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MEDICARE

Cost-Sharing Policies Problematic for Beneficiaries and Program

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Madam Chairwoman and Members of the Subcommittee:

I am pleased to be here today as you consider the need to modernize and strengthen the Medicare program and review the role of supplemental "Medigap" policies that many seniors buy to help improve their Medicare coverage. Medicare provides valuable and extensive coverage for beneficiaries' health care needs. 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 is an important source of this supplemental coverage because it is widely available to beneficiaries. The other sources—employer-sponsored policies, Medicare+Choice plans, and Medicaid programs—are not as widely available to all beneficiaries. However, concerns exist that supplemental coverage can be expensive and may undermine the legitimate role of cost sharing in a health insurance plan—to encourage cost-effective use of services.

To assist the Subcommittee as it considers proposals to improve coverage for beneficiaries and the financial health of the Medicare program, my remarks today focus on the design of Medicare's benefit package and the role of private 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 undermines the cost control incentives of Medicare's cost-sharing requirements. My comments are based on our prior and ongoing work[1] on Medicare and Medigap as well as other published research.

In summary, Medicare's benefits 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. At the same time, Medicare's cost-sharing requirements are poorly targeted and fail to promote prudent use of services.

[1]The Consolidated Appropriations Act of 2000 mandated that we report to the Congress by July 2001 on various aspects of Medigap coverage.

Medigap policies that many Medicare beneficiaries purchase help to fill in some of Medicare's gaps but are themselves problematic. Premiums paid for Medigap policies averaged $1,300 in 1999, with 20 percent going to administrative costs. While these policies pay for some or all Medicare cost-sharing requirements, they do not fully protect beneficiaries from potentially significant out-of-pocket costs. In particular, some Medigap policies offer prescription drug coverage, however, this coverage can be inadequate because beneficiaries still pay most of the cost and the maximum Medigap benefit is capped. In addition, Medigap 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 deductibles, 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 $50 per month.[2] Beneficiaries are also responsible for part B deductibles, coinsurance, and copayments.

[2]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 for 2001

Part A Coverage	Beneficiary copayments, coinsurance, and deductibles
Inpatient hospital	$792 deductible per admission[a] $198 copayment per day for days 61-90 $396 copayment per day for days 91-150[b] All costs beyond 150 days
Skilled nursing facility	No cost sharing for first 20 days $99 copayment or less for days 21-100 All costs beyond 100 days
Home health	No cost sharing 20 percent coinsurance for durable medical equipment
Hospice	$5 copayment for outpatient drugs 5 percent coinsurance for inpatient respite care
Blood	Cost of first 3 pints
Part B Coverage[c]	
Physician and medical	$100 deductible each year 20 percent coinsurance for most services 50 percent coinsurance for mental health services
Clinical laboratory	No cost sharing
Home health	No cost sharing 20 percent coinsurance for durable medical equipment
Outpatient hospital	Coinsurance varies by service and may exceed 50 percent
Blood	Cost of first 3 pints 20 percent coinsurance 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 91-150). 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: *Medicare & You 2001*, Health Care Financing Administration.

Most Medicare beneficiaries have some type of supplemental coverage to help pay for Medicare cost-sharing requirements as well as some benefits 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 39 million beneficiaries have employer-sponsored supplemental coverage. These benefits typically pay for some or all of the costs not covered by Medicare, such as coinsurance, deductibles, and 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.[3] Small employers are even less likely to offer retiree health benefits.

Approximately 15 percent of Medicare beneficiaries enroll in Medicare+Choice plans, which include health maintenance organizations and other private insurers who are paid a set amount each month to provide all Medicare-covered services. These plans typically offer lower cost-sharing requirements and additional benefits compared to Medicare's traditional fee-for-service program, in exchange for a restricted choice of providers. However, Medicare+Choice plans are not available in all parts of the country. As of February 2001, about a third of all beneficiaries lived in counties where no Medicare+Choice plans were offered.

About 17 percent of Medicare beneficiaries receive assistance from Medicaid, the federal-state health financing program for low-income aged and disabled individuals. All Medicare beneficiaries with incomes below the federal poverty level can have their Medicare premiums and cost sharing paid for by Medicaid. Beneficiaries with incomes slightly above the poverty level may have all or part of their Medicare premium paid for by Medicaid. Also, some low-income individuals may be entitled to full Medicaid benefits (so called "dual eligibles"), which include coverage for certain services not available through Medicare, such as outpatient prescription drugs. However, the income level at which beneficiaries qualify for full Medicaid benefits varies, as determined by each state, and many Medicare beneficiaries with low incomes may not qualify.[4]

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

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

[4]In addition, many low-income beneficiaries who are eligible for Medicaid and other federal/state programs to 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 *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS-99-61, April 9, 1999). Aiming to increase awareness and enrollment in these programs, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directed the Social Security Administration to identify and notify potentially eligible individuals and the Department of Health and Human Services to develop and distribute to states a simplified uniform enrollment application.

than 10 million individuals—more than one-fourth of all beneficiaries—were covered by Medigap policies.[5] The Omnibus Budget Reconciliation Act (OBRA) of 1990[6] required that Medigap policies be standardized and allowed a maximum of 10 different benefit packages offering varying levels of supplemental coverage to be provided. All policies sold since July 31, 1992 have offered one 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.

