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Report to Congressional Requesters

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HEALTH INSURANCE FOR THE ELDERLY

Owning Duplicate Policies Is Costly and Unnecessary

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Health, Education, and
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The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990)[1] amended federal requirements for Medicare supplemental (Medigap) insurance policies. One of the changes prohibits the sale of health insurance policies that duplicate coverage beneficiaries receive under Medicare or other health insurance.[2] Some in the insurance industry complained that this prohibition prevented them from selling policies such as hospital indemnity insurance (which pays a set amount for each day a person is hospitalized) to Medicare beneficiaries and from selling Medigap policies to beneficiaries who have employer-sponsored retiree health plans. The insurers believed that selling such policies to Medicare beneficiaries would provide them worthwhile and important coverage.

In 1991, 86 percent of the 28 million elderly[3] Medicare beneficiaries had some form of additional health insurance. About 73 percent of all elderly

[1]Public Law 101-508, title IV, part 5, Nov. 5, 1990.

[2]42 U.S.C. 1395ss(d)(3)(A).

[3]For this report, the term "elderly" refers to persons 65 years of age and older but excludes those who have employer-sponsored health coverage through a current employer.

beneficiaries had one additional policy, but about 13 percent had multiple additional policies.

You asked us to examine the potential for duplicate coverage among health insurance policies sold to elderly Medicare beneficiaries. You also asked us to assess the necessity for a beneficiary covered by an employer-sponsored retiree plan to purchase a Medigap policy. We used a 1991 survey of beneficiaries conducted for the Health Care Financing Administration (HCFA) to obtain the number and types of additional policies purchased by beneficiaries. We surveyed employers to determine coverage under their retiree plans. (See app. I for additional details on our scope and methodology.)

Results in Brief

Owning multiple health insurance policies to supplement Medicare is both costly and unnecessary. We estimate that about 3 million elderly Medicare beneficiaries paid about $1.8 billion in 1991 for policies that probably involved duplicate coverage. Many of these people had supplemental coverage through employer-sponsored plans. We reviewed 192 employer-sponsored plans, and in our opinion, they usually provided reasonably comprehensive coverage. Enrollees of such employer-sponsored insurance plans did not need to purchase a Medigap policy.

About 500,000 other Medicare beneficiaries who were also eligible for Medicaid because of their limited incomes spent about $190 million on unnecessary supplemental insurance. Medicaid recipients receive comprehensive medical coverage at little or no out-of-pocket cost and do not need additional insurance.

Although retirees with employer-sponsored coverage do not as a rule need to purchase a Medigap policy, employer-sponsored insurance is not secure. A recent nationwide survey disclosed that many employers offering retiree health plans are increasing cost-sharing or tightening eligibility requirements. Such changes may make an employer-sponsored plan less attractive. In addition, the employer may terminate the plan.

Federal Medigap requirements provide, in effect, a one-time "open season" for people to purchase Medigap insurance, regardless of health status, within 6 months of enrolling in part B of Medicare.[4] If a retiree's employer-sponsored plan is changed or terminated after the open season,

[4]42 U.S.C. 1395ss(s)(2)(A).

the retiree has lost the guaranteed access to a Medigap plan contained in the law. To alleviate this potential problem, the Congress would have to revise the law. Alternatives include changing the federal Medigap law to guarantee a Medigap open season for retirees whose employer-sponsored plans are terminated or substantially changed, or requiring a periodic open season for all Medicare beneficiaries.

Background

Medicare is a federal health insurance program for persons aged 65 years and older and certain disabled persons. Medicare benefits are provided under two parts. Part A covers inpatient hospital, skilled nursing facility, home health, and hospice services. Part B covers physician services and a broad range of other ambulatory services, such as laboratory and X-ray services and medical equipment used in the home. Beneficiaries share in the cost of their health care through deductibles and coinsurance for parts A and B and premiums for part B.

Medigap insurance is private insurance specifically designed to complement Medicare by filling in some of the gaps in coverage, such as deductibles and coinsurance. Some policies also pay for health services not covered by Medicare, such as outpatient prescription drugs. To facilitate comparison shopping, OBRA 1990 amended the Medigap law to require that Medigap policies be standardized into no more than 10 benefit combinations.[5] (See app. II for a description of these combinations, which are denoted by letters "A" through "J.")

Employer-sponsored health plans generally offer retirees 65 years old or older broad coverage. Typical employer plans assist in paying Medicare coinsurance and deductibles for basic medical services, including hospital, physician, laboratory, and X-ray services. Plans may also cover prescription drugs, a major expense for some senior citizens, and plans may cap a retiree's liability through an out-of-pocket limit. Retirees may be required to share in the cost of their coverage through deductibles, coinsurance, and premiums.

Hospital indemnity, specified disease, and long-term care policies are limited benefit insurance. Hospital indemnity insurance pays a fixed amount, such as $75, for each day the insured is a hospital inpatient, up to a designated number of days. These benefits are not based on the insured's actual expenses. Specified disease insurance provides coverage for a named disease or diseases; a common form is cancer insurance. These

[5]42 U.S.C. 1395(p)(2).

