

Medigap PPACA Subgroup

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Brief summaries of Medigap cost-sharing research and literature distributed to Subgroup

Effects of Cost-Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study, Mitchell D. Wong, Ronald Anderson, Cathy D. Sherbourne, Ron D. Hays, and Martin F. Shapiro (American Journal of Public Health, November 2001).

- Because of limitations of the RAND Health Insurance Experiment (which excluded disabled and elderly) in observing the impact of cost-sharing on health outcomes, the authors analyzed data from the Medical Outcomes Study (which followed chronically ill adults) to determine whether cost-sharing deters use of care and leads to worse health outcomes in a more vulnerable population.
- Notes that, unlike other cost-controlling strategies such as drug formularies and use reviews that target the behavior of doctors and medical groups, cost-sharing is aimed at the consumer.
- **Findings:** Both low and high-copays deterred care for minor symptoms, and high-copays deterred care for serious symptoms.
- **Conclusion:** In a chronically ill population, cost-sharing reduced the use of care for both minor and serious symptoms. Health plans featuring cost-sharing need careful monitoring for potential adverse health effects because of their propensity to reduce use of care that is considered necessary and appropriate.

Cost-sharing: Effects on Spending and Outcomes, Katherine Swartz (Robert Wood Johnson Foundation, December 2010).

- Since there have been tremendous changes in health insurance and medical care since the RAND Health Insurance Experiment was conducted in the 1970s, this report examines research conducted since the mid-1990s.
- **Findings:**
 - Unclear how distribution of health care spending would be affected by increased cost-sharing. Currently health care spending is very concentrated (top 5% in health care spending accounts for ½ of all spending, and 50% of population only spend 3% of total health care spending).
 - Any reductions in care in response to cost-sharing are likely to come from the half of the population with low medical expenses.
 - Once a patient seeks medical attention, the intensity of services is driven by the provider, not the patient.
 - Patients are not able to discern between appropriate and inappropriate care in response to increased cost-sharing. (Increased cost-sharing would be successful in slowing health

spending if the reduction of low-value and medically unnecessary care is not offset by the use of more expensive services and do not result in adverse outcomes that may be more expensive to treat).

- For vulnerable populations, increased cost-sharing may shift the types of services used rather than reduce overall health expenditures.
- Increases in cost-sharing for the elderly may result in higher Medicare program costs due to an increase in hospitalizations for chronically ill beneficiaries.
- For the average person, increased cost-sharing may not adversely affect health outcomes. For vulnerable populations, increased cost-sharing is associated with adverse health outcomes.
- Low-income populations are likely to be disproportionately affected by increased cost-sharing. Whether responses to cost-sharing differ by race and ethnicity is unknown. People in poor health respond differently to cost-sharing changes than healthy people.
- **Conclusions:** Patient cost-sharing is not necessarily an effective mechanism for significantly slowing health care spending. Cost-sharing is not well targeted on low-value services. Caution should be used when increasing cost-sharing for low-income populations or the chronically ill.

Supplemental Insurance and Mortality in Elderly Americans, Mark P. Doescher, Peter Franks, Jessica S. Banthin, Carolyn M. Clancy (Archives of Family Medicine, March 2000).

- Notes studies that show a correlation between lack of insurance coverage with adverse health outcomes and the fact that Medicare coverage increasingly had gaps in coverage. Decided to study the possible implications of out-of-pocket costs in the elderly.
- Examined a subset of elderly with supplemental private health insurance + Medicare.
- **Working hypothesis:** As the liability for out-of-pocket expenditures increases, the risk for mortality also increases.
- **Conclusion:** Even for persons with supplemental coverage, there was an adverse association between higher liability for out-of-pocket expenditures and mortality. Finds support for policies that would reduce, rather than increase, financial barriers to care for elderly Americans.

Medigap Coverage and Medicare Spending: A Second Look, Jeff Lemieux, Teresa Chovan, Karen Heath (Health Affairs, 2008).

