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MEDIGAP

Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives

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Madam Chairwoman and Members of the Subcommittee:

I am pleased to be here today as you consider the role of "Medigap" policies in supplementing the Medicare benefit. Medicare provides valuable and extensive coverage for the health care needs of 40 million elderly and disabled beneficiaries. Nevertheless, recent discussions have underscored the significant gaps that leave some beneficiaries vulnerable to sizeable financial burdens from out-of-pocket costs. Most beneficiaries have additional supplemental coverage that helps to fill Medicare's coverage gaps and pay some out-of-pocket expenses. Privately purchased Medigap policies are an important source of this supplemental coverage because they are widely available to beneficiaries. The other sources—employer-sponsored policies, Medicare+Choice plans, and Medicaid programs—are not available to all beneficiaries. However, concerns exist that Medigap policies can be expensive and may undermine the legitimate role of cost-sharing in a health insurance plan—that is, to encourage the cost-effective use of services. Moreover, due to statutory restrictions, these policies provide only limited prescription drug coverage, leaving an important gap in beneficiary protection against high health care expenses.

In this context, the president has proposed adding 2 new types of Medigap plans to the existing 10 standard plan types.[1] The new plans would provide protection against catastrophic expenses for Medicare-covered services and would include different levels of prescription drug coverage. To help keep premiums affordable, the new plans would also require beneficiary cost-sharing. At this point, detailed specifications for these plans are not available.

To assist the subcommittee as it considers ways to improve protections for beneficiaries, my remarks today focus on the design of Medicare's benefit package and the role that Medigap plays in providing supplemental coverage. Specifically, I will discuss (1) beneficiaries' potential financial liability under Medicare's current benefit structure and cost-sharing requirements, (2) the cost of Medigap policies and the extent to which they provide additional coverage, and (3) concerns that Medigap's so-called "first dollar" coverage—its coverage of Medicare's required deductibles and coinsurance—undermines the cost control incentives of Medicare's cost-sharing requirements. My comments are based on our

[1]*Budget of the United States Government, Fiscal Year 2003* (Washington, D.C.: Government Printing Office, Feb. 4, 2002).

prior and ongoing work on Medicare and Medigap as well as other published research.[2]

In summary, Medicare's benefit package and cost-sharing requirements leave beneficiaries liable for high out-of-pocket costs. As currently structured, Medicare provides no limit on out-of-pocket spending and no coverage for most outpatient prescription drugs—a component of medical care that is of growing importance in treatment and rapidly increasing in cost. Recent estimates suggest that about 45 percent of Medicare beneficiaries' health care costs are not covered.

Medigap policies help to fill in some of Medicare's gaps but also have shortcomings. They are often expensive. In 1999, premiums paid for Medigap policies averaged $1,300, with more than 20 percent going to administrative costs. Medigap plans typically cover Medicare's required deductibles, coinsurance, and copayments but do not fully protect beneficiaries from potentially significant out-of-pocket costs. Medigap policies offering prescription drug coverage can be inadequate because beneficiaries still pay most of the cost and the Medigap benefit is capped. In addition, Medigap's first-dollar coverage eliminates the effect Medicare's cost-sharing requirements could have to promote prudent use of services. The danger is that some services may be overused, ultimately increasing costs for beneficiaries and the Medicare program.

Background

Individuals who are eligible for Medicare automatically receive Hospital Insurance (HI), known as part A, which helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health care services. Beneficiaries pay no premium for this coverage but are liable for required deductible, coinsurance, and copayment amounts. (See table 1.) Medicare-eligible beneficiaries may elect to purchase Supplementary Medical Insurance (SMI), known as part B, which helps pay for selected physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for part B coverage, currently $54 per month.[3] Beneficiaries are also responsible for part B deductibles and coinsurance.

[2]U.S. General Accounting Office, *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs*, GAO-01-941 (Washington, D.C.: July 31, 2001).

[3]The premium amount is adjusted each year so that expected premium revenues equal 25 percent of expected part B spending.

