future, although enrollment projections vary widely. The Department of Health and Human Services estimates that by 2013, 30 percent of Medicare beneficiaries will be enrolled in Medicare Advantage plans, while the Congressional Budget Office projects an enrollment rate of 16 percent.

Figure 3.1
Sources of Supplemental Insurance Coverage Among Medicare Beneficiaries, 2002

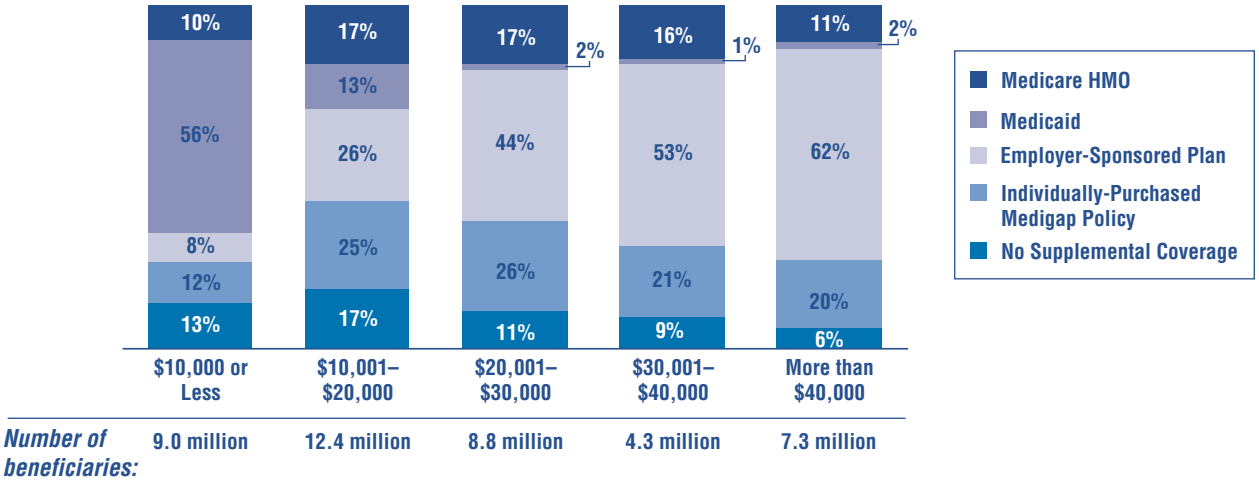


Total = 41.8 Million Medicare Beneficiaries, 2002

Note: Total number of Medicare beneficiaries is based on weighted number of respondents in the Medicare Current Beneficiary Survey 2002 Cost and Use file.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Most Medicare beneficiaries (88 percent) have supplemental health insurance coverage to help pay Medicare's cost-sharing requirements and pay for services not covered by Medicare. This coverage comes from a range of sources, including employer-sponsored insurance (covering 35 percent of all beneficiaries), individually-purchased Medigap policies (21 percent), Medicaid (17 percent), and HMOs and other Medicare Advantage plans (15 percent).

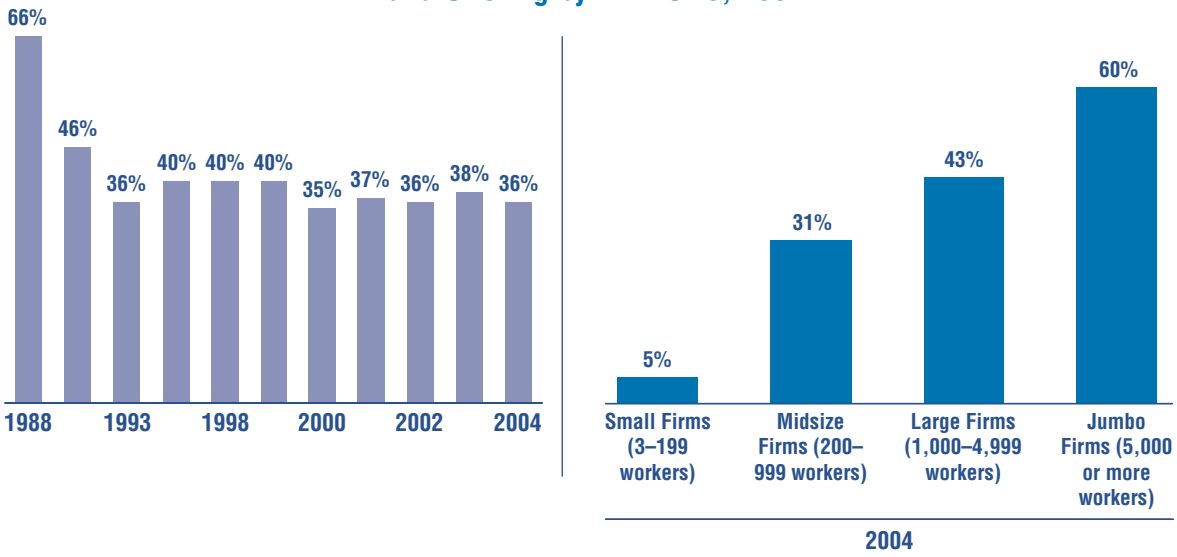
Figure 3.2
Primary Source of Supplemental Insurance Coverage Among Medicare Beneficiaries, by Income, 2002



