



**TRENDS IN MEDICARE SUPPLEMENTAL INSURANCE AND  
PRESCRIPTION DRUG BENEFITS, 1996-2001**

**DATA UPDATE**

**Prepared for:**

The Henry J. Kaiser Family Foundation

**Prepared by:**

Mary Laschober  
BearingPoint, Inc.

**June 2004**

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**Acknowledgements:** Tom Rice, Ph.D., Chair of the Department of Health Services, UCLA School of Public Health, provided National Association of Insurance Commissioner Medigap data, as well as reviewed drafts of the policy brief, providing helpful comments and suggestions to improve its clarity and usefulness for policymakers. Michelle Kitchman, M.H.S., Senior Policy Analyst at the Kaiser Family Foundation provided valuable input about the data analysis and content of this data update. Data processing and analytical support were provided by Erika Melman, M.S., Consultant, BearingPoint.

# TRENDS IN MEDICARE SUPPLEMENTAL INSURANCE AND PRESCRIPTION DRUG BENEFITS, 1996-2001

## DATA UPDATE

Historically, Medicare beneficiaries have relied on supplemental insurance from a range of public and private sources to help with Medicare's cost-sharing requirements and to help fill gaps in Medicare's benefit package, particularly prescription drugs. The recent enactment of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) raises questions about the extent to which beneficiaries will continue to rely on these supplemental coverage sources in the future. The new law represents the first major improvement in Medicare-covered benefits since its inception in 1965. Among other provisions, it includes the implementation of a Medicare-endorsed prescription drug discount card and transitional assistance program in spring 2004, and a new Medicare-sponsored outpatient prescription drug benefit that will be available beginning January 2006. These significant changes to the Medicare program will undoubtedly affect both the number of beneficiaries who will obtain supplemental coverage and the type of coverage they might acquire.

This data update uses the Medicare Current Beneficiary Survey (MCBS) *Access to Care* files to provide estimates of supplemental insurance and prescription drug coverage rates and trends between 1996 and 2001. These figures provide important context for assessing future changes in supplemental insurance and drug coverage rates after provisions of the MMA take effect.

### Methods

The figures presented in this data update are based on the Medicare Current Beneficiary Survey (MCBS) *Access to Care* file data, represent point-in-time estimates, and pertain to non-institutionalized aged and disabled Medicare beneficiaries who were enrolled in Medicare for the entire year. While some beneficiaries report more than one type of supplemental source of coverage, this analysis assigns beneficiaries to only one insurance category (their "primary" source of supplemental coverage), according to the following hierarchy: current employer-sponsored insurance, Medicaid, Medicare HMO,<sup>1</sup> employer-sponsored retiree insurance, individually-purchased policy ("Medigap"), "other public" insurance (i.e., state or private pharmacy assistance programs), and traditional Medicare fee-for-service coverage only.

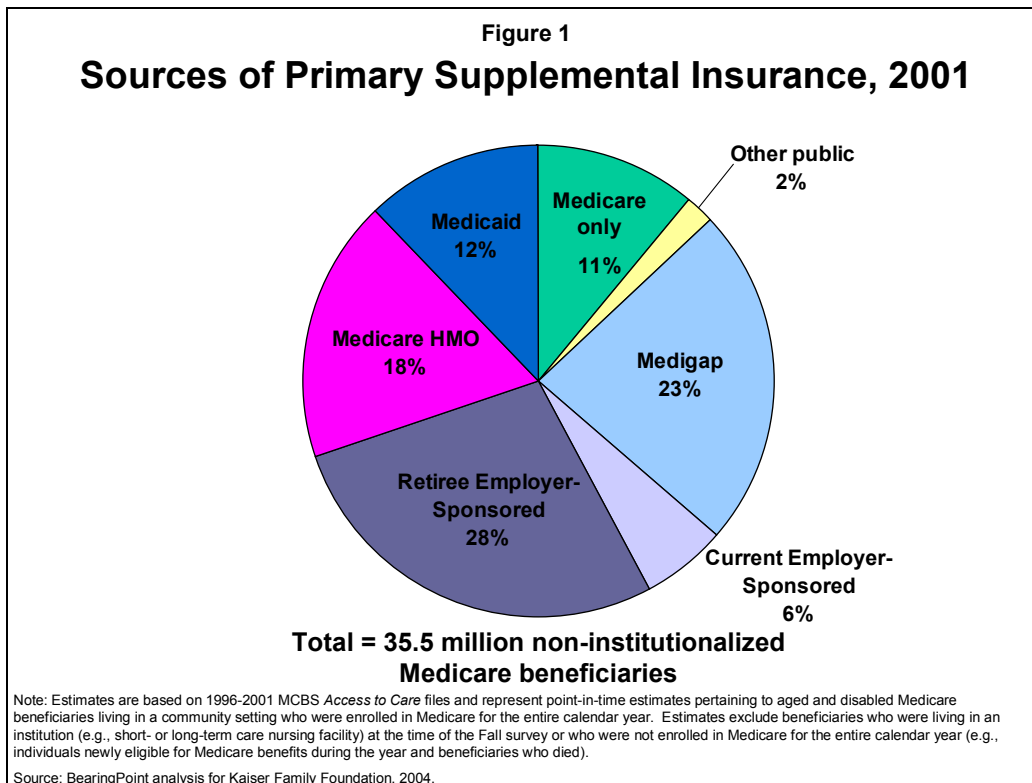
Outpatient prescription drug coverage estimates are based on beneficiary self-reports of drug benefits derived from either their primary or secondary source of supplemental insurance to help ensure that all sources of drug coverage are counted. However, drug coverage estimates are not reconciled through matches with drug payment information because this information is not available in the *Access to Care* file. Medigap policies with reported drug benefits and reported premiums of \$500 or less for 1996-1997 and \$1,000 or less for 1998-2001 were assumed not to

