APRIL 2004

REPORT TO THE CONGRESS

Market Variations and Medicare Supplementation: Looking Ahead

MEDPAC Medicare Payment Advisory Commission

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Executive summary

Executive Summary

Specific factors have encouraged or posed barriers to the effective functioning of markets for insurance products that supplement basic Medicare coverage for different beneficiary populations. This report describes case studies of five diverse markets undertaken in July and August 2003 to explore those factors. We visited Atlanta (GA), Long Island (NY), Minneapolis/St. Paul (MN), Nebraska (entire state) and San Diego (CA). MedPAC staff conducted the interviews and analysis in collaboration with our contractor, Mathematica Policy Research, Inc. The sites were not selected to be nationally representative; rather, they were chosen to illustrate significantly different configurations of supplemental markets and state approaches to market regulation.

In each market we sought to learn about the structure of available Medicare supplemental options, including historical and unique factors that contributed to market development. We met with key state policy staff, health plan administrators and executives, Medigap insurers, insurance brokers, representatives of major health systems, hospitals, physician organizations, employers, and staff from beneficiary education and counseling agencies (including staff from insurance commissioners' offices, Medicaid programs, and pharmacy assistance programs) in each market. The structured interview protocols included questions about the role played by state regulation, provider infrastructure, population and labor market characteristics, and other factors that could be relevant to the market. We also asked how supplemental coverage patterns affected access to care. In addition, we queried respondents about whether the unique characteristics of the market had particular implications for Medicare policy reforms.

Our analysis of those factors provides direction for evaluating Medicare beneficiaries' health insurance coverage and access to care in a rapidly changing environment.

Background

As detailed in this report, the demand for, and cost of, prescription drug coverage has been a driving force behind many of the changes taking place in all sources of supplemental coverage—Medigap, Medicare+Choice (M+C, renamed Medicare Advantage or MA as of 2005) plans, employer-sponsored insurance (ESI) retiree benefits, and Medicaid. Medicare reform legislation was being actively debated when the fieldwork reported here was conducted in the summer of 2003. The enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) heightens our need to focus on the factors that shape Medicare supplemental markets. Prescription drug coverage will require some changes in commercial supplemental products, and the drug benefit provisions included are likely to alter the incentives driving employer-sponsored supplemental retiree insurance. The MMA also may lead to significant changes in state Medicaid and prescription drug programs that currently provide supplemental benefits to low-income Medicare beneficiaries. Further, the MMA provides for new types of local and regional products, including regional health plans and freestanding prescription drug plans. Understanding how supplemental markets have evolved may help us to anticipate issues that need to be considered as the MMA is implemented.

Some forms of supplemental insurance are marketed directly to beneficiaries in commercial markets, while others are made available to employers and other organizations through the group insurance market. To function effectively, these markets need to be able to offer a choice of

products that Medicare beneficiaries (or other payers) can select based on cost, service quality, health care preferences, and other preferences. Beneficiaries need to have access to enough information to make informed choices among insurance alternatives, and sufficient stability among options should support the reasonable expectation that coverage and benefit provisions will remain in place after an option has been selected.

Over the past two years, MedPAC has been concerned about the cost and availability of supplemental coverage. The Commission's work led to the conclusion, however, that it is difficult, if not impossible, to sort out from available data the multiple, interconnected factors that shape specific markets for Medicare supplemental products. Therefore, we designed new qualitative research to help us better understand how these pieces fit together, and whether particular policies related to supplemental products have been effective in supporting markets that meet beneficiaries' needs.

Looking ahead: competition, access, and consumer protection

Looking across the sites, we have identified five focal points for future evaluations of supplemental coverage in a changing Medicare environment.

- *Monitoring how employers react to the MMA*: The decline in employer sponsored coverage was a topic of concern in every market we visited.

- *Identifying local barriers to accessing affordable Medicare private plan and supplemental coverage*: Local demographic and economic factors, the organization of providers and health care delivery systems, and state regulatory environments all affect how markets deliver supplemental coverage; local markets will react differently as the MMA is implemented. Lower-income beneficiaries who do not qualify for state Medicaid benefits could be at particular risk.

- *Educating and protecting consumers:* Beneficiaries will need help navigating the expanding array of supplemental product options, otherwise consumer backlash could undermine market competition.

- *Reducing barriers to effective competition among health plans:* Medicare policy needs to address how the existing structure of insurance markets will factor into the process for establishing payment areas for Medicare Advantage plans. Medicare payment areas and the market areas that have evolved for private supplemental products do not generally coincide; disparities in payments within and across market areas can create obstacles to effective competition among health plans.

- *Monitoring access to supplemental coverage among disabled beneficiaries and identifying possible effects of Medigap underwriting on risk selection in Medicare Advantage plans:* This will be important, particularly in states that conform to the basic Medigap model regulations.

Market variations and Medicare supplementation: Looking ahead

This report identifies factors that have encouraged or posed barriers to the effective functioning of markets for insurance products that supplement basic Medicare coverage for different beneficiary populations. Our analysis of those factors provides direction for evaluating Medicare beneficiaries' health insurance coverage and access to care in a rapidly changing environment.

Medicare's benefit design leaves beneficiaries open to significant out-of-pocket liability for their health care (MedPAC 2002, 2003a, 2003b). MedPAC's 2002 *Report to the Congress* concluded that some beneficiaries do not have good access to supplemental insurance. Beneficiaries who were disabled, poor, living in rural areas, or in poor health were more likely to have Medicare fee-for-service (FFS) with no supplement. Analysis presented in our March 2003 report showed that in some states and metropolitan areas a substantial portion of the Medicare population has no supplemental coverage. In other markets, specific types of supplemental coverage dominate.

We also found that local market factors and regulatory policies affect the structure of supplemental coverage, beneficiaries' access to coverage, and their ability to make meaningful choices among insurance options, although it may be impossible to sort out from available data the many interconnected factors shaping specific markets for Medicare supplemental products. Our evidence suggests that regulatory policies shape markets, and that the division of regulatory authority between the federal government and the states will continue to shape the evolution of Medigap, employer-sponsored, and Medicare private plan options as well as supplementation available through Medicaid. In particular, the interplay between standardization and flexibility in the design of benefits will be increasingly important for beneficiaries, employers sponsoring retiree health benefits, and health plans and insurers as they choose how, or whether, to participate in Medicare markets. We initiated new qualitative research to help us understand these issues.

The enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) heightens the focus on Medicare supplemental markets. Prescription drug coverage will require changes in supplemental products. The MMA's drug benefit provisions are likely to alter the incentives driving employers to sponsor, and retirees to take up, supplemental insurance. The MMA may also lead to changes in state Medicaid and prescription drug programs, which now provide supplemental benefits to low-income Medicare beneficiaries. Further, the MMA introduces new regional and local products such as regional health plans and freestanding prescription drug plans.

The importance of supplementing Medicare

Limitations in the Medicare benefit package will likely continue to lead most beneficiaries to obtain some form of supplemental coverage for acute care services. Medicare requires a deductible ($840 in 2003) for hospital care, 20 percent coinsurance for physician services, high cost sharing for certain covered services such as mental health care, and no limits on either catastrophic costs for very long hospital stays or total out-of-pocket spending. Medicare does not cover certain preventive services, most vision or hearing care or equipment, dental care, or long-term care services (which Medigap or employer-sponsored supplemental insurance generally do not cover either). Until the MMA is implemented (see text box), Medicare will not

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Medicare supplemental insurance products

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) will affect the demand for supplemental coverage and the ways in which specific supplemental products are designed.

Medicare drug plans

The MMA establishes a voluntary prescription drug benefit program (Medicare Part D) to cover outpatient drugs beginning in 2006. The law defines the standard drug benefit under Part D and describes the conditions under which alternative benefit designs can be offered. The standard benefit includes (for 2006):

- An expected average premium of $35 per month,
- A $250 deductible,
- Coverage for 75 percent of drug costs up to $2,250 (25 percent coinsurance),
- An out-of-pocket limit of $3,600 for catastrophic coverage (this represents $5,100 in total drug spending based on the other benefit parameters), and
- 5 percent coinsurance for drug spending above the catastrophic limit.

Drugs will be provided through competing prescription drug plans and Medicare Advantage (MA). The law establishes a fallback plan in regions that do not have at least one prescription drug plan and one MA plan available. The federal government will subsidize premiums by nearly 75 percent and offer additional subsidies for low-income beneficiaries.

Medicare Advantage plans

MA plans must, beginning in 2006, offer at least one plan with a Part D prescription drug benefit. The law also requires regional MA plans (those MA plans that cover large regions) to offer a single deductible for parts A and B, and a catastrophic cap on out-of-pocket spending.

Employer-sponsored supplemental insurance

The law encourages employers to continue providing retiree drug coverage. Employers who offer retiree drug coverage that is at least actuarially equivalent to the new Part D benefit will have three options. They can:

- Receive a 28 percent federal payment for drug spending between $250 and $5,000 in return for providing primary drug coverage. The subsidy would be excluded from taxation.
- Drop primary coverage and instead subsidize premiums and cost sharing for retirees who enroll in Medicare stand-alone drug plans or MA plans.
- Establish their own prescription drug plan.

Medigap

The MMA prohibits the sale, issuance, or renewal of Medigap policies with prescription drug coverage for beneficiaries enrolled in Part D. Beneficiaries who do not enroll in Part D may renew existing policies that provide Medigap prescription drug coverage. Beneficiaries who enroll in Part D but previously had a Medigap policy with drug coverage could renew those policies if modified to exclude drug coverage. Alternatively, they could enroll in other, nondrug Medigap policies offered by the same carrier, within certain limits. The law also asks the National Association of Insurance Commissioners to revise the Medigap standards to reflect Medicare and other relevant changes.

Medicaid and low-income drug benefits

Medicare covers drug benefits for individuals dually eligible for Medicaid and Medicare. Those with incomes up to 100 percent of poverty will have no deductibles and nominal copayments for covered drugs. Low-income beneficiaries who are not eligible for Medicaid but who have incomes below 135 percent of poverty and meet an assets test also will be eligible for coverage of the drug premium and have only nominal cost sharing for covered drugs; those with incomes between 135 and 150 percent of poverty who meet assets requirements will have sliding scale subsidies for premiums and reduced deductibles and cost sharing.

States will have to use their own funds to cover any drugs not on a plan's formulary for dual eligibles. States will still cover Medicare Part A and Part B cost sharing for dual eligibles. Those states that have low-income drug assistance programs will need to determine how the programs will work with the new Medicare drug benefit.

cover most outpatient prescription drugs. Even after the new benefit is in place, many beneficiaries will still have to pay for a large portion of prescription drug costs out of pocket.[1]

Many beneficiaries now have a complex array of options for supplementing traditional fee-for-service Medicare. In 2001, 33 percent of beneficiaries living in the community had employer-sponsored insurance (ESI) retiree benefits, 28 percent had individually purchased Medigap, 16.2 percent were enrolled in Medicare+Choice (M+C) plans (including those in M+C plans through employer-sponsored arrangements), 12 percent were enrolled in Medicaid, and almost 9 percent had Medicare with no supplemental coverage. Levels of coverage varied by demographic and economic characteristics. Older beneficiaries, those in rural areas, and lower-income beneficiaries were less likely to have ESI. Older beneficiaries were more likely to have Medigap, and disabled beneficiaries under age 65 and those with incomes between 125 and 150 percent of the poverty level were more likely to have no supplemental coverage (Table 1).

Table 1. Sources of additional coverage, by selected beneficiary characteristics, 2001

	Number of beneficiaries (In millions)	Percent distribution					
		Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other	Medicare only
All beneficiaries	38.5	32.6%	28.1%	12.2%	16.2%	2.1%	8.9%
Age							
Under 65	5.3	27.9	5.8	35.2	8.2	3.9	19.0
65-69	9.2	38.8	24.2	8.6	17.3	1.7	9.5
70-74	8.4	32.7	32.0	7.5	18.3	2.0	7.4
75-79	7.2	32.6	34.8	8.8	16.8	1.5	5.6
80-84	4.8	30.7	36.2	8.4	17.8	1.7	5.2
85+	3.5	26.5	38.1	9.9	16.4	2.0	7.2
Income status							
Below poverty	5.9	10.2	14.9	51.2	10.4	2.3	11.1
100 to 125% of poverty	3.9	19.4	23.6	23.4	15.0	2.9	15.7
125 to 200% of poverty	8.5	28.6	31.1	6.1	19.7	2.7	11.8
200 to 400% of poverty	12.8	41.9	30.1	1.1	18.5	1.5	7.0
Over 400% of poverty	7.2	46.8	34.8	0.3	13.1	1.7	3.3
Eligibility status							
Aged	33.1	33.4	31.7	8.4	17.4	1.8	7.3
Disabled	5.1	27.2	5.8	35.1	8.5	4.0	19.4
End-stage renal disease	0.3	39.1	10.7	37.2	6.3	1.0	5.8
Residence							
Urban	29.3	34.3	24.4	11.6	20.3	1.9	7.5
Rural	9.2	27.1	40.1	14.0	3.0	2.6	13.3
Sex							
Women	21.4	30.8	30.8	13.5	16.7	1.9	6.4
Men	17.1	35.0	24.8	10.5	15.5	2.3	12.0
Health status							
Excellent/very good	15.6	35.3	32.1	5.7	17.9	1.5	7.4
Good/fair	19.2	31.4	26.8	14.6	15.7	2.3	9.1
Poor	3.5	28.0	17.0	27.5	10.6	3.5	13.4

Note: Income status is defined in relationship to the poverty level ($8,494 if living alone and $10,715 if living with a spouse). Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. Analysis includes only beneficiaries living in the community.

Source: MedPAC analysis of 2001 Medicare Current Beneficiary Survey, Cost and Use file from CMS.

For those who have access to it, ESI can provide the most comprehensive supplemental coverage available. In addition to covering Medicare deductibles, coinsurance, and catastrophic costs, many ESI plans cover services not covered by Medicare, including preventive services, vision and hearing services, and most significantly, prescription drugs. Some ESI plans wrap around Medicare, covering deductibles and coinsurance for covered services and additional services not covered by Medicare, leaving beneficiaries with very little out-of-pocket liability. However, the plans are increasingly being designed as "carve-out" plans that add benefits onto Medicare so that retirees' total coverage matches the coverage offered to active workers. This coverage often requires enrollees to pay deductibles and coinsurance. In fact, ESI plans display a wide range in both the richness of benefits available and the level of subsidy borne by employers. Some ESI plans offer generous benefits, with retirees paying only a small portion of the premium; other plans are far less comprehensive, with employers not subsidizing any of the premium cost in some cases.

Medigap insurance is designed to wrap around the Medicare benefit package. Medigap plans cover the Part A and Part B coinsurance, leaving beneficiaries with little out-of-pocket cost for most covered services. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) led to standardized Medigap plan options, based on a model developed by the National Association of Insurance Commissioners (NAIC). Some Medigap plans offer some additional coverage of preventive services, and some include a limited drug benefit (see appendix, Figure 1 for additional detail on the standardized plans).

Medicaid is an important source of supplemental coverage for some low-income beneficiaries. Beneficiaries who meet state requirements for full Medicaid coverage receive full Medicaid benefits, including prescription drugs, to supplement Medicare benefits. Medicaid also covers the cost of Medicare premiums and cost sharing for dual eligible individuals.

Other federal programs—called Medicare Savings Programs—provide assistance with Medicare premiums and cost-sharing requirements. Under the qualified Medicare beneficiary (QMB) program, states pay Medicare premiums, deductibles, and coinsurance for all beneficiaries whose income is at or below 100 percent of the federal poverty level and whose assets are at or below twice the Supplemental Security Income limit. The specified low-income Medicare beneficiary (SLMB) covers the Medicare Part B premium for beneficiaries with incomes between 100 percent and 120 percent of poverty, and the qualifying individuals-1 (QI-1) program pays the Part B premium for beneficiaries with incomes between 120 and 135 percent of poverty.

M+C plans generally provide some additional benefits, including limits on cost sharing, preventive benefits, and in some cases prescription drug coverage. The plans include HMOs, HMOs with point-of-service options (allowing beneficiaries to use out-of-network providers at additional cost), preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans. Under federal law, insurers cannot sell Medigap plans to beneficiaries enrolled in M+C plans, because it was expected that the coverage would duplicate the basic coverage of Medicare cost sharing included in M+C benefits. In 2003, about 30 percent of plans charged no cost sharing for inpatient services in network hospitals and about 10 percent required no cost sharing for visits to network physicians. About half of the plans included coverage for outpatient prescription drugs, but some plans that did not provide a drug benefit in their basic plan offered high-option (higher-cost) plans that included a prescription drug benefit (MedPAC 2003a).

The markets for ESI and public benefit programs are different than individual insurance markets. Employers may decide to offer retirees some choice among supplemental insurance options. Some large regional or national employers offer retirees a wide range of options, but others limit choice to a small number of plan options or to a single plan.[2] Public programs do not compete for beneficiary enrollment: Beneficiaries have to qualify for participation in these programs, and the rules for participation are defined by law. These programs can, however, significantly affect local insurance markets.

New and emerging patterns of coverage

Patterns of supplemental coverage were changing before the MMA. After a rapid increase in the mid-1990s, M+C enrollment declined from its peak in 1999 and 2000, and the richness of supplemental benefits available in the plans declined as well. Meanwhile, economic pressures led some employers to eliminate or reduce coverage, particularly for future retirees. Lower ESI coverage rates among more recent retirees reflect these changes in employer policy. In 2001, 36 percent of Medicare beneficiaries age 65 to 74 had ESI coverage, compared with 39 percent in 1993. Medigap enrollment has been essentially flat in the past three years, after losing some enrollees to M+C plans in the mid-1990s.[3] Beneficiaries age 65 to 74 are less likely to have purchased Medigap than older beneficiaries, and slightly more likely to have enrolled in an M+C plan. Medicaid enrollment has remained fairly level among beneficiaries living in the community, generally between 11 to 13 percent (with differences across states, reflecting differences in state eligibility requirements). The combined effect of these shifts is that, after declining through the 1990s, the percentage of beneficiaries without any supplemental coverage increased slightly from 1999 to 2001.

The MMA could lead to greater participation in private plans. If not, rates of supplemental coverage will probably continue to decline, affecting beneficiaries' access to care and out-of-pocket spending. MedPAC analyses have shown that beneficiaries with only fee-for-service Medicare coverage are more likely—controlling for other factors including age, sex, ethnicity, health status, and income—to report having access problems such as not seeing a doctor when necessary, delaying care due to cost, and not having a usual source of care or usual doctor (MedPAC 2003).

Project design and methods

For insurance markets to function effectively, beneficiaries (or other payers) must be able to make informed choices among the available insurance products based on cost, service quality, and their preferences about health care. Sufficient stability among options will give beneficiaries assurance that coverage and benefit provisions will stay the same. This report identifies factors that have encouraged or posed barriers to effective markets for products to supplement basic Medicare coverage for different types of beneficiaries. MedPAC studied five very different markets: Atlanta (GA), Long Island (Nassau and Suffolk counties, NY), Minneapolis/St Paul (MN), Nebraska (entire state) and San Diego (CA). Some of these markets are located in states that have unique regulatory features. Minnesota is one of three states with a waiver from the 1990 Medigap standardization requirements. New York heavily regulates the Medigap market. Finally, California insurers offer a greater variety of Medigap options than most other states.

In collaboration with our contractor, Mathematica Policy Research, Inc., we conducted interviews in July and August of 2003. In each market we learned about the options to supplement Medicare and the historical and unique factors that contributed to market structure. We considered Medigap, MA, employer group plans, and Medicaid, and state-subsidized drug coverage and other governmental plans (e.g., military or Department of Veterans Affairs). We met with state staff; M+C plan administrators and executives; Medigap insurers; insurance brokers; representatives of major health systems, hospitals, and physician organizations; employers; and

staff from beneficiary education and counseling agencies (including staff from the insurance commissioners' offices, Medicaid, and pharmacy assistance programs). We conducted at least 12 interviews at each site (most in person, some by telephone conference call) and interviewed more than 150 individuals across the five sites. Our structured interview protocols included questions about the role played by state regulation, provider infrastructure, and population and labor market characteristics, and examined how supplemental coverage patterns affected access to care.

Medicare reform legislation was being debated during the fieldwork period. In each interview, we asked respondents whether the characteristics of their market had particular implications for Medicare policy reforms and discussed aspects of reform bills.

A detailed report on the site visits is in the appendix to this report. Among the most significant features of these sites were:

- In Atlanta, Medigap, employer-sponsored, and M+C coverage are relatively rare, and M+C options are very limited. One of the two plans enrolling beneficiaries in 2003 left the Medicare program at the end of the year. The proportion of beneficiaries with incomes below the poverty line is higher than in the other sites, and eligibility criteria for Medicaid coverage are more restrictive. Medigap dominates supplemental coverage, but Medigap enrollment is lower than average for major metropolitan areas. Insurers have not actively marketed Medigap policies over the past decade. Access to Medigap for the under-65 disabled population is limited—Georgia does not require guaranteed issue for disabled beneficiaries. Few insurers offer policies and, if offered, they are expensive. Providers have resisted integrated payment and delivery systems. Some respondents believe Atlanta's delivery system and negative attitudes towards managed care limit development of new private plans to serve Medicare beneficiaries.

- On Long Island, we see a high rate of employer-sponsored retiree coverage and a history of M+C plan withdrawals contrasted with a relatively stable M+C market in neighboring New York City boroughs. M+C enrollment has declined steeply. New York regulates Medigap coverage well beyond federal requirements, requiring guaranteed issue and community rating for all insurance products (including policies marketed to under-65 disabled beneficiaries). The availability of Medigap policies that include a drug benefit is even more limited than in other states. New York has a strong commitment to its pharmacy benefit program and to enrolling eligible beneficiaries in Medicaid and the Medicare Savings Programs. Provider risk sharing is limited and local demand for health care services is high.