Note: Numbers may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Supplemental insurance coverage varies greatly by beneficiaries' income, with lower-income beneficiaries less likely to have coverage to supplement Medicare. Medicaid provides supplemental coverage for over half (56 percent) of Medicare beneficiaries with the lowest incomes ($10,000 or less), while employer-sponsored coverage is the primary source of supplemental insurance for beneficiaries with the highest incomes (more than $40,000), covering 62 percent of this group.

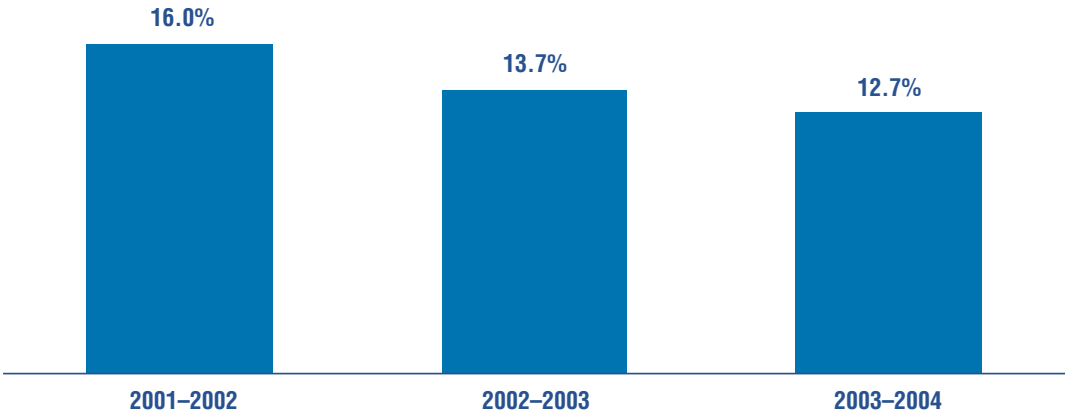
Figure 3.3
Percent of Large Employers Offering Retiree Health Benefits, 1988-2004, and Offering by Firm Size, 2004



Note: Large employers include firms with 200 or more workers.
SOURCE: Kaiser/HRET Employer-Sponsored Health Benefits, 2004.

The share of large employers providing health coverage to their retirees fell from 66 percent in 1988 to 36 percent in 2004, a trend which is expected to reduce the number of retirees with such coverage in the future. The share of employers that offer retiree health benefits varies substantially by firm size. Thirty-six percent of firms with 200 or more employees offer retiree health benefits, compared to just 5 percent of small firms (those with fewer than 200 employees).

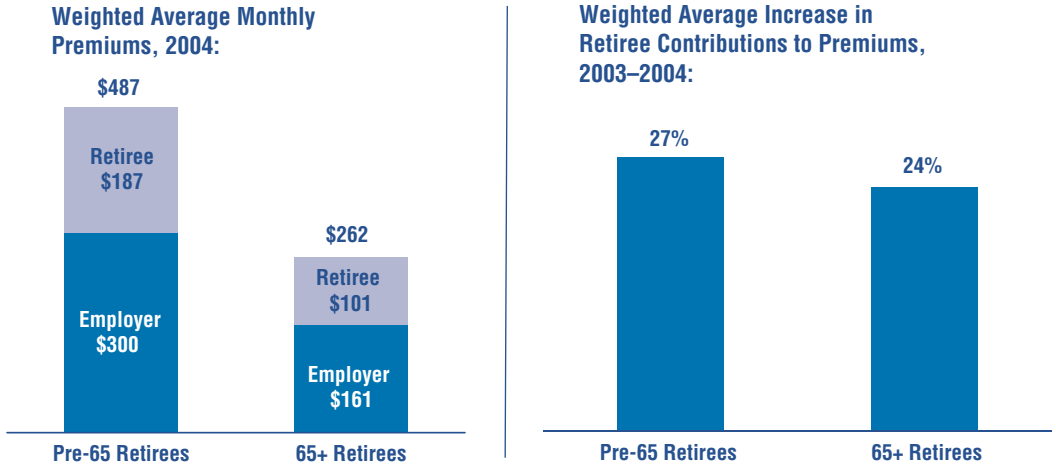
Figure 3.4
Average Increase in Total Retiree Health Costs, 2001–2004



SOURCE: Kaiser/Hewitt Survey on Retiree Health Benefits, 2002, 2003, and 2004.