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<sup>1</sup> The large majority of Medicare HMOs are Medicare+Choice (M+C) plans, but this definition also includes so-called Full Cost HMOs, Health Care Prepayment Plans, and Medicare demonstration managed care plans.

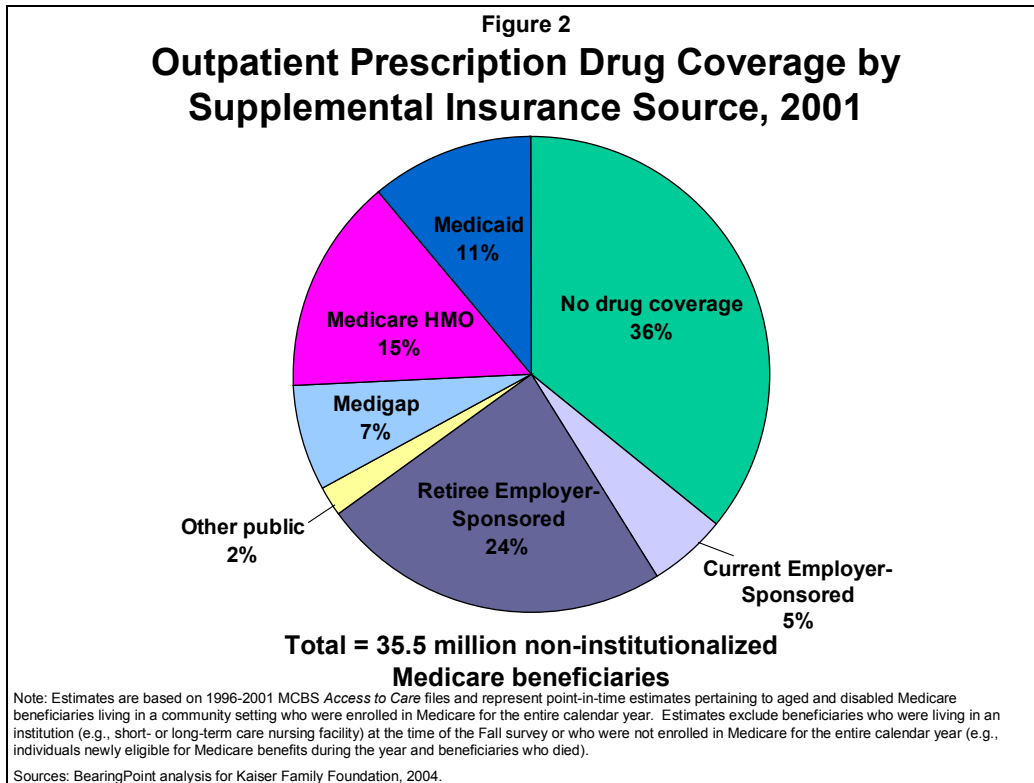
include prescription drug benefits, as described in the appendix of the brief. Drug coverage indicators for Medicaid and “other public” insurance for 1996-1998 period were obtained by trending backward the percentages of beneficiaries reporting drug coverage from each source for 1999-2001 and applying these rates to the 1996-1998 estimates. This method is also described in the methods section.