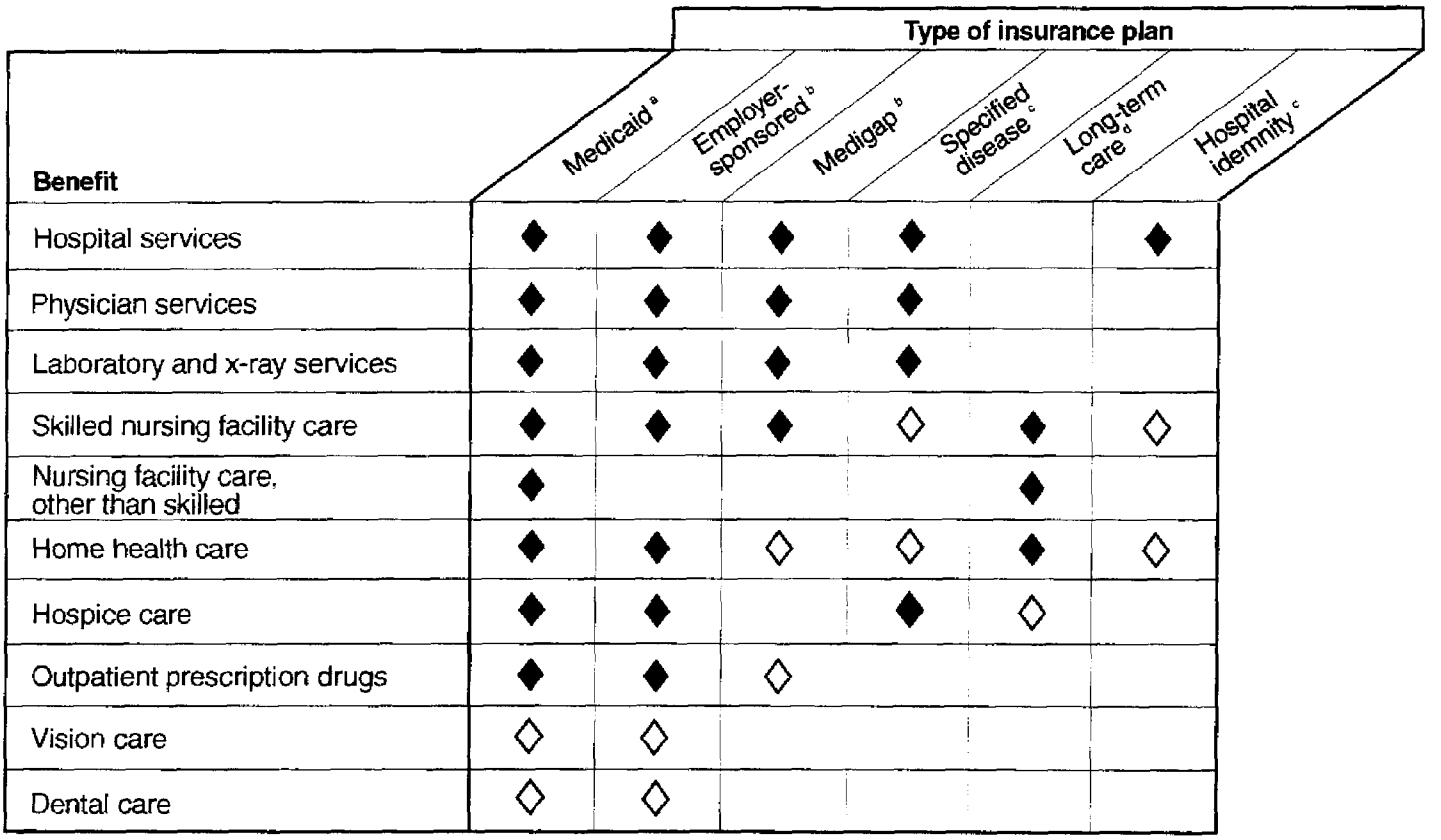
policies generally pay a fixed amount for each day of hospitalization or outpatient treatment for the specified disease. Some policies help pay for certain surgical procedures or provide a first-occurrence payment if the insured is diagnosed with the covered disease. Long-term care policies typically pay a fixed daily benefit when the insured is in a nursing facility or requires home health care. Coverage typically includes skilled, intermediate, and custodial nursing facility care and home care. These policies may allow the purchaser to choose among different options for waiting periods (the number of days one must be in the facility before benefits begin), the amount of daily benefit, and the number of benefit days, for varying premium levels.

Medicaid is a federal-state program that pays for health services needed by eligible low-income people. Medicaid covers a broad range of health care services, requiring, at most, nominal out-of-pocket payments from its enrollees. It is administered by the states, with financial participation by the federal government.

Potential for Duplicate Coverage

Purchasing multiple policies to supplement Medicare can result in overlapping benefits and duplicate coverage. Figure 1 shows benefits available under different types of supplemental insurance, which illustrates where duplication may occur. Medigap and employer-sponsored plans generally cover all or part of the policyholder's Medicare-required deductibles and coinsurance, and these plans may cover some types of service that are not covered by Medicare. Medicaid beneficiaries who are also eligible for Medicare have their liability for Medicare coinsurance and deductibles covered by Medicaid and typically are covered for a number of services not covered by Medicare, such as prescription drugs and long-term nursing home care.