Despite ongoing efforts to manage the cost of retiree health benefits, the total cost of providing these benefits has increased rapidly in recent years. Large, private-sector employers (with 1,000 or more employees) offering retiree health benefits report that retiree health costs have risen at double-digit rates in each of the last three years—increasing by an estimated 12.7 percent between 2003 and 2004.

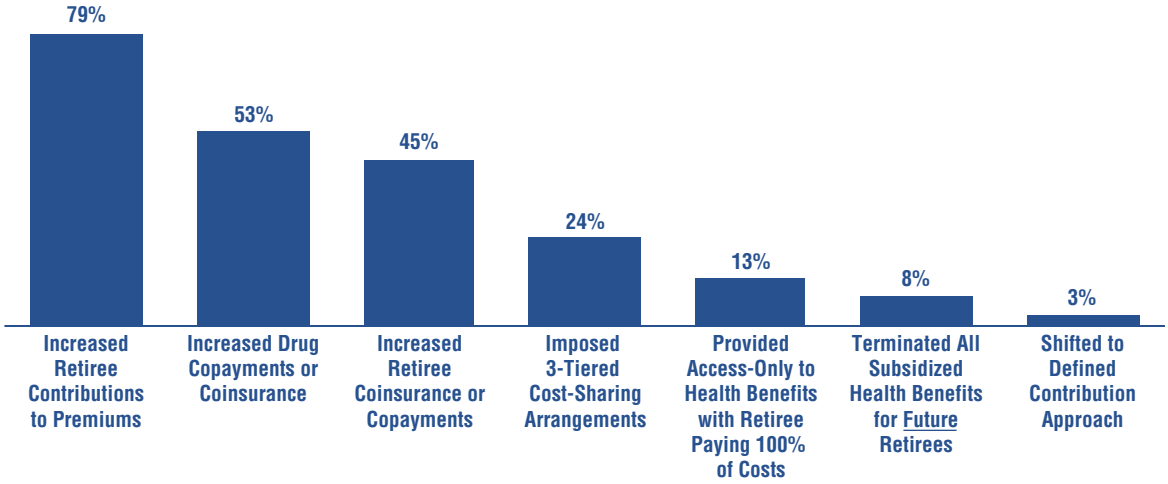
Figure 3.5
Average Monthly Premiums for New Retirees, 2004



Note: Includes firms that do not require retiree contributions. Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits. Premiums for retiree-only coverage for full-time employees retiring on or after January 1, 2004 (new retirees), in plans with the largest number of enrolled retirees.
SOURCE: Kaiser/Hewitt 2004 Survey on Retiree Health Benefits, December 2004.

Retirees of large private-sector firms experienced double-digit increases in premium contributions between 2003 and 2004. A typical worker under the age of 65 who retired in 2004 would pay $2,244 in premiums annually ($187 per month), which is 27 percent more than a pre-65 worker who retired in 2003. A typical Medicare-eligible worker (age 65 or older) who retired in 2004 would pay $1,212 in premiums annually ($101 per month), which is 24 percent more than they would have paid in 2003.

Figure 3.6
Percent of Large Private-Sector Employers Making Changes to Retiree Health Benefits in the Past Year



Note: Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2004 Survey on Retiree Health Benefits, December 2004.

Employers offering retiree health benefits have made substantial changes to manage rising costs. The majority of firms have increased retiree contributions to premiums (79 percent) and nearly half (45 percent) have increased general cost-sharing requirements. Prescription drug costs also remain a major focus for employers, with just over half (53 percent) reporting that they have recently increased copayments or coinsurance amounts for prescription drugs.