## Supplemental Coverage, Fall 2001



- ◆ Among the nearly 36 million non-institutionalized Medicare beneficiaries in Fall 2001, nearly 9 of 10 (89 percent) had some form of health insurance coverage to supplement their Medicare benefits, and 11 percent had Medicare coverage only (Figure 1).
- ◆ The leading source of supplemental insurance was employer-sponsored coverage, with 34 percent of beneficiaries receiving benefits from either a current or former employer.
  - 27.6 percent of Medicare beneficiaries had retiree health benefits through a former employer.
  - 5.7 percent of Medicare beneficiaries had health insurance from a current employer.
- ◆ Nearly a quarter of all Medicare beneficiaries (23.3 percent) had a Medicare supplemental insurance policy (Medigap) to help fill gaps in Medicare benefits.
- ◆ Medicare HMOs were a source of health coverage for 18.1 percent of all beneficiaries.
- ◆ Over 12 percent of non-institutionalized Medicare beneficiaries (12.2 percent) had supplemental coverage from Medicaid, the public program that provides insurance for low-income individuals.

## Drug Coverage, Fall 2001



- ◆ More than one-third of nearly 36 million non-institutionalized Medicare beneficiaries (36 percent) lacked drug coverage in Fall 2001<sup>2</sup> (Figure 2).
- ◆ Employers were the leading source of drug coverage in 2001. Twenty-four percent of all Medicare beneficiaries had retiree health insurance and drug coverage and 5.2 percent of all beneficiaries had a current employer-sponsored health plan and drug coverage. The majority of employer supplemental insurance plans offered drug coverage as part of their benefits package, which helps to explain why employers were the predominant source of drug coverage for all Medicare beneficiaries.
  - The Kaiser/Hewitt 2003 Survey on Retiree Health Benefits, a survey of large private-sector firms offering retiree health benefits, found that nearly all employer-sponsored retiree plans (93 percent) provide coverage of prescription drugs.
  - Similarly, 86 percent of Medicare beneficiaries in the MCBS who reported having employer-sponsored retiree health benefits also reported having prescription drug benefits through these plans.

<sup>2</sup> Some beneficiaries categorized as having no prescription drug coverage may have had access to limited drug benefits through Veterans Affairs or military retiree facilities, which are not captured in MCBS *Access to Care* data.

- 81 percent of Medicare beneficiaries with health insurance from a current employer reported having prescription drug coverage through these plans.<sup>3</sup>
- ◆ 15.2 percent of all Medicare beneficiaries in Fall 2001 were enrolled in a Medicare HMO and had drug benefits. About four of five Medicare HMO enrollees were offered prescription drug benefits in 2001 through their health plan (80 percent).<sup>4</sup>
  - The 80 percent drug coverage rate represents a decline from 86 percent of Medicare HMO enrollees in the MCBS who reported receiving drug benefits from their plan in 1999.
  - Declining drug benefits for Medicare HMO enrollees reported in the MCBS during this timeframe is consistent with a recent study of Medicare+Choice (M+C) plan benefits.<sup>5</sup> The authors found that the proportion of M+C enrollees who had prescription drug coverage through their plan fell from 84 percent in 1999 to 70 percent in 2001. Moreover, many remaining M+C plans reduced the generosity of their prescription drug benefits. For example, 18 percent of plans reduced the drug coverage limit offered under their basic benefit package in 1999 and 2000.<sup>6</sup>
- ◆ Overall, only 6.7 percent of all Medicare beneficiaries reported having a Medigap policy and drug coverage. While nearly one-quarter of non-institutionalized beneficiaries purchased a Medigap policy in 2001 (23.2 percent), only one-quarter of these policyholders report that their policy included prescription drug benefits (22.9 percent).<sup>7,8</sup>

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<sup>3</sup> Another 10 percent of beneficiaries with current employer-sponsored plans said they had drug coverage from a secondary source of supplemental insurance, and another one percent of beneficiaries with retiree supplemental coverage said they had drug coverage from a secondary source.

<sup>4</sup> Another four percent of Medicare HMO enrollees said they had drug coverage from a secondary source of supplemental insurance.

<sup>5</sup> Achman, L. and M. Gold. *Medicare+Choice 1999-2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums*. Prepared by Mathematica Policy Research, Inc., for The Commonwealth Fund, February 2002.

<sup>6</sup> Ibid.

<sup>7</sup> Another six percent of beneficiaries with a Medigap policy said they had drug coverage from a secondary source of supplemental insurance.