- Examined the conventional wisdom that Medigap coverage substantially raises Medicare claims costs, including the assumption by CBO that “Medigap policyholders use at least 25% more services than Medicare enrollees who have no supplemental coverage and 10% more services than enrollees who have supplemental coverage from a former employer”.
- Notes that Medigap policyholders tend to have low or moderate incomes, are more likely than average to be female, are older than average Medicare beneficiaries, and are more likely than average to live in rural areas.

- Found that previous studies did not properly control for VA and military services (which incur no cost to Medicare) and depended too much on self-reported health status.
- Also found that previous studies relied heavily on self-reported health status, and examination of actual Medicare diagnosis data showed that Medigap policyholders are sicker than overall Medicare beneficiaries.
- **Conclusion:** Previous studies might have overestimated the impact of Medigap coverage on Medicare costs, and past projections of potential Medicare cost-savings from restrictions on Medigap coverage are likely overstated.

Increased Ambulatory Care Copayments and Hospitalizations among the Elderly, Amal N. Trivedi, Husein Moloo, Vincent Mor (New England Journal of Medicine, January 2010).

- Notes that economic theory suggests that patients use fewer health services when they have to pay more out of pocket. Previous studies have shown that increasing the copayment for ambulatory care (outpatient care) has been shown to reduce the number of outpatient visits.
- Notes that elderly patients may be more sensitive to cost-sharing because they have lower incomes, are more likely to be in poor health, and have greater out-of-pocket spending on health care than nonelderly populations.
- Examined the effect of increasing copayments on a group of Medicare enrollees in managed care plans, as compared with control plans where copayments were unchanged.
- Results found that the copayment increases resulted in fewer initial outpatient visits during the first year of the increase, but then found an increase in admissions for acute care and inpatient days after the first year. These results were magnified for low-income, and low-education enrollees, and for enrollees with certain chronic conditions.
- **Conclusion:** Raising copayments for ambulatory care for elderly patients among elderly patients may have adverse health consequences and may increase total spending on health care.

Patient Cost-Sharing and Hospitalization Offsets in the Elderly, Amitabh Chandra, Jonathan Gruber, Robin McKnight (American Economic Review, 2010).

- Notes that the elderly are the most intensive consumers of health care in the US and consume 36% of medical care while representing only 13% of the population.
- This study attempted to take a closer look at the hypothesis that increasing cost-sharing for Medicare beneficiaries with supplemental coverage has an impact on overall medical spending
- **Conclusion:** Seniors are very price-sensitive in their use of office visits and prescription drugs. Overall found a modest offsetting rise in hospital care when physician and drug copayments are raised. But found substantial offsets for the sickest populations with chronic diseases, so for these populations there is little financial gain from higher copayments.

Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly, Christopher Hogan
(Direct Research for the Medicare Payment Advisory Commission, June 2009).

- Looks at the effects of secondary insurance on health care use and spending for elderly Medicare beneficiaries. Compares individuals with secondary coverage to those without. Used the Medicare Current Beneficiary Survey (MCBS) as the main source of data.
- Rebutts the Lemieux study's finding that previous research did not take VA and military coverage into account – and found that the treatment of VA coverage made little difference.
- While it is not possible to prove beyond a doubt that a causal relationship exists between secondary insurance and spending, the analysis strongly suggests secondary insurance genuinely causes higher spending. Beneficiaries themselves report that out-of-pocket costs are a significant reason for delaying care. There was also a clear relationship between the depth of insurance coverage and increased spending, with those with first-dollar or near first-dollar coverage with much higher spending. The type and source of secondary coverage was not significant.
- **Findings:** Found that secondary insurance has a substantial impact on Medicare spending.
 - Found that individuals with Medigap had Medicare costs 33% higher than those with no secondary insurance. Other private secondary insurance was associated with smaller increases in spending.
 - Found a large increase in Part B spending, but no difference in Part A spending.
 - There was no impact of secondary coverage status on emergency care, therefore it is reasonable to suggest that beneficiaries in emergency situations will not take copayments into account when obtaining such care.
 - Found that essentially all of the additional spending by those with secondary insurance came from beneficiaries with first dollar or nearly first-dollar coverage. Those paying less than 5% of the total Part B costs out-of-pocket averaged 68%-84% higher total Part B spending than individuals with only Medicare. Those paying more than 5% of the total Part B costs out-of-pocket averaged 0-23% higher spending compared to individuals with only Medicare.
 - Found that the largest differences in spending tended to be for more discretionary care such as elective hospital admissions, preventive care services, office-based care, medical specialists, and persons without any diagnosis among the leading causes of death.
- **Conclusion:**
 - Secondary insurance increases service use and raises Medicare's Part B costs substantially. But there is no way to suggest that the additional services used are all bad or all good. Policy actions in this area would require judgment as to whether the benefit of the additional health care use induced by insurance coverage does or does not appear to be worth the additional cost.