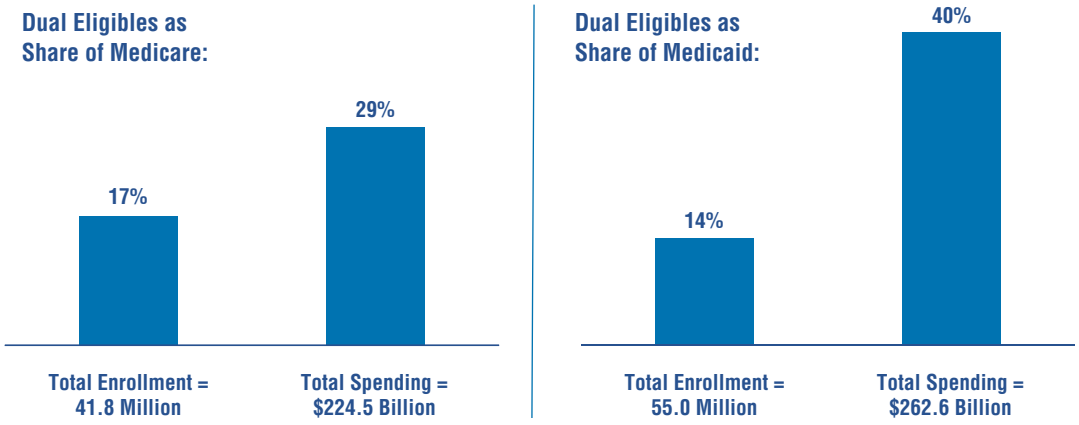
Figure 3.7
Medicaid Eligibility and Benefits for Medicare Beneficiaries, 2005

Pathway to Eligibility	Income Eligibility	Asset Limit Individual/Couple	Medicaid Benefits	Medicare Premiums & Cost-Sharing
Mandatory Coverage				
SSI Cash Assistance*	≤ 74% of poverty (SSI income eligibility)	$2,000 $3,000	✓	✓
Qualified Medicare Beneficiary (QMB)	≤ 100% of poverty	$4,000 $6,000		✓
Specified Low-Income Beneficiary (SLMB)	100%–120% of poverty	$4,000 $6,000		premium only
Optional Coverage				
Medically Needy	Individuals who spend income down to a specified level	$2,000 $3,000	✓**	✓
Poverty Level	≤ 100% of poverty	$2,000 $3,000	✓	✓
Special Income Rule for Nursing Home Residents	Institutionalized individuals with income < 300% of the SSI level	$2,000 $3,000	✓	✓
HCBS Waivers	Must be eligible for institutional care		✓	✓

Note: *States that elect the so-called "(209b)" option can set lower levels.
**Medicaid benefits may be more limited than for SSI.
SOURCE: Kaiser Commission on Medicaid and the Uninsured.

Medicare beneficiaries can obtain Medicaid through different eligibility pathways and receive varying levels of assistance. Medicare's poorest beneficiaries receive assistance with Medicare premiums and cost-sharing and coverage of Medicaid benefits, such as prescription drugs (until 2006), dental services, and long-term care. Those with incomes or resources just above the federal poverty level receive more limited assistance, primarily coverage of Medicare premiums.

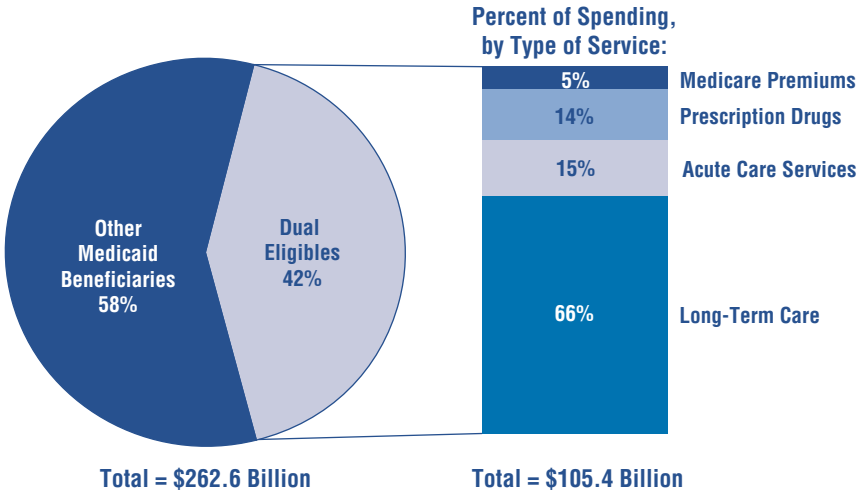
Figure 3.8
Dual Eligibles as a Share of Medicare and Medicaid Enrollment and Spending, 2002–2003



SOURCE: Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2001 MSIS data applied to CMS-64 FY2003 data.

Medicare beneficiaries who also are enrolled in their state Medicaid program, known as "dual eligibles," comprise a relatively small share of the Medicare and Medicaid populations but account for a disproportionate share of spending by both programs. In 2003, 14 percent of the 55 million people with Medicaid coverage were dual eligibles, accounting for 40 percent of total Medicaid benefit spending. Dual eligibles were 17 percent of the Medicare population in 2002, and accounted for 29 percent of total Medicare spending.