<sup>8</sup> To address potential Medigap drug coverage over-reporting, we estimated which beneficiaries may have mistakenly reported prescription drug coverage from their Medigap plan by first re-assigning “no drug coverage” to Medigap plans in which a respondent reported he had drug coverage under the plan, but paid an annual premium for the plan in the amount of \$500 or less for 1996-1997, and \$1,000 or less for 1998-2001. Based on Weiss Rating reports of Medigap premiums for plans H, I, and J during those periods, these low premium levels suggest that the Medigap plan either was not a true Medigap policy or was not likely to cover prescription drugs. MCBS respondents are allowed to report up to five Medigap policies each year. We performed the same re-assignment algorithm for each of the five policies for each year for respondents who said they had prescription drug coverage through their Medigap plan but did not know the amount of the premium and for respondents who said they did not pay any premium for their Medigap plan with drug coverage. Re-assignment decreased the estimated share of beneficiaries with a Medigap plan as their primary source of supplemental insurance with prescription drug coverage by 1.4 percentage points in 2001.

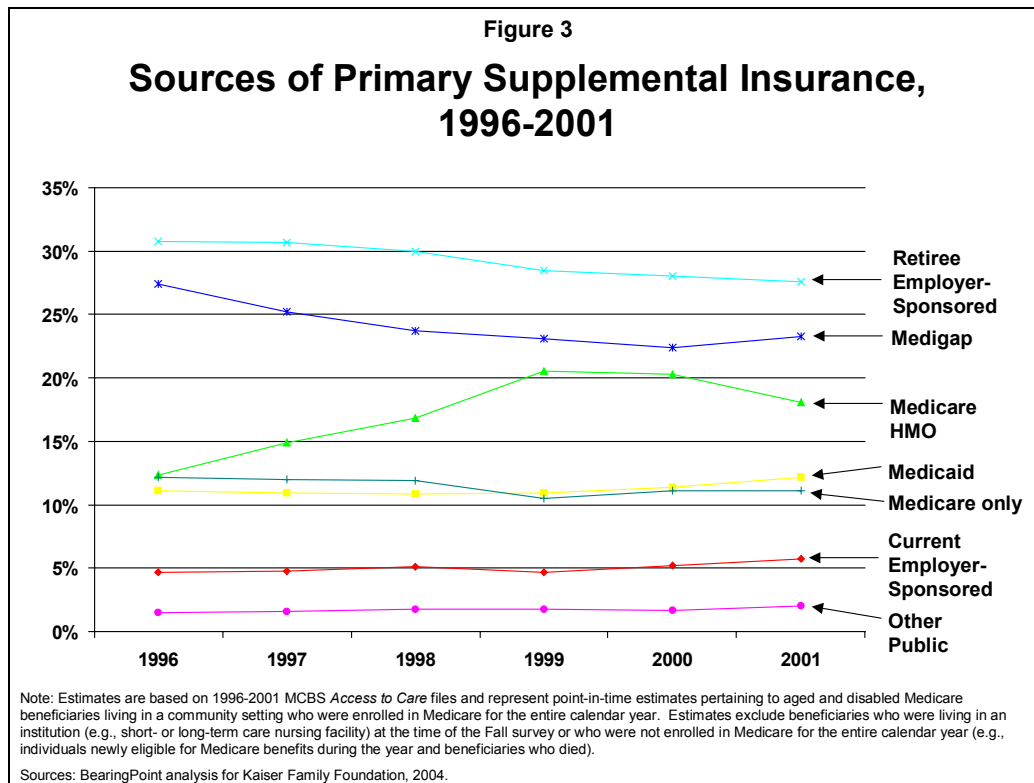
- ◆ Eleven percent of all non-institutionalized Medicare beneficiaries had Medicaid coverage and drug benefits because Medicaid provided drug coverage to the vast majority of dually eligible beneficiaries (86.8 percent).<sup>9</sup>

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<sup>9</sup> Another three percent of beneficiaries with Medicaid said they had drug coverage from a secondary source of supplemental insurance.