Figure 1: Benefits for Medicare Beneficiaries Available Under Other Insurance Plans



[a]Medicaid covers all Medicare deductibles, coinsurance, and premiums. Also, Medicaid programs cover services not covered by Medicare, such as prescription drugs.

[b]Employer-sponsored plans for retirees 65 years old or older and Medigap policies typically cover all or a part of Medicare deductibles and coinsurance for Medicare-covered services and may pay for some services not covered by Medicare.

[c]Specified disease and hospital indemnity policies generally pay fixed amounts that represent only a fraction of the cost of services received.

[d]Long-term care policies typically pay a fixed amount per day when a policyholder is in a nursing home or receiving home health care. These policies usually cover custodial care, whereas Medicare does not cover custodial care.

Because coverage provisions and benefit levels may vary from one policy to another, specific plans must be compared to determine whether duplication occurs, but as shown in figure 1, several types of plans may duplicate one another. For example, employer-sponsored plans and Medigap policies cover many of the same benefits. OBRA 1990 attempted to prevent duplication. The law authorizes a fine of up to $25,000 if someone knowingly sells a health insurance policy that would duplicate benefits to which the prospective purchaser is already entitled. This prohibition is effective for policies issued or sold after November 5, 1991.

Extent of Duplication

In 1991, 86 percent of the 28 million elderly Medicare beneficiaries had some form of additional health insurance.[6] The remaining 14 percent had no other health insurance. Table 1 shows additional health insurance coverage for elderly Medicare beneficiaries in 1991.

[6]The survey that is the source of the data reported in this section did not inquire about hospital indemnity, specified disease, or long-term care policies. The sampling errors for estimates from this survey are in appendix I.

Table 1: Health Insurance Coverage of Elderly Medicare Beneficiaries, 1991

Type of health insurance[a]	Number of beneficiaries (thousands)	Percent
Medicare only	**3,922**	**14**
Medicare plus supplemental coverage through	**20,826**	**73**
An employer-sponsored plan	7,902	28
An individually purchased plan	8,910	31
Medicaid	2,674	9
Other or unknown source	1,339	5
Medicare plus MULTIPLE additional coverage through	**3,632**	**13**
Two or more employer-sponsored plans	589	2
Two or more individually purchased plans	950	3
Employer-sponsored and individually purchased plans	1,214	4
Medicaid and employer-sponsored or individually purchased plans	485	2
Other or unknown sources	393	1
Total	**28,380**	**100**

Note: Numbers may not add to totals because of rounding.

[a]Individually purchased plans include Medigap and other insurance that covers hospital and physician charges or prescription drugs, but do not include hospital indemnity, specified disease, or long-term care insurance.

Source: Derived by GAO from data in the 1991 Medicare Current Beneficiary Survey, HCFA.

About 13 percent of the Medicare beneficiaries (or 3.6 million people) had multiple sources of additional insurance in 1991. About 91 percent of those 3.6 million beneficiaries had 2 supplemental plans; the other 9 percent had 3 or more supplemental plans. Because these people were covered under the more comprehensive supplemental plans (Medigap, employer-sponsored plans, and Medicaid), the potential for duplication is great.

We estimate that those Medicare beneficiaries (who did not also have Medicaid) who paid premiums for their multiple plans spent about $1.8 billion for potentially duplicate coverage in 1991; the Medicaid beneficiaries paid about $190 million for unnecessary supplemental insurance. About 9 percent of the 3.6 million people with multiple insurance policies received their coverage at no cost.[7]

[7]In computing the estimate of unnecessary premiums for those without Medicaid coverage we counted the premium paid for a second and any additional supplemental plan as unnecessary. We counted any premium paid by a Medicaid beneficiary for a supplemental policy as unnecessary.

The HCFA survey showed that higher-income Medicare beneficiaries were more likely to have multiple supplemental insurance policies than lower-income beneficiaries. This is shown in table 2.

Table 2: Income of Medicare Beneficiaries and Their Health Insurance Coverage, 1991

		Percent of beneficiaries with		
Annual family income	Number of beneficiaries (thousands)	Medicare only	One supplemental plan	Multiple supplemental plans
Up to $10,000	8,458	22	70	8
$10,001-$20,000	7,927	11	76	13
$20,001-$30,000	4,051	7	78	15
Over $30,000	4,283	5	75	20
Unknown	3,661	18	70	12

Source: Derived by GAO from data in the 1991 Medicare Current Beneficiary Survey, HCFA.

Purchasing Multiple Additional Policies Is Unnecessary

Retirees enrolled in Medicare have little if any need to have more than one comprehensive policy to supplement Medicare. Hospital indemnity and specified disease policies typically pay only a small portion of the policyholder's costs for the services covered and should not be viewed as a substitute for a more comprehensive supplemental policy. Beneficiaries do not need to purchase long-term care policies with provisions that duplicate Medicare or Medigap coverage. Purchasing more than one comprehensive supplemental policy entails substantial cost for little or no additional coverage.