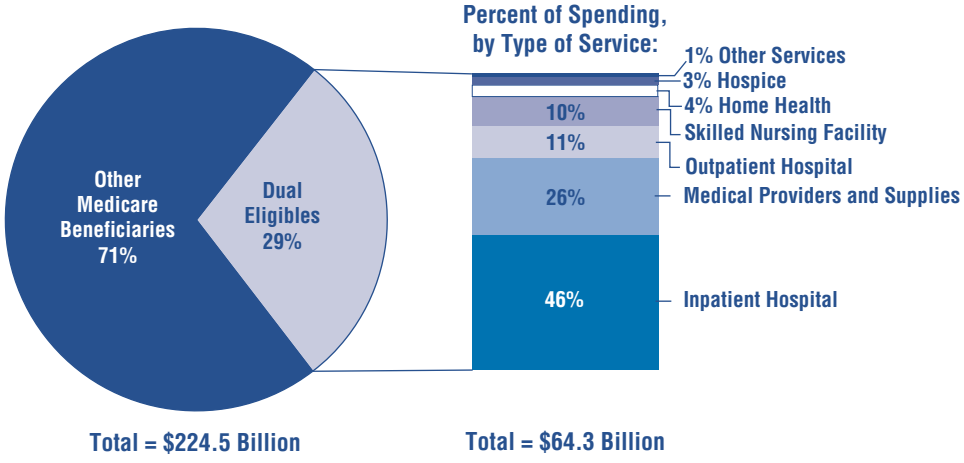
Figure 3.9
Medicaid Expenditures for Dual Eligibles, FY2003



SOURCE: Urban Institute estimates for KCMU based on an analysis of 2001 MSIS and Financial Management reports (CMS Form 64 FY2003).

Medicaid spending for dual eligibles totaled $105.4 billion in FY2003. The majority of Medicaid expenditures for dual eligibles are for long-term care services (66 percent); 15 percent of spending on dual eligibles is for acute care services, 14 percent of spending is for prescription drugs, and 5 percent is for payment of Medicare premiums for dual eligibles.

Figure 3.10
Medicare Expenditures for Dual Eligibles, 2002



Note: Other services include prescription drugs, dental, and long-term care facility stays.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Medicare spending for dual eligibles totaled $64.3 billion in 2002. The majority of Medicare expenditures for dual eligibles are for inpatient hospital events and services (46 percent); 26 percent of spending on dual eligibles is for medical provider services and supplies, 11 percent for outpatient hospital services, 10 percent for short-term skilled nursing facility stays, and 4 percent for home health visits.

Figure 3.11
Standard Medigap Plan Benefits

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F[a]	Plan G	Plan H	Plan I	Plan J[a]	Plan K[b]	Plan L[b]
Coverage for:												
– Part A coinsurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
– 365 additional hospital days during lifetime	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
– Part B coinsurance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
– Blood products	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
Skilled nursing facility coinsurance			100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
Part A deductible		100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	75%
Part B deductible			100%			100%				100%		
Part B balance billing (excess charges)[c]						100%	80%		100%	100%		
Foreign travel emergency			100%	100%	100%	100%	100%	100%	100%	100%		
Home health care				100%			100%		100%	100%		
Prescription drugs (not available for purchase after 2005)								50%[d]	50%[d]	50%[d]		
Preventive medical care				100%						100%		
Part A hospice coinsurance											50%	75%
Part B Medicare-covered preventive benefits											100%	100%
Medicare cost-sharing out-of-pocket maximum											X[e]	X[e]

Note: Amount in table is the plan's coinsurance amount for each covered benefit after beneficiary pays deductibles or cost-sharing amounts, where applicable.

[a] Plans F and J also have a high-deductible option that requires the beneficiary to pay $1,730 (the deductible in 2005) before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs ($250 per year for plan J) and foreign travel emergency ($250 per year for plans F and J) which are required in these plans with or without the high-deductible option.

[b] Plans K and L will be available for purchase beginning in 2006.

[c] 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.