## Trends in Supplemental Coverage, 1996-2001

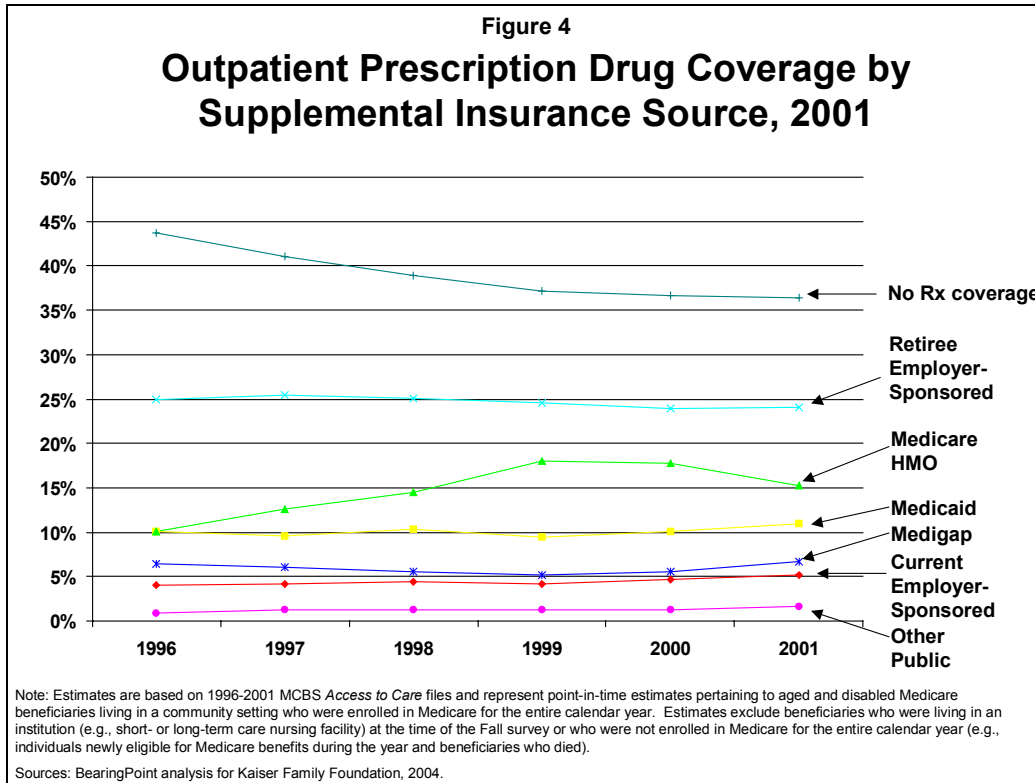


- ◆ The proportion of beneficiaries with any form of supplemental insurance increased slightly between 1996 and 2001, from 87.8 percent to 88.9 percent (Figure 3).
- ◆ The share of beneficiaries with employer-based coverage declined slightly between 1996-2001, from 35.5 percent to 33.3 percent.
  - The share of Medicare beneficiaries who had employer-sponsored retiree coverage declined from 30.8 percent to 27.6 percent.
  - The share of beneficiaries with current employer-sponsored coverage increased slightly, by about one percentage point over the six-year period (from 4.7 percent to 5.7 percent).
- ◆ Medicare HMO enrollment drove most of the increase in coverage rates throughout the period, with HMO coverage increasing from 12.3 percent in 1996 to 20.3 percent in 2000. In 2001, Medicare HMO enrollment declined to 18.1 percent, but modest increases in current employer-sponsored insurance, Medicaid, and “other public” insurance made up for the declining enrollment in Medicare HMOs.
- ◆ There was a nearly steady decline (4.1 percentage points) in the share of beneficiaries with a Medigap policy as their primary source of supplemental coverage over the six-year period. The exception to the trend is apparent in 2001, the most recent year of MCBS data available,

when the proportion rose by almost one percentage point over the previous year, from 22.4 percent to 23.3 percent.

- ◆ A slight increase in the share of beneficiaries with Medicaid as a source of primary supplemental coverage for Medicare was observed, with coverage rates rising from 11.1 percent to 12.2 percent between 1996 and 2001.

## Trends in Drug Coverage, 1996-2001



- ◆ The percentage of Medicare beneficiaries who reported having no outpatient prescription drug coverage from any source of Medicare supplemental insurance decreased over the six-year period, from 43.7 percent in 1996 to 36.4 percent in 2001 (Figure 4).
  - Between 1996 and 1999, the growth in drug coverage was primarily due to increasing Medicare HMO enrollment. By contrast, in the period between 1999 and 2001, small increases in drug coverage observed are attributable to the slight increases in such coverage through current employer-sponsored, Medigap, Medicaid and “other public” supplemental insurance plans.
- ◆ The share of beneficiaries with employer-based drug coverage increased slightly between 1996-2001, from 28.9 percent to 29.2 percent.
  - Although the share of all Medicare beneficiaries with employer-sponsored retiree coverage declined over the period, the proportion of beneficiaries that received drug benefits from their plan increased over the six years (from 79 percent to 86 percent). As a result, the share of all beneficiaries with employer-sponsored retiree drug benefits to remain fairly constant, totaling 24.9 percent in 1996 and 24.0 percent in 2001.