- In the Minneapolis/St. Paul area, Medigap dominates supplemental coverage. Although some Medigap premiums are higher than in other metropolitan areas with similar demographic characteristics, a significantly higher proportion of Minneapolis/St. Paul beneficiaries with Medigap have policies that cover prescription drugs. Under Minnesota's waiver from the national Medigap standards, insurers offer a somewhat more comprehensive set of supplemental policy designs, including richer drug benefits than are available under the NAIC model standardized plans. Minnesota is an active Medigap regulator and has a tradition of strong consumer activism in the senior community.

Minnesota has implemented several special programs integrating Medicare and Medicaid benefits. Relatively high M+C enrollment reflects the area's high levels of managed care and integrated delivery systems; Medicare cost plans play a major role in the market.[4] Medigap SELECT plans, which cover more of beneficiaries' cost sharing when they use network providers, compete directly with M+C and cost plans. A relatively small and shrinking number of beneficiaries in Minneapolis/St. Paul have ESI coverage.

- In San Diego, the overall rate of supplemental coverage is high, reflecting both a high M+C enrollment (40 percent) and an extensive military presence; over 46,000 military retirees have TRICARE for Life supplemental coverage. The Department of Veterans Affairs health care system also plays a significant role in market dynamics. Many providers accept capitated payments, and some large physician groups are strongly committed to managed care. The Medigap market is changing, as policies offer innovative benefits, high-deductible options, and a freestanding generic drug plan.

- In Nebraska, Medigap dominates supplemental coverage. Two urban areas—Lincoln and Omaha—are large enough to have competing health systems, but there is very little managed care. Only two statewide PPO networks serve the commercial market. M+C plans are available in the Omaha area; PFFS plans are available statewide. Few employers offer ESI coverage, and that number is declining as some of the largest employers phase out coverage for their retirees. Disabled beneficiaries under age 65 have little or no access to affordable Medigap insurance.

Individual insurance markets: Medigap and M+C products and premiums

Medigap and M+C plan offerings and premiums differ widely among the five markets we studied.

Medigap

To illustrate how differences in market-based insurance products play out for individual beneficiaries, we compare options for supplementing Medicare for beneficiaries who do not have ESI coverage and are not eligible for Medicaid.

Available data included print and web information from the national Medicare Personal Plan Finder on Medigap plans compiled by CMS, and information on Medigap policies from the state insurance commissioners' offices and the state or local health insurance counseling program agencies. Some of this information is likely incomplete, inaccurate, or dated. The uneven quality of data affects beneficiaries. Health insurance information is complicated, and summary information is often either too general to be useful or so complicated that it is impossible to draw meaningful comparisons among options. Despite the shortcomings of the data, we can infer whether state policies affect the cost and availability of supplemental coverage in the sites we visited.

Access to Medigap insurance varies among the five sites. Nebraska and Georgia have incorporated the NAIC model regulations for Medigap into state law and regulations. For the

open-enrollment period when beneficiaries enroll in Medicare at age 65, these regulations provide guaranteed issue—with no underwriting—for all the plans sold in the state. Under-65 disabled persons, however, are not guaranteed the same open enrollment period. Insurers may decide case by case whether they will issue policies to disabled applicants. Medigap policies are guaranteed renewal, but—after the initial open-enrollment period—insurers can medically underwrite new applicants for policies. Insurers can base premiums on beneficiary age when the policy is initially purchased or on age when the policy is renewed (MedPAC 2003a). Additional provisions apply to beneficiaries who lose coverage due to the withdrawal of M+C or ESI plans.

In three of our sites, state regulation exceeds those in the NAIC model. New York requires community rating of all health insurance products, open enrollment, and guaranteed issue. This means that all beneficiaries—including those under age 65—can purchase any policy sold in the state, at the same premium as everyone in their same geographic region. In Minnesota, the six-month open enrollment period extends to disabled beneficiaries under age 65 (from the date of their enrollment in Part B) without any medical underwriting. Medical underwriting is permitted after the open enrollment period, and plans can set higher premiums for smokers, but Minnesota law prohibits age rating on Medigap policies. California allows age rating, but has recently expanded initial open enrollment for a subset of policies to disabled persons under age 65; prices for these policies are not restricted.

Table 2 compares the *lowest* listed premiums across the five sites for Medigap policies available to a 65-year-old woman during her initial Medicare open enrollment period.[5] Policy A provides a "minimum" supplemental benefit. (Figure 1 of the appendix shows the benefits covered in standard Medigap policies A through J). Policies C and F account for most of the policies sold across the country. Information on Minnesota Medigap is included in the chart despite some differences in the policy design. Medigap policies H, I, and J (of interest because they include a drug benefit) account for less than 10 percent of Medigap policies. Unless otherwise noted, the premiums are the lowest on the CMS Personal Plan Finder in October 2003.

For a new enrollee, Medigap coverage is considerably more expensive on Long Island than in the other markets for most policy types. In part, the higher costs in New York reflect community rating, which is intended to spread costs across the entire covered population within the policy type and geographic area. In addition, supplemental insurance costs are directly related to the costs of medical services, because Medigap is designed to cover cost sharing and therefore tracks directly to Medicare payments. Medicare costs for Long Island are higher than in many other areas of the country, because of the higher costs and use of services. No J policy (the policy with the somewhat richer prescription drug benefit) is sold in the individual market anywhere in New York state. According to the insurers we spoke with, community rating prevented underwriting, and adverse selection—when beneficiaries with greater health care disproportionately buy coverage—made the product unsustainable.

In San Diego, new beneficiaries have a variety of Medigap offerings, including high-deductible policies (beneficiaries in 2003 were responsible for the first $1,530 of Medicare costs), plans offering innovative benefits such as health promotion programs and alternative health care, and a SELECT plan (requiring use of network providers to qualify for full benefits) with a limited

prescription drug benefit. Here, as in some other California markets, the role of large physician groups in the delivery system may promote development of network-based insurance products.

The options in Minnesota are structured differently: Basic plan coverage combines with riders to make it similar to a Medigap policy F. These are somewhat more expensive than in the other sites (except New York). On the other hand, a SELECT plan—with benefits that are richer than those covered under a standard J policy—is not much more expensive than J policies in the other sites. The provider networks participating in the Minnesota SELECT plans are extensive.

In Nebraska, a new enrollee can buy a high deductible F or J plan as well as typical plans.

For older beneficiaries buying coverage for the first time or changing their coverage, Medigap options can be more limited and expensive than for younger beneficiaries, depending on state regulations. Table 3 shows the lowest listed premium for a 75-year-old woman in 2003. In Atlanta and San Diego, age rating results in higher premiums for most A and C plans available to a 75-year-old versus a 65-year-old, but some insurers (including AARP/United Healthcare) do not age rate. In general, community-rated premiums in New York are higher than in our other sites. In all the other sites, however, insurers may medically underwrite new policies after the initial enrollment period at age 65, pricing or denying coverage based on health status. Denial of coverage to older beneficiaries in poor health is reportedly most common for comprehensive policies (including plans with drug benefits). An older beneficiary in poor health, in other words, may not be able to purchase a policy at the listed price. The insurer may choose to offer coverage if a beneficiary already holds a policy, but unless required by state law, is not obligated to do so.

Disabled beneficiaries under age 65 have limited access to Medigap in Georgia and Nebraska (Table 4). Insurers may decide on a case-by-case basis whether to issue policies to individual applicants. Nebraska has a high-risk insurance pool for disabled beneficiaries under age 65 who otherwise cannot get insurance, but the premiums are more expensive than Medigap's. In Nebraska, the lowest listed premiums for A and C Medigap for disabled beneficiaries and 75-year olds are similar. In Minnesota and New York, disabled beneficiaries pay the same rate as those over 65 for all policies.

M+C

Medigap is one set of supplemental insurance options. Coverage may also be available from an M+C plan. Beginning in 2006, most types of MA plans will offer a drug benefit. Unlike Medigap plans, M+C (and the new MA) plans must accept all applicants (except those with end-stage renal disease) regardless of age or health status, and premiums are community rated.

In some markets, M+C plans have provided supplemental coverage with preventive benefits and prescription drug coverage, with limits on out-of-pocket costs. M+C plans with these benefits have been particularly important for disabled beneficiaries, who typically cannot afford coverage in the Medigap market, but may incur relatively high health care costs. For example, the incidence of severe mental illness, dementia, and mental retardation is high among disabled beneficiaries. Disabled beneficiaries with cognitive and mental health disorders often have high costs for prescription drugs and pay high cost sharing for mental health services (Foote and Hogan 2001).

Table 2. Medigap options for a 65-year-old woman enrolling in Medicare in 2003: Lowest listed monthly premiums

Insurance Market	Policy A	Policy C	Policy F	Policy H	Policy I	Policy J	Restrictions, options, special circumstances
Atlanta	$48	$100	$102	$188	$189	$233	
Long Island, NY	$80	$140	$141	$160	$230	not sold	All plans are community rated, guaranteed issue, with continuous open enrollment.
Minneapolis, MN	$69 (Basic plan, no riders)		$101 (Basic with riders for Part A & B deductibles) $114 *SELECT/ extra benefits*			$351 Extended *$229 Select Basic/R_x rider (50%)*	Standard plans differ from national standard forms. All plans cover Part A coinsurance and catastrophic hospital costs, Part B coinsurance, Part A nursing home copayment up to 100 days, 50% cost-sharing for mental health, 80% of emergency travel, immunizations, and the Part A blood deductible. Basic plans have six riders but the R_x rider is now sold only with SELECT policies. The R_x rider covers at least 50% of prescription drug costs, with no cap. Extended plans include additional benefits, including a prescription drug benefit (either 50% or 80% of drug costs) and an annual limit of $1,000 out-of-pocket liability for all covered expenses.
Nebraska	$48	$86	$82 *$30, High-deductible*	$152	$157	$209 *$70 High-deductible*	
San Diego, CA	$53 *$93 SELECT/ innovative benefits* *$225 SELECT/ R_x benefit*	$81	$59 $44 *High-deductible, limited generic R_x benefit*	$146	$147	$176	

Note: Medigap information from the CMS Medicare Personal Plan Finder. Not all insurers have provided complete information to CMS, and rate quotes in some cases are incomplete or outdated. Information for Minneapolis is based on the Minnesota Senior Federation's *Minnesota Health Care Choices, 2003*. Information on SELECT and innovative benefits in San Diego is from the California Department of Insurance. Information on policies available to the disabled under age 65 in Atlanta is from the Georgia Department of Insurance. Information on policies offered to the under-65 disabled in Nebraska is from the Nebraska Health Insurance, Counseling, and Assistance Program.

Table 3. Medigap options for a 75-year-old woman in 2003: Lowest listed monthly premiums

Insurance Market	Policy A	Policy C	Policy F	Policy H	Policy I	Policy J	Restrictions, options, special circumstances
Atlanta	$54	$121	$113	$188	$189	$237	Insurers can refuse to issue more comprehensive policies (e.g., replace policy A with a policy B or higher). Policies are subject to underwriting after the initial Medicare open enrollment period, and therefore may be unavailable to beneficiaries in poor health.
Long Island, NY	$80	$140	$141	$160	$230	not sold	All plans are community rated, guaranteed issue, with continuous open enrollment.
Minneapolis, MN	$69 (Basic plan, no riders)		$101 (Basic with riders for Part A & B deductibles) $114 *SELECT/ extra benefits*			$351 Extended *$229 Select Basic / R_x rider (50%)*	*See Table 1 for discussion of Minnesota's Basic and Extended Basic Medigap policy forms.* SELECT drug benefit riders and the sale of Extended Basic plans are subject to underwriting after the initial Medicare open enrollment period, and therefore new policies may be unavailable to beneficiaries in poor health.
Nebraska	$55	$99	$98 *$34, High-deductible*	$153	$157	$209 *$82 High-deductible*	Insurers can refuse to issue more comprehensive policies (e.g., replace policy A with a policy B or higher). Policies are subject to underwriting after the initial Medicare open enrollment period, and therefore may be unavailable to beneficiaries in poor health.
San Diego, CA	$72 *$139 SELECT/ innovative benefits* *$349 SELECT/ R_x benefit*	$98	$84 $76 *High-deductible, limited generic R_x benefit*	$146	$147	$176	Insurers can refuse to issue more comprehensive policies (e.g., replace policy A with a policy B or higher). Policies are subject to underwriting after the initial Medicare open enrollment period, and therefore may be unavailable to beneficiaries in poor health.

Note: Medigap information from the CMS Medicare Personal Plan Finder. Not all insurers have provided complete information to CMS, and rate quotes are in some cases incomplete or outdated. Information for Minneapolis is based on the Minnesota Senior Federation's *Minnesota Health Care Choices, 2003*. Information on SELECT and innovative benefits in San Diego is from the California Department of Insurance. Information on policies available to disabled under age 65 in Atlanta is from the Georgia Department of Insurance. Information on policies offered to under-65 disabled in Nebraska is from the Nebraska Health Insurance, Counseling, and Assistance Program.

Table 4. Medigap options for an under 65-year-old disabled woman in 2003: Lowest listed monthly premiums

Insurance Market	Policy A	Policy C	Policy F	Policy H	Policy I	Policy J	Restrictions, options, special circumstances
Atlanta	$74	$209	$113	$188	$189	$237	Insurers selling Medigap to disabled, under-65 beneficiaries can decide on a case-by-case basis whether to issue policies. One carrier offers SELECT policy forms B, C, D, and F to disabled under-65 beneficiaries only; premiums are higher than those shown here.
Long Island, NY	$80	$140	$141	$160	$230	not sold	All plans are community rated, guaranteed issue, with continuous open enrollment
Minneapolis, MN	$69 (Basic plan, no riders)	NA	$101 (Basic with riders for Part A & B deductibles) $114 *SELECT/ extra benefits*			$351 Extended *$229 Select Basic/R_x rider (50%)*	See Table 1 for discussion of Minnesota's Basic and Extended Basic Medigap policy forms. Drug riders and Extended plans are available to under-65 disabled without underwriting during an initial six-month enrollment period.
Nebraska	$152	Not sold (B policy is $225)	Not sold	Not sold	Not sold	Not sold	Insurers selling Medigap to disabled, under-65 beneficiaries can decide on a case-by-case basis whether to issue policies.
San Diego, CA	$71	$98	$101 $93 *High-deductible, innovative benefits*	$146	$147	$176	Newly disabled beneficiaries under age 65 have a six-month open enrollment period for policies A, B, C, and F and one of the drug policies (H, I, or J) offered if the insurer sells one. Premiums set for the policies have no restrictions. After the six-month open enrollment period, insurers can underwrite, and can refuse to issue new policies or more comprehensive policies to individuals during annual open enrollment periods.

Note: Medigap information from the CMS Medicare Personal Plan Finder. Not all insurers have provided complete information to CMS, and rate quotes are in some cases incomplete or outdated. Information for Minneapolis is based on the Minnesota Senior Federation's *Minnesota Health Care Choices, 2003*. Information on SELECT and innovative benefits in San Diego is from the California Department of Insurance. Information on policies available to disabled persons under age 65 in Atlanta is from the Georgia Department of Insurance. Information on policies offered to under-65 disabled in Nebraska is from the Nebraska Health Insurance, Counseling, and Assistance Program.

If they enroll in M+C plans and their cost sharing is higher because of the mix of services they use (and not their health status, which risk adjustment would account for), M+C plans would pay for these costs. Differing rules governing access to insurance products, thus, could undermine fair competition.

Beneficiaries in San Diego had several M+C plans that offer some drug coverage (three plans with generic-only coverage, one with some brand coverage), and other supplemental benefits. Premiums for these plans ranged from $20 to $60 per month in 2003. One cost plan in Minneapolis offered a relatively generous prescription drug benefit with additional preventive benefits, for $209 per month; and one PFFS plan with a limited drug benefit was available. On Long Island in 2003, the two M+C plans offered more limited supplemental benefits, and had premiums more than $100 per month. HMO and PPO plans in Omaha and one PFFS plan throughout Nebraska included an outpatient prescription drug benefit. In Atlanta, the only remaining M+C plan does not offer any prescription drug coverage (see appendix).

The interplay of Medigap and MA

We found two sites that may illustrate emerging policy issues around new benefit designs and consumer education. Both Minneapolis and San Diego offer more complicated options for supplementing Medicare. In California, a variety of new benefit options, including high-deductible plans, are offered alongside M+C plans (see appendix). The M+C plans also include a wide range of benefit offerings, some of which look much like Medigap options. In some instances, insurers offer both M+C and Medigap products ranging from low-cost and high out-of-pocket coverage to more comprehensive coverage. The rules determining which of these products are available to beneficiaries, as well as the oversight and regulation of these products, vary depending on whether the plans are M+C or Medigap products.

In Minneapolis and St. Paul, low-end Medigap products cost more than in Atlanta, San Diego, or Nebraska, but Minnesota's unique benefit design is somewhat richer (see Table 2). The more comprehensive products in Minnesota, including those with drug benefits, have encouraged a competitive marketplace for relatively expensive supplemental products. Table 5 illustrates some of these options. Medigap SELECT policies in Minnesota are described as "a cross between HMOs and Medigap with some riders." Four of these plans are available. The most popular is in the first column of the table: The SELECT plan enrolls about 150,000 people. Minnesota allows these plans to underwrite (to deny coverage for health reasons) after the initial enrollment period.

The M+C plans in Minneapolis charge relatively high premiums, compared with those in San Diego, Atlanta, or Nebraska, but offer additional benefits. The cost plan shown in the second column includes a drug benefit and access to a large network of providers. Like the SELECT plan, it covers 100 percent of deductibles and physician coinsurance for in-network care. The M+C plan in the third column is the most expensive one in the market. Although not as rich as the SELECT or the cost plans, it has a more comprehensive drug benefit than similar plans serving Minneapolis. It costs about the same as basic Medigap, and offers additional benefits, including routine physical exams, preventive screening, a limited dental benefit, some discounts on hearing aids and glasses, and a rider covering the hospital deductible.

Table 5. Three options for supplementing Medicare in Minneapolis/St. Paul, 2003

	Medigap Select	Medicare Cost Plan	Medicare Advantage
Cost sharing	100% coverage for Medicare services	100% coverage for Medicare services	Beneficiary pays $50 per hospital admission; $10 for physicians, $15 for specialist visits
R_x benefit	50% coverage of outpatient drugs (no cap)	$500 limit on brand; unlimited generics with $11 copay	Maximum benefit of $100 per quarter; $10 copay for generics, $30 brand; covers 80% of insulin
Network	Statewide network: 170 hospitals; 11,450 physicians	Most of MN: 7,500 physicians, 120 hospitals (no referrals needed for network providers)	MSA area: 27 hospitals, 126 primary care clinics, 3,400 physicians
Monthly premium	$229 - nonsmoker (health screening after open enrollment period)	$202 (no health screening)	$103 (no health screening)

Note: MSA (metropolitan statistical area).

Market dynamics across the five sites

Medigap markets vary significantly across the sites, but most Medigap insurers, brokers, beneficiary advocates, and state regulators we spoke with believe that standardization of Medigap benefits has stabilized the market and protected beneficiaries.

Beneficiary advocates strongly supported standardizing supplemental insurance products to help beneficiaries make informed choices among insurance options. New options make consumer education more difficult. In San Diego, for example, we found that the local Medicare health insurance counseling program could not inform beneficiaries about Medigap premiums. Staff at the local agency told us they were not able to track policy options open to beneficiaries, and information from the state's insurance commissioner's office was incomplete or outdated. Because the state's Department of Managed Health Care regulates several major Medigap carriers, putting together reliable and consistent information across all plan offerings is difficult. To obtain accurate and complete information, beneficiaries must contact individual carriers.

State Medigap regulation has increased access for disabled beneficiaries (under age 65) in New York and Minnesota, and community rating and open enrollment rules make plans available to seniors switching among Medigap options. Community rating may affect market dynamics, such

as the number of plans offered. But where regulation was seen as heavy (New York) or firm (Minnesota), carriers reported adapting to a stable environment.

New York has fewer insurers offering Medigap products (nine on Long Island, and no individual Medigap plan offering a policy J drug benefit plan), but no one complained about a lack of options on Long Island. In other sites, respondents did not characterize the state regulatory environment as harmful to the marketplace.

Medigap markets generally are large, often covering either the entire metropolitan statistical areas (MSA) or the non-MSA areas of states. Across the sites, however, insurers reported that establishing networks for Medicare SELECT plans (generally involving discounts for care provided in participating hospitals) can be difficult, even in areas (like Atlanta or Nebraska) where commercial networks are in place. Hospital occupancy rates or Medicare payment rates for M+C plans may dissuade hospitals or physicians from participating. Some large insurers believe they could put together statewide or regional provider networks (as in Minneapolis). Crossing state borders, however, presents a variety of regulatory issues (including prohibitions on insurers engaging in out-of-state business, as in New York) as well as challenges of establishing relationships with local provider organizations. Insurers in all the sites generally believe that they need to be able to vary prices within the state to adjust for differences in costs and the supply of providers.

Insurers have mixed views about the demand for lower-cost, high-deductible Medigap products and attractiveness of greater flexibility in the design of Medigap products. The presence or absence of rules regarding community rating and guaranteed issue underlie insurers' views. Plans that have traditionally offered community-rated policies are concerned about the potential for risk selection to affect premiums for new PFFS and high-deductible products. Insurers and regulators told us that low premiums could be attractive to low-cost beneficiaries, while sicker beneficiaries would remain in the more comprehensive traditional plans. Premiums might spiral in the traditional plans as a growing concentration of sicker enrollees forced insurers to raise premiums, in turn driving out the remaining policyholders who do not expect to need more comprehensive benefits.

Because states do not have clear authority to regulate Medicare PFFS premiums, some Medigap insurers and beneficiary advocates were concerned about these plans' ability to market inexpensive products, then quickly increase premiums (or leave the market). Regulators noted that although federal provisions governing PFFS plans require CMS to review and approve plan contracts, they specifically exempt PFFS plans from CMS's approval of premium rates. The review of other M+C plans includes whether premiums and supplemental benefits meet federal requirements, but PFFS plans can design benefits with high premiums, as long as the total value of the benefits is deemed reasonable by the Medicare program. Some state regulators believe that this less structured oversight could leave beneficiaries vulnerable to large annual rate increases. Under the provisions for M+C plans, PFFS plan enrollees may seek new supplemental coverage within a special open enrollment period, if the plan withdraws from their service area. However, beneficiaries who drop coverage because it has become too expensive do not have this protection.