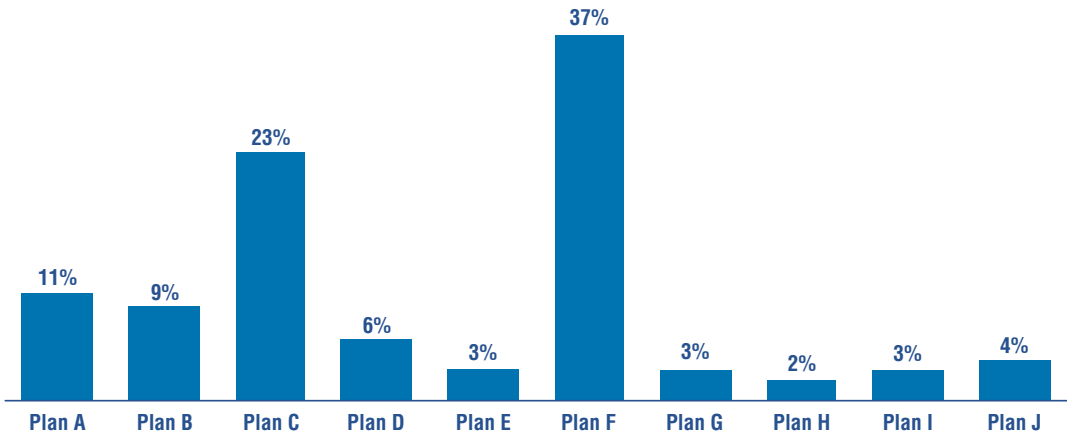
[d] Plans H and I pay 50% of drug charges up to $1,250 per year and have a $250 annual deductible. Plan J pays 50% of drug charges up to $3,000 per year and has a $250 annual deductible.

[e] Plan K pays all covered items at 100% after beneficiary pays $4,000 out of pocket. Plan L pays all covered items at 100% after beneficiary pays $2,000 out of pocket.

SOURCE: Medicare Payment Advisory Commission, Report to Congress: Assessing Medicare Benefits, June 2002; Centers for Medicare and Medicaid Services, Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare, April 2005.

In 2002, 21 percent of beneficiaries reported having an individually-purchased private health insurance policy to supplement Medicare, known as Medigap. Two-thirds of Medigap policies conform to one of 10 standard benefit packages (Plans A through J). Beginning in 2006, Medigap insurers will not be allowed to issue new policies that include drug coverage (Plans H, I, and J). Two new packages of benefits that offer catastrophic coverage (Plans K and L) will be available.

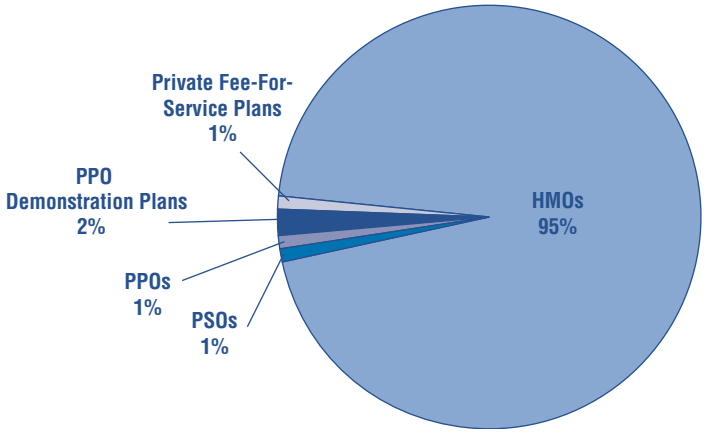
Figure 3.12
Enrollment in Standard Medigap Plans, 2001



SOURCE: Medicare Payment Advisory Commission analysis of 2001 Medicare Supplemental Exhibits from the National Association of Insurance Commissioners.

Of the 10 standardized Medigap policies, Plans C and F are the most popular, accounting for 23 percent and 37 percent of all standard Medigap policies held in 2001, respectively. These policies pay most of Medicare's cost-sharing requirements but do not cover prescription drugs. Plans H, I, and J include some drug coverage but are only a small share (9 percent) of Medigap policies held.