- The share of Medicare beneficiaries with drug coverage from a current employer or a secondary supplemental insurance source increased modestly during the six-year period, from 4.0 percent in 1996 to 5.2 percent in 2001. However, two-thirds of the increase in this group’s drug coverage over the period was *not* attributable to their current employer-sponsored plan but to secondary supplemental insurance holdings.
- ◆ The share of all Medicare beneficiaries enrolled in a Medicare HMO who had drug coverage climbed from 10.1 percent in 1996 to 18.0 percent in 1999 and dropped back to 15.2 percent in 2001. This decline is attributed to both decreasing Medicare HMO enrollment and a decreasing proportion of Medicare HMO enrollees with drug benefits from their HMO.<sup>10</sup>
- ◆ The share of all beneficiaries with Medicaid insurance and drug coverage was fairly constant, at about 11 percent, over the six-year period.
- ◆ Beneficiaries who had a Medigap policy as their primary source of supplemental coverage *and* who had some prescription drug benefits declined as a share of all beneficiaries from 6.4 percent in 1996 to 5.2 percent in 1999, but then increased by 1.5 percentage points over the following two years to 6.7 percent in 2001.
  - Nearly two-thirds of this change is attributable to an increase in beneficiaries who said their Medigap policy included drug benefits, but the other one-third increase is due to Medigap policyholders who reported drug benefits through “other public” insurance plans (not through their Medigap policy).
  - The direction of estimated drug coverage trends for Medigap policyholders based on MCBS *Access to Care* files is consistent with other data and research, but the magnitude of the changes vary. Insurance data from the National Association of Insurance Commissioners (NAIC) indicates an almost 14 percentage point growth in the number of beneficiaries covered under Medigap policies H, I, and J nationwide between 1999 and 2001 (i.e., the standardized Medigap plans that include outpatient prescription drug benefits). However, those plan types as a share of all purchased Medigap A-J plans increased by only 0.4 percentage points over that period.<sup>11</sup> This compares with the estimated 4.1 percentage point increase in the share of beneficiaries reporting Medigap drug benefits on the MCBS survey over the same period.

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<sup>10</sup> Kaiser Family Foundation, April 2003; Achman, L. and M. Gold. *Trends in Medicare+Choice Benefits and Premiums, 1999-2002*. Prepared by Mathematica Policy Research, Inc., for The Commonwealth Fund, November 2002.

<sup>11</sup> NAIC data provided by Dr. Thomas Rice, UCLA School of Public Health, April 2003.

- Unlike MCBS, the NAIC data do not include pre-standard Medigap policies,<sup>12</sup> but this is an unlikely explanation for the variation in the percentage point increase observed over the period since non-standardized policies are no longer sold. Although reported Medigap drug coverage policies thought to be drug discount cards or state pharmacy assistance programs were removed (based on survey-reported premiums), some of the greater growth in “Medigap” prescription drug coverage reported in the MCBS may still be due to beneficiary misreporting on source of drug benefits.

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<sup>12</sup> That is, a Medigap policy issued before legislation enacted in 1992 that allowed only for the sale of 10 standardized Medigap plans. Nearly one-third of Medigap policyholders still has pre-standard policies and may have prescription drug coverage, although one study found that only 13-14 percent of pre-standardized policies included drug coverage in 1991 (Rice, T., et al., “The Impact of Policy Standardization on the Medigap Market” *Inquiry*, 1997). Additionally, the benefit designs of most pre-standard policies are not known. The little evidence available indicates that the drug coverage in pre-standard plans is much more modest than in standard plans (Chollet, D.J., “Medigap Coverage for Prescription Drugs,” presented as testimony before the U.S. Senate Committee on Finance, *Finding the Right Fit: Medicare, Prescription Drugs and Current Coverage Options*, Washington, DC, April 24, 2001).

## Discussion

The Medicare Current Beneficiary Survey is one of the most useful resources for examining health coverage and experiences of the Medicare population. Estimates of supplemental coverage, based on this survey, have been used to document the extent to which beneficiaries lack needed coverage, and the characteristics of beneficiaries most likely to be without drug benefits.