Employers we interviewed indicated that cutbacks in retiree health benefits (for Medicare eligibles) are likely to occur sooner than widely anticipated. Public sector employees generally have more comprehensive retiree benefits than private-sector employees. In New York, the benefits offered by some large private employers are also quite comprehensive, possibly reflecting both union presence and public sector competition for private employees. By contrast, Nebraska and Minnesota state employees eligible for Medicare receive no subsidies toward the purchase of supplemental benefits.

The employers we spoke with were interested in the Medicare reforms that Congress was considering. Those employers who wanted to keep retiree health benefits were actively trying to structure their benefits design to hold down costs and allow retirees to keep benefits. In some industries, employers view retiree benefits as a basic part of the compensation package they offer to recruit and retain employees. One effective means of limiting liability for retiree costs is to shift retirees (in particular over-64 retirees) into a separate risk pool. The resulting premiums can lead retirees to drop coverage, but these employers see few, if any, viable alternatives for controlling employer costs. But even when employers entirely end their subsidies for retirees' coverage, group coverage is still attractive to employers and employees if it provides comprehensive drug coverage not widely available elsewhere. This is because Medigap drug coverage is limited, the individual market has offered few comprehensive options, and most retirees do not qualify for low-income drug benefits in states where such programs exist.

Most organizations offering retiree health benefits are large, often regional or national firms, and benefits decisions are shaped by industry-wide competition more than local market factors. But the influence of employers on the local health plans and insurance markets can be significant. In markets like San Diego, where managed care predominates, it is not surprising to find that employer group plans represent a significant share of M+C plan enrollment (over one-third of one HMO's enrollees are in employer contract arrangements). But even in other markets (Minneapolis and Nebraska), where the M+C market is more unstable, employers have continued to offer coverage through M+C plans.

The comprehensive supplemental benefits available to military retirees enrolled in Medicare are a special and interesting case. The introduction of the new TRICARE for Life program led many military retirees to drop Medigap or M+C plans. In San Diego, M+C plans lost about 10,000 members to TRICARE for Life; in Atlanta, a major Medigap carrier lost nearly 10 percent of policyholders to the program. Providers in San Diego told us that the change to the relatively generous, open-ended benefit has increased retirees' use of Medicare-covered services.

Medicare Advantage plans operate in local delivery systems. The payment areas established for M+C plans—counties—do not necessarily mesh with the payment areas that have evolved in the private market. In San Diego, the county and the market happen to coincide, only because San Diego county is geographically isolated. In Minneapolis/St. Paul, Medigap insurers rate the Twin Cities MSA as a distinct market. In Atlanta, M+C payment rates varied by nearly 20 percent in 2003 by county, but Medigap insurers generally treat the Atlanta MSA as a single market, with Medigap premiums somewhat higher ($7 to $10 per month) in Atlanta compared with the rest of the state.

In New York, Medigap insurers group Long Island with the New York City boroughs when setting rates. Variation in county M+C payment rates, however, has had a significant effect on M+C markets. The 2003 M+C payment rates for Nassau and Suffolk counties were much lower than the rates for the five boroughs of New York City. There, M+C plans offered relatively generous prescription drug benefits, with little or no additional premium. The lower capitation payments to M+C plans in Nassau and Suffolk counties could not support those sorts of benefits. M+C plans left the market, enrollment on Long Island declined significantly, and the plans had problems negotiating with hospitals and other provider groups.

These payment differences will narrow considerably under the MMA, but differences in payment to plans in neighboring counties within the same MSA will continue. Payments to the new regional plans could also differ from those to local plans. The regional plans' premiums will reflect areawide costs—areas may be states, or multi-state areas—and thus will be lower than those for some counties and higher than for others.

In all the markets (with the exception of San Diego), health plan representatives described difficulty in sustaining provider networks as a major contributor to M+C plans' strategic retrenchment. In the three markets most affected by M+C plan withdrawals (Atlanta, Long Island, and Nebraska), plans reported difficulty establishing arrangements in which providers take risks for either their own or other health care services. In these markets, consumer acceptance of HMO products was low from the start. Conversely, in San Diego, provider integration and financial arrangements with physicians and groups have contributed to a high rate of M+C participation. However, across all the sites, insurers agreed that the PPO arrangements, while more attractive to consumers, do not manage health care as effectively as more integrated models like staff-model or group-model HMOs.

The Minneapolis/St. Paul area has well-established provider networks, but the structure of Medicare managed care is unique in that the capitated M+C plans operate alongside cost plans. Cost plans account for almost half of beneficiary managed care enrollment and are seen as having an unfair advantage because they are paid for the full cost of the services they provide. These plans, however, also provide an example of how different models of care management and reimbursement can compete. The one insurer that operates a Medicare cost plan and a Medicare SELECT plan, using the same network of providers, reported that the cost per enrollee (risk adjusted) is significantly lower in the cost plan than in the SELECT PPO; their cost plan, as an HMO, is better able to manage patient care than their PPO.

Several MA plans we interviewed are planning to offer a wider array of products to seniors. These include PPO options (a non-demonstration plan in Nebraska) and PFFS options in Nebraska and Minnesota. Several plans have launched Medigap products; others have products on the drawing board. Insurers in several sites told us that existing contract relationships in the commercial market can delay the development of new Medicare plans, as they work through the required contracting requirements for Medicare plan participation and revise prior commercial contract agreements. For example, some insurers' contracts with provider groups included payment rates that differ from Medicare rates, entailing new contracting for ongoing arrangements before developing new Medicare products. Consequently, several told us that they had been unable to work out all the details in time to submit proposals for Medicare PPO contracts.

Medicaid eligibility and other low-income programs varies across the sites. The monthly maximum income levels to qualify for full Medicaid benefits range from $317 in Georgia to $748 in Minnesota; allowable total asset levels are typically between $2,000 and $4,000 (except in Minnesota where they are up to $10,000). Though income tests for Medicare Savings Programs options are set nationally, assets tests vary by state (see appendix).

The prescription drug programs for low-income beneficiaries are even more variable, including the scope of benefits, eligibility rules, the amount of the subsidy, and, thus, the value to beneficiaries. New York's EPIC program is well supported financially and politically. It is considered highly effective in filling the drug gap for elderly beneficiaries in the Medicare program. (It does not, however, cover the under-65 disabled.) In fact, some are concerned that Medicare reforms could undermine this very popular program. Minnesota's drug program for the elderly wraps around Medicare Savings Programs' benefits. Georgia's program is a public-private partnership that helps beneficiaries navigate private sector discount or charity programs. California regulates the price of prescription drugs sold to all Medicare beneficiaries. Nebraska had no state program to subsidize drug costs for low-income seniors in 2003.

The design of low-income drug plans can affect how M+C plans design their products. M+C plans that offer a drug benefit (as in San Diego) have found that coordinating drug and other benefits with state Medicaid benefits for dual eligibles can be complicated. Some plans have seamless systems for coordinating with Medicaid: In Minnesota, for example, M+C plans offer a range of programs designed specifically to attract dual eligibles. However, in other sites, M+C plans do not market to dual eligibles and enroll very few.

Looking ahead: competition, access and consumer protection

As long as gaps in the basic Medicare benefit package drive beneficiaries to seek supplemental coverage, policymakers will want to promote competition in supplemental markets that is fair and meets beneficiaries' needs. Five priority areas for future evaluations of supplemental coverage in a changing Medicare environment are drawn from our work.

- *Monitoring how employers react to the MMA*: The decline in employer-sponsored coverage was of concern in every market we visited**.**

Most small- and mid-sized and many large employers do not offer coverage, and some large employers that still offer plans require retirees to pay the full premium (i.e., employers arrange group coverage, but do not contribute to the premium). However, a few significant exceptions remain in some sectors of private industry (such as telecommunications, financial services, and some large manufacturing industries), and in the public sector in some states (notably New York and California). The employers we interviewed were not yet able to predict how a new Medicare drug benefit would affect their retiree benefits, but some expressed a clear preference for retaining benefits if they can afford to do so.

- *Identifying local barriers to accessing affordable Medicare private plan and supplemental coverage*: Local demographic and economic factors, the organization of providers and

health care delivery systems, and state regulatory environments all affect how markets deliver supplemental coverage; local markets will react differently as the the MMA is implemented. Lower-income beneficiaries who do not qualify for state Medicaid benefits could be at particular risk.

In some markets (including San Diego and Minneapolis), lower-income Medicare enrollees have access to affordable supplemental options, either through M+C plans that offer supplemental benefits, or (in California) high-deductible policies (although the value of newer Medigap options to low-income beneficiaries is not yet known). In other sites, low-income beneficiaries did not have access to affordable supplemental coverage. Public programs that supplement Medicare vary, with some localities having devoted additional state or local resources to supplementing Medicare beyond the basic federal programs (including Medicaid). New York and Minnesota respondents had special concerns about the potential effect of a Medicare pharmacy benefit on state pharmacy programs and state programs serving beneficiaries dually eligible for Medicaid and Medicare.

In areas with generous employee benefits, employer-sponsored retiree coverage may remain an important source of supplemental benefits, despite the downward trends in other areas of the country. Some Medicare enrollees—such as retirees from highly unionized industries, government, and the military—will continue to have good benefits. However, beneficiaries who lose retiree benefits will have to sort through a growing number of nonstandard options with differences in exposure to health care costs.

Supplemental markets reflect differences in the organization and history of the health delivery systems, which also will affect their development over time. Although some respondents told us that establishing networks is more difficult in rural areas, local circumstances can contradict general assumptions about Medicare insurance products. In areas with mature managed care markets or well-integrated health care systems (such as Minneapolis and San Diego), providers and beneficiaries alike had generally positive views of Medicare managed care and may be more likely to participate in non-traditional Medicare options. These views do not prevail in markets where the delivery system is more fragmented (including some urban areas with large numbers of providers, such as Atlanta).

Some large insurers in Minneapolis told us that they believe they could put together statewide or regional provider networks. Crossing state borders raises important regulatory issues (including New York's prohibitions on insurers engaging in out-of-state business, or Minnesota's prohibitions of for-profit health plans).

- *Educating and protecting consumers*: Beneficiaries will need help navigating the expanding array of supplemental product options, otherwise consumer backlash could undermine market competition.

Even before the passage of the MMA, we found that competition among alternatives for supplementing Medicare was changing, and in some sites, changing rapidly. In most markets, comprehensive M+C benefit packages with zero or minimal premiums were no longer available. Some M+C plans had developed benefit designs including high deductibles for some services,

similar to high-deductible Medigap options. Medigap insurers provided some level of prescription drug coverage, mimicking available M+C plan benefits. New insurance products could undermine Medigap standardization set out in federal and state law, which still appeared to have broad support among the beneficiaries, insurers, and regulators we interviewed. For beneficiaries, sorting though complicated plan offerings can be very difficult, and frustration and lack of information can discourage good choices.

- *Reducing barriers to effective competition among health plans*: Medicare policy needs to address how the existing structure of insurance markets will factor into the process for establishing payment areas for Medicare Advantage plans. Medicare payment areas and the market areas that have evolved for private supplemental products do not generally coincide; disparities in payments within and across market areas can create obstacles to effective competition among health plans.

Insurers in all the sites generally believe that to set prices, they need to adjust for local differences in the cost and supply of providers. Medigap markets are generally large (often MSA and non-MSA areas of states). The county-based payment areas for local M+C plans drive significant payment differences within a commercial market area. Some of these payment differences will narrow under the MMA, but some differences may continue. Payments for the new regional plans established under the MMA could also differ from payments to local plans.

- *Monitoring access to supplemental coverage among disabled beneficiaries, and identifying possible effects of Medigap underwriting on risk selection in Medicare Advantage plans*: This will be important, particularly in states that conform to the basic Medigap model regulations.

State regulation affects Medigap competition. Community rating spreads the costs across populations, which can raise premiums for younger or healthier beneficiaries over those for other products, such as PFFS plans. The state's role in providing access to Medigap for disabled beneficiaries is particularly important. In the states we visited without laws to expand access to disabled beneficiaries, few, if any affordable Medigap options exist. Provisions that subsidize the costs of the new drug benefit (premiums and cost sharing) for low-income beneficiaries will be of great value to some disabled beneficiaries who are now unable to purchase Medigap. But those who are not eligible for Medicaid will continue to face problems of access to supplemental coverage. Lack of access to Medigap may create greater demand for private plan products among the disabled population. Even if the risk adjustment system used to pay the MA plans beginning in 2006 results in adequate payment for covered services for disabled beneficiaries, unmeasured costs might remain, such as the costs associated with the treatment of chronic mental illness that are largely uncovered by Medicare.

Endnotes

1. The Congressional Budget Office (CBO) has estimated that the cost of the new Medicare drug benefit enacted in the MMA would total about $1.6 trillion from 2004 to 2013 (CBO 2003); federal spending for the drug benefit would account for about $400 billion or a quarter of that cost; beneficiaries or private payers would pay for the rest through premiums and coinsurance.

2. A 2003 survey of private sector firms with 1,000 or more employees that offer retiree health benefits found that 45 percent offered only one plan, 23 percent offered two plans, and 32 percent offered three or more plans (McArdle et al. 2004).

3. Our analysis of NAIC data suggests the number of Medigap policies decreased from 2000 to 2002. The number of policyholders counted in NAIC data declined, and the number of beneficiaries has increased, so the percentage of beneficiaries with Medigap appears to have declined even more in real terms.

4. Cost HMOs have been authorized to participate in the Medicare program since 1972. They were designed to allow Medicare beneficiaries who had been in HMOs before they became eligible for Medicare to stay in those HMOs. Medicare pays the HMOs their cost, as determined by a cost report, for providing Medicare benefits for their members, less the actuarial value of traditional Medicare cost sharing. The beneficiaries in cost HMOs generally cover this cost sharing through monthly premiums rather than payments as services are delivered ("prepaid healthcare"). In addition, members are free to seek Medicare-covered services outside the HMO's network. If a beneficiary goes to a non-network provider, Medicare pays the provider the same as if the beneficiary were in the traditional FFS program, and the beneficiary is responsible for the usual Medicare FFS cost sharing. To the beneficiary, this structure is similar to being in a point-of-service HMO (MedPAC 2003).

5. Neither the CMS Medicare website nor the states' department of insurance websites show that policies are actually being marketed by a particular insurer, or what the premiums might be under a range of special circumstances that could apply. For example, some policies are "closed" to new sales, and some insurers offer discounts under special circumstances.

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APPENDIX

Variation in Medicare supplemental markets: Views from the field

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Policy Research, Inc.

Variation in Medicare Supplemental Markets: Views from the Field

Final Report

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REPORT OVERVIEW

This project was commissioned by the Medicare Payment Advisory Commission to provide further understanding of the Medicare supplemental market and the reasons why coverage varies across markets. The project involves analysis of findings across case studies developed in July and August 2003 of five diverse markets.

The five markets are Atlanta, Long Island (NY), Minneapolis/St. Paul, Nebraska (entire state), and San Diego. Given existing information on markets, Atlanta appears to have one of the lowest rates of supplementation in the nation, whereas San Diego has among the highest, including a very high rate of penetration of Medicare+Choice (M+C) plans and an extensive military presence that affects supplemental choices. Long Island has a high level of employer-sponsored group retiree supplements and an M+C history of withdrawals that contrasts dramatically with neighboring New York City. Nebraska has among the highest rates of Medigap coverage in the nation and includes extensive rural areas. Minneapolis/St. Paul has a mature managed care market characterized by highly integrated delivery systems. The states in which these markets are located also have unique features: Minnesota is one of three states with a waiver from the OBRA-90 Medigap standardization requirements, and New York has a heavily regulated Medigap market.

In each market, we focused on the structure of available Medicare supplemental options, including their history and any unique factors that contributed to market design. The major focus of the study was on Medigap, Medicare+Choice, employer group, and Medicaid supplements; however, we also examined state-subsidized drug coverage and any role played by other purchasers, such as the military or the Veterans Administration, in the market. We conducted at least 12 interviews with diverse respondents in each market, with the interviews including around 155 people in total (some interviews included multiple participants). Staff from the Medicare Payment Advisory Commission collaborated in the study, and they had exclusive responsibility for the Minnesota and San Diego case studies.

This report summarizes what we learned across all five sites about each of the supplemental options, about the interplay among them, and about the factors that contribute to market variation. (Brief summaries of each market are in the Appendix.)

CHAPTER I

PROJECT OBJECTIVES AND STUDY DESIGN

A. PROJECT OBJECTIVES

This project was initiated to provide further understanding of the Medicare supplemental market's dynamics and to learn more about why supplemental coverage patterns vary across markets. The Medicare Payment Advisory Commission (MedPAC) commissioned the study to complement its ongoing work on related topics.

MedPAC's June 2002 *Report to Congress on Assessing Medicare Benefits* highlighted the interplay between Medicare benefits and supplemental coverage. Over 90 percent of Medicare beneficiaries have additional coverage through supplemental fee-for-service benefits (including Medicaid) or integrated options under the Medicare+Choice program (MedPAC 2002). However, supplemental coverage is offered to beneficiaries through a diverse set of products that are differentially available to beneficiaries based on their geographic location, employment history, income, and other characteristics that determine eligibility for subsidized retiree group or public coverage as well as on the availability of Medigap and Medicare+Choice alternatives.

In its March 2003 report to Congress, MedPAC presented additional analysis on the structure of the Medicare supplement market, including the market for various types of supplementation. The analysis revealed that the sources of coverage differ substantially across the country. This study results directly from that analysis, aiming to provide more detail on particular markets that appear to differ widely in their coverage patterns and to learn more about how supplemental coverage patterns work and why they differ from market to market.

After briefly reviewing the study design, this report summarizes key findings across the five sites on the nature of the market for various supplemental products, interactions among product types, and the factors that influence the patterns of supplementation. The report concludes with a summary of key findings.

B. STUDY DESIGN

This project involves a cross-cutting analysis of case studies from five diverse markets undertaken in July and August 2003: Atlanta, Long Island (that is, Nassau and Suffolk counties, NY), Minneapolis/St. Paul, Nebraska (entire state), and San Diego (see Table 1).

The five markets were chosen to provide insight into markets with diverse configurations of Medicare supplementation. Atlanta has one of the lowest rates of supplementation found in the country. In contrast, San Diego has among the highest, including a high rate of M+C plans and an extensive military presence that adds further Medicare supplements in the market. Long Island has a high level of employer-sponsored group retiree supplements and an M+C history of withdrawals that strongly contrasts with the neighboring New York City boroughs. Nebraska has among the highest rates of individual Medigap policyholders in the nation and extensive rural areas. Minneapolis/St. Paul has a managed care market characterized by highly integrated delivery systems. In addition, Minnesota, which is one of three states with a waiver from the OBRA-90 standardization requirements for Medigap, has unique Medigap insurance products that account for a large proportion of supplementation in the state. New York heavily regulates Medigap coverage as well as other aspects of the health care system.

In each market, we sought to learn about the structure of available Medicare supplemental options, including their history and any unique factors that contributed to market design. We included Medigap, Medicare+Choice, employer group plans, and Medicaid among the four major supplements we considered. While all are present in each market, the mix of supplements relative to one another differs substantially. We also identified available state-subsidized drug coverage and any role played by other retiree plans or health systems (e.g., military or Veterans Administration) in the market. We asked about the role played by state regulation, provider infrastructure, population and labor market characteristics, decision support systems, and other factors that could be relevant to the market. We also asked about how supplemental coverage patterns affected access to care and about any unique characteristics of the market and whether they had particular implications for Medicare.

We conducted at least 12 interviews in each market with a diversity of stakeholders. Our targets, which were applied with some flexibility across markets to deal with their diversity, were:

- **State policy environment**. Interview the insurance commissioner's staff person who regulates the Medigap market as well as the Medicaid staff knowledgeable of dual-eligible coverage options and any pharmacy assistance programs in the state.

- **Medicare+Choice options**. Interview the person responsible for Medicare products in up to four plans per market (depending on prevalence).

Table 1. MedPAC Site Visits: Basic Statistics for Markets Studied

	Atlanta (MSA)	Nassau/ Suffolk Counties (MSA)	San Diego (MSA)	Minneapolis/ St. Paul (MSA)[1]	Nebraska (entire state)
Total population, 2000	4.1 million	2.8 million	2.8 million	2.9 million	1.7 million
Medicare beneficiaries, 2003	334,000	439,000	362,000	330,000	264,000
Percent over 65 with incomes < 100% FPL, 2000	9.7%	5.6%	6.6%	5.7%	7.5%
Percent of population covered by collective bargaining agreements (total), 2002	5.5%	26.7%	18.4%	18.1%	11.1%
M+C payment rate, 2003 (weighted area average)	$605.92	$651.37	$604.13	$564.10	$529.56
Medicare managed care penetration, 2003	8.6%	11.7%	40.2%	24.5%	3.6%

SOURCE: Population data from Bureau of the Census, Medicare data from CMS. Union penetration data from Hirsch, Barry T., and David A. Macpherson, "Union Membership and Coverage Database from the Current Population Survey: Note," *Industrial and Labor Relations Review,* Vol. 35, No. 2, January 2003, pp. 349-354.

[1]The Minneapolis/St. Paul MSA contains two counties in Wisconsin that are excluded from the statistics in this table.

- **Medigap options.** Interview the person responsible for Medigap at one or more major Medigap insurers in the market and an independent insurance agent. (Because AARP products are administered centrally across the county by United HealthCare, MedPAC also convened a meeting with United HealthCare staff administering the AARP product to review their experience across all the markets.)

- **Provider environment and perspective.** Interview representatives from two to three major health systems and providers to get physician and hospital perspectives.