Figure 3.13
Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2005

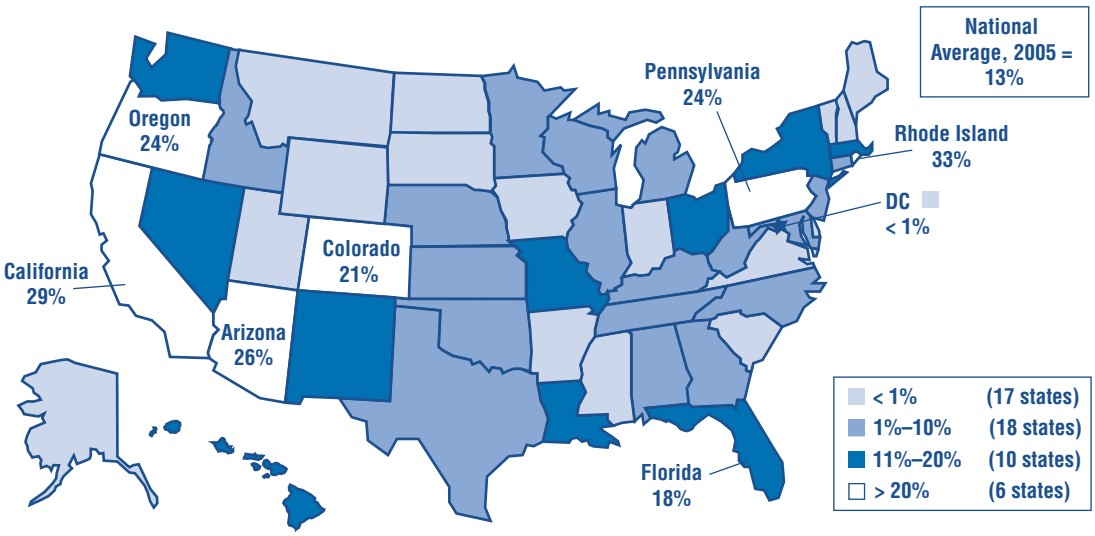


Total = 4.9 Million Medicare Beneficiaries in Medicare Advantage Plans, 2005

Note: Total includes approximately 100,000 beneficiaries enrolled in the PPO demonstration plans.
SOURCE: Mathematica Policy Research, Inc. analysis of CMS Geographic Service Area File for AARP Public Policy Institute, January 2005.

Nearly 5 million Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans. A majority of MA enrollees are in local Medicare HMOs, which have been an option under Medicare since the 1970s. The Balanced Budget Act (BBA) of 1997 expanded the types of private plans to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and private fee-for-service (PFFS) plans, but a relatively small share of beneficiaries are enrolled in these plans currently.

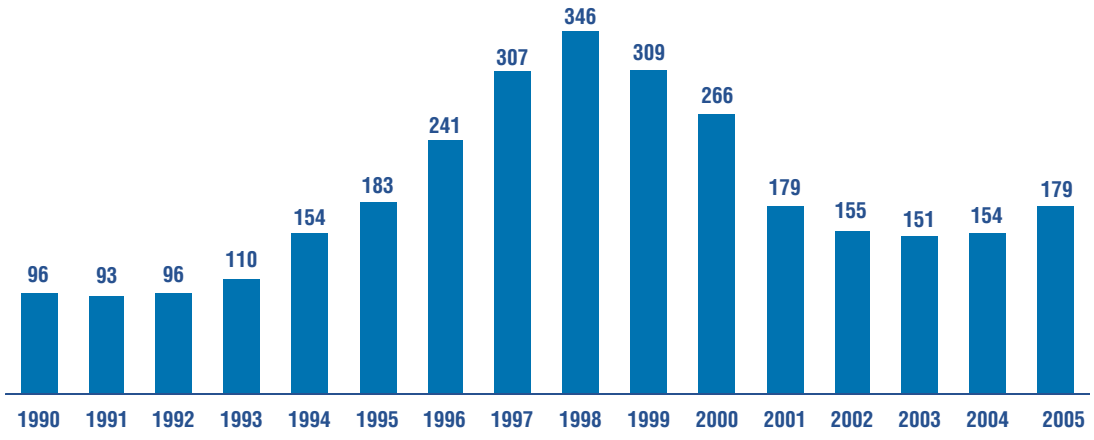
Figure 3.14
Medicare Advantage Enrollees as a Percent of Medicare Beneficiaries, by State, 2005



Note: Various states are identified to show cross-state variation. Share of Medicare Advantage enrollees include beneficiaries enrolled in Medicare HMOs, PPOs (demonstration and non-demonstration), and PSO plans, and excludes private fee-for-service cost contract enrollees, and other demonstration plans. National average shows enrollment in all MA plan types.
SOURCE: Mathematica Policy Research, Inc analysis of Centers for Medicare and Medicaid Services State/County Market Penetration Files, March 2005.

Medicare Advantage enrollment varies widely across states. Less than 1 percent of Medicare beneficiaries are enrolled in HMOs, PPOs, and POS plans in 17 states, while at least 20 percent are enrolled in MA plans in Arizona, California, Colorado, Oregon, Pennsylvania, and Rhode Island. Overall, more than one in four Medicare Advantage enrollees live in California.