The enactment of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* will undoubtedly affect the type and scope of supplemental health insurance that Medicare beneficiaries acquire, including employer-sponsored insurance, Medigap, Medicaid, and Medicare managed care enrollment. It is unclear at this time how major changes to Medicare will affect beneficiaries' reliance on current sources of supplemental insurance to help pay for their outpatient prescription drug needs.

Monitoring the extent to which sources of supplemental coverage shift over time will be of particular interest in light of the new changes to Medicare. For example, the MMA contains substantial financial incentives for employers to maintain retiree health benefits, but whether employers will maintain coverage for their retirees remains to be seen. Additionally, the extent to which Medicare beneficiaries continue to rely on Medigap drug coverage as an alternative to the new Medicare prescription drug benefit will also be important to monitor. Moreover, dual eligibles will obtain drug coverage through Medicare beginning in 2006 and Medicaid will no longer be a source of drug coverage for Medicare's low-income beneficiaries. Lastly, changes to the Medicare+Choice program (re-named Medicare Advantage), including increases in payments to private plans and new reliance on private plans to deliver the Medicare prescription drug benefit, may reverse trends in declining health plan participation in the Medicare program and declining drug benefits offered by these plans. Continued tracking of trends in supplemental insurance and prescription drug coverage will be critical in documenting and assessing the effects of the new Medicare legislation over time.

## Appendix: About the MCBS

Each year, CMS releases two sets of public use files derived from the Medicare Current Beneficiary Survey. Data from the MCBS *Access to Care* files – generally available in the fall one year after data collection ends – provide “point-in-time” estimates of beneficiary self-reported Medicare supplemental insurance and prescription drug coverage. Beneficiaries new to the survey (but not new to the Medicare program) report their sources of coverage held at the time of their fall interview, and continuing survey participants report coverage held since their last quarterly interview and at the time of their fall interview. *Access to Care* files also contain summaries of Medicare-covered health care use and expenditures for the year from Medicare claims files. The sample population includes only individuals who were enrolled in the Medicare program for the full year. The MCBS *Cost and Use* files are made available about two years after the close of field work. These files contain reconciled information on all health care events (Medicare- and non-Medicare-covered), charges, and payments from both survey and claims for the entire year, as well as all sources of health insurance and prescription drug coverage held at any time during the year. The sample population includes all individuals who were enrolled in the Medicare program at any time during the year.

Supplemental insurance and drug coverage estimates reported in this brief are based on the annual MCBS *Access to Care* files for 1996 through 2001, representing point-in-time estimates that pertain to non-institutionalized aged and disabled beneficiaries enrolled in Medicare for the entire year. Beneficiaries are included in only one insurance category according to the following hierarchy: current employer-sponsored insurance, Medicaid, Medicare HMO,<sup>13</sup> employer-sponsored retiree insurance, individually-purchased policy (“Medigap”), “other public” insurance (i.e., state or private pharmacy assistance programs), and traditional fee-for-service Medicare coverage only. Drug coverage indicators for Medicaid and “other public” insurance for 1996-1998 period were obtained by trending backward the percentages of beneficiaries reporting drug coverage from each source for 1999-2001 and applying these rates to the 1996-1998 estimates.

The remainder of the appendix discusses several measurement issues that can lead to varying estimates of supplemental and prescription drug coverage rates. The discussion is designed to assist policymakers in understanding the range of figures that have been published in recent health policy journals and to place into context the estimates described in the policy brief.

### Key Measurement Issues

Estimates of supplemental insurance and drug coverage are sensitive to several factors. The first, and most important for estimating beneficiary lack of drug coverage, is the time period over which Medicare beneficiary coverage is measured. This data update uses data from the MCBS *Access to Care* files, which measure coverage in the fall of each calendar year, providing (fall) point-in-time estimates of supplemental insurance and prescription drug coverage rates.<sup>14</sup>

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<sup>13</sup> The large majority of Medicare HMOs are Medicare+Choice plans, but this definition also includes so-called Full Cost HMOs, Health Care Prepayment Plans, and Medicare demonstration managed care plans.

<sup>14</sup> The *Access to Care* files also exclude beneficiaries newly eligible for Medicare benefits during the calendar year and those who died or lost Medicare entitlement during the year.

In contrast, estimates based on the MCBS *Cost and Use* files – which capture survey information for the entire year – generally describe the number of beneficiaries who had supplemental insurance or prescription drug coverage at any time during the calendar year. Consequently, estimates based on *Cost and Use* files generally produce higher estimates of coverage than do those based on the *Access to Care* files. For instance, a recent article that used *Cost and Use* data estimated that 78 percent of beneficiaries had drug coverage in 2000 (and 22 percent lacked drug coverage),<sup>15</sup> while this analysis using *Access to Care* data found that 63 percent of beneficiaries had drug coverage in the Fall 2000 (and 37 percent lacked drug coverage). While seemingly inconsistent, the difference in estimates is primarily attributable to the definition of the period examined.