- **Employer options.** Interview at least one large public and one large private employer that offer retiree benefits in each market.

- **Beneficiary perspective.** Interview staff from both the State Health Insurance Assistance Program (SHIP) and the major local information sources for Medicare beneficiaries.

In total, 12 to 16 interviews were conducted in each of the five markets, some involving multiple participants generally from the same organization or related organizations. In total, around 155 individuals were involved in the interviews across the sites.

In each market, the project team reviewed background materials, spoke to selected contacts to identify interviewees particularly relevant to each respondent category in that market, conducted three days of on-site interviews, and interviewed by telephone individuals we could not reach when on site. The team from Mathematica Policy Research (MPR) was responsible for three of these markets; each visit involved a senior staff member (either Dr. Hurley or Dr. Gold), an analyst, and a member of the MedPAC senior staff who joined in the visit. MedPAC staff were responsible for visits to Minneapolis and San Diego.

Each interview was guided by a semistructured protocol that indicated the questions to be covered with each type of respondent. After the visit, a staff member from the site visit team summarized the notes, and the summaries were then reviewed by other members of the team. A two-page summary of each site visit was also developed using a common format to support analysis (see Appendix). Though responsibilities for visits were split between MPR and MedPAC, similar methods were used in all five markets, and this report provides a consolidated profile across all five markets.

CHAPTER II

CROSS-CUTTING FINDINGS

This chapter first reviews the key features of the four major supplemental choices that are available across the diverse markets: Medigap, Medicare+Choice, employer group coverage, and Medicaid. Second, it describes the extent of interaction across these choices and how they relate to other, more specialized choices that beneficiaries may have (state drug assistance programs, military retiree benefits, and Veterans Administration services). Third, it identifies what we have learned about the way in which various local circumstances—state regulation, provider infrastructure, and population and economic context—explain the variation that exists across the five studied markets. Finally, it identifies the principal conclusions.

A. STRUCTURE OF SUPPLEMENTAL SUBMARKETS

1. Medigap

Medigap coverage varies substantially among the five states, ranging from a low of 17 percent in Georgia and New York to a high of 54 percent in Nebraska (based on MedPAC's analysis of the 2001 Current Population Survey). There are sizable numbers of insurers offering Medigap products in all of the markets, ranging from approximately 9 to over 35, though many insurers have very small enrollments and do little or no active marketing. A number of firms appear to participate primarily to fill out a product portfolio for their own or independent agents. Most of these insurers have too few clients in a single state to develop actuarial estimates and use aggregated counts of policyholders across states when developing new rate requests. Typically, in these markets, a handful of substantial players have the bulk of beneficiaries, with the AARP/United HealthCare product and the local Blue Cross-Blue Shield (BC-BS) plan vying for market leadership.[1]

[1] We use the terms " Blue Cross-Blue Shield," "Blue Cross," and "Blues" interchangeably in this report. In some states (e.g., California), separate Blue Cross and Blue Shield plans operate. In others (e.g., New York), a consolidated Blue Cross-Blue Shield firm offers products, but the state is served by three different consolidated Blues organizations. Further, for historical reasons, some purchasers in New York use different organizations for hospital and physician coverage so that, for example, the BC-BS organization might be under

Marketing and distribution of products vary by carriers, with only AARP's product (administered by United HealthCare and a few other insurers in specific states) portrayed as being aggressively marketed. Although AARP/United HealthCare markets its products centrally across the country with mass media and direct-to-consumer mailing programs, they do not rely on agents and brokers or have local offices (they have no direct relationship with local United HealthCare offices); therefore, their competitors cannot precisely gauge their presence and influence in local markets. The AARP set of products were viewed as a strong competitor in all markets except Minnesota, where their presence was more limited because of Minnesota's unique Medigap structure.[2] The AARP product—available to all members who are 65 and older (and to younger beneficiaries in selected states)—is, in most markets, community-rated and includes all 10 of the standardized Medigap plans (see Figure 1 for description of basic options). These features, as well as the AARP affiliation of the product, are seen as having broad appeal, especially when many other insurers underwrite products and vary premiums by age.

Figure 1: Benefits Covered in Standard Medigap Plan Options

Benefits	A	B	C	D	E	F[a]	G	H	I	J[a]
Part A coinsurance and lifetime days										
Part B coinsurance										
Blood (first 3 pints a year)										
Part A deductible										
Skilled nursing coinsurance										
Foreign travel emergency										
At-home recovery										
Part B excess charges						100%	80%		100%	100%
Part B deductible										
Basic drug benefit[b]								$1,250 limit	$1,250 limit	$3,000 limit
Preventive care										

Source: Adapted from www.cms.hhs.gov/professionals/partners/nmep/pdfs/materials/nonrenewals/05policy.pdf. Accessed August 5, 2003.

[a] May be sold with no deductible or with a high deductible (for Plan F, $1,530 per year).

[b] Each plan design requires a separate deductible and 50 percent coinsurance on the drug benefit.

Offerings vary among the Blue Cross-Blue Shield firms serving our five markets, though all BC-BS firms participate. Such firms typically have their own sales force, although some also work with independent agents and brokers. In Nebraska, the Blue Cross-Blue Shield plans have had a longstanding relationship with local banks in rural communities as a

(*continued*)
contract only for the professional services component of the package with another firm handling payments for institutional services.

[2] Minnesota is one of three states that is exempted from the federal Medigap standardization requirements because the state had its own program that predated the federal requirements. (The structure of Minnesota's program is discussed later in the context of regulatory influences.) AARP/United HealthCare has been discussing with the state ways of participating more extensively in the Minnesota market.

distribution base for individual coverage for those under and over 65 years old (see box below). Across the markets, the Blues have the advantage of strong brand-name recognition and a large presence in the private individual market, which is a natural feeder into the Medigap market.

Blue Cross and Blue Shield (BC-BS) of Nebraska's Bank Depositor Program

BC-BS of Nebraska markets both under-65 individual policies and Medigap policies in rural areas primarily through its bank depositor program. The relationship with community-based banks started about 40 years ago, and BC-BS now has 16 representatives who write policies for individual depositors through banks. The policies are grouped, but individuals are underwritten separately. BC-BS pays banks a fee to set up kiosks that BC-BS staffs on a regularly scheduled basis; 95 percent of the banks in the state participate. The program is more successful in rural communities, where the banks remain the commercial center of the area and continue to encourage foot traffic. The program has enabled BC-BS to have much lower marketing costs for its individual and Medigap products, which, it reports, enables it to enjoy pricing advantages that can be extended to policyholders.

Other insurers rely on their own or independent agents or some combination of the two to sell their products. Agents commonly assist seniors in selecting a Medigap policy as they reach Medicare eligibility and do not have access to employer-sponsored retiree coverage or age out of an individual under-65 policy. In many cases, the customers know the agents because they sell them other lines of insurance. Personal service and explanation are other selling points for agents who receive commissions structured in various ways to support their efforts.

Except in Minnesota, which has its own set standard plans, and in New York, where the only Plan J available is a limited group offering, each one of the 10 standardized plans is available in each state from at least one insurer. However, the actual distribution of enrollment is skewed toward a small number of standardized plan options. Even some insurers with large membership offer a relatively limited number of plans. For example, we were told that there was limited demand for high-deductible products and that the cost of some plans (i.e., those with drug coverage) sometimes exceeded the likely payout to beneficiaries because of adverse selection and other factors. Typically, the largest enrollment is in Plan F, which offers protection against balance billing. In states such as New York that have a ceiling on balance billing that effectively prohibits it, Plan C, which is similar to Plan F except for the balance billing coverage, is the most popular product for the large carriers.[3]

Participation in plan options H, I, and J with drug benefits is very low in nearly all states (except for Minnesota, which uses its own plan design). Despite the widespread concern about the need for drug coverage among beneficiaries, fewer than five firms offer such

[3] Minnesota also has such a ceiling, though it is not structured identically to that in New York.

coverage in New York, Georgia, and Nebraska. Insurers report that the value of the protection in these products is less than the cost of the products to beneficiaries, and many do not offer them at all. For example, since 1997, Mutual of Omaha, with 350,000 policyholders across the country, has had no open H, I, and J policies in any state. They, like many insurers, do make drug card programs available to policyholders. (These cards offer discounts off the purchase price of selected drugs.) Minnesota's higher level of coverage through Medigap is associated with the particular structure of the products available under the state's standardized options, which were in place before OBRA-90 and exempted from its requirements. In Minnesota, those with drug coverage through Medigap purchase it through an *Extended Basic Supplement* that is, in effect, a high-option plan that includes additional benefits besides prescription drugs.[4]

In addition to the lack of affordable drug coverage in current Medigap products, the other major limitation noted in the Medigap market was the absence of products available for the under-65 beneficiary population, especially in states where required offerings for beneficiaries under 65 do not go beyond federal requirements (see box next page). Although Medigap plan prices for beneficiaries under 65 vary across states, they tend to be high.[5] In addition, except where states explicitly prohibit it, Medigap insurers may reject even newly entitled beneficiaries under 65 due to medical underwriting. When participation in M+C was expanding in Atlanta, there seemed to be new opportunities for coverage for under-65 disabled beneficiaries, but that has contracted sharply with the M+C decline in the market, leaving disabled beneficiaries who are not eligible for Medicaid to face a very difficult environment in which to seek supplements to Medicare.

Most of the observers interviewed believe that the federal government's standardization of Medigap's benefits achieved its goal of reducing beneficiary exploitation and providing a reasonably stable and decipherable set of options. Insurers, agents, and, to a lesser extent, SHIP and insurance department personnel felt that beneficiaries have become more knowledgeable about coverage and gaps related to the standardized plans (though unique variants on these standard plans were still confusing). In general, they view beneficiaries as making trade-offs to get coverage suited to their needs and their ability to pay.

The absence of affordable drug coverage was the major point of concern among those interviewed. Cost trends in the standardized products are said to have been generally in single digits, increasing less than commercial premiums but more than Medicare Part B, typically ranging, we were told, from 5 to 10 percent in plans without a prescription drug benefit. Very few concerns were voiced about consumer protection issues in terms of either marketing abuses or other difficulties between policyholders and carriers.

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[4] See box on page 20 for additional detail about the structure of Minnesota's Medicare supplements. While a more limited drug benefit is authorized as an option under Minnesota's *Basic Medicare Supplement*, no carrier offers it.

[5] In Nebraska, for example, only Plans A and B are available to the under-65 disabled population, and they cost at least $1,677 (Plan A) and $2,697 (Plan B) compared to a minimum of $574 (Plan A) and $888 (Plan B) for a beneficiary age 65, according to the Nebraska Department of Insurance Web site.

State Rules on Medigap Access for the Under-65 Disabled

- **California.** New regulations effective January 1, 2004, require firms to offer those under 65 the same plans as they offer the elderly (only one drug plan must be offered if any is offered), with a six-month guaranteed issue at initial eligibility. Separate rates may be established for those under 65, and MedPAC staff were told that these rates are generally high (e.g., comparable to those for 80-year-olds). Most firms provide open enrollment annually at the beneficiary's birthday for plans of equal or lesser value. (California also allows those over 60 who have worked for five years to use COBRA until they are Medicare-eligible.)

- **Georgia.** For those under 65, Georgia follows National Association of Insurance Commissioners (NAIC) guidelines and has no special provisions on access to Medigap. We heard that at most only three of the many firms in Georgia's Medigap market write coverage for Medicare beneficiaries under 65; the Centers for Medicare and Medicaid Services (CMS) Web site shows only two firms, and they offer only Plan B.

- **Minnesota.** Minnesota is one of three "waiver" states for Medigap. Under Minnesota's program, those under 65 have the same access to Medigap as do the elderly, including guaranteed issue for six months at initial eligibility. In addition, the state-run high-risk pool offers a Medigap policy open to those who lose Medicare supplemental coverage (except for nonpayment) and cannot find coverage elsewhere at a reasonable price.

- **Nebraska.** For those under 65, Nebraska follows NAIC guidelines and has no special provisions on access to Medigap. We were told that at most only 2 of the state's 35 Medigap insurers have products for the under-65 population. The CMS Web site shows only one firm, which offers only Plans A and B.

- **New York.** All Medigap plans are community-rated with guaranteed issue and continuous open enrollment. Those under 65 have access to the same plans as the elderly, and a single pooled rate applies for all. No health screening is allowed. Coverage for pre-existing conditions is excluded for six months, but this waiting period may be reduced by the number of days with "creditable" coverage without extensive (over 63 days) breaks.

In general, the view of respondents was that standardization had been offered a reasonable accommodation with the desire for maximizing choice opportunities for beneficiaries. Outside of California, where insurers offer a number of products that depart from the regular standardized Medigap and M+C options (see box next page), there have been few instances of innovative benefits being introduced in the existing array of Medigap products in the other four states. Some insurers, we were told, have avoided them because they would only add to product costs, and they perceive that there is little demand for them. The same has been true in many states for policies with high deductibles, which are not seen as providing the kind of protections beneficiaries are looking for. Lack of interest may also explain limited offering of enhancements to Medigap policies such as Select designs, where beneficiaries could gain cost advantages by going to a restricted provider network. Few plans have successfully launched and sustained these models, though this may be more due to provider contracting issues, as discussed later, than to perceived beneficiary interest. Some observers worry that new options being rolled out in M+C (Private Fee-for-Service [PFFS] and Preferred Provider Organizations [PPO]) and the Medigap market (Select

products and innovative benefits) have the potential to confuse beneficiaries. We heard concerns about policy options that might disrupt the ability of many seniors to retain the kind of supplement with which they are familiar.

Innovative Benefits Available in California: Selected Examples

Blue Cross's Medicare supplements (statewide). The Office of Managed Healthcare in California regulates Blue Cross; other insurers are regulated by the Department of Insurance. Blue Cross's Medigap and Select offerings in the state are extensive and depart at times from standardized models. For example, Plan C requires a $5 copayment per physician visit up to $100, with a $100 deductible for nonparticipating providers. The Blue Cross plans generally offer premiums among the lowest in the state at age 65 but are also more likely than other plans to use attained age rating and to include waiting periods for pre-existing conditions. Some of the plans carry a high deductible and offer generic drug benefits.

Blue Cross's SeniorSecure. In San Diego County, this is a high-deductible network-based M+C plan. For a $30 per month premium (in addition to the Medicare Part B premium), beneficiaries are covered for all Medicare's cost sharing after a $2,200 deductible that applies only to out-of-pocket costs for in-network providers based on the Blue Cross–allowed fee levels. With some caveats, this appears to be equivalent to an out-of-pocket limit applied to the basic Medicare benefits when care is sought through the network; however, physician visits are not subject to either the deductible or the out-of-pocket limit. Also, generic drugs are covered up to $2,000 annually if they are on the formulary at a copayment of $8 per 30-day supply or $20 per 90-day mail-order supply.

Pacificare's drug-only plan. This new plan is available in California and six other states. and offers unlimited prescriptions from the plan's list of nearly 400 covered prescription drugs. The monthly premiums range from $35 to $54, depending on age. The mail-order copayment structure is as follows: $30 copayment for medications costing $45 or less for a 30-day supply; $60 copayment for medications costing more than $45 for a 30-day supply. The Secure Horizons Prescription Advantages Plan also provides a discount of up to 15 percent retail and up to 30 percent mail order. On non-network pharmacy orders, the copayment structure is a $15 copayment for medications costing $45 or less; a $30 copayment for prescription drugs costing more than $45.

While the state regulatory environment probably influenced the way in which Medigap markets developed in different states, most Medigap insurers and others now participating in those markets seem to have accommodated to the requirements. Respondents did not see the state regulatory environment as substantially influencing either the current Medigap market or participating insurers in terms of impeding beneficiary access to Medigap.

State Medigap policies appear to have positively affected access for disabled beneficiaries under age 65 in states such as Minnesota and New York, where guaranteed issue, open enrollment, and community rating make it easier for the under-65 population to qualify for coverage that keeps prices down by expanding the risk pool. Regulation was seen as "heavy" in New York or "firm" in Minnesota, but carriers were able to adapt to what they see as stable environments. Probably in response to these requirements, New York State has a lower number of insurers offering Medigap products (9 on Long Island and 12 statewide),

but none of those interviewed complained about the number of options available on Long Island. Review of rate filings involving Medigap premium increases is largely perfunctory in some states while more rigorous in others, but insurers reported few instances where suitable resolution was not promptly reached. The insurance departments make available price lists for the full array of Medigap products that are easily accessible to beneficiaries and the organizations that provide information and assistance to them. In California, the complexity of Medigap pricing has led the SHIP to institute a policy of not providing information on Medigap premiums. The California Department of Insurance also followed this policy but has recently begun providing sample rates for Medigap policies on its Web site.

Interviewed hospitals and physicians were not aware of the specific Medigap products or insurers, since these products are paying only deductibles and coinsurance in most instances. However, physicians expressed concern about their patients who have little or no drug coverage because it can interfere with necessary treatment. A number of physicians noted that if there is no publicly subsidized prescription drug program for their patients, they will work with them to find access to necessary drugs through a variety of community-based or pharmaceutical company programs. But this practice is not universal among all those interviewed.

2. Medicare+Choice (M+C)

The five markets varied markedly in Medicare+Choice coordinated care plan (CCP) and cost plan enrollment, ranging from a high of 40 percent in California and 24 percent in Minneapolis to 12 percent on Long Island and Omaha to a low of 9 percent in Atlanta. Statewide penetration rates are much lower, and, in fact, CCP enrollment in Nebraska and Georgia is limited to the immediate Omaha and Atlanta metropolitan areas. Every market was faced with some degree of declining participation, deteriorating benefits, and rising premiums. Plan participation has fallen most sharply, from eight to two plans, on Long Island and from seven participants to two in Atlanta, with another withdrawal announced in September for 2004. In Minnesota, HMO membership has been sustained but seems to result from the continued availability of cost plans, which retain an important role in the market. Only in San Diego has M+C enrollment remained very high, but since 1998 penetration has fallen from 49 to 40 percent, and plans have added and increased premiums and reduced benefits.

In each market, the most notable benefit changes have been substantial shrinkage in pharmaceutical coverage. Those we interviewed in these markets almost universally agree that the program changes have left the CCP program scarred and discredited in the eyes of many beneficiaries, employers, and providers. Even in Minneapolis and San Diego, where M+C continues to have a strong presence, many participants view the continued availability of the product as due to the favorable environment locally rather than to Medicare policy per se. Respondents were particularly concerned about what they view as payment rates that are inequitably low in most of the markets we visited.

While M+C has historically been concentrated in urban areas, it has become more so in the five study markets in recent years as plans withdraw to a smaller subset of metropolitan

counties where rates and delivery systems enable the plans to remain successful. Even when plans have remained active, they have differentially increased premiums and altered benefits in adjacent markets, as noted on Long Island where beneficiaries see advertisements for plans for New York City beneficiaries that are much more favorably designed and priced (see box below).

The "Human Face" of Choice: One Real-World Example

- **Grandma moves 10 miles from Queens to Nassau County to be with her children.** Grandma's children moved from Queens to Long Island to buy a house. In time as Grandma aged, she became more frail, and her worried children decided to have her live with them. They did not realize that Grandma was in an M+C plan in Queens where she paid no premium. In Nassau County, there are only two M+C plans, with premiums of at least $100 per month and limited drug coverage at best. Only one of the plans included the hospital system that dominates the north side of the county where the children live. The children were taken by surprise—all the television advertisements they heard in Nassau County (for New York City–offered plans) stressed the availability of zero-premium plans with extensive benefits.

The current picture is far removed from the period of 1998 and 1999 when plans were still entering markets and zero-premium products with relatively comprehensive benefits, including rich drug benefits, were in vogue. Every market saw growth in M+C penetration at that time given the appeal of these options. Blue Cross in Georgia, for example, reported that it virtually ceased to market its Medigap products (a sector in which it is the market leader) because it put its full effort in senior-related programs into expanding its M+C plan. For the first time during this period, Mutual of Omaha, a long-time mainstay in the Medigap market, launched two HMOs, including one in Omaha. The comparatively lower-priced M+C products at that time provided low- and moderate-income beneficiaries with an attractive alternative to Medigap offerings. In some cases, provider groups counseled their patients to explore the M+C plans because of the richness of the benefit package. For under-65 beneficiaries with few Medigap options, these M+C plans were seen as a "godsend." Some SHIP counselors indicated that they had advised beneficiaries to move into areas served by M+C plans or to avoid moving out of these areas because the plans were required to accept all beneficiaries.

The M+C program has largely collapsed in two (Atlanta and Long Island) of the five markets, and growth has stalled out in two others (Minneapolis and San Diego.) In the fifth market—Nebraska—M+C never really developed, though there was some activity around Omaha. Plans attribute this situation to payment rate problems, including both the small rates of increase relative to medical cost trends, including drug expenses (San Diego), as well as to flaws in the underlying payment methodology that penalize markets such as Minnesota and Nebraska where historical Medicare costs have been low and markets such as Long Island where suburban payment rates vary markedly. (Plans in San Diego also complained about payment rates that are much lower, for a variety of reasons, than in nearby Los Angeles.)

In nearly all of the markets, respondents portrayed difficulty in sustaining provider networks for M+C plans as a major contributor to strategic retrenchment. In the three markets with the most severe problems, they cited negative experience with providers bearing risk as a problem, and these were also markets where consumer acceptance of HMO products had been low from the start.

Conversely, provider integration and preferences for risk bearing have contributed to sustaining the San Diego penetration rate. The picture in the Twin Cities is more complicated because of the respective roles of risk and cost plans that were originally slated to be eliminated but have continued to exist (to the chagrin of some plans that phased them out in anticipation). Notably, both of these markets have remained managed care hotbeds in the commercial sector.

The adverse consequences associated with this rapid rise and decline of M+C is evident among nearly all observers of the Medicare supplement market at the local level. Plans, although initially enthusiastic about M+C, seem discouraged by the retreats and associated criticisms they have had to undergo. Employers reported frustration over products that plans promised to retirees but simply could not deliver on a sustainable basis. Regulatory and community information agencies remain acutely aware of the confusion, disruption, and dislocation that beneficiaries experienced in the wake of the withdrawals as they scrambled to find alternative coverage (see box below).