Table 1: Medicare Coverage and Beneficiary Cost-Sharing, 2002

Part A Coverage	Copayments and deductibles
Inpatient hospital	For each benefit period: $812 deductible for up to 60 days[a] $203/day for days 61 through 90 $406/day for days 91 through 150[b] All costs beyond 150 days
Skilled nursing facility	For each benefit period: Nothing for up to 20 days $101.50/day or less for days 21 through 100 All costs beyond 100 days
Home health	Nothing 20 percent of approved amount for durable medical equipment
Hospice	$5 or less for outpatient drugs 5 percent of approved amount for inpatient respite care
Blood	Cost of first 3 pints
Part B Coverage[c]	
Physician and Medical	$100 deductible each year 20 percent of approved amount 50 percent of approved amount for mental health
Clinical laboratory	Nothing
Home health	Nothing 20 percent of approved amount for durable medical equipment
Outpatient hospital	Coinsurance or copayment varies according to service (after part B deductible)
Blood	Cost of first 3 pints 20 percent of approved amount (after part B deductible) for additional pints

[a]No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

[b]After the first 90 days of inpatient care, Medicare may help pay for an additional 60 days of inpatient care (days 91 through 150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

[c]No cost-sharing is required for certain preventive services—including specific screening tests for colon, cervical, and prostate cancer and flu and pneumonia vaccines.

Source: Centers for Medicare and Medicaid Services, *Medicare & You 2002*, CMS-10050 (Baltimore: Sept. 2001).

Most Medicare beneficiaries have some type of supplemental coverage to help pay for Medicare cost-sharing requirements as well as for some services not covered by Medicare. They obtain this coverage either through employers, Medicare+Choice plans, state Medicaid programs, or Medigap policies sold by private insurers.

About one-third of Medicare's 40 million beneficiaries have employer-sponsored supplemental coverage. These plans, which typically include cost-sharing requirements, pay for some costs not covered by Medicare, such as shares of coinsurance and deductibles and the cost of prescription drugs. However, many beneficiaries do not have access to employer-sponsored coverage. A recent survey found that more than 70 percent of large employers with at least 500 employees did not offer these health benefits to Medicare-eligible retirees.[4] Small employers are even less likely to offer retiree health benefits.

Approximately 14 percent of Medicare beneficiaries are enrolled in Medicare+Choice plans, which include health maintenance organizations (HMO) and other private insurers who are paid a set amount each month to provide nearly all Medicare-covered services. Compared to Medicare's traditional fee-for-service program, HMOs typically offer lower cost-sharing requirements and additional benefits, including prescription drugs, in exchange for a restricted choice of providers. However, Medicare+Choice HMOs are not available in all parts of the country. In 2002, about 40 percent of all beneficiaries live in counties where there are no Medicare+Choice HMOs.

In 1997, about 17 percent of Medicare beneficiaries received assistance from Medicaid, the federal-state health financing program for low-income aged and disabled individuals. Depending upon state-defined eligibility policies, some of these low-income individuals are entitled to full Medicaid benefits (so called "dual eligibles"), which include coverage for certain services not available through Medicare, such as most outpatient prescription drugs. Under federal law, all Medicare beneficiaries with incomes below the federal poverty level are entitled to have their Medicare premiums and cost-sharing paid for by Medicaid. Similarly, Medicare beneficiaries with incomes slightly above the poverty level are eligible to have all or part of their Medicare premiums paid for by Medicaid.[5]

[4]William M. Mercer, Incorporated, *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000* (New York, N.Y.: 2001).

[5]Many low-income Medicare beneficiaries who are eligible for Medicaid and other federal-state programs that provide assistance with premiums and cost-sharing requirements may not enroll, in part due to limited awareness of these programs and the administrative complexity of demonstrating eligibility. See U.S. General Accounting Office, *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment*, GAO/HEHS-99-61 (Washington, D.C.: Apr. 9, 1999).

Medigap is the only supplemental coverage option available to all beneficiaries when they initially enroll in Medicare at age 65 or older. Medigap policies are offered by private insurance companies in accordance with state and federal insurance regulations. In 1999, more than 10 million individuals—about one-fourth of all beneficiaries—were covered by Medigap policies.[6] The Omnibus Budget Reconciliation Act of 1990 (OBRA) required that Medigap policies be standardized and allowed a maximum of 10 different benefit packages offering varying levels of supplemental coverage.[7] Policies sold in most states since July 31, 1992, are modeled on 1 of the 10 standardized packages, known as plans A through J. (See table 2.) Policies sold prior to this time were not required to comply with the standard benefit package requirements. The Balanced Budget Act of 1997 permitted insurers to offer high-deductible versions of the existing F and J plans.[8]

Table 2: Benefits Covered by Standardized Medigap Policies

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F[a]	Plan G	Plan H	Plan I	Plan J[a]
Coverage for: • Part A coinsurance • 365 additional hospital days during lifetime • Part B coinsurance • Blood	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B balance billing[b]						X	X		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
Home health care				X			X		X	X
Outpatient prescription drugs								X[c]	X[c]	X[d]
Preventive medical care					X					X

Note: This chart does not apply in Massachusetts, Minnesota, and Wisconsin, where alternative standards for supplemental health policies exist.