Limited Benefit Plans

Hospital indemnity and specified disease plans pay amounts that are not related to the cost of care received, and generally the payments represent only a minor portion of those costs. We consider these plans to be poor substitutes for comprehensive health insurance because of their limited economic value and the limited circumstances under which benefits are paid. We have assessed such limited benefit plans in the past,[8] and the market has not changed enough since then to change our opinion.

[8]See Health Insurance: Hospital Indemnity and Specified Disease Policies Are of Limited Value (GAO/HRD-88-93, July 12, 1988). In this report, we reported that the 5-year cumulative loss ratios (the percentage of premiums returned to policyholders as benefits) for the larger insurers in these lines ranged from 19 percent to 67 percent over the period 1982-86. Since our report was issued, there have been no significant regulatory changes suggested by the National Association of Insurance Commissioners affecting these products, and 1991 loss ratios for large insurers in these lines ranged from 35 percent to 79 percent.

Long-Term Care Policies

Medicare is not designed to cover long-term care but rather pays for patients who need skilled nursing or physical or speech therapy on a daily (for skilled nursing facility) or intermittent (for home health care) basis. However, most extended nursing facility stays and home care involve services at a level lower than skilled care and thus do not qualify for Medicare coverage.

Medicare pays the full cost of covered skilled nursing facility stays for the first 20 days and requires an $87-per-day coinsurance (in 1994) for the next 80 days, after which benefits end. Medicare pays the full cost of as many home health visits as meet its definition of home health care. Medigap policies, except for plans A and B, cover Medicare coinsurance requirements for the 21st through the 100th day of covered nursing home stays. Medicare beneficiaries who are also eligible for Medicaid would normally have their long-term care needs paid by Medicaid.

If a beneficiary intends to purchase a long-term care policy, he or she should consider policies having longer waiting periods (for example, up to 100 days) because Medicare or a combination of Medicare and Medigap may cover short nursing home stays or the early portion of longer stays. However, policies with longer waiting periods would require beneficiaries to pay out of pocket for services that do not meet Medicare's coverage criteria.

Comprehensive Supplemental Plans

If a person is eligible for both Medicare and Medicaid, it is extremely unlikely that he or she would need additional insurance. In fact, by federal law, Medigap insurers must allow a person to suspend a Medigap policy when the person becomes eligible for Medicaid and reinstate the policy if Medicaid eligibility ceases.[9]

Purchasing more than one Medigap policy is also never necessary, and, in fact, federal law prohibits knowingly selling a Medigap policy to someone who already has one, unless the purchaser indicates in writing his or her intent to replace existing coverage with the new policy.

In addition, employer-sponsored retiree plans generally provide comprehensive Medicare supplement coverage, and most retirees covered by such a plan would be wasting money if they purchased additional health insurance. We examined 192 employer-sponsored plans for retirees

[9]42 U.S.C. 1395ss(q)(5)(A).

65 years old and older currently available from 142 employers.[10] We calculated what these employer-sponsored plans would cover for a typical set of health services received in a year by a beneficiary who is hospitalized once with a subsequent Medicare-covered stay in a nursing home.[11] Our intention is to illustrate how employer-sponsored retiree plans would supplement Medicare across an array of services, including some services not covered by Medicare.

In this example, if a Medicare beneficiary received these services during 1993, he or she would have incurred $3,345 in charges that would not have been paid by Medicare. On average, the 192 employer-sponsored plans would have paid $2,324 of those charges, leaving the retiree responsible for $1,021.

While facing some out-of-pocket expenses after the employer-sponsored plan payments, a retiree would generally be better off to pay those expenses than to try to obtain a Medigap policy as a supplement to an employer-sponsored plan. The result of purchasing a Medigap plan C or J to supplement an employer-sponsored plan is illustrated in table 3. Under both plans, the premiums for the Medigap policy exceed the benefits that could be expected, and in our opinion, purchasing the Medigap policy would be a waste of money.

Table 3: Additional Cost of Purchasing a Medigap Plan to Supplement an Employer-Sponsored Plan

	For a Medigap plan purchased in Ohio[a]	
	Plan C	Plan J
Annual premium for the Medigap plan (in 1993)	$780	$1,500
Payment Medigap plan would make for charges left after the employer-sponsored plan's payment	$670	$740
Excess Medigap premiums over benefits	$110	$760

[a]We chose Ohio because it is a populous state with a large Medicare population (seventh largest among the 50 states in 1991) and rates for both plans C and J were within 1 percent of the median of all rates nationwide for the company used in this illustration. Figures are rounded to the nearest $10.

Of the 192 plans we reviewed, 17 percent were provided by the former employer free of charge, and for 44 percent of the plans, the former

[10]The number of plans exceeds the number of employers because some employers offer more than one plan.

[11]Appendix III presents the services and how we arrived at the costs associated with each. Most beneficiaries would not receive this many services in any given year; only about 20 percent are hospitalized in any year. A small percentage of beneficiaries would receive more services than those in our illustration.

employer and retiree each paid a portion of the premiums.[12] Thus, for over 60 percent of the plans, the retiree could obtain an employer-sponsored plan free or at subsidized rates. For 10 percent of the plans, the retiree paid the full cost, and for the remaining plans, those data were unavailable or we could not determine the payment arrangement from the information provided to us. (See app. IV for a summary of the principal features of the 192 employer-sponsored plans.)