Provider Disenchantment with M+C Plans: An Illustration

The medical director of a large multispecialty group detailed how his group was a strong early supporter of Medicare risk plans. The physicians encouraged their patients to consider enrollment in one plan because of zero premiums, a rich drug benefit, and support for care coordination. Many patients followed this advice, and the group's patients became a mainstay of the plan's membership. But changes made by the plan to premiums and benefits in the wake of the Balanced Budget Act of 1997 resulted in reduced provider payments and dramatic reductions in drug coverage for beneficiaries. The medical director characterized the group as now feeling very guilty for having encouraged patients to join the plan and in effect trapping them in what they say has become a very unattractive product. The group has discussed terminating its contract with the plan, but to do so would mean abandoning patients who cannot easily escape the plan while it remains active without facing underwriting or pricing barriers in seeking Medigap coverage. The group would prefer to see the plan withdraw and has refused to participate in any new product offerings the plan proposes.

Several of the surviving plans in M+C are trying to expand their product portfolios by adding new M+C options or Medigap products as they position themselves to offer a fuller array of "senior solutions." These include PPO options (nondemonstration PPO in Nebraska) and PFFS options in Nebraska and Minnesota. Several plans have also launched Medigap products. Other plans have similar products on the drawing board. These options all have very small memberships at this time so it is difficult to assess if they will achieve their goals of (1) attracting membership in markets where CCP networks are not possible, (2)

pursuing potential profits in floor markets, or (3) providing their CCP network members with alternative options if that product continues to witness declining enrollment.

3. Employer-Sponsored Retiree Health Benefits

Employer-sponsored or subsidized retiree health benefits displayed somewhat less variation across the five markets than did Medigap and M+C participation. State data from the Current Population Survey in 2001 show that the states ranged from a high of 38 percent in New York to a low of 24 percent in Georgia and 23 percent in Nebraska. The other two states were at the 30 percent level. This pattern reflects a correlation between large and unionized employers (especially public employers in New York) and higher levels of employer-sponsored benefits. Conversely, the lower level of coverage was attributed to both the occupational mix, smaller-scale employer bases, and, in the case of Nebraska, a high percent of farm-based workers.

While employers seem to have little difficulty determining health benefits offered by their competitors, we found few precise and reliable data on employer-sponsored coverage on a market or statewide basis. In the markets we visited, the state departments of insurance indicated that they had little insight into self-funded employers, particularly private employers, which are the employers that dominate group retiree plans. The dominant firms in a market typically cannot be identified because many large national or regional firms span multiple markets and data may be reported by the headquarters location rather than at the establishment or local level. It is also difficult to disentangle retirees from active workers who may have the same plan and perhaps the same coverage. Likewise, Medicare has limited information on employers that offer group Medigap or M+C options, though data on group M+C enrollment are improving.

Despite these limitations, the interviews suggest that employer-sponsored retiree health benefits may have deteriorated even more severely than is commonly recognized. While few firms have eliminated coverage for current retirees, most of the organizations that have been providing retiree subsidies have made important changes in recent years. Many employers have raised the minimum years of service to qualify for retiree health benefits and now prorate their subsidies based on years of service. Some have recently discontinued coverage for new hires as of a specified date (a large private employer with 8,000 active employees). Others separate retirees out of the active employee pool to slow contribution increases for active workers (a public university system with more than 12,000 covered lives), thereby leading to higher premiums for retirees. Still others have reduced (to zero in some cases) the amount of subsidy provided for spouses and, in some cases, to retirees themselves. One employer, for example, had increased costs for retirees by a total of 300 percent over the past three years by creating a separate pool for them and eliminating its subsidy altogether. In effect, this is the equivalent of dropping coverage, but retirees may still receive a premium break by being part of a risk pool and might still have access to a richer drug benefit. One very large multisite employer with more than 50,000 employees revealed that it would discontinue retiree health benefits to newly hired nonunion employees on January 1, 2004. Virtually all of these changes were for over-65 retirees (Medicare-eligible) because employers

see maintaining under-65 retiree coverage as an important instrument to promote early retirement and achieve workforce reductions.

The gap in access to post-retirement health benefits between unionized and nonunionized employers seems to be growing, though the salience of this issue varies across markets (based on the extent of unionization). The important role that unions play in maintaining high levels of health coverage was most evident on Long Island, the most heavily unionized of the sites visited. On Long Island, many retirees have been members of public employee and private sector unions that in the past have won rich benefits that they have been able to retain thus far. Though employers may have been reconsidering details of their coverage, those we interviewed tended to believe that any changes would be at the margin, with public sector employees in particular retaining quite comprehensive coverage.

The five markets we studied reflected the national data showing more comprehensive retiree benefits for public versus private sector employees, but the markets also highlight diversity. In Georgia and California, public retirees fare better than many private retirees. This also appears to be the case in New York, though benefits offered by some large private employers also seem fairly comprehensive, a situation that appears to reflect both the union presence and the influence of the public sector on the overall market. In Nebraska and Minnesota, however, public employees who work for the state government receive no explicit subsidies to assist in purchasing retiree coverage. Some localities, such as St. Paul, provide such a subsidy and thus its city workers have access to subsidized coverage after retirement while state workers do not. Very large private employers generally continue to offer subsidized benefits, but these appear to be at risk of erosion, as noted above. Few small employers provide any support for retiree benefits, and coverage among medium-sized employers also appears to be limited.

One of the most significant facts about employer-sponsored coverage is that drug benefits in these plans have been among the best available to retirees and a major reason for retirees to pursue coverage under group plans. (Those we interviewed reported very high take-up rates of group retiree coverage, and the availability of drug coverage was an important reason.) But this feature of their coverage also has persuaded a number of employers that such rich coverage is unsustainable, and several noted they are looking to the federal government to provide relief with a Medicare drug benefit. Some employers suggested that if a new drug benefit were added, they could reduce costs to retirees while others looked at the benefit as chance to improve the benefits for retirees since the firm's benefits already are limited. Still others suggested that a drug benefit could make future decisions to drop retiree plans easier because retirees would be getting assistance from another source.

Employer interest in group retiree options with M+C plans has waned markedly with the recent decline of M+C plans and products. Many employers do not see these options as stable or reliable enough to justify making them available. San Diego is a clear exception, not only because there remain a number of viable contracting options but also because the preponderance of the retirees have had long-term relationships with HMOs and wish to continue with them after retirement. For some retirees, such as those enrolled with Kaiser

in San Diego, affiliation has been for a lifetime, and they expect to age naturally into an M+C option. To a lesser extent, this is also true in the Twin Cities where HMO enrollment among active workers has been high for many years. But because payment rates to plans have been problematic in Minnesota for a number of years, the transition to retiree HMO enrollment has been less seamless.

Employers are not impervious to the impact of these changes and acknowledge that retiree take-up rates are declining as the financial burden of maintaining coverage grows. As they look to the future, there are other options under consideration beyond simply dropping coverage. Some employers are, or are considering, offering retirees more access to group-negotiated rates with specific Medigap plans. Two large public employers noted that their current retiree design is an extension of the design they offer active workers and is taken up by retirees despite what would seem like prohibitive rates (over $400 per month in some cases) to retain existing levels of drug coverage or ensure access to current providers. These employers are actively investigating a Medigap policy that would be far less costly, and they are counseling employees, in effect, to self-insure for much of their drug coverage. Other employers are contemplating moving toward a fixed contribution by workers to offset some of the cost of an individually purchased Medigap policy to limit their future exposure to cost growth.

4. Medicaid/Medicare Savings Programs

For very-low-income persons with minimal assets who have Medicare coverage, Medicaid enrollment is available; others with very high medical expenses may also qualify if they are in states with "spend down" programs. By federal law, other Medicare beneficiaries with low incomes may obtain more limited coverage than that in the full Medicaid program by enrolling in the Medicare Savings Program (this includes those covered by the Qualified Medicare Beneficiary [QMB] and Specified Low Income Beneficiary [SLMB] programs, for example). Depending on their incomes, the Medicare Savings Program includes coverage for the Medicare Part B premiums alone or combined with coverage for Medicare cost sharing. Nationally, 15 percent of Medicare beneficiaries in 2000 were full dual eligibles, and 3 percent had more limited coverage under the Medicaid program (Kaiser Commission 2000).

The monthly income levels to qualify for full Medicaid benefits in the states we visited range from $317 in Georgia to $748 in Minnesota, and asset levels are typically between $2,000 and $4,000, except in Minnesota, where they are allowable up to $10,000. Though income tests for Medicare Savings Program options are set nationally, asset tests vary by state. Most observers see the asset tests as very low due both to the original level at which they were set and the limited updates since then. The result is that access is restricted to only the poorest of Medicare beneficiaries.

Among Medicare beneficiaries, the share covered by any form of Medicaid ranged from a low of 7 percent in Minnesota and Nebraska to a high of 21 percent in California, with the other two states in the 15 and 18 percent range (Current Population Survey analysis by MedPAC staff). While states report increases in the percentage of eligible persons who

actually pursue and receive benefits, a sizable portion of the eligible population does not seek out benefits for which it is eligible. A number of initiatives have been undertaken to identify and remove barriers to seeking eligibility, including simplified application and recertification processes and more aggressive mailings and outreach programs. For the most part, these initiatives appear to target Medicare Savings Program eligibility versus those qualifying for full Medicaid benefits who must continue to complete a lengthy application.

However, even when simplified applications and outreach are stressed, interviewees believe that major barriers remain, including beneficiary reluctance to apply for what they perceived to be "welfare benefits" and be stigmatized as being "on welfare." SHIP workers point out that, for beneficiaries, even going to welfare offices can be a daunting prospect because of distance and because offices are often located in undesirable areas. Moreover, the clientele and atmosphere of these offices, some of which are staffed by armed guards, may seem intimidating to seniors. In addition to the asset test, which is particularly problematic in the case of lower-income property owners (such as family farms in Nebraska and Minnesota), some states vigorously enforce estate recovery for persons who received Medicaid benefits through the Medicare Savings Program, giving property owners further reason to hesitate before applying for assistance.

Taking these impediments to participation together, then, Medicaid officials suggest that the program almost certainly attracts those beneficiaries with the highest of costs, including drug costs, for whom the financial burden is sufficient to overcome whatever qualms they might have about participation. States are vividly aware of how much dual eligibles, who represent an important component of Medicare Savings Program beneficiaries, are costing Medicaid programs. For example, Georgia stated that about 35 percent of its total Medicaid budget is spent on drugs and that 50 percent of its entire drug expenses are attributable to the dual-eligible population. These kinds of statements help explain states' interest in having the federal government assume pharmacy costs for the dual-eligible population.

The difficulties states currently have in managing the care of duals are also a source of concern. Medicare is the primary payer for medical care. Outside of long-term care, this means that states mainly pay for drugs whose costs they cannot control because the providers who order them are paid primarily by Medicare. States are responsible for Medicare's cost sharing when individuals are also covered by Medicaid, but some states have looked to reduce their cost-sharing obligations by calculating cost sharing on the state Medicaid payment level and using any savings to reduce their cost-sharing obligations. In Georgia, this is termed "maintenance of benefits": others refer to "state equalization of payment rules." While states can legally reduce the way they calculate their obligation for Medicare cost sharing, this may cause Medicare providers to be less willing to accept those who are dually eligible into their practices.

For dual eligibles, Medicare is primary, and no state can force a Medicare beneficiary to enroll in an M+C plan since this decision must be voluntary by federal law. Operationally, this means that, in effect, states also cannot require enrollment of dually eligible Medicare beneficiaries in the Medicaid managed care programs all of these states currently offer. At best, they can work out arrangements when dually eligible beneficiaries enroll in an M+C

plan voluntarily that is also in Medicaid or construct "wrap-around" or demonstration arrangements. States contend this hampers their ability to manage the cost and quality of services to dual eligibles while ensuring that care is being provided to them in a coordinated and effective manner. Only in Minnesota has the state obtained the necessary waivers to mount demonstration programs to manage care for dually eligible seniors; it also has a much smaller program for dually eligible disabled beneficiaries. (This also is a voluntary program.)

State-Sponsored Drug Assistance Programs. While a number of states have developed their own state-sponsored and state-funded drug subsidy programs for low- and moderate-income seniors, there is great variation in the types of programs, eligibility, amount of subsidy, and, ultimately, value to the eligible population (see box next page). New Yorkers have access to the Elderly Pharmaceutical Insurance Coverage (EPIC) program, an extensive public program that is well supported financially and politically. The program is seen as highly effective in filling in the drug gap for elderly in the Medicare program—so much so that some worry that Medicare reform might harm this program and penalize the state for its contribution. The under-65 disabled are not covered, however.

The program in Georgia, portrayed as a public/private partnership to facilitate access to drugs, is extremely limited in scope. In effect, publicly supported personnel attempt to connect low-income persons with a wide variety of subsidy, discount, and charity programs sponsored by pharmaceutical firms to reduce costs for one or many specified drugs; there are reportedly more than 100 different programs.

State drug programs vary in the extent to which they are integrated with other coverage. For example, Minnesota's program is stitched together with existing subsidy programs (e.g., the state drug subsidy program is available to those in the Medicare Savings programs). In other cases, the connection is less clear. For example, a low-income person who has a Medigap policy or participates in an M+C plan would be ineligible because he or she has some form of supplemental coverage, however scant the drug coverage. To the extent that state programs require no other drug coverage, this means that a beneficiary enrolled in an M+C plan with a $500 generic benefit receives no support. The way eligibility requirements integrate across diverse programs probably merits more careful consideration for what it reveals about the difficulties associated with coordinating a stand-alone drug benefit with the existing array of Medicare supplements in the market.

B. INTERPLAY AMONG SUPPLEMENTS

Relatively few individuals at the local market level have a broad sense of the full range of Medicare supplement options available. Staff in SHIP agencies field questions from a full range of Medicare beneficiaries and appear to be the most well versed (specifics on employer group options being an exception). Most other observers have a narrower field of vision given their specialized roles, specific clientele, and limited choice sets. Their limitations also seem to result from the fact that the array of products has not been viewed as a series of substitutes in many instances. Some health plans are changing this picture by developing Medigap options to augment M+C products or adding new M+C products, but most of

these new offerings are still in the start-up phase, and the plans' product portfolios are skewed toward traditional offerings.

State Prescription Drug Programs

- **California.** State law limits pharmacies to charging no more than 115 percent of the Medicaid rate to Medicare beneficiaries without drug coverage.

- **Georgia**. Under GeorgiaCares, volunteers assist the elderly in applying for private prescription drug discount programs. There are over 100 of these programs, some covering only a single drug and each requiring a separate and unique application. Volunteers will assist with applications for at least eight plans, but the applicants must obtain the support and endorsement of their personal physician. The individual drug companies retain authority to decide who is eligible for each program and how much medication to dispense.

- **Minnesota**. The Prescription Drug Program covers aged and disabled Medicare beneficiaries enrolled in Medicare Savings programs (QMB/SLMB) who have incomes below 120 percent of the federal poverty level ($918 per month for an individual and $1,232 for a couple) and no more than $10,000 in assets ($18,000 for a couple). Individuals cannot have had other prescription drug coverage of any type in the past four months. There are no additional charges after a $35 per month deductible in months where prescriptions are sought. Coverage is limited to drugs on a formulary that covers most prescriptions. In mid-2003, 7,000 were enrolled statewide. As of October 2003, this program began requiring that beneficiaries apply for all available private plans before receiving coverage, which reportedly has been making this program less attractive.

- **Nebraska.** The state does not offer and has not seriously considered a prescription drug assistance program.

- **New York**. The EPIC program covers those not eligible for Medicaid who are 65 years and older with an income of $35,000 or less ($50,000 for a couple). Individuals with incomes below $20,000 ($26,000 for couples) pay an annual income-related premium and can purchase prescription drugs for fixed copayments with no deductible. Others do not pay an annual premium and have access to prescription drugs for fixed copayments after they meet an income-related deductible. Applications are simple and premiums are on a sliding scale. In September 2001, 228,057 were enrolled statewide and 33,731 on Long Island.

Among the five markets, Minnesota appears to have the most comprehensive information on all the options available, at least in the individual market, which could be because Minnesota's options are more fully elaborated and distinctions more finely graded than in other states (see box next page). However, it is not clear if this results from the flexibility permitted in Medigap policies through the state's waiver status, the proactive state regulatory environment, the widespread acceptance of HMOs in the market, the distinctive provider market structure, the low rate of payment for M+C, or the anomalous nature of the large cost plans that remain active in the market. It likely is a function of all of these factors as well as of other unspecified social and cultural characteristics unique to the area.

Despite what is a "silo-like" status of many of these supplements, there are some key intersections among products, which we discuss below, focusing first on the individual market and then on subsidized products.

Minnesota's Distinct Market for Private Medicare Supplements/ Replacements

Medicare supplements. Minnesota had standardized Medicare supplements before federal standardization and maintains the structure today under a federal waiver. The *Basic Medicare Supplement* fills in all of Medicare's cost sharing but not the Part A and Part B deductible. It also provides 80 percent coverage for emergency foreign travel care. Up to six standardized riders can be added to cover the deductibles, balance billing, specified preventive care, and extra at-home assistance. (Though authority for a rider covering 50 percent of drug costs is authorized, none is offered.) *Extended Basic Supplements* include the basic plan with all authorized riders and cover 80 percent of prescription drugs, a $1,000 out-of-pocket limit, 100 percent coverage of immunization and routine cancer screening, 80 percent of balance billing (including foreign travel), and additional outpatient mental health coverage. Nineteen companies offer policies of each of the two types. Minnesota requires the same coverage for the disabled and elderly, and premiums are community-rated. (Premiums can vary by geography and for smokers.)

Medicare select plans. Minnesota describes these as a cross between Medicare supplements and HMOs**.** These state-regulated plans provide basic supplemental coverage with some riders but limit some supplemental coverage to use of a specified network of providers. Four firms offer these plans (Blue Cross-Blue Shield, Health Partners, Medica, and Unicare; specifics of each plan vary).

Medicare cost plans. These federally authorized plans provide HMO-like coverage; enrollees can go out of network if, in most cases, they are willing to give up supplemental coverage. Three firms offer these plans (Health Partners, Medica, and First Plan), often offering multiple alternative packages at premiums that trade off extensiveness of benefits for cost-sharing protection.

Medicare+Choice HMO plans. These federally authorized plans require individuals to remain in network to receive Medicare benefits. The plans cover most of Medicare's cost sharing and many preventive services but require additional premiums for drug coverage (if offered). Two firms offer these plans, Health Partners and Ucare, the latter offering two products.

Medicare+Choice private fee-for-service plans. These are federally authorized indemnity plans that integrate Medicare and supplemental benefits. Sterling Option I is offered in Minnesota, and, recently, Unicare and Humana entered the market.

Source: Authors' analysis from the Minnesota Senior Federation's *Minnesota HealthCareChoices 2003* guide.

1. Interplay among Individual Coverage Options (Medigap and M+C)

Medigap and M+C. During the high-water mark of M+C expansion in 1998–1999, plans reported good success in attracting members by offering plans with zero premiums and relatively comprehensive benefits that included rich drug benefits. This was even true in markets like Atlanta, Nebraska (Omaha), and Long Island, where beneficiaries had little or no experience with HMO enrollment. Plans that already had supplemental products switched their marketing emphasis to newly launched M+C plans to develop the product and to compete with other new entrants vying for beneficiaries looking for price-competitive options. While there was some concern about the adverse selection that open enrollment might bring because of the benefits offered (especially in states without guaranteed issue for the under-65 beneficiaries), overall enrollment growth softened this concern.

Plans also expanded their M+C markets to reach more potential members and generally were able to find providers willing to participate in networks, encourage patients to join, and, in some cases, accept risk. Some providers reported that they joined networks in part to ensure that they would not lose patients who were attracted by the M+C products. Still others saw participation as a natural extension of their plans to move to integrated delivery systems. Insurers with Medigap policies did little to innovate at this time, even in the area of developing Select options on existing products, since M+C products were so favorably priced relative to their benefits.

The drastic reversal of fortune for M+C plans in the past four years has effectively reversed the dynamics of individual option choices. In places where most plans abruptly withdrew, beneficiaries have moved back to Medigap, sought refuge in remaining plans despite rising premiums and declining benefits, or have chosen to go without coverage altogether. Almost no new growth in membership is evident in the surviving plans (except to the extent that they have picked up enrollment from plans departing the M+C market), and marketing personnel in some markets suggest their products are largely "un-saleable" given benefit design changes and the products' damaged credibility in many markets. We were told, for example, that the instability and uncertainty of some markets make it difficult for any objective observer to encourage enrollment except perhaps in the case of very-low-income beneficiaries or those under 65 who cannot afford costly supplements.

Shrinkage in the availability of M+C plans across the country has also reduced their appeal in specific markets because it means out-of-area coverage is much more problematic than it once was. For retirees who travel or spend parts of the year elsewhere (e.g., cooler climates in the summer, warmer climates in the winter), the M+C option has clearly become less appealing because the limited number of plans has also limited the availability of services out of area, except in emergencies. These retirees may previously have been able to use a plan owned by the same national firm in areas like Arizona, Texas, and Florida, but this may no longer be possible if the firm has reduced its offerings nationally.

Insurers suggest that new product development is now needed, and several are exploring either innovations in Medigap offerings, including renewed interest in Medicare Select designs to control premium growth through incentives to use provider networks with devised negotiated prices, or high-deductible products that might substantially reduce premiums. While the Select options and the high-deductible products have been introduced in a few markets, as discussed previously, they have not been extensively field tested here or elsewhere to see how successful they might be. Georgia Blue Cross, which is also owned by Wellpoint, Blue Cross of California's parent, could provide a useful indicator about these efforts. Other insurers are looking to M+C products, including PFFS and PPO designs, to revitalize their senior offerings. For example, Unicare (another organization related to Wellpoint) recently launched a PFFS in Nebraska and Minnesota as well as in a number of other states with a monthly premium of under $10. It is too soon to judge whether these new offerings will be able to overcome recent skepticism about new types of supplements.