[a]Plans F and J also have a high-deductible option ($1,620 in 2002) under which beneficiaries also pay deductibles for prescriptions ($250 per year for plan J) and foreign travel emergency ($250 per year for plans F and J).

[6]The National Association of Insurance Commissioners reports that Medigap enrollment has declined from about 14 million in 1994.

[7]Pub. L. 101-508, § 4351, 104 Stat. 1388-30, 1388-127 (1990).

[8]Pub. L. No. 105-33, § 4032, 111 Stat. 251, 359 (1997).

[b]Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payment rate. Plan G pays 80 percent of balance billing; plans F, I, and J cover 100 percent of these charges.

[c]Plans H and I pay 50 percent of drug charges up to $1,250 per year and have $250 annual deductibles.

[d]Plan J pays 50 percent of drug charges up to $3,000 per year and has a $250 annual deductible.

Source: Health care Financing Administration, *2001 Guide to Health Insurance for People with Medicare*, HCFA-02110 (Baltimore: 2001).

Currently, Medicare beneficiaries aged 65 and older are guaranteed access to Medigap policies within 6 months of enrolling in part B, regardless of their health status.[9] Subsequent laws have added guarantees for certain other beneficiaries. Beneficiaries who enroll in a Medicare+Choice plan when first becoming eligible for Medicare at age 65 and then leave the plan within 1 year are also guaranteed access to any Medigap policy. Those who terminate their Medigap policies to join a Medicare+Choice plan can return to their previous policies or, if the original policies are not available, be guaranteed access to plans A, B, C, and F, none of which covers prescription drugs. Also, individuals whose employers eliminate retiree benefits or whose Medicare+Choice plans leave the program or stop serving their areas are guaranteed access to these four standardized Medigap policies.[10] Beneficiaries who do not meet any of these conditions may be denied coverage or be charged higher premiums.

[9]42 USC § 1395ss(s)(2)(A).

[10]These protections, which applied to beneficiaries aged 65 and older, were added by the Balanced Budget Act, Pub. L. 105-33, § 403,111 Stat. 251, 330. In addition to these federal protections, 21 states provided for additional Medigap protections in 2000.

Medicare's Cost-Sharing Requirements and Gaps in Prescription Drug Coverage Put Beneficiaries at Considerable Financial Risk

In Medicare, the lack of dollar limits on beneficiaries' cost-sharing obligations—deductibles, coinsurance, and copayments—puts beneficiaries with extensive health care needs at risk for very large expenses for Medicare-covered services. Similarly, Medicare's lack of coverage for certain services, especially most outpatient prescription drugs, can expose beneficiaries to substantial financial risk. The increasingly important role of pharmaceuticals in medical care and the continuing rapid increases in drug prices accentuate this risk.

Unlike most employer-sponsored plans for active workers, Medicare does not limit beneficiaries' cost-sharing liabilities, which can represent a significant share of their personal resources. In 2000, premiums, deductibles, coinsurance, and copayments that beneficiaries were required to pay for services that Medicare covers equaled an estimated 23 percent of total Medicare expenditures. For Medicare-covered services alone, beneficiaries who obtained services in 1998 had an average liability of $1,458, consisting of $932 in Medicare cost-sharing in addition to the $526 in annual part B premiums for that year.