While employer-sponsored plans can provide good coverage, we concluded in a previous report[13] that employer-sponsored retiree health benefits are not secure because employers have been changing their health benefit plans for retirees. Employers frequently reserve the right to change health benefit plans at their discretion, and plans negotiated under collective bargaining contracts may be changed when those contracts are renegotiated. Employers generally cite rapidly rising costs as the reason for reducing health benefits. The recent changes to these health benefit plans have primarily involved shifting costs to retirees, but a few employers have terminated health plans for their retirees. A recent nationwide survey conducted by a benefits consulting firm reported that the number of employers offering retiree health plans is continuing to decline and that many employers who offer retiree coverage are ending free coverage, increasing cost-sharing provisions, and tightening eligibility requirements.[14] This trend is expected to continue, at least for the short term.

Potential Problem for Retirees

Federal law effectively provides persons aged 65 or older a 6-month "open season" after first enrolling in part B of Medicare during which beneficiaries cannot be denied Medigap insurance because of their health status. As discussed in the previous section, given the choice between retaining an employer-sponsored plan and purchasing a Medigap plan, most retirees are probably better off selecting the employer-sponsored plan. However, the employer may subsequently terminate the plan or future changes in cost sharing may make the employer-sponsored plan less attractive, resulting in the retiree deciding to replace his or her employer-sponsored plan with Medigap insurance. If either event occurs

[12]The plan descriptions provided by employers generally did not include current premiums for the plans.

[13]See Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (GAO/HRD-93-125, July 9, 1993).

[14]See Health Care Benefits Survey, Report 2, Retiree Health Care, 1992, A. Foster Higgins & Co., Inc.

after the open season, the retiree has lost the guaranteed access to Medigap insurance contained in the law.

Several alternatives exist that could alleviate potential problems in changing from an employer-sponsored retiree plan to a Medigap policy after the beneficiary's open season. For example, federal Medigap law could be amended to require insurers to offer policies to retirees whose employer-sponsored plans are terminated or substantially changed. Also, the federal Medigap law could be amended to require periodic open seasons.[15]

Conclusion

The Congress enacted a valuable protection for Medicare beneficiaries in OBRA 1990 by amending Medigap requirements to prohibit duplicate coverage. Survey data show that (in 1991) about 13 percent of the elderly Medicare population likely had purchased policies with duplicate coverage, at a cost to them of about $2 billion in premiums.

However, the prohibition may have resulted in a dilemma for about one-third of retirees, who must choose between retaining their employer-sponsored supplemental plan or exercising their guaranteed open season for purchasing a Medigap policy when they first enroll in part B of Medicare. If a retiree has an employer-sponsored plan available, it is frequently his or her best option. However, because some companies have reduced the coverage offered retirees and this trend is expected to continue, this source of supplemental insurance is not secure.

Matter for Congressional Consideration

One-third of retirees get supplemental insurance through their former employers. If a Medicare beneficiary's plan is subsequently modified or discontinued by the employer and the person desires to obtain a different supplemental policy, the beneficiary will not be eligible for the 6-month open enrollment period provided for persons who are newly enrolled in Medicare part B. Thus, obtaining an alternate Medigap policy may not be possible. For this reason, the Congress may wish to consider amending the law to provide a mechanism for retirees to obtain Medigap insurance when these circumstances occur.

[15]A periodic open season for all Medigap policyholders could lead to some adverse selection problems. Such problems could occur if policyholders switched to plans with more generous benefits in anticipation of needing services and then switched back to less generous plans during their next open season after the need was satisfied or if they postponed purchasing a policy to older ages, when the likelihood of health care use is higher.

This review was conducted from May 1992 to May 1994. Except as noted in appendix I, we did our work in accordance with generally accepted government auditing standards. We did not obtain agency comments because this report is not concerned with the operation of a federal agency or program.

We will send copies of this report to interested parties and make copies available to others on request.

This report was prepared under the direction of Sarah F. Jaggar, Director of Health Financing and Policy Issues, who may be reached on (202) 512-7119 if you have any questions. Other major contributors to this report are listed in appendix V.

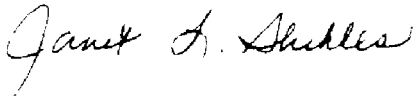


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Figure

Abbreviations

HCFA	Health Care Financing Administration
OBRA 1990	Omnibus Budget Reconciliation Act of 1990

Scope and Methodology

Scope

We identified 335 companies who indicated in their response to an earlier GAO survey that they provided health benefits to retirees eligible for Medicare. We supplemented this selection with an additional 23 large employers that offered retiree health plans. We asked these 358 companies to send us descriptions of their current health benefit plan(s) for retirees. Two hundred sixty-two companies responded, and 142 of them provided information on their plans. Because some companies offer more than 1 plan, we had descriptions on a total of 192 retiree health plans. The remaining 120 companies responded that they do not provide health benefits to retirees, or the information they provided was incomplete. We abstracted data describing each of the 192 health benefit plans and summarized their features. (See app. IV.)