2. Subsidized Coverage Options

Medigap and Employer-Sponsored Coverage. Because of the way data are reported, we cannot determine with certainty how much Medigap coverage is currently sponsored or subsidized by groups, including employers. But interviews suggest that, while this has not been a common approach to facilitating access to retiree health benefits in the past, it is almost certainly going to grow in the future. Employers are already looking at adding group Medigap policies to a menu of retiree choices (where such choices are made available) to offer lower-cost alternatives, just as some are now making high-deductible options available to their active workers. In addition, the process of reconfiguring premium contributions could make Medigap supplements more attractive in the group market.

Employer-sponsored Medigap policies can be offered in many ways. For example, employers in the past may have offered retiree coverage under a pooled premium arrangement with active employees; retirees under 65 received the full set of benefits and those 65 and over received benefits that "wrap around" Medicare's benefits. Active workers in effect subsidized retiree coverage, especially for those not eligible for Medicare. If employers move to separate retirees from active workers and reduce the subsidies to retirees, contribution levels would increase dramatically. For a Medicare-enrolled retiree, the dramatic increase in contribution levels for a policy that in effect pays Medicare's cost sharing and drugs could become less attractive than unsubsidized Medigap coverage that is more related to the retiree's needs. In one example, retiree and spouse coverage is now $565 per month for retirees with Medicare to maintain access to a benefit package that is comparable to active workers. Benefits managers believe they can obtain some premium discount on Medigap supplemental products but expect that retirees will be stunned by their limited drug benefits.

This same kind of "sticker shock" will occur if more employers follow through on their plans to move toward some kind of fixed contribution to retirees toward the purchase of an individual supplement. This practice may be particularly attractive for those smaller employers who cover retiree benefits but do not have the benefit of a large group discount as well as for firms that want to continue to provide some subsidy but fall well short of meeting the full cost of a Medigap policy. Such an approach is not uncommon for small employers to take with active workers. But one large employer that is planning to discontinue retiree subsidies to new hires said his company was not prepared at this point even to make any explicit commitments for a fixed contribution for retiree benefits in the future.

M+C and Employer-Sponsored Coverage. The decline in interest in M+C among employers fully parallels that for individuals. In some ways, the decline is even more disappointing given the active efforts by a number of M+C plans to cultivate this market and the eagerness with which some employers looked to M+C plans to relieve some of the burden of their future retiree health benefits liability. Employers have more flexibility in plan design than individuals do. Employers could choose to raise their contributions to maintain HMO membership or to shield retirees from some of the deterioration in benefits. But few of them have done this because they have lost confidence in the capacity and durability of the M+C HMO product. Plan withdrawals have persuaded a number of

multistate employers that M+C plans cannot meet their needs sufficiently to justify relying on them, and they have turned back to indemnity-type designs to ensure maximum availability and uniformity.

Those firms remaining with M+C appear to be dominated by companies with longstanding arrangements with particular managed care plans for their active workers, whom they do not want to disrupt. This affects mainly markets with long traditions of managed care (e.g., San Diego, Minneapolis) and particularly older plans, most of which were initially formed around prepaid group practices (e.g., Kaiser-Permanente on the West Coast, plans that derive from Group Health in Minneapolis, and HIP in New York). Any interest employers may have had in seeking out new affiliations with M+C plans to complement their traditional offerings seems to have waned amid concern over these products' lack of stability.

Medicaid and M+C. Despite the fact that so many states have committed themselves to adopting managed care models for their Medicaid beneficiaries, the development of managed care programs for dually eligible individuals has proven to be an elusive goal. Minnesota has one of the few federal waivers that permits a state to devise a combined risk-based program, and it appears to have attained success in attracting plans and beneficiaries to participate. The plan participation is probably facilitated by the fact that all plans in Minnesota must participate in the Medicaid managed care program and that most of them also have longstanding Medicare programs (see box on next page for Minnesota's low-income programs). In addition, the state requires all network-based health plans to be not-for-profit. In the other states, however, the dually eligible populations are explicitly excluded from participating in Medicaid managed care (i.e., states have not obtained a waiver to do so) such that this intersection remains undeveloped.

3. Other Sources of Coverage

Military and Veterans' Programs. Medicare beneficiaries also use the Department of Defense (DoD) and Department of Veterans Affairs (VA) health systems. In some markets, DoD and VA facilities play a significant role not just in the local delivery system but also in the insurance markets as well. The introduction in October 2001 of a new form of supplemental insurance for military retirees enrolled in Medicare, TRICARE for Life, significantly affected insurers and health care systems in several sites we visited, most notably San Diego, which has one of the largest concentrations of military retirees in the United States. TRICARE for Life currently has approximately 46,600 enrollees in San Diego County (13 percent of all beneficiaries).

TRICARE for Life is a relatively comprehensive Medigap plan. Military retirees (with 20 years of service, including service in the reserves) and their eligible dependents obtain coverage automatically if they are enrolled in Medicare Part A and have been registered in the military enrollment eligibility system. There is no premium. Cost sharing for Medicare claims is made automatically via computer links between CMS and DoD. A separate, also generous, prescription drug plan was created to augment TRICARE for Life, which is also

Low-Income Options in Minnesota

Medicaid-eligible beneficiaries in the Twin Cities have access to managed care programs that can provide medical and support services. Beneficiaries who are not eligible for full Medicaid benefits also have access to the Prescription Drug Program (see box on page 19) and to two other special programs characteristic of that market, one old and the other new.

M+C option for QMB/SLMB beneficiaries. Under provisions of a waiver recently approved by CMS, HealthPartners is establishing an M+C option for beneficiaries who are enrolled in Medicare Savings programs (the QMB or SLMB programs for low-income beneficiaries). Under this option, the health plan waives its monthly premium ($99 per month in 2003) for these beneficiaries, and beneficiaries have full plan benefits, including coverage of most Medicare cost sharing, plus physical examinations, discounts on hearing aids, and a limited dental benefit. For QMB beneficiaries, cost-sharing requirements, like copayments for visits, are waived as well. Because the plan does not cover outpatient prescription drugs (except for injectible insulin), beneficiaries can also enroll in the state Prescription Drug Program.

Senior Partners Care (SPC). The program is a public service program that was put in place 28 years ago, sponsored by the Minnesota Senior Federation and the Minnesota Hospital Association. In the Minneapolis/St. Paul metropolitan area, 19 hospitals participate, but the number of SPC health providers is smaller than the networks offered by Medigap or M+C providers serving the area. For beneficiaries who are not eligible for QMB benefits and have gross incomes under $14,469 (single) or $17,952 (couple) and assets under $36,800 (one house and one car are exempt), participating hospitals and physicians agree to waive Medicare copayments and deductibles. Beneficiaries participating in the program are asked to pay an annual administrative fee to the Minnesota Senior Federation ($25) and to become dues-paying members of the federation ($19 single, $29 couple).

Minnesota Prepaid Medical Assistance Program (PMAP). The program is a state waiver program that operates in 56 of the state's 87 counties to provide health care services for people eligible for state medical assistance (Medicaid) benefits. Under the waiver, those eligible for medical assistance living in PMAP counties are required to enroll in prepaid health plans to receive state benefits. The Elderly Waiver (EW) component of the state program funds home- and community-based services for people age 65 and older who are eligible for Medical Assistance (MA) and require the level of medical care provided in a nursing home but choose to reside in the community. Counties administer the program. Covered services include visits by a skilled nurse, home health aide, homemaker, companion, and personal care assistant as well as home-delivered meals, adult day care, supplies and equipment, home modifications, and certified community residential services (that is, assisted living, foster care, residential care).

Minnesota Senior Health Option (MSHO). MSHO is a separate demonstration program for PMAP-eligible seniors. It integrates Medicare and Medicaid financing and benefits and acute and long-term services in a market-based managed care delivery system under an M+C contract between the federal government and the state of Minnesota. The program contracts with health plans to provide and manage health care and support services for seniors age 65 and over in the seven-county Minneapolis/St. Paul metropolitan area and in three rural counties in Minnesota. MSHO provides individualized care coordination designed to meet the chronic care needs of seniors. Nationally, MSHO is the first and largest state-sponsored demonstration that integrates Medicaid and Medicare for people in all settings. In September 2001, the state expanded the MSHO model to enroll people from age 18 through 64 with physical disabilities in a program called Minnesota Disability Health Options (MnDHO).

available to retirees enrolled only in Medicare Part B. Because the TRICARE for Life benefit is comprehensive, a large number of military retirees who are Medicare-eligible are said to have left the M+C health plan in which they had been enrolled or the Medigap market. Providers in San Diego hospital systems and managed care plans, as well as the VA manager, reported that military retirees now using TRICARE for Life to supplement Medicare are using more health services than they did in the past, when they relied on military treatment facilities, Medicare+Choice plans, Medicare plus Medigap, or the VA to help pay for their care.

All veterans of military service also may seek health care from VA facilities. Access priorities apply. The VA facilities first favor those with at least a 50 percent service-connected disability and then other veterans with priority based on financial status. The VA provides extensive drug coverage to eligible veterans with no or limited copayments, but only when prescriptions are written by VA providers. In San Diego, MedPAC staff were told that the wait to access primary care was not long relative to other communities, but they also heard elsewhere that long waits encourage veterans to seek out Medicare providers. Demand for VA services is said to expand when coverage is "squeezed" in the community (e.g., drug coverage is reduced under M+C). The VA is precluded by law from billing Medicare or Medicare replacement products, but it can seek Medigap reimbursement. In San Diego, MedPAC staff were told that Medicare covered about 35 percent of all patients treated but that only about 16 percent of all treated patients have any "billable" insurance. Most of the treated Medicare patients do not have Medigap. Under an arrangement with DoD, the VA system treats those with spinal cord injuries, but otherwise the two systems are distinct.

The recent changes in supplemental coverage embodied in TRICARE for Life had an effect on the Atlanta, San Diego, and other markets. Blue Cross in Georgia reported about an 8 to 10 percent drop in Medigap enrollment when policyholders moved to TRICARE for Life. In San Diego, M+C plans estimate that more than 10,000 people left health plans to move to the TRICARE for Life program (though in San Diego there exists what may be a unique option for individuals to continue within the Kaiser program). TRICARE for Life has provided retirees eligible for Medicare with a fairly rich supplemental policy and a rich drug benefit, in which one can enroll even if not enrolled in the supplemental policy. The rich drug benefit is seen as having major appeal to military retirees. Observers in San Diego, however, speculated that, because these beneficiaries have moved from a managed care arrangement to a fee-for-service one, Medicare costs will likely increase despite the fact that DoD, not Medicare, is now paying for the supplemental.

C. Influence of Policy, Market, and Other Forces on Availability of Supplements

The site visits permitted us to explore how several different environmental forces influenced access to Medicare supplemental coverage for beneficiaries. The forces examined include the state policy context, provider and insurance market structure and dynamics, the decision support system for beneficiaries, and geographic, socioeconomic, and cultural influences.

1. State Policy Context

State policy affects the availability of supplements on both a broad and narrow level, determining laws that govern how supplements are brought to market and developing and enforcing the rules and regulations that police the market. Both of these areas are affected by federal policy limitations placed on states, though the actual boundaries appear to be less clear in practice than in theory. Across the five markets, legislative interventions, such as guaranteed issue or community rating for Medigap policies, appear to improve significantly the availability of coverage for certain populations (e.g., those under age 65 in states such as New York) while, by implication, their absence lessens the availability of coverage (in states such as Nebraska and Georgia).

In a more global sense, the Minnesota experience with a waiver from federal Medigap standardization has positioned the state to be much more actively engaged than other states in influencing product designs and plans' practices. Some plans believe that state regulators may actually be exceeding the scope of their responsibilities vis-à-vis preempted activities in some plan requirements. On the other hand, state regulators express some frustration that they lack jurisdiction to review certain types of plans like M+C PFFS that have many characteristics similar to Medigap products. While state policies in other states have not influenced the actual array of Medigap plans offered to and taken up by beneficiaries, they have not impeded Medigap carrier participation since each state appears to have a sizable number of players. Based on interviews with multistate Medigap companies, none of the five states has a particularly difficult policy environment, though New York and Minnesota are characterized as "heavy" or "firm" regulators. As noted earlier, though New York has fewer carriers than other states, those remaining seem to have accommodated to the system, and those interviewed seemed satisfied with the range of choices offered in the market, albeit not always with the price. Conceivably, greater regulation leads some carriers with only a marginal role in the market to withdraw because they do not find value in the cost associated with specialized compliance.

The enforcement function may be a better gauge of the regulatory environment per se, including approving new entrants and product offerings, reviewing rates, performing market conduct audits, and dealing with consumer complaints. Observers in the five states generally gave high markets to their insurance departments for not being excessively intrusive and being generally responsive and accommodating to reasonable requests in the Medigap realm. Insurers characterized rate review processes as ranging from demanding to perfunctory but in all cases fair and even-handed. From the insurance departments' perspective, the insurers and agents in the Medigap market are generally responsible, owing in large measure to the impact of product standardization.

Observers with sufficient seniority to recall the prestandardization days indicated that there has been a complete change in the Medigap market in terms of consumer exploitation. Though specific details were not collected from states, insurance officials believe that Medigap-related complaints are a small fraction of all consumer concerns registered with their departments. Insurers also noted that insurance departments have generally been cooperative regarding new product design and features, though these have been relatively rare in the Medigap market in most states. Some insurance officials were disappointed with

the lack of innovation in the Medigap area, but they attributed this to general uncertainty associated with proposals for major Medicare reform.

Because of federal preemption provisions, state regulatory impact on the M+C market has not been significant. Presumably, general managed care regulation has affected the overall hospitability of local markets to health plan products. Also, specific state requirements have influenced the delivery systems (e.g., Minnesota precludes for-profit managed care firms, California limits hospital ownership of physician practices). Regulatory authorities were well aware of M+C enrollment's rapid rise and decline in their markets because they, along with the SHIP agency, receive many calls when beneficiaries are dislocated by plan withdrawals. Regulators also note how much prescription drug coverage has declined in the remaining M+C plans and how few Medigap products include this benefit. They see this coverage gap as the most pressing concern for the senior market.

Medicaid programs vary markedly in the five states on several dimensions, including eligibility, benefits, provider payments, and the type and extent of managed care enrollment among beneficiaries. Broader eligibility in particular means greater access to the relatively rich standard Medicaid benefit package, which includes prescription drugs. In addition, states vary considerably in the way in which they promote access to eligibility and provide administrative resources to facilitate and maintain eligibility. Though a number of steps have been taken in each state to reduce barriers for dually eligible Medicare-Medicaid beneficiaries, variation across the states remains notable as does the large number of potentially eligible persons who have chosen not to participate because they worry about the stigma, estate recovery, and other matters.

As described earlier, state prescription drug programs can be very important in helping low- and moderate-income beneficiaries gain access to a necessary service. In the states that have these programs, they are both very costly and very popular, which explains why they have been jeopardized but maintained in the midst of the current state budget crises.[6] But other states that lack the financial wherewithal and political support must get by with very limited initiatives (Georgia) or none at all (Nebraska), and they have no immediate prospects of developing credible subsidy programs.

2. Provider Market

Across all five markets, the lack of awareness about or interest in Medigap products and carriers among physicians and hospitals was notable, if not surprising. Providers have a very undifferentiated perspective toward these payers since all Medigap does is pay the specified elements that complement the Medicare benefit package. Providers do not negotiate rates with Medigap sponsors and are not subjected to treatment-related authorization or approvals. Only when a provider or groups of providers encounter difficulties with timeliness of payment does a Medigap insurer get on the providers' radar screens.

[6] California's regulation of the rates pharmacies can charge is an exception that involves no state funds, though it obviously affects pharmacies' revenues.

Providers are obviously aware of the consequences of beneficiaries not having any supplemental coverage because of the added financial responsibility this represents, and financial counselors in hospitals, in particular, encourage beneficiaries to consider acquiring Medigap if they can afford it. A large private hospital in Atlanta, for example, told us that 20 percent of its patients had no source of Medicare supplementation.

Physicians are frequently confronted with the fact that their Medicare patients have little or no prescription drug coverage. Several of them report that they and their office personnel spend growing amounts of time trying to arrange some kind of free or subsidized drug coverage for prescriptions they see as essential for their patients' well-being. In some cases, they may work directly with a pharmaceutical company; in other cases, with a community-based organization or foundation. In still other cases, there may be public initiatives to match patients with manufacturers, such as the GeorgiaCares program.

With respect to M+C products, variation in provider market structure and dynamics is very important and has been quite influential in affecting the future of M+C plans across the five markets. Provider systems are significant forces in all the markets, though the particular structures vary in each of the markets. For example, hospital-centered systems are most notable in Long Island, Atlanta, and Omaha while, in San Diego and Minneapolis, integrated health systems that include both influential hospitals and strong physician groups are the most powerful actors. Physicians in the first three markets either practice alone or are organized into groups and independent practice associations (IPA). They have had considerably less experience with commercial managed care than their counterparts in San Diego and Minneapolis, including relatively little exposure to capitation payments.

In the late 1990s when the M+C emphasis was on expansion, providers in the Long Island, Atlanta, and Omaha markets willingly signed on to Medicare risk contracts and accepted some financial risk, thereby opening the way for rapid growth in product enrollment. In the mature markets of San Diego and Minneapolis, physician groups had flourished in a capitated, managed care environment so they looked upon expanded M+C as bolstering their enterprises and sustaining their commitment to the delegation of risk and care management responsibility. Hospitals were less enthusiastic about the potential impact of declining inpatient care associated with HMO enrollment, but many saw participating in these arrangements as a way to maintain Medicare market share and, at least for a time, a means to support their efforts to develop more completely integrated health systems. Hospital executives in Long Island, Atlanta, and Omaha, however, all noted that their enthusiasm for such integrated models has declined markedly in recent years.

The financial pressures on plans (and hospitals) that came out of the Balanced Budget Act (BBA) brought the expansion era to a quick end. In most markets, plans found that rate increases did not keep pace with medical trends, but, more ominously, many provider groups discovered that even more substantial rate increases did not achieve financial success in the risk arrangements they negotiated with plans. Physicians in the three markets with little experience with capitated payments reported that financial losses were common and growing; at the same time, plans were contending they could not maintain current levels of payment. Hospitals, faced with other revenue consequences of the BBA, said they started to

evaluate all of their contracts with managed care plans and resolved to negotiate with them more forcefully. Many M+C plans quickly realized that their networks could start to collapse, such as they did in 2002 on Long Island as the two major health systems balked at contract renewals and led at least one plan to withdraw its product altogether. In some cases, this pushback was not restricted only to Medicare but extended to commercial managed care contracts as well.

In San Diego and Minnesota, a somewhat different result has been observed. Particularly in San Diego, where medical groups and IPAs have longstanding relationships with plans to bear professional risk and share risk for inpatient care, physicians' organizations have remained strongly supportive of prepaid models of care for both Medicare and commercial enrollees. This has been true even when their affiliated hospitals have been less enthusiastic about sustaining these arrangements. In Minneapolis, integrated health systems—including both hospitals and physicians' groups—have remained strongly supportive of managed care despite persistent concerns about the level of payment rates in the Medicare risk program. Plans have responded by adjusting benefits and premiums and maintaining cost plans that help maintain a sizable Medicare HMO enrollment.

The influence of provider market structure on the availability of new M+C options remains uncertain as more PFFS plans are launched and PPO products are introduced. Virtually all plans note that contracting in rural areas, especially with hospitals, is extraordinarily difficult. In addition, the disappointment associated with M+C plans' decline clearly makes many providers leery of these new options. For the most part, the PFFS plans in the markets remain too small to assess whether physicians will agree to accept payment from them rather than from Medicare, let alone whether physicians might encourage (or discourage) their patients from joining. The same is true for the PPO products, though as network-based options, plans will need to negotiate terms to get these products on the market and give them credibility. It may be instructive that one (nondemonstration) PPO launched in the five markets (Nebraska) currently has a provider network that is actually narrower than the HMO/CCP product that the firm already has in place. Those who counsel beneficiaries in Nebraska told us that many rural providers have been unwilling to participate in the PFFS plan in that state. But others elsewhere reported they were unaware of any problems.

When questioned about whether Medicare beneficiaries are experiencing current access problems even in the traditional program, most observers were unaware of problems, though some had heard anecdotal reports of them. Some suggested that had the planned 2003 Medicare physician fee rollback been implemented, the problem would have been much more visible and pervasive. Others suggested that physician loyalty to existing patients ensures continuing care irrespective of payment levels. But the problem does appear to be more likely to arise for new Medicare patients who are looking to establish a relationship with a physician. Another perspective was that many physician practices, especially the most well- respected, are typically full; therefore, gaining access to them is problematic for all new patients. Whether physicians are actively discriminating among patients based on source of payment was disputed by some but seemed evident to others who suggested that, since this is the case for Medicaid, it is reasonable to expect this to be true for Medicare as well.

3. Insurance Market

Despite the large number of insurers found in the Medigap market in each state, the market leaders tend to dominate the commercial market and the broadly marketed AARP/United HealthCare product. The dominant commercial insurer in each market is the Blue Cross-Blue Shield plan, although it was not possible to confirm this for San Diego because enrollment data for many Medigap insurers were unavailable.

The market leadership of Blue Cross-Blue Shield reflects the degree to which private insurance coverage shapes retirees' choices and preferences. With employer-sponsored retiree coverage, many employers offer either modified versions of their active workers' plan or negotiate with the same carrier for alternative products customized for retirees. In markets where private individual coverage has been particularly pervasive, Blue Cross-Blue Shield plans have been the leading sellers and have effectively parlayed this position into selling Medigap policies. All observers acknowledge the importance of the Blues' brand-name recognition, particularly because it conveys stability and durability to seniors. The Blue Cross-Blue Shield plans also have the most inclusive provider networks in their respective states, including rural areas where they may be the only carrier with an established network. The Blues' plans generally have been able to maintain satisfactory relationships with the provider community, though there are some notable exceptions. Medigap products per se and Blue Cross-Blue Shield plans in particular also are very attractive to beneficiaries who travel or spend part of the year elsewhere (for example, snowbirds and sunbirds).