However, the burden of Medicare cost-sharing can be much higher for beneficiaries with extensive health care needs. In 1998, the most current year of available data on the distribution of these costs, about 3.4 million beneficiaries (11.5 percent of beneficiaries who obtained services) were liable for at least $2,000 for Medicare cost-sharing and part B premiums. Approximately 736,000 of these beneficiaries (2.5 percent) were liable for at least $5,000, and about 167,000 beneficiaries (0.6 percent) were liable for at least $10,000. In contrast, private employer-sponsored health plans for active workers in 2000 typically limited maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[11]

Furthermore, Medicare provides no coverage for certain health care services, such as most outpatient prescription drugs. These limitations put beneficiaries at additional risk of incurring potentially catastrophic expenses. Current estimates suggest that the combination of Medicare's cost-sharing requirements and limited benefits leaves about 45 percent of beneficiaries' health care costs uncovered. In 2000, the average beneficiary is estimated to have incurred about $3,100 in total out-of-pocket expenses

[11]The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, Calif. and Chicago: 2000).

for health care—an amount equal to about 22 percent of beneficiary income.[12]

The combination of Medicare cost-sharing and costs of uncovered services represents a much greater financial burden for some beneficiaries. For example, in 2000, elderly beneficiaries in poor health and with no Medicaid or supplemental insurance coverage are estimated to have spent 44 percent of their incomes on health care. Low-income single women over age 85 who are in poor health and not covered by Medicaid are estimated to have spent more than half (about 52 percent) of their incomes on health care services.[13] These percentages are expected to increase over time as Medicare premiums and costs for prescription drugs and other health care goods and services rise faster than incomes.

Current Medigap Policies Address Some Medicare Shortcomings But Are Expensive

The shortcomings in Medicare's benefit package underscore the importance of supplemental health insurance for program beneficiaries. More than one-fourth of beneficiaries have Medigap policies to fill Medicare coverage gaps, but these policies can be expensive and do not fully protect beneficiaries from catastrophic out-of-pocket expenses. Medigap policies that provide drug coverage offer only limited protection from prescription drug expenses because of high cost-sharing and low coverage caps. The extent to which the president's proposed plan types—which include catastrophic coverage protection, a prescription drug benefit, and beneficiary cost-sharing requirements—would address these shortcomings will depend on the details of the new policies.

Medigap Fills Some Needs

More than 10 million Medicare beneficiaries have Medigap policies to cover some potentially high costs that Medicare does not pay, including cost-sharing requirements, extended hospitalizations, and some prescription drug expenses. By selecting from among a group of standardized plans, beneficiaries can match their coverage needs and financial resources with plan coverage. Medigap policies are widely available to beneficiaries, including those who are not eligible for, or do not have access to, other insurance to supplement Medicare, such as

[12]Stephanie Maxwell, Marilyn Moon, and Mesha Segal, *Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries* (Washington, D.C.: Urban Institute, 2000).

[13]Maxwell, Moon, and Segal.

Medicaid or employer-sponsored retiree benefits. In fact, most Medicare beneficiaries who do not otherwise have employer-sponsored supplemental coverage, Medicaid, or Medicare+Choice plans purchase Medigap policies, demonstrating the value of this coverage to the Medicare population.

Medigap Policies Can Have High Premiums

Medigap policies can be expensive. In 1999, the average annual Medigap premium was more than $1,300. Premiums varied based on the level of coverage purchased. Plan A, which provides the fewest benefits, was the least expensive, with average premiums of nearly $900 per year. (See table 3.) The most popular plans—C and F—had average premiums of about $1,200. The most comprehensive plans that provide some drug coverage—I and J—were the most expensive, with average annual premiums around $1,700.

Table 3: Distribution of Medigap Plans and Annual Premiums Per Covered Life, 1999

Medigap plan	Covered lives (percentage)	Average annual premium
A	2.7	$877
B	7.8	1,093
C	15.7	1,158
D	3.7	1,032
E	1.5	1,067
F	22.9	1,217
G	1.5	981
H	1.4	1,379
I	1.5	1,698
J	2.6	1,672
Prestandard (policies sold before July 1992)	34.9	1,525
Plans in states in which insurers are exempt from offering standardized plan[a]	4.0	1,368
Total[b]	**100.0[c]**	**1,311**

[a]Massachusetts, Minnesota, and Wisconsin have alternative plans in effect and waivers that exempt them from selling the national standard Medigap plans.

[b]Data reported by insurers to the National Association of Insurance Commissioners (NAIC) do not include plan type for policies representing less than 8 percent of Medigap policy covered lives, with an average paid premium of $1,275. These plans are not included in the table.

[c]Percentages do not add to 100 due to rounding.