Methodology

To identify areas of potential duplication, we reviewed our prior reports and studies conducted by benefit consultants and other researchers. We supplemented these studies by reviewing and comparing the benefits offered by the standard Medigap combinations, Medicaid, and private plans, such as employer-sponsored, long-term care, specified disease, and hospital indemnity plans.

To assess the extent of potential duplication, we obtained the computerized results of round one of the Health Care Financing Administration's Medicare Current Beneficiary Survey. This is a continuous, multipurpose survey of a representative sample of the Medicare population. Round one interviews were conducted in the last 4 months of calendar year 1991. These interviews captured baseline information on a sample of 12,677 Medicare beneficiaries, including information on supplemental coverage from private insurance and Medicaid. For purposes of HCFA's survey, private insurance included an individually purchased plan (usually referred to as Medigap insurance), health plans from former employers, and other plans that may cover hospital, physician, or drug charges, but HCFA's survey did not include long-term care, hospital indemnity, or specified disease insurance. We analyzed the survey data for the 10,154 Medicare beneficiaries who were 65 years of age and older, excluding those who have employer-sponsored health coverage through a current employer. We did not verify the accuracy of the information in the computerized file.

To assess the need for additional insurance coverage, we calculated the benefits that each of the 192 employer-sponsored retiree health benefit

plans would pay under a set of standardized charges for certain medical services. (See app. III.)

Sampling Errors

Data reported in tables 1 and 2 are derived from the Medicare Current Beneficiary Survey. Because these are derived from a sample, each estimate has a sampling error associated with it. The size of the sampling error reflects the precision of the estimate; the smaller the sampling error, the more precise the estimate. We computed sampling errors for tables 1 and 2 at the 95-percent confidence level. This means that the chances are about 95 out of 100 that the actual number or percentage being estimated falls within the range defined by our estimate, plus or minus the sampling error. The sampling errors for tables 1 and 2 are in tables I.1 and I.2.

Table I.1: Point Estimates and Sampling Errors for Health Insurance Coverage of Elderly Medicare Beneficiaries, 1991

Type of health insurance	Number of beneficiaries (thousands)	Percent
Medicare only	**3,922 ± 273**	**14 ± 1.0**
Medicare plus supplemental coverage through	**20,826 ± 321**	**73 ± 1.1**
An employer-sponsored plan	7,902 ± 428	28 ± 1.5
An individually purchased plan	8,910 ± 404	31 ± 1.4
Medicaid	2,674 ± 218	9 ± 0.8
Other or unknown source	1,339 ± 135	5 ± 0.5
Medicare plus MULTIPLE additional coverage through	**3,632 ± 241**	**13 ± 0.8**
Two or more employer-sponsored plans	589 ± 105	2 ± 0.4
Two or more individually purchased plans	950 ± 133	3 ± 0.5
Employer-sponsored and individually purchased plans	1,214 ± 145	4 ± 0.5
Medicaid and employer-sponsored or individually purchased plans	485 ± 86	2 ± 0.3
Other or unknown sources	393 ± 77	1 ± 0.3
Total	**28,380 ± 171**	**100**

Note: Numbers may not add to totals because of rounding. Sampling errors are computed at the 95-percent confidence level.

Table I.2: Point Estimates and Sampling Errors of Medicare Beneficiaries and Their Health Insurance Coverage, 1991

Annual family income	Number of beneficiaries (thousands)	Percent of beneficiaries with		
		Medicare only	One supplemental plan	Multiple supplemental plans
Up to $10,000	8,458 ± 401	22 ± 1.7	70 ± 1.5	8 ± 1.0
$10,001-$20,000	7,927 ± 320	11 ± 1.7	76 ± 1.9	13 ± 1.5
$20,001-$30,000	4,051 ± 216	7 ± 1.5	78 ± 2.6	15 ± 2.0
Over $30,000	4,283 ± 340	5 ± 1.2	75 ± 2.5	20 ± 2.2
Unknown	3,661 ± 265	18 ± 1.9	70 ± 2.7	12 ± 2.0

Note: Sampling errors are computed at the 95-percent confidence level.

In addition, the percentage estimates in the text on pages 6 through 8 have sampling errors ranging from ± 1 percent to ± 1.9 percent, and the dollar estimates in the text from page 7 have the following sampling errors:

- beneficiaries who did not also have Medicaid paid about $1.8 billion ± $0.2 billion for potentially duplicate coverage in 1991 and
- Medicaid beneficiaries paid about $190 million ± $58 million for duplicate coverage in 1991.

Features of Standardized Medicare Supplement Plans

In 1991, the National Association of Insurance Commissioners approved the following 10 standardized benefit combinations for Medicare supplement policies. Forty-four states, the District of Columbia, Puerto Rico, and the Virgin Islands approved all 10 plans. Pennsylvania and Vermont approved 7; Delaware approved 6; and Massachusetts, Minnesota, and Wisconsin had alternative simplification programs in effect and have waivers from these standard plans. Benefits included in a plan are marked by "X."