Product mix does not map as clearly between active workers and retirees because the range of options for retirees is more constrained. A high proportion of active workers is enrolled in broad network PPO products in Long Island, Atlanta, and Omaha, where HMO penetration has leveled off and is now declining. Provider participation in commercial PPOs has remained strong, at least in the metropolitan areas of these markets. In these locations, retirees are generally enrolling in non-network Medigap products, since even Select designs have proven difficult to launch and M+C PPOs are just beginning to make an appearance. Given their acceptance in the provider community, Medigap policies give beneficiaries maximum opportunity to maintain existing relationships.

The situation in San Diego is also one of accommodating retiree preferences, but in that market most active workers have some type of HMO product so the M+C CCP plans continue to flourish. Beneficiaries are typically affiliated with large groups of physicians who, in turn, typically participate in multiple M+C offerings. For the large Kaiser Permanente membership in the market with its unique closed system, aging into Medicare from active worker status is an easy transition whether or not an employer is subsidizing the beneficiary's retiree coverage. In Minnesota, the picture is more varied because of a broader range of alternatives whose product distinctions are not as sharply drawn as in other markets. While most active workers participate in some kind of managed care product, the amount of management found in the alternative offerings is more diverse for retirees because of the constrained participation of HMOs in the M+C market due to plan concerns about adequacy of payment rates. Management seems more likely to exist in markets where integrated systems of care are more dominant, as in San Diego where the Kaiser, Sharp, and Scripps systems are well developed.

4. Decision Support System

The SHIPs in each of the states provide substantial decision support to beneficiaries despite what most see as very limited financial resources. The SHIP responsibility is variously lodged in departments of insurance, other public agencies, or with private organizations under contract with the state. Relying on extensive numbers of trained volunteers, these organizations are achieving an impressive volume of contacts by telephone, mailings, distribution of written materials, and, in some instances, personal encounters with beneficiaries seeking information, guidance, interpretation, and support. The SHIPs' efforts are also ably integrated or augmented in some states by publicly supported area agencies on aging (AAA) and by community-based information and advocacy organization such as the Medicare Rights Organization in New York and the Minnesota Senior Federation, which rely heavily on foundation and other sources of community support. The information needs of beneficiaries regarding Medicare supplements represent a major portion of the contacts with these organizations.

SHIP officials report that information is provided to beneficiaries at two key points: (1) when they are approaching retirement and need to decide whether to obtain a supplement and (2) when they are in "crisis mode" resulting from the death of a spouse and the potential change in their coverage and financial situation, the onset or discovery of a serious illness, the notice of a large increase in premium, or incurring a large medical cost often related to a pharmaceutical expense. SHIP staff and their local affiliates also deal with routine calls related to provider bills or Medicare payments and the like. All of the agencies reported being inundated with calls during the period of M+C plan withdrawals as beneficiaries tried to understand their options and alternatives.

SHIP counselors are well versed on Medicare supplemental policies and are very adept at making referrals to appropriate additional sources of information, including Medicare, departments of insurance, and individual carriers or insurance agents. But the complexity of Medigap pricing in California given the number of rating factors involved has led the SHIP to institute a policy of not providing information on Medigap premiums. The California Department of Insurance also followed this policy but has recently begun providing rates for Medigap policies on its Web site.

Most of the SHIP counselors believe that there are currently a substantial number of options available for Medicare supplementation and that beneficiaries appear to be able to understand what the options offer once they receive some orientation and education. But, as noted, most do not seek out information until they reach a time of critical need and thus may not be well prepared to make choices with due deliberation. This is particularly significant in the case of initial selection of Medigap coverage and difficulties in changing coverage later. Likewise, a number of employers also have "once out, always out" rules for retirees that penalize beneficiaries who make poor initial choices. Counselors did note that it is more difficult to reach minority subpopulations because of language barriers, their preference for relying on their own communities for support and assistance, and some distrust of public agencies and services. In these instances, they attempt to work through a settlement house or other indigenous community organizations but note that such arrangements are not as extensive as they would like them to be.

SHIP counselors uniformly noted that the cost of the options is a serious and growing problem, most notably because of the meagerness of affordable prescription drug coverage but also because of the amount of the premiums themselves. They particularly singled out how the evaporation of drug coverage in the M+C plans has heightened cost concerns because those plans had represented a particular refuge for lower-income beneficiaries. Because of the frustrations created out of the earlier wave of withdrawals, it is very difficult for the counselors now to encourage beneficiaries to consider these options seriously. The plight of the under-65 beneficiary is a major concern in states where the options are very limited and the costs, we were told, are extremely high. In some markets, this beneficiary group is one of the few that counselors suggest continue to consider joining an M+C plan.

Counselors said that new options or proposals that involved drug coverage were seen as promising but also potentially problematic in terms of added beneficiary confusion. SHIP and associated decision support structures noted the limited amount of resources they had, the cutbacks in federal funds they already had experienced, and their inability to assume new demands for education. In addition, because of negative experience with M+C plans, interest and confidence in newly launched options such as PFFS and PPOs face considerable skepticism among counselors and beneficiaries that will have to be overcome.

5. Geographic, Socioeconomic, and Cultural Influences

The preceding factors reflect the larger forces that shape the supplement option choices available to beneficiaries in the five markets. Since individual beneficiaries were not interviewed, we cannot address the degree to which personal characteristics affect preferences among the available options, but observers did identify important beneficiary-related attributes that they believe influence the overall patterns of Medicare supplementation. Clearly, on one level, geography is destiny in the sense that most rural residents have no access to M+C CCPs and, only recently, have they seen PFFS options. These residents have also seen little of managed care in their active employer-subsidized coverage or individually purchased health benefit policies. There is no indication that Medicare policies to promote additional supplements have, at least yet, expanded choice in rural areas except possibly by growth of PFFS. Interest in these products among beneficiaries, however, was reported by counselors to be low, at least now.

Statewide carriers like Blue Cross plans indicated that they typically have different product pricing structures for products in rural and urban regions to reflect total cost of care (mainly physician services since they are the most influential in terms of Medigap coinsurance costs). The patterns are not always as expected, namely, higher costs in urban areas. In some states, carriers note that urban areas may actually have lower payments to providers (at least in commercial products) because of competitive dynamics not found in rural areas where providers may enjoy monopoly status. On the other hand, utilization levels in rural areas are commonly lower, offsetting some of the consequences of high payment rates. The payment picture is less clear in a state like Nebraska where 55 hospitals qualify for the Critical Access Hospital program and thus receive a substantial portion of payments on a cost basis, which in turn affects how sole community providers may negotiate rates with other payers.

Respondents also view relative beneficiary affluence as important because it enables beneficiaries to afford more costly coverage or to seek care from more costly settings and specialty providers (Long Island) or to have a high probability of being unable to afford any supplement that requires cost contribution (Atlanta). Georgia was described by many as a state with substantial income disparities. The very low level of Medigap coverage in the state would be consistent with a profile of persons unable to buy policies. When M+C plans were expanding to cover outlying counties of metropolitan areas, they may have been able to provide some relief to beneficiaries in less urban and well-to-do areas who found the zero premium very appealing.

Very low standards for Medicaid program eligibility in some states make that program a very unappealing or inaccessible option for what are clearly low-income beneficiaries. In Georgia, the SHIP reported that it often has to make clear to adult children that plans to relocate an ailing parent to the state could result in loss of benefits because the level of coverage is so much lower there. Conversely, states with attractive senior drug subsidy programs appear attractive to persons who need subsidies but reside in states without such a program.

Several observers noted the importance of cultural disposition toward obtaining or maintaining insurance coverage and particular types of coverage. Some suggested that the high levels of Medigap coverage in Minnesota and Nebraska and other Midwestern states with strong agricultural economies reveal a commitment to individual self-reliance and a desire to protect one's hard-earned assets. In addition, we were told, at least in Minnesota, that loyalty to brokers was strong, with brokers providing service over a lifetime for a range of insurance products. Other observers suggested that seniors' lack of interest in high-deductible Medigap policies reflects their desire to get as much predictability in spending and as much protection as they can afford. Conversely, the stigma associated with accepting welfare benefits in the markets we visited is viewed as an impediment to participating in the Medicare Savings Program.

In San Diego and Minnesota, acceptance of managed care as a preferred means for obtaining health benefits appears to have a strong history and heritage, but it is noticeably absent in the other markets. On Long Island, for example, observers say beneficiaries are "heavy users" since they prefer extensive diagnostic testing, specialty orientation, and a desire for open access to all providers. Though difficult to quantify and largely beyond the scope of this study, concerns about cultural diversity are seen as an important consideration for policymakers interested in engineering major Medicare reform.

D. PRINCIPAL CONCLUSIONS

Several general conclusions about the Medicare supplement market can be drawn from the results of the site visits:

- At this time, participants' single greatest concern with the Medicare supplemental market is the absence of affordable drug coverage, and their

search for such coverage drives their decisions on supplementation in many ways.

- At the community level, Medigap markets appear relatively stable, and beneficiaries have become familiar with the 10 basic standard packages. However, rising costs are pricing low- and some moderate-income seniors out of the markets. In addition, the availability and affordability of coverage for the under-65 Medicare disabled population is a significant problem, especially in states that do not require access beyond federal statutory mandates.

- The M+C experience in these markets parallels national trends: enrollment remains high in longstanding markets but has largely disappeared in markets that developed later, with severe erosion in benefits, especially drug coverage, evident across all markets.

- The recent history with M+C coordinated care products has strongly shaped participants' perceptions in local markets and has led to serious doubts in some quarters about reliance on private plans to deliver sustainable alternatives to traditional Medicare.

- New options being mounted in M+C, such as private fee-for-service plans and Medicare PPO and Select products, face considerable skepticism from many of the providers and employers interviewed, and counselors report that beneficiaries will need to overcome lack of awareness and understanding of them.

- Employer-sponsored retiree coverage appears to be falling at an accelerating rate among employers in many of the markets visited, especially as related to loss of all coverage for new hires and sharply rising costs for existing retirees. Many employers are uncertain about how they might respond to a new Medicare drug benefit.

- Medicaid coverage as a source of Medicare supplementation varies across states but is limited only to very poor beneficiaries whose health care needs and costs are great enough to overcome concerns about the stigma and other impediments to these benefits.

- State investment in the Medicare-Medicaid dual eligibles represents a substantial portion of Medicaid costs, particularly for pharmaceuticals. In Georgia, for example, expenditures on dual eligibles account for one-third of total Medicaid costs and half of pharmaceutical spending.

- State-sponsored drug assistance programs are highly uneven across states and provide substantial assistance in at most two of the five states we visited.

Though Medicare is a standardized national program, the need for supplementation has led to substantial and growing diversity in options, costs, and benefits across beneficiaries and markets. This diversity depends on the states for further Medigap protections and on state programs such as Medicaid and drug assistance programs. It also depends on employment history, income level, and availability of M+C and publicly subsidized options in the various markets. The structure and dynamics of the provider and insurance markets further contribute to variation. All of these factors contribute to both the inherent complexity and tension in the way individuals currently obtain Medicare supplemental coverage and to the challenges associated with substantially changing this process in response to the many moving parts and parties whose separate decisions collectively affect beneficiaries' choices for Medicare supplements.

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Appendix

Summaries of the Five Sites Visited

Medicare Supplemental Coverage: Market Profile

Atlanta, Georgia (MSA)

BASIC STATISTICS

Total Population (2000):	**4,112,198**
M+C Penetration (2003):	**8.6%**
Under 65 as Percent Total Population:	**92.4%**
M+C Choices:	**2 plans, 3 options (BC-BS offers 2 different options); no PPO demonstration or PFFS**
Medicare Beneficiaries (2003):	**334,150**
M+C Average Payment Rate (2003):	**$605.92**
Percent of Medicare Beneficiaries over 65 with Incomes below 100% FPL:	**9.7%**
Percent of Workforce Covered by Collective Bargaining Agreements (2002):	**5.5%**

Statistics are for the Atlanta, Georgia, MSA, which contains the following counties: Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, and Walton.

SUPPLEMENTAL OPTIONS

Medicare+Choice History. After more than doubling between 1997 and 2000, the M+C market has been eroding. Enrollment and M+C penetration decreased from 53,980 and 14.8 percent in 2000 to 28,726 and 8.6 percent in 2003. There were seven plans in 1998; there are currently only two M+C plans in the Atlanta metropolitan area (hereafter, "Atlanta"), and neither plan is actively marketing at this time. Furthermore, premiums have increased and benefits have decreased—in 1998 and 1999, all M+C plans had zero premiums and offered prescription drug benefits. Now, premiums for all three M+C options range from $20 to $55, only the most expensive of which has a prescription drug benefit with a $500 limit. Observers express concern that remaining plans might also withdraw from participation.

Medigap Market. Although Georgia has one of the lowest rates of Medigap take-up in the country**,** many insurers are writing Medigap policies in Atlanta—at least 20 firms offer Plans A through D and F (Blue Cross-Blue Shield of Georgia [BC-BS]) recently began offering a high-deductible Plan F). For Plans H, I, and J, however, at most three plans are available. Only four plans write policies for disabled Medicare beneficiaries under age 65

according to Georgia's Department of Human Resources Web site. AARP and Blue Cross-Blue Shield of Georgia are the most prominent players in the Medigap market. Marketing fell off when the M+C plans entered the market, and there is very little visible Medigap marketing, most of which is done through brokers. Until recently, insurers have not sought to market Medicare Select plans (none is currently available in Atlanta). Few insurers have sought to introduce innovative benefits under Medigap, but more activity is anticipated since Wellpoint recently acquired BC-BS. Medigap premiums have been stable over time; in recent years, rate increases have generally been in the single-digit range. There have been larger increases for higher-end Medigap policies with drug benefits due to both the higher price and utilization of prescription drugs.

Group Insurance. The declining availability of private retiree health coverage accentuates the contrast between the generosity of benefits in the public and private sectors. Private companies are increasing cost sharing and decreasing retiree benefits in response to both rising health care costs and a stagnant economy. Reductions in retiree benefits have been larger for new and active employees than for current retirees. Although cost sharing is substantial for public retiree coverage, benefits are appreciably more generous than in the private sector.

Publicly Subsidized Coverage. Publicly subsidized coverage is more limited in Georgia than in many other states. Full Medicaid coverage is available only to elderly individuals with incomes below $317 per month and $2,000 in resources ($375 per month and $4,000 in resources for a couple). QMB requirements are $759 per month and $4,000 in resources ($1,015 per month and $6,000 in resources for a couple). Despite these limits, Medicaid officials note that about 35 percent of the state Medicaid budget is spent on dually eligible beneficiaries and that roughly half of its prescription expenditures are for this population. The stigma associated with Medicaid (especially with the Division of Family and Children Services [DFCS] offices) is a reported barrier to enrollment. A simplified mail-in application for the Medicare Savings programs (SMB/SLMB) has increased enrollment of dual eligibles in recent years. Public assistance for prescription drugs outside full Medicaid coverage is limited to the GeorgiaCares program, a public/private partnership that assists the elderly in applying for private prescription drug discount programs.

CONTEXT

Demographics and Economics. Insurers, agents, and beneficiary counselors all indicated that Medigap premiums may be unaffordable to the relatively large number of low-income beneficiaries in Atlanta. In the mid-1990s, M+C was an appealing option for low-income beneficiaries, especially those under 65. Disabled beneficiaries still have access to M+C plans in the Atlanta area (but not in most of the rest of the state), but the supplemental benefits available in the plans are now more limited. The relatively low level of employer-sponsored retiree coverage appears to reflect the nature of the employment market. State workers, however, have relatively generous retiree health benefits.

Provider Infrastructure. The sprawling nature of the metropolitan area has allowed a number of regional health systems to coexist and compete in the Atlanta hospital market.

Some of the largest systems are finding it difficult to remain consolidated. The fragmented nature of the physician market in metropolitan Atlanta is typical of many other markets in the southeastern United States. Both physicians and hospitals were active participants in M+C plans, but both now see the plans as fading away. Although some single-specialty physician groups exist, many physicians practice independently, partly because consolidation did not lead to substantial gains in negotiating leverage. Risk sharing by physicians is also limited—their lack of success with it in the past has rendered them hesitant to enter into such arrangements. Some specialty groups (including cardiologists) have full practices and are not accepting new patients (including Medicare patients). Others with open practices seem to be continuing to accept Medicare patients despite perceived problems with reimbursement rates, which some contend barely allow them to break even. Some interviewees reported hearing that some beneficiaries might be having difficulties finding physicians who accept new Medicare patients.

Regulatory Context. Georgia Medigap is not highly regulated. Community rating is not required, and guaranteed issue requirements for Medigap policies do not go beyond those specified in federal regulations. Insurers do not see regulatory restrictiveness as a barrier. There is anecdotal evidence suggesting that disabled beneficiaries under 65 have trouble obtaining Medigap coverage. Medigap companies in Georgia have the option of rating differentially within the state, and, although there does not appear to be a single method for doing so, most companies classify Atlanta as a higher-cost area.

Resources for Beneficiary Education. GeorgiaCares, the State Health Insurance Assistance Program (SHIP) in Georgia, provides individual counseling via telephone (and in-person counseling at a beneficiary's home, if necessary) for beneficiaries with questions related to Medicare and other health insurance concerns. In addition to individual counseling, GeorgiaCares distributes written materials at various community locations (for example, Wal-Mart pharmacies and DFCS offices). The majority of calls to GeorgiaCares concern prescription drugs, and it has recently begun assisting beneficiaries in applying for private prescription drug programs (free or discounted drugs) offered by individual pharmaceutical companies (or, in some cases, by groups of companies offering a discount card for specific brand-name drugs). This process may involve GeorgiaCares volunteers completing applications for up to eight different programs. There is not a common application form across programs.

Other Contextual Factors. There is a substantial number of federal employees and military retirees in the market. BC-BS reported significant migration of Medigap policyholders to Tri-Care for Life when the program started. The size of the market and degree of difficulty in travel across the market have contributed to regionalizing care among hospitals and affiliated specialists.

Medicare Supplemental Coverage: Market Profile

Long Island, New York (Nassau/Suffolk Counties)

BASIC STATISTICS

Total Population (2000):	**2,753,913**
M+C Penetration (2003):	**11.7%**
Under 65 as Percent Total Population:	**86.6%**
M+C Choices:	**2 plans, no PPO demonstration or PFFS**
Medicare Beneficiaries (2003):	**439,243**
M+C Average Payment Rate (2003):	**$651.37**
Percent of Medicare Beneficiaries over 65 with Incomes below 100% FPL:	**5.6%**
Percent of Workforce Covered by Collective Bargaining Agreements (2002):	**26.7%**

SUPPLEMENTAL OPTIONS

Medicare+Choice History. Long Island (defined here as Nassau and Suffolk counties) has experienced a steep decline in the number of M+C options available over the last several years, and the premiums for the remaining plans have risen substantially. There now are two plans serving Nassau and Suffolk counties. From extensive choice of zero-premium plans that offered substantial drug coverage a few years ago, beneficiaries can now choose only plans with premiums of $100 or more per month with limited pharmacy coverage. M+C penetration has dropped from over 20 percent in 2000 to 12 percent in 2003. Market difficulties are attributed to M+C payment rates substantially below those in New York City, even though costs are said to be the same; to hospital consolidation that makes rate negotiation with hospitals difficult; and to beneficiary preferences for extensive provider choice and heavy use of services and specialized care.

Medigap Market. Nine Medigap insurers offer products on Long Island, although only three offer any of the plans that cover prescription drugs (Plans H, I, and J). In fact, Plan J is not available in New York State now (with one limited group exception). The largest Medigap insurers are United HealthCare's AARP plan and Empire Blue Cross-Blue Shield (which offers only Plans A, B, and H and is not actively marketing the products). Insurers tend to include Long Island with New York City in pricing Medigap. Premiums are said to have been rising more rapidly for higher-end policies that cover drugs.

Group Insurance. Public sector employers and employee unions heavily influence the availability of retiree coverage on Long Island. Among these sectors, coverage appears to be relatively broad, with limited beneficiary contributions to premiums and cost sharing. Outside of a few large private firms, Medicare beneficiaries have little access to group retiree benefits. In small to medium-sized companies, the financial contribution by employers (if any) is more limited, with ongoing reductions and less coverage for new employees and active workers than current retirees.

Publicly Subsidized Coverage. New York's Medicaid program is substantially more comprehensive than that of other states. Full Medicaid coverage is available to individuals with incomes below $642 per month and $3,850 in resources ($934 and $5,600 for a couple). QMB requirements are $769 per month and $4,000 in resources ($1,030 and $6,000 for a couple). Those not eligible for Medicaid—if age 65 or higher—may enroll in the Elderly Pharmaceutical Insurance Coverage (EPIC) program if their incomes are $35,000 or less ($50,000 for a couple). Individuals with incomes up to $20,000 ($26,000 for a couple) pay an annual income-related premium and can purchase drugs for fixed copayments with no deductible. Others do not pay an annual premium and have access to prescription drugs for fixed copayments after they meet an income-related deductible. Application requirements are substantially easier for EPIC than for Medicaid. New York State operates a number of programs to enhance enrollment in Medicaid by dual eligibles, but barriers reportedly continue to exist (e.g., limited staffing in Nassau County's social service office and the need to apply for coverage in person).

CONTEXT

Demographics and Economics. Incomes tend to be above average, though pockets of poverty exist and ethnic diversity is common. For those without cars, access is limited by lack of public transportation and roads that are more developed for east/west travel than north/south travel. Residents of Long Island are viewed as heavy consumers of health care, demanding the latest technology in prestigious institutions. New York City's media market extends to Nassau and Suffolk counties. As a result, advertisements about the availability of zero-premium M+C products (in New York City) reach residents in outlying counties and generate confusion and resentment complicated by proximity to and migration out of the city. The New York metropolitan area is heavily unionized. Few expected to see dramatic erosion in retiree benefits, especially within the public sector. This stands in direct contrast to private retiree coverage among small to medium-sized companies, which appear to be witnessing the rapid erosion of retiree benefits.