Source: GAO analysis of data collected by the NAIC from the 1999 Medicare Supplement Insurance Experience Exhibit.

Medigap premiums also varied across geographic areas and insurers. For example, in 1999, average annual premiums in California were 35 percent higher than the national average for policies conforming to the standard plans. While premiums may reflect geographic differences in use of Medicare and supplemental services and costs, beneficiaries in the same state may face widely varying premiums for a given plan type offered by different insurers.[14] For example, in Illinois, plan A premiums for a 65-year-old ranged from $467 to $1,202, depending on the insurer. Similarly, in New York, plan F premiums for a 65-year-old ranged from $1,617 to $2,800, and in Texas, plan J premiums ranged from $2,059 to $5,658.

Medigap policies are becoming more expensive. One recent study reported that, from 1999 to 2000, premiums for the three Medigap plan types offering prescription drug coverage (H, I, and J) increased the most rapidly—by 17 to 34 percent. Medigap plans without prescription drug coverage rose by 4 to 10 percent.[15]

A major reason premiums are high is that a significant share of premium dollars is used for administrative costs rather than benefits. On average, more than 20 cents from each Medigap premium dollar is spent for costs other than medical expenses, including administration. Administrative costs are high, in part, because nearly three-quarters of policies are sold to individuals rather than groups.[16] The share of premiums spent on benefits varies significantly among carriers. The 15 largest sellers of Medigap policies spent from 64 to 88 percent of premiums on benefits in 1999. The share of premiums spent on benefits is lower for Medigap plans than either typical Medicare+Choice plans or health benefits for employees of large employers. In comparison, 98 percent of Medicare fee-for-service funds are used for benefits.

[14]Premium quotes are from 2000 and 2001 state consumers guides on Medigap policies.

[15]Weiss Ratings Inc, "Prescription Drug Costs Boost Medigap Premiums Dramatically," (Palm Beach Gardens, Fla.: Mar. 26, 2001). http://www.weissratings.com/NewsReleases/Ins_Medigap/20010326Medigap.htm (downloaded May 3, 2001).

[16]Federal law requires Medigap plans to spend at least 65 percent of premiums over time on benefits for policies sold to individuals and 75 percent for policies sold to groups. *See* 42 USC § 1395ss(r)(1)(A).

Medigap Provides Limited Coverage for Prescription Drugs

Medigap policies can leave beneficiaries exposed to significant out-of-pocket costs for prescription drugs. Medigap policies with a drug benefit are expensive, yet the drug benefit offered can be of limited value to many beneficiaries. The Medigap annual prescription drug benefit has a $250 deductible, requires 50 percent coinsurance, and limits coverage to $1,250 or $3,000, depending on the plan purchased. These dollar amounts have not been increased since they were established in 1992. As a result of the deductible and coinsurance provisions, a beneficiary with Medigap plan type J would have to incur $6,250 in prescription drug costs to get the full $3,000 benefit. Moreover, Medigap policies offering drug coverage typically cost much more than policies without drug coverage. For example, plan type J—the most popular plan with prescription drug coverage—costs, on average, $450 a year more than the most popular plan without drug coverage (plan F).

Having a Medigap policy with drug coverage versus one without has little effect on beneficiaries' out-of-pocket spending on drugs. In 1998, Medigap policyholders with prescription coverage spent, on average, $548 out of pocket on prescription drugs. Medigap paid only 27 percent of policy holders drug costs. Medigap policyholders without prescription drug coverage spent, on average, $618 out of pocket on drugs—about 13 percent more than beneficiaries with drug coverage.

The high cost and limited benefit of existing Medigap plans may explain why more than 90 percent of beneficiaries with Medigap coverage purchased standard plans that do not include drug benefits.[17] Another reason is that, in most states, Medicare beneficiaries who do not purchase Medigap policies when they initially enroll in part B at age 65 or older are not guaranteed access to the Medigap policies with prescription drug coverage. For those beneficiaries, insurers may either deny coverage or charge higher premiums.

[17]While less is known about the benefits offered by prestandardized plans that were sold prior to 1992—representing about one-third of Medigap enrollment in 1999—one expert estimated that most are likely to have some coverage for prescription drugs but that this coverage is even more limited than that offered by the standardized plans. See Deborah J. Chollet, Mathematica Policy Research Inc., "Medigap Coverage for Prescription Drugs," testimony before the U.S. Senate Committee on Finance, April 24, 2001.