A second source of variation in estimates of coverage based on MCBS data arises because the *Access to Care* files rely solely on beneficiary self-reports of drug coverage from their supplemental insurance, whereas the *Cost and Use* files include beneficiary reports of sources of payment for their prescription drugs. Some beneficiaries may misreport drug coverage under their supplemental insurance but later report their insurance paid for a particular prescription; and, therefore, drug coverage estimates based on *Cost and Use* files that reconcile drug coverage rates for this type of misreporting may be higher.<sup>16</sup> Variation might also occur because neither the MCBS *Access to Care* nor *Cost and Use* files included direct drug coverage questions for Medicaid and other public insurance sources until 1999, requiring researchers to estimate coverage.

Another key factor that results in differences between estimates relates to treatment of MCBS respondents with more than one source of supplemental insurance coverage. For analytical purposes, beneficiaries are often included in only one insurance category, listed as the beneficiary's "primary" source of insurance according to a hierarchical ordering. Researcher differences in constructing this hierarchical ordering can affect distributions by type of supplemental coverage. An additional source of variation in coverage estimates can derive from using beneficiary reports of primary sources of supplemental insurance or using both primary and secondary sources to estimate drug coverage rates.

Other important factors that affect supplemental insurance and drug coverage estimates include researcher choice of reference population (e.g., full-year or part-year Medicare-eligible beneficiaries, aged or disabled beneficiaries, institutionalized or non-institutionalized persons), and differences in coverage estimates based on potentially biased beneficiary self-reported data, such as the MCBS, versus estimates based on more objective secondary data, such as private company Medigap insurance data reported to the National Association of Insurance Commissioners or Medicare managed care plan-reported data on CMS's Medicare Compare website.

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<sup>15</sup> MedPAC, *Health Care Spending and the Medicare Program, A Data Book* (June 2003): pg.163.

<sup>16</sup> A 1999 study estimated that such reconciliation contributed between four and nine percentage points to their drug coverage estimates (M. Davis, et al., "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries," *Health Affairs* (January/February 1999): 231-243). However, recent conversations with MCBS staff John Poisal and Frank Eppig of the Centers for Medicare & Medicaid Services suggest that this estimate is much lower for more current releases of MCBS data.



Outpatient prescription drug coverage estimates are based on beneficiary self-reports of drug benefits derived from either their primary or secondary source of supplemental insurance but are not reconciled through matches with drug payment information. Recent discussions with MCBS staff at CMS indicate concerns that some respondents may be misreporting a state- or privately-sponsored drug discount card or pharmacy assistance plan as a Medigap policy. CMS is closely examining individually-purchased plans reported on the MCBS to determine if true Medigap policies can be separated from these other types of partial-benefits plans. Because of the strong potential for biased reporting of Medigap drug coverage in the MCBS due to beneficiary confusion about where their drug benefits originate, we assumed that Medigap policies with reported drug benefits and reported premiums of \$500 or less for 1996-1997 and \$1,000 or less for 1998-2001 did not actually include prescription drug benefits.

To address potential Medigap drug coverage over-reporting, we estimated which beneficiaries may have mistakenly reported prescription drug coverage from their Medigap plan by first re-assigning “no drug coverage” to Medigap plans in which a respondent reported he had drug coverage under the plan, but paid an annual premium for the plan in the amount of \$500 or less for 1996-1997, and \$1,000 or less for 1998-2001. Based on Weiss Rating reports of Medigap premiums for plans H, I, and J during those periods, these low premium levels suggest that the Medigap plan either was not a true Medigap policy or was not likely to cover prescription drugs. MCBS respondents are allowed to report up to five Medigap policies each year. We performed the same re-assignment algorithm for each of the five policies for each year for respondents who said they had prescription drug coverage through their Medigap plan but did not know the amount of the premium and for respondents who said they did not pay any premium for their Medigap plan with drug coverage. Re-assignment decreased the estimated share of beneficiaries with a Medigap plan as their primary source of supplemental insurance with prescription drug coverage by 1.4 percentage points in 2001.

A technical appendix featuring a more in-depth description of methodological considerations is available by writing to the author at <a href="mailto:mlaschober@bearingpoint.net">mlaschober@bearingpoint.net</a> .
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