Provider Infrastructure. On Long Island, hospitals generally have consolidated into two systems—NorthShore-Long Island Jewish (NorthShore-LIJ) and the Long Island Health Network—each of which contracts as a group. Physicians typically practice individually or in small groups. Provider risk sharing is limited—NorthShore-LIJ's risk-sharing arrangement with one health plan disintegrated after extensive losses. Hospitals tend to want diagnosis-related-group–based payment at the Medicare level or higher. Physicians are not typically organized and contract with plans on a one-on-one basis. Provider supply is extensive, with teaching affiliations common and a specialist/specialty services orientation.

Supply is more limited (though perceived as relatively adequate) on the easternmost part of Long Island, which is more isolated.

Regulatory Context. New York is a highly regulated state. In the Medigap market, offerors are required to community rate (for disabled as well as the elderly), and open enrollment is required (with limited exclusions for pre-existing conditions). Offerors appear to have adapted to the requirements and view them as creating a level playing field. Until 1997, New York State had hospital rate regulation, which meant that providers had limited infrastructure in place to negotiate and handle differential rates (this structure has now been developed).

Resources for Beneficiary Education. Both New York State and Long Island specifically appear to have an above-average set of written materials that describe options available under M+C and Medigap. However, resources for answering questions and counseling beneficiaries on a face-to-face basis are highly limited, with very little financing and a reliance on volunteers.

Other Contextual Factors. In New York State, three Blue Cross-Blue Shield plans operate. Empire BC-BS serves the greater New York metropolitan area and eastern New York State. (Excellus serves central New York, and Health Now serves western New York.)

Medicare Supplemental Coverage: Market Profile

Minneapolis/St. Paul, Minnesota (MSA)[7]

BASIC STATISTICS

Total Population (2000):	**2,868,847**
M+C Penetration (2003):	**24.5%**
Under 65 as Percent Total Population:	**90.4%**
M+C Choices:	**2 M+C risk plans, 2 cost plans, 3 PFFS, Evercare, dual-eligible demonstration**
Medicare Beneficiaries (2003):	**329,761**
M+C Average Payment Rate (2003):	**$564.10**
Percent of Medicare Beneficiaries over 65 with Incomes below 100% FPL:	**5.7%**
Percent of Workforce Covered by Collective Bargaining Agreements (2002):	**18.1%**

Statistics are for the Minneapolis/St. Paul MSA (Minnesota counties only): Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright.

SUPPLEMENTAL OPTIONS

Medicare+Choice History. Although managed care is well established in the state, enrollment in Medicare managed care in Minnesota over the past decade declined almost by half. M+C payment rates are significantly lower than in many other urban areas (the current rate is the urban floor rate). In the Minneapolis/St. Paul metropolitan area, however, enrollment is still relatively high and has been relatively stable over the past few years. The authority to continue Medicare cost plans has contributed to stability. Some organizations offer both risk and cost Medicare plans, often as a residual effect of plan mergers. Monthly premiums for M+C plans, which offer minimal drug benefits, range from $66 to $103; premiums for cost HMOs with relatively generous outpatient drug benefits (50 percent for outpatient drugs; 80 percent for Medicare-eligible drugs) are as low as $209 per month; and cost plans are able to provide a range of additional services, such as dental care, that are not available under Medigap riders. The cost plans compete directly on drug benefits with Select Medigap plans (see below). Three private fee-for-service plans have entered the Minnesota market, but only one has been there for a full year, and enrollment is small to date. One of the plans offers a prescription drug benefit but high deductibles for inpatient care.

[7] The Minneapolis/St. Paul MSA contains two counties in Wisconsin that are excluded from the statistics presented below.

Medigap Market. Enrollment in Medigap is higher than the national average—37 percent in the Minneapolis/St. Paul MSA (counties in Minnesota only)—and the state estimates that Minnesota beneficiaries with Medigap are far more likely than beneficiaries nationally to have a prescription drug benefit (43 percent compared to 27 percent). There are two basic types of supplemental policies sold by 19 companies statewide—Basic and Extended Basic. Basic plans include 100 percent of Medicare Part A and B costs except deductibles, some preventive services, foreign care, and half of most outpatient mental health services. Plans may (but are not required to) offer up to six specific riders under Basic. One authorized rider is a prescription drug benefit (but no insurer currently offers a Basic drug rider). The extended plan includes all six Basic riders and a set of additional riders that can be offered, including an expanded drug benefit. In 2003, Basic Medigap plans with a rider to cover the Part A deductible ranged between $100 and $200 per month. Extended Basic plans with drug coverage cost about three times as much. There are also four Select policies that require use of provider networks. Nondrug coverage Select plan premiums are in the same general range as Basic plans, but several Select Extended Basic plans with a standard (50 percent, no cap) drug benefit are relatively low-cost (as low as $229 per month). Medicare Select policies account for a large proportion of the Medigap market in Minnesota.

Group Insurance. Employer-sponsored supplemental has generally been less common in the Twin Cities than in many other metropolitan areas and is becoming even less common. Union membership is relatively low, but, even among large public employers with public sector unions, employer contributions to retiree health insurance for people over age 65 are becoming rare. Neither state employees nor retirees from the state university system receive any employer contributions to the retiree health benefit plans made available to them at group rates. The state has instituted a retirement insurance savings plan that allows employees to put aside pretax income to help pay for retirement health care and insurance costs.

Publicly Subsidized Coverage. Minnesota's programs that serve low-income beneficiaries are relatively generous. Income limits for full Medicaid are $748 for an individual and $1,010 for a couple; asset limits are $3,000 for an individual and $6,000 for a couple. For the Medicare Savings Programs (QMB and SLMB), Minnesota allows assets of $10,000 for an individual and $18,000 for a couple; however, the state now enforces estate recovery rules to the benefits, which may discourage participation in the Medicare Savings programs. The state prescription drug program is available to beneficiaries who have no other drug coverage (including even minimal coverage through an HMO) and who are enrolled in the Medicare QMB or SLMB program. Eligible participants pay only a $35 per month deductible for prescriptions; most drugs are covered. As of October 2003, this program began requiring that beneficiaries apply for all available private plans before receiving coverage, reportedly making this program less attractive. Minnesota's Senior Health Options Program is a waiver program that provides coordinated care through participating HMOs for dual eligibles. The state also offers a guaranteed issue high-risk pool supplemental insurance plan.

CONTEXT

Demographics and Economics. Compared to the national average, Minnesota beneficiaries have higher household incomes, more education, and are more likely to be white. The proportion of beneficiaries living in urban areas of the state is smaller than the percent of beneficiaries living in urban areas nationally. Consequently, beneficiaries statewide have less access to the highly integrated health care system available in urban areas; the proportion enrolled in M+C (risk or cost) plans is more than twice as high in the MSA counties as in rural counties. Metropolitan areas have more large employers and therefore more access to employer-sponsored retiree coverage, but beneficiaries in the Minneapolis/St. Paul MSA (counties in Minnesota only) are still less likely to have retiree coverage than the national average. Out-of-state benefits are also important for a significant number of Minnesota retirees and appear to influence their choice among supplemental insurance options.

Provider Infrastructure. Minneapolis/St. Paul is characterized primarily by the dominant role of integrated health care systems built on multispecialty and primary care practices. The metropolitan area is dominated by three hospital systems that are affiliated, and, in some cases fully integrated, with large physician groups. Minnesota law prohibits the operation of for-profit hospitals, HMOs, or PPOs. Commercial insurers can market Medigap in Minnesota, and they can participate in the market as contractors that help organize networks and administer claims. The provider/network relationships that have developed could affect the future structure of competition in and among Minnesota markets.

Regulatory Context. Minnesota is one of three "waiver" states with its own regulations for supplemental insurance that predated and differed from federal standards. Beneficiaries under age 65 have the same access to Medigap as Minnesotans age 65 and older, including open enrollment without underwriting for six months after enrolling in Part B. Attained and issue age rating are not permitted in Minnesota. Minnesota takes a very active role in the regulation of insurance products. State regulators believe they have a responsibility to oversee not only Medigap products marketed under the state's waiver rules but also aspects of other products, including M+C products (PFFS as well as HMOs and PPOs) sold in the state. The state's regulatory activism raises issues about the scope and intent of federal preemption of state regulations in the areas of benefits, coverage, marketing requirements, and other consumer protections.

Resources for Beneficiary Education. In addition to state resources, including a statewide telephone and Internet information service for Medicare beneficiaries, Minnesota beneficiaries receive extensive help from the Minnesota Senior Federation, a large statewide membership and advocacy organization. Among its other activities, the federation provides telephone and in-person counseling to seniors about health insurance options and publishes a comprehensive guide to all forms of Medicare supplementation, which is used by state offices, providers, payers, health advocates, and beneficiaries throughout the state.

Other Contextual Factors. Providers, insurers, and beneficiary advocates in the Twin Cities are very concerned about both Medicare payment rates for M+C plans and the relatively low total Medicare payments to providers in the state, which they believe

undermine the area's strong commitment to integrated care delivery and a leadership role in the development of innovative models of coordinated care. The state is also facing a major budget crisis that limits resources available for Medicaid and the state prescription drug program.

Medicare Supplemental Coverage: Market Profile

State of Nebraska

BASIC STATISTICS	
Total Population (2000):	**1,711,263**
M+C Penetration (2003):	**3.6% (12.7% in Omaha)**
Under 65 as Percent Total Population:	**86.4%**
M+C Choices:	**1 HMO, 1 PPO, 2 PFFS (HMO available only in Omaha, PPO available in Omaha and 5 surrounding counties), no PPO demonstration or PFFS**
Medicare Beneficiaries (2003):	**263,677**
M+C Average Payment Rate (2003):	**$529.56**
Percent of Medicare Beneficiaries over 65 with Incomes below 100% FPL:	**7.5%**
Percent of Workforce Covered by Collective Bargaining Agreements (2002):	**11.1%**

SUPPLEMENTAL OPTIONS

Medicare+Choice History. Nebraska's experience with Medicare+Choice has been centered in Omaha (Douglas County). Since 1999, when Mutual of Omaha withdrew its M+C HMO plan, United HealthCare has been the only M+C HMO plan in Nebraska, serving only the Omaha area. United HealthCare's risk contract goes back to 1985. Currently, United HealthCare offers a low- and high-option plan in Douglas County. As of April, United HealthCare also began offering a PPO product (nondemonstration) in Douglas County and five surrounding counties. The PPO is a zero-premium product, with much the same cost-sharing provisions as the low-option HMO product. Outside of Omaha, Medicare beneficiaries can enroll in two private fee-for-service plans: Sterling's Option 1 plan or Unicare's Security Choice plan, neither of which offers a drug benefit. Combined, the two private fee-for-service plans have enrolled fewer than 150 Medicare beneficiaries in Nebraska and do not appear to be a major competitive concern for Medigap insurers in the state. The relative lack of M+C HMO plans in areas outside of Omaha is credited to the rural nature of the state and the inability to put together workable provider networks.

Medigap Market. Medigap is by far the most common source of supplemental insurance coverage in Nebraska. Approximately 54 percent of Medicare beneficiaries in the state have supplemental coverage through a Medigap plan. Thirty-five Medigap insurers offer products in Nebraska, though only four offer any of the prescription drug plans. There is no guaranteed issue law in Nebraska for under-65 Medicare beneficiaries, and only two of the Medigap insurers offer products to them. The largest Medigap insurer, covering between 75,000 and 80,000 individuals in the state, is Blue Cross-Blue Shield (BC-BS) of Nebraska (which offers Plans A, B, C, and F.) Approximately 90 percent of BC-BS of Nebraska's individual policyholders are in Plan F. BC-BS of Nebraska has always been the dominant Medigap insurer in the state due in part to the insurer's historic ties to the banks. BC-BS sells its Medigap policies, especially in rural areas, primarily through the banks, which have agreements with BC-BS to allow BC-BS representatives to come into the banks on a regular basis to provide information on their products and sell policies to the bank's customers. BC-BS of Nebraska sets premiums for its policies on a statewide basis, though some of the other insurers have different rates according to whether the individual is in Lincoln, Omaha, or any other part of the state. High-deductible plans are available in the state, though they are not very popular.

Group Insurance. Levels of employer-sponsored retiree coverage in Nebraska are low due primarily to the lack of large businesses and unions in the state. Businesses traditionally have not had to offer retiree health coverage to attract employees. The state government itself does not offer retiree health coverage to Medicare-eligible retirees. In recent years as employer contributions have decreased, those individuals with employer-sponsored coverage have had to fund more of that health care coverage themselves. However, take-up rates among those employers offering coverage are high, primarily because of the prescription drug coverage included in the plans. Employer-sponsored coverage is likely to decrease in the future as more employers are expected to stop offering retiree coverage to new hires.

Publicly Subsidized Coverage. Full Medicaid coverage is available to elderly, blind, and disabled individuals with incomes below $768 per month and $4,000 in resources (100 percent of federal poverty level plus a $20 disregard). The main barrier to enrollment has been the asset test, especially in some rural areas where individuals may own a family farm but have very little income. Nebraska does not have a prescription drug assistance program nor has it seriously considered establishing a program.

CONTEXT

Demographics and Economics. There are two distinct geographic markets in Nebraska, the metropolitan areas surrounding Interstate 80 (known as the I-80 corridor) and the rural areas. The metropolitan areas are more comparable to other urban areas of the country in terms of income and demographics. However, the state's rural areas are comparatively poor relative to urban areas and are said to be getting poorer. The populist nature of the state places a high value on self-reliance, which some suggest accounts for the high rate of Medigap and individual insurance in the state as people want to feel that they are paying their own bills. In rural areas, long distances between towns are common. Medical care in Nebraska has historically been conservative, low in utilization and costs.

Provider Infrastructure. Omaha and Lincoln are the only two areas of the state with true competing health systems. In Omaha, there are four competing hospital systems, and in Lincoln there are two. The rest of the state is served by small, local hospitals (under 25 beds) and a few somewhat larger regional hospitals. Nebraska has the highest number of critical access hospitals in the country. The critical access program, which mandates that critical access hospitals receive billed charges, is credited with providing some stability to these small hospitals across the state. The lack of provider competition in most of the state has meant there has been almost no managed care throughout rural areas since providers have been unwilling to join networks. There are only two statewide preferred provider networks in Nebraska: Blue Cross-Blue Shield of Nebraska and Midland's Choice. The provider networks are paid based on discounted fee-for-service rates. In rural areas of the state, local physicians provide primary care, but specialty care is provided in clinic settings by physicians from Omaha and Lincoln who rotate through. In the metropolitan areas of the state, where there are some managed care arrangements on the commercial side, provider risk sharing is uncommon. While there have been some reports of doctors not accepting new Medicare patients, this appears to be uncommon and not a major concern to beneficiaries. There have been some issues surrounding providers who have been unwilling to participate in the M+C private fee-for-service plans because they would rather deal directly with Medicare than with a third party.

Regulatory Context. Nebraska conforms to NAIC requirements. Insurers and consumers seem comfortable with the regulatory environment. In order for their rate increases to be credible, the Department of Insurance generally requires Medigap insurers to pool nationally. The lack of innovative benefits within Medigap (no insurers offer innovative benefits) is considered to be the result of a lack of interest on the part of Medicare beneficiaries and insurance companies rather than the result of any regulatory impediments from the Department of Insurance. Should a prescription drug benefit pass at the federal level, one state regulation that might come into play is that the state does not allow insurers to give their beneficiaries a discount on cost sharing if the beneficiary uses mail order. The regulation was passed at the behest of rural drug stores in the state.

Resources for Beneficiary Education. The state Department of Insurance houses the Nebraska Health Insurance Information, Counseling, and Assistance Program (NICA), which provides education and assists seniors and disabled individuals with their health insurance options. NICA publishes an annual Medigap rate guide, has a toll-free telephone line to answer questions from individuals, and does some outreach throughout the state. In addition, beneficiaries can get information from local area agencies on aging. Medicare beneficiaries also rely on the help of insurance agents.

Other Contextual Factors. Blue Cross-Blue Shield of Nebraska is the dominant insurer in the state, both in the Medigap market and on the commercial side. Providers told us they are very happy with BC-BS of Nebraska because they have been administratively easy to deal with and process payments promptly.

Medicare Supplemental Coverage: Market Profile

San Diego, California (County/MSA)

BASIC STATISTICS

Total Population (2000):	**2,813,933**
M+C Penetration (2003):	**40.2%**
Under 65 as Percent Total Population:	**88.8%**
M+C Choices:	**4 M+C risk plans, no PPO demonstration, no PFFS**
Medicare Beneficiaries (2003):	**361,966**
M+C Average Payment Rate (2003):	**$604.13**
Percent of Medicare Beneficiaries over 65 with Incomes below 100% FPL:	**6.6%**
Percent of Workforce Covered by Collective Bargaining Agreements (2002):	**18.4%**

SUPPLEMENTAL OPTIONS

Medicare+Choice History. San Diego has among the highest penetration rates of M+C enrollment in the country; however, the M+C enrollment has been declining. San Diego has experienced a decline in the number of M+C options available, and there are no longer any zero-premium plans in the county. There were eight plans in 1998, including four with county enrollments of at least 10,000 members; there are now four plans, including three with 10,000 or more members. Premiums for the plans range from $20 to $60 per month. Three of the plans include coverage of only generic drugs while the fourth plan also offers coverage for brand-name drugs. Enrollment in M+C plans has dropped from about 165,000 members in 1998 to about 145,000 members in 2003. M+C penetration dropped from 49 percent to 40 percent in 2003. Observers say that perhaps half of that drop may have been due to military retirees moving into TRICARE for Life, the free supplemental insurance policy that was introduced in 2001.

Medigap Market. San Diegans have a wide choice of Medigap products. The CMS Web site lists 29 different insurers offering Medigap to seniors in San Diego. Each of the 10 different Medigap plans (Plans A through J) is available from at least six different insurers. The under-65 disabled have a narrower range of choices but still have at least three options available for each plan and have guaranteed issue rights when they become eligible for Medicare. While data on Medigap enrollment is not available, it is likely that the largest proportion of Medigap enrollees are in plans offered by Wellpoint. Other than the Plan A offering, the Wellpoint plans are all Select products, which means that beneficiaries must use

network providers to receive full Medigap coverage. Also, the Wellpoint plans (Blue Cross of California) may have high deductibles and offer innovative benefits such as a generic drug benefit.

Group Insurance. Outside of public sector employees and unionized workers, subsidized retiree health insurance appears to be scarce. The San Diego labor market seems to be comprised of mostly small and medium-sized employers, with little union membership. These employers usually do not offer retiree coverage, especially for over-65 retirees. Some of these employers may help retirees by negotiating a group policy that includes drug coverage, but the employer does not subsidize the plan. Thus, some Medicare beneficiaries may have access to retiree health benefits, but they must pay the full cost.

Publicly Subsidized Coverage. California's Medicaid program (MediCal) is county-based. San Diego County's program (Healthy San Diego) uses a Geographic Managed Care (GMC) model and relies heavily on managed care plans. However, M+C plan members may not join MediCal plans. Few M+C members are dual eligibles. Full Medicaid coverage is available to individuals with incomes below $757 per month and $2,000 in resources ($1,334 and $3,000 for couples). QMB requirements are $769 per month and $4,000 in resources ($1,030 and $6,000 for couples). California does not have a low-income drug program but requires all pharmacies participating in Medicaid to sell prescription drugs to Medicare beneficiaries at 115 percent of the Medicaid rate.

CONTEXT

Demographics and Economics. San Diego is geographically isolated from other U.S. health care markets. It is contained by the Mexican border on the south, the Pacific Ocean on the west, a very large military base (Camp Pendleton) on the north, and mountains on the east. While the cost of living, especially the cost of real estate, is high, low-income people, including undocumented immigrants, are a relatively high proportion of the population. San Diego also has a large military presence, in terms of bases, military health care facilities, and military retirees. TRICARE for Life currently has approximately 46,600 enrollees in San Diego County (13 percent of all beneficiaries).

Provider Infrastructure. San Diego is one of the few places left in the country where providers are willing to accept capitated payments. Three large integrated systems dominate the market: Kaiser, Scripps, and Sharp. Each system controls hospitals and large physician groups, although insurers may not own physician practices. There are also a large number of physicians employed by military and veterans facilities. Those facilities and physicians that are not affiliated with one of the large systems tend to be independent and solo practitioners. There is no public hospital in San Diego, so uncompensated care tends to be spread across many hospitals. Physicians in San Diego, particularly those unaffiliated with the large groups, are very upset by what they feel are low Medicare rates relative to the cost of living. The geographic adjustments for the physician fee schedule is the same as that for rural California, and lower than that for the other major urban areas in the state.

Regulatory Context. Medigap insurers and M+C plans seem comfortable with the regulatory environment in California despite the fact that there are two different state agencies involved. The Department of Insurance regulates the Medigap plans, except for the Blue Cross-Blue Shield plans. The Department of Managed Health Care regulates the Blues' plans, along with the HMOs. State regulations ban the "corporate practice of medicine"; therefore, physician groups may not be owned by the plans.

Resources for Beneficiary Education. The Health Insurance Counseling and Advocacy Program (HICAP) for San Diego serves both San Diego and Imperial counties. Resources for answering questions and counseling beneficiaries on a one-on-one basis are highly limited, with very little financing and a reliance on volunteers. The California Healthcare Foundation publishes extensive guides to options available in California.

Other Contextual Factors. The Blue Cross plan in California is Wellpoint and has traditionally been strong in southern California while the Blue Shield plan is separate and has been stronger in northern California. The Blue Shield plan does not seem to have much of the San Diego senior market.

MEDPAC Medicare Payment Advisory Commission

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