Table II.1: Benefit Combinations of the Standardized Medicare Supplement Plans

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Basic benefits[a]	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 excess charges[b]						X	X[c]		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
At-home recovery				X			X		X	X
Prescription drugs								X[d]	X[d]	X[e]
Preventive medical care					X					X

[a]Basic benefits pay the beneficiary's Medicare part B coinsurance (generally 20 percent of Medicare-approved charges after the $100 annual deductible), part A coinsurance for the 61st—90th day of a Medicare-covered hospital stay, part A coinsurance during the use of a beneficiary's 60 lifetime reserve days, eligible expenses after a beneficiary's hospital benefits are exhausted up to a lifetime maximum of 365 days, and parts A and B blood deductible (3 pints).

[b]Part B excess charges are the difference between the actual charge for a service or item and the Medicare-allowed charge for that service or item. Medicare prohibits charging more than 115 percent of the Medicare-allowed charge.

[c]This plan pays 80 percent of Part B excess charges.

[d]Prescription drug coverage under plans H and I requires an annual deductible of $250, then the plan pays 50 percent of covered charges, up to a maximum plan payment of $1,250 per year.

[e]Prescription drug coverage under plan J requires an annual deductible of $250, then the plan pays 50 percent of covered charges, up to a maximum plan payment of $3,000 per year.

Summary of Coverage of Typical Health Services by Employer-Sponsored Retiree Health Plans

To assess the need for insurance in addition to an employer-sponsored plan, we constructed a set of typical health services that a Medicare beneficiary might receive during a year if the beneficiary was hospitalized and had a subsequent Medicare-covered stay in a nursing home. In addition to the hospital and nursing home stay, these services included physician charges and some other outpatient services, including routine preventive services and services not covered by Medicare. Most beneficiaries would not receive all these services in any given year; for example, only about 20 percent of Medicare beneficiaries are hospitalized in any year. Conversely, a small percentage of beneficiaries would receive more services than those in our illustration. We then calculated what Medicare would pay for those services, what each of the 192 employer-sponsored plans would pay, and how much would remain for the beneficiary to pay.

Table III.1: Health Services and Charges Used for Calculating Benefits Under Medicare and Employer-Sponsored Plans

Health service	Typical charge or term	Beneficiary's obligation after Medicare payment (based on allowances in 1993)	For all 192 plans reviewed	
			Average payment by employer-sponsored plans	Beneficiary's remaining obligation
Inpatient hospital stay[a]	9 days	$ 676	$ 393	$ 283
Physician office visit charges[b]	$900	260	140	120
Physician hospital visit charges[b]	$1,365	273	175	98
Physician charges in excess of Medicare allowed amounts[c]	Up to $340	340	264	76
Outpatient prescription drugs[d]	$1,000	1,000	797	203
Outpatient X-ray[d]	$100	20	14	6
Routine dental checkup[d]	$100	100	23	77
Medicare-approved skilled nursing facility stay[e]	28 days	676	517	159
Total		**$3,345**	**$2,324**	**$1,021**

Note: Numbers may not add to totals because of rounding.

[a]The 9 days for hospital stays was the average for short-stay hospital discharges in 1991, reported by HCFA's Bureau of Data Management and Strategy.

[b]Some employer-sponsored plans pay different amounts for physician services in the office than in a hospital, but Medicare would have paid 80 percent of allowed charges in either setting. The charges of $900 and $1,365 for physician office and hospital visits were computed from Medicare reimbursement and utilization data we obtained from HCFA's Office of the Actuary. The dollar amounts are based on Medicare reimbursements for aged beneficiaries who had an inpatient hospital stay during calendar year 1991, updated to 1993 dollars with inflation factors provided by HCFA. The beneficiary's obligation after Medicare payment assumes that the part B deductible ($100) was applied to the office visit charges. (Beneficiary's obligation is computed as $100 deductible plus 20 percent of $800.)

[c]Under payment provisions contained in the Omnibus Budget Reconciliation Act of 1986, physicians could not charge Medicare beneficiaries more than 115 percent of Medicare-approved amounts for their services in 1993. This limit applies regardless of the setting, so the limit above Medicare-approved charges was 15 percent of ($900 + $1,365), or $339.75, which we rounded up to $340.

[d]Readily available sources did not contain data for prescription drugs, X-rays, and routine dental checkup. The amounts used are our estimates based on various data sources.

[e]The 28-day stay in a skilled nursing facility was the average length of a Medicare-covered stay in 1991, obtained from HCFA's Office of Research and Demonstrations.

Principal Features of Employer-Sponsored Retiree Health Plans

The 192 employer-sponsored retiree health plans we reviewed covered a broad range of health-related services. Several common services and the number of plans covering the services are listed in table IV.1. Many employer-sponsored plans covered services not covered by Medicare. Almost all employer-sponsored plans covered outpatient prescription drugs.[1] About one quarter covered routine vision and dental care.

Table IV.1: Benefits Available Under Employer-Sponsored Retiree Health Plans

	Plans that cover the service	
Benefit	**Number**	**Percent (of 192 plans)**
Hospital services	192	100
Physician services	192	100
Laboratory and X-ray services	192	100
Skilled nursing facility care	179	93
Home health care	158	82
Hospice care	128	67
Outpatient prescription drugs	180	94
Vision care	52	27
Dental care	57	30

[1]Medicare provides narrow coverage of outpatient prescription drugs, such as immunosuppressive outpatient prescription drugs following transplant surgery and certain oral cancer drugs.