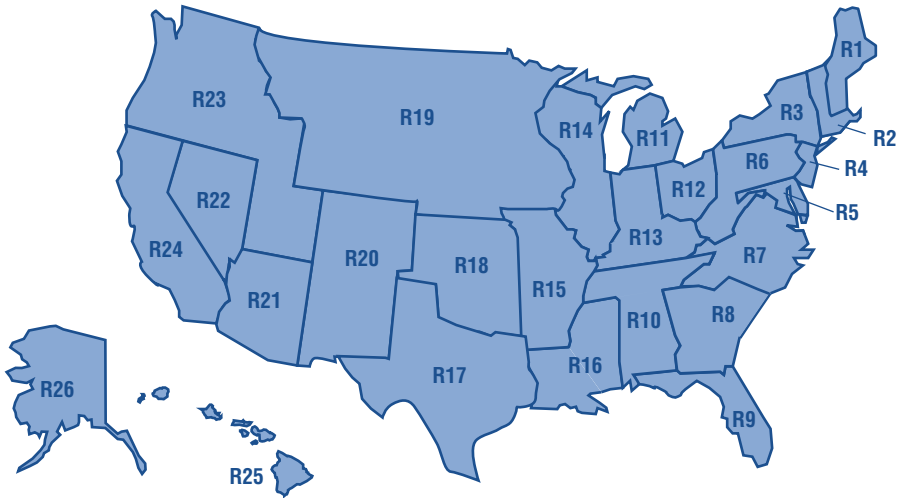
Figure 3.15
Number of Medicare Advantage Plans, 1990-2005



Note: All data are from December of the given year, except 2005 data are from March. Number of plans include Medicare HMOs, PPOs (non-demonstration), and PSO contracts; excludes PFFS, demonstrations, and cost contracts.
SOURCE: Centers for Medicare and Medicaid Services, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report.

Medicare Advantage plan participation and enrollment have fluctuated in recent years. After a period of rapid growth in the MA program between 1992 and 1998, the number of plans participating in Medicare Advantage declined by half. As of March 2005, there were 179 Medicare Advantage plans (Medicare HMOs, non-demonstration PPOs, and PSO contracts) in operation nationwide.

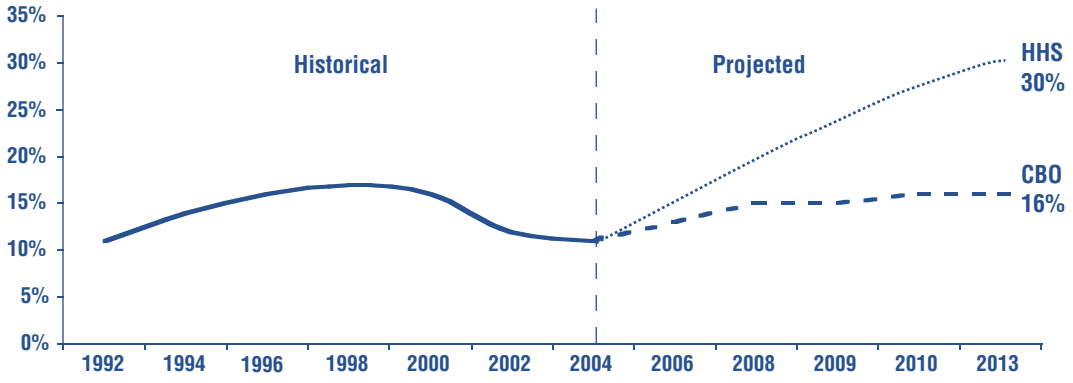
Figure 3.16
Medicare Advantage Regions



Note: R = Region Number. Total number of MA regions = 26.
SOURCE: Centers for Medicare and Medicaid Services, December 2004.

Beginning in 2006, there will be 26 Medicare Advantage regions comprised of single states or groups of states. Regional PPO plans will also be available, in addition to county-based private plans currently participating in the Medicare Advantage program. PPO plans that want to enter the Medicare Advantage market are required to serve a region in its entirety and must offer the same benefits within a region.

Figure 3.17
Historical and Projected Share of the Medicare Population Enrolled in Medicare Advantage Plans, 1992–2013



Note: All actual data are from December of the given year. HHS = Department of Health and Human Services. CBO = Congressional Budget Office.
SOURCE: Historical data from CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report. Projections from President's FY2006 Budget, Office of Management and Budget, February 7, 2005; and CBO Medicare Baseline, March 2005.

Enrollment of Medicare beneficiaries in Medicare HMOs and other private plans increased from 11 percent in 1992 to 17 percent in 1998, then decreased to approximately 11 percent in 2004. Private plans are expected to play a greater role in Medicare in the future, although enrollment projections vary widely. The U.S. Department of Health and Human Services estimates that 30 percent of Medicare beneficiaries will be enrolled in Medicare Advantage plans by 2013, while the Congressional Budget Office projects an enrollment rate of 16 percent that year.