Supplemental Insurance: Medicare’s Accidental Stepchild, Adam Atherly (Medical Care Research and Review, June 2001).

- Summarizes the literature regarding supplemental insurance between 1973 and 1999. Reviewed past studies on the topic of supplemental coverage and impact on Medicare expenditures.
- When looking at factors leading individuals to seek different types of supplemental coverage, studies found that holders of individually purchased supplemental policies were older, female, more educated, white, middle income or wealthier with greater asset income, more knowledgeable about Medicare , and less likely to smoke.
- Found mixed results in looking at relationship between health status and the purchase of individual supplemental policies. Some articles found that healthier individuals are more likely to buy such insurance or that low- and high-risk beneficiaries buy similar amounts of insurance. But there has also been a consistent finding that some specific chronic illnesses, such as heart disease, diabetes, cancer, or overall chronic illness are associated with the purchase of supplemental insurance. One study showed that healthier individuals were more likely to purchase supplemental insurance with low levels of knowledge of Medicare benefits and limitations. At higher levels of knowledge sicker beneficiaries became more likely to purchase supplemental insurance and the insurers experienced adverse selection.
- **Conclusion:** Studies have consistently found that supplemental insurance policies are associated with increased Medicare expenditures, but the size, nature, and cause of the effect differs from study to study. Also, the impact of such decreased use of services on health is unclear.

Improving Traditional Medicare’s Benefit Design, Chapter 6, MedPAC Report to Congress – Improving Incentives in the Medicare Program - June 2009.

- Notes that the prevalence of supplemental coverage prevents Medicare from being able to use cost-sharing as a policy tool. In order to effectively pursue such policy measures, decision makers also need to redefine when supplemental coverage may fill in Medicare’s cost-sharing.
- Supplemental insurance can protect beneficiaries from catastrophic financial liability, but also shields beneficiaries from seeing the cost of care which in turn can lead them to use more or higher priced services.
- Notes that analyses by the Physician Payment Review Commissioner (PPRC) showed that Medigap coverage was associated with a 35% increase in Medicare spending. CBO estimated that use of services ranged from 17% higher for those with employer coverage to 28% percent higher for those with Medigap. Larger differences occurred for Part B services than for Part A services.
- Discussion of Hogan study and impact of secondary coverage on Medicare spending. Found that emergency and urgent care appear unaffected by secondary coverage, and office-based care was more responsive than hospital-based care. Found that specialist and preventive care was

strongly associated with secondary coverage. Those with serious chronic illnesses are sensitive to cost-sharing. Some evidence that the presence of secondary insurance had a moderately stronger effect on Medicare spending for lower-income beneficiaries. Beneficiaries without secondary insurance use less care.

- Suggests that cost-sharing could be used as a tool to complement larger Medicare policy goals, including improving Medicare's financial sustainability. One approach related to Medigap would be to redefine Medigap policies so that they no longer completely filled in Medicare's cost-sharing requirements.
- Suggests changes to traditional Medicare that include different levels of cost-sharing for the same medical intervention based on its clinical benefit to the patient, and the application of tiered copays to steer beneficiaries toward preferred providers or to discourage the use of services prone to overuse (such as imaging).
- Also suggests that one approach is to levy an excise tax on Medigap policies.