The employer-sponsored plans commonly apply financial limits to their benefits. These include deductibles, coinsurance, and lifetime maximum benefits. Some plans also include out-of-pocket maximums, or catastrophic benefits, and these plans will pay all covered expenses for the beneficiary after the out-of-pocket maximum is reached, up to the policy maximum. The financial limits of the 192 plans we reviewed are summarized in table IV.2.

Table IV.2: Principal Financial Characteristics of Employer-Sponsored Health Plans for Retirees

Employer-sponsored plan characteristic	Number of plans[a]	Range		Median
		Minimum	Maximum	
Annual deductible per covered person	161[b]	$20	$5,000	$200
Percentage of covered charges paid after the deductible is met	170	70%	100%	80%
Annual out-of-pocket limit	138	$250	$10,000	$1,000
Lifetime maximum benefit	125	$20,000	$2,000,000	$1,000,000

[a]Represents number of plans (out of 192) for which data were available. The remaining plans may or may not include the characteristic.

[b]For nine additional plans, there was no deductible or the deductible varied depending on the retiree's salary or years of service.

The predominant form of employer-sponsored plan was a conventional fee-for-service plan. Under this arrangement, the beneficiary selects the provider and submits claims for reimbursement for charges, to be paid to the beneficiary or to the provider on behalf of the beneficiary. About one-quarter of the plans were network plans, such as health maintenance or preferred provider organizations. Under network plans, the beneficiary is encouraged to obtain services through the organization. Obtaining services outside the network will generally cost the beneficiary more than those same services within the network. (See table IV.3.)

For most elderly retirees, Medicare is their primary health insurer; employer-sponsored plans are secondary sources. Employer-sponsored plans exhibited four methods of integrating their benefits with Medicare: carve-out, exclusion, Medicare supplemental (Medigap), and coordination of benefits. Under carve-out, the employer-sponsored plan calculates what the plan would pay without Medicare coverage, then Medicare benefits are subtracted from the employer-sponsored plan amount, and the plan pays the remaining amount, if any. Under exclusion, Medicare benefits are subtracted from the total claim and employer-sponsored plan benefits are calculated on the remainder. Medigap plans typically pay Medicare coinsurance and may cover Medicare deductibles. Under coordination of benefits, the plan pays the difference between Medicare payments and the actual charges, up to the amount the plan would have paid in the absence of Medicare. Among these four, carve-out is the least advantageous to the retiree, and coordination of benefits is the most advantageous. The incidence of each type is shown in table IV.3.

Table IV.3: Principal Nonfinancial Characteristics of Employer-Sponsored Health Plans for Retirees

Employer-sponsored plan characteristic	Number of plans	Percent of plans
Type of plan		
Conventional fee-for-service	140	73
Network	47	24
Combination	5	3
Total	**192**	**100**
Method of integration with Medicare		
Carve-out	96	50
Exclusion	38	20
Medigap	22	11
Coordination of benefits	6	3
Other[a]	30	16
Total	**192**	**100**

[a]Includes plans that are health maintenance organizations and plans that use a mixture of integration methods (for example, carve-out for some services and exclusion for others).

The differences in plan payments can be substantial, as illustrated in table IV.4, which shows how an employer-sponsored plan would pay the same Medicare part B claim under the four different integration methods. This example assumes a Medicare part B medical expense claim with total Medicare-approved charges of $1,000 and the employer-sponsored plan has an annual deductible of $200 and pays 75 percent of covered charges after the deductible is met. Medicare would pay $720 of the approved charges ($1,000 minus $100 deductible, or $900, times 80 percent), leaving a balance of $280 to be paid by the retiree and employer-sponsored plan.

Table IV.4: Comparison of Employer-Sponsored Plan Payments Under Common Methods of Integrating Benefits With Medicare

Medicare-approved part B charges	$1,000			
Medicare payment	**$720**			
Method of integrating with Medicare	**Carve-out**	**Exclusion**	**Medigap**	**Coordination of benefits**
Employer-sponsored plan payment in the absence of Medicare	$600[a]	N/A	N/A	$600[a]
Actual employer-sponsored plan payment	0[b]	$60[c]	$180[d]	$280[e]
Retiree's out-of-pocket costs	$280	$220	$100	0

[a]Computed as ($1,000 minus $200 plan deductible) times 75 percent.

[b]The Medicare payment exceeds employer-sponsored plan payment in the absence of Medicare, so the plan pays nothing.

[c]Computed as (($1,000 minus $720) minus $200 plan deductible) times 75 percent.

[d]Assumes the Medigap plan pays Medicare part B coinsurance but not the deductible. This plan pays ($1,000 minus $100 Medicare annual deductible) times 20 percent.

[e]The amount remaining after the Medicare payment is less than what the employer-sponsored plan would pay in the absence of Medicare, so the plan pays what remains after the Medicare payment, consisting of the retiree's Medicare part B deductible and coinsurance ($100 plus 20 percent of $900).

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