First-Dollar Coverage Increases Medigap Premiums and Weakens Medicare's Cost Control Features

The most popular Medigap plans are fundamentally different from other health insurance policies, which typically include cost-sharing provisions in the form of deductibles, coinsurance, and copayments. Cost-sharing requirements are intended to make beneficiaries aware of the costs associated with the use of services and encourage them to use these services prudently. In contrast, Medigap's first-dollar coverage—the elimination of any deductibles or coinsurance associated with the use of covered services—undermines this objective. All standard Medigap plans cover hospital and physician coinsurance, with some of them also covering the full hospital deductible, skilled nursing facility coinsurance, or the part B deductible. Nearly all beneficiaries purchasing a standard Medigap plan choose one that covers the full hospital deductible, and most select plans that cover the full skilled nursing home coinsurance and part B deductible. The president's proposed plan types would be different from the existing popular Medigap plans in that they would not include first-dollar coverage.

Medigap's first-dollar coverage reduces financial barriers to health care, but it also diminishes beneficiaries' sensitivity to costs and likely increases beneficiaries' use of services, adding to total Medicare spending. Having first-dollar coverage may also add to Medigap premiums. The extra spending induced by first-dollar coverage causes insurers' outlays to rise and likely increases Medigap premiums. The premiums may increase not only to cover the additional expected health care expenses but also insurers' administrative costs.

Our analysis and other research indicate that Medicare spends more on beneficiaries with supplemental insurance than on beneficiaries who have Medicare coverage only. For example, our analysis of the 1998 Medicare Current Beneficiary Survey data found that annual Medicare expenditures for beneficiaries with Medigap insurance were about $2,000 higher than for beneficiaries with Medicare only.[18] Medicare annual spending for beneficiaries with employer-sponsored plans was about $1,700 higher than for beneficiaries with Medicare only.

Some evidence suggests that first-dollar, or near first-dollar, coverage may partially be responsible for the higher spending. For example, one study found that beneficiaries with Medigap insurance use 28 percent more medical services (outpatient visits and inpatient hospital days) compared

[18]GAO-01-941.

to beneficiaries who did not have supplemental insurance but were otherwise similar in terms of age, sex, income, education, and health status.[19] Service use among beneficiaries with employer-sponsored supplemental insurance was approximately 17 percent higher than the service use of beneficiaries with Medicare coverage only.

Unlike Medigap policies, employer-sponsored supplemental insurance policies and Medicare+Choice plans typically reduce beneficiaries' financial liabilities but do not offer first-dollar coverage. Although there is a wide variety in design of employer-sponsored insurance plans, many retain cost-sharing provisions. Medicare+Choice plans also typically require copayments for most services. Moreover, unlike the traditional fee-for- service program, Medicare+Choice plans require referrals or prior authorization for certain services to minimize unnecessary utilization.

Under the president's Medigap proposal, the two new plan types would require beneficiary cost-sharing and, in this way, would be similar to the features of employer-sponsored insurance plans. In eliminating first-dollar coverage, the proposal seeks to keep the new policies more affordable for beneficiaries and create incentives to restrain overall program spending.

Concluding Observations

Interest remains high in improving supplemental coverage available to Medicare beneficiaries while fostering the prudent use of health care services. The president's proposal to create two new plan types that require cost-sharing and provide coverage for prescription drugs seeks to balance access and affordability with incentives for beneficiaries to be cost-conscious. The exclusion of first-dollar coverage from the new Medigap policies would make them more like employer-sponsored supplemental insurance policies that include incentives to minimize unnecessary use. These reforms could serve the interests both of beneficiaries and the program, making drug coverage more affordable while helping to moderate program expenditures. Details of the president's proposal will reveal the extent to which the new plan types offer better value for beneficiaries' premium dollars than the existing Medigap plan types. In our view, an effective health insurance plan would discourage the inappropriate use of services and protect beneficiaries from catastrophic health expenses, including prescription drug costs. We

[19]Sandra Christensen, Ph.D. and Judy Shinogle, M.S., "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review* 19 (1997).

look forward to working with this subcommittee as it considers various options to reform Medigap and improve health care coverage for individuals.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or members of the subcommittee may have.

Contacts and Acknowledgments

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