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 products	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
Prescription drugs								X[c]	X[c]	X[d]
Preventive medical care					X					X

Source: HCFA *2001 Guide to Health Insurance for People with Medicare*.

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

[a]Plans F and J also have a high deductible option of $1,580, 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).

[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 a $250 annual deductible.

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

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

[6]P.L. 101-508, Nov. 5, 1990.

Under OBRA 1990, Medicare beneficiaries are guaranteed access to Medigap policies within 6 months of enrolling in part B regardless of their health status. Subsequent laws have added guarantees for certain other beneficiaries. Beneficiaries who enrolled in a Medicare+Choice plan when first becoming eligible for Medicare and then leave the plan within one year are also guaranteed access to any Medigap policy; those who terminated their Medigap policy to join a Medicare+Choice plan can return to their previous policy or, if the original policy is not available, be guaranteed access to plans A, B, C, or F. 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 4 standardized Medigap policies. However, none of these 4 guaranteed policies include prescription drug coverage.[7] Otherwise, insurers can either deny coverage or charge higher premiums to beneficiaries who are older or in poorer health.

Medicare Cost-Sharing Requirements And Benefit Design Are Out Of Step With Current Private Sector Practices

Medicare's design has changed little since its inception 35 years ago, and in many ways has not kept pace with changing health care needs and private sector insurance practices. Medicare cost-sharing requirements are not well designed to discourage unnecessary use of services. At the same time, they can create financial barriers to care. In addition, the lack of a cost-sharing limit can leave some beneficiaries with extensive health care needs liable for very large Medicare expenses. Moreover, gaps in Medicare's benefit package can contribute to substantial financial burdens on beneficiaries who lack supplemental insurance or Medicaid coverage.

Medicare's Cost-Sharing Requirements Not Well Structured

Health insurers commonly design cost-sharing provisions—in the form of deductibles, coinsurance, and copayments—to ensure that beneficiaries are aware there is a cost associated with the provision of services and to encourage them to use services prudently. Ideally, cost sharing should encourage beneficiaries to evaluate the need for discretionary care but not discourage necessary care. Optimal cost-sharing designs would generally require coinsurance or copayments for services that may be discretionary

[7]These protections were added by section 4003 of the Balanced Budget Act of 1997 (P.L. 105-33, 111 Stat. 330). In addition to these federal protections, 21 states provide for additional Medigap protections in 2000.

and could potentially be overused, and would also aim to steer patients to lower cost or better treatment options. Care must be taken, however, to avoid setting cost-sharing amounts so high as to create financial barriers to necessary care.

The benefit packages of Medicare+Choice plans illustrate cost-sharing arrangements that have been designed to reinforce cost containment and treatment goals. Most Medicare+Choice plans charge a small copayment for physician visits ($10 or less) and emergency room services (less than $50). Relatively few Medicare+Choice plans charge copayments for hospital admissions. Plans that offer prescription drug benefits typically design cost-sharing provisions that encourage beneficiaries to use cheaper generic drugs or brand name drugs for which the plan has negotiated a discount.

Medicare fee-for-service cost-sharing rules diverge from these common insurance industry practices in important ways. For example, as indicated in table 1, Medicare imposes a relatively high deductible for hospital admissions, which are rarely optional. In contrast, Medicare requires no cost sharing for home health care services, even though historically high utilization growth and wide geographic disparities in the use of such services have raised concerns about the potentially discretionary nature of some services.[8] Medicare also has not increased the part B deductible since 1991. For the last 10 years the deductible has remained constant at $100 and has thus steadily decreased as a proportion of beneficiaries' real income.

Medicare Does Not Limit Beneficiaries' Cost-Sharing Liability

Also unlike most employer-sponsored plans for active workers, Medicare does not limit beneficiaries' cost-sharing liability, which can represent a significant share of their personal resources. Premiums, deductibles, coinsurance, and copayments that beneficiaries are required to pay for services that Medicare covers equaled an estimated 23 percent of total Medicare expenditures in 2000. The average beneficiary who obtained services in 1997 had a total liability of $1,451, consisting of $925 in Medicare copayments and deductibles in addition to the $526 in annual part B premiums required that year.

[8]See *Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available* (GAO/HEHS-00-9, Apr. 2000).

The burden of Medicare cost sharing can be much higher, however, for beneficiaries with extensive health care needs. In 1997, the most current year of available data on the distribution of these costs, slightly more than 3.4 million beneficiaries (11.4 percent of beneficiaries who obtained services) were liable for more than $2,000. Approximately 750,000 of these beneficiaries (2.5 percent) were liable for more than $5,000, and about 173,000 beneficiaries (0.6 percent) were liable for more than $10,000. In contrast, private employer-sponsored health plans typically limit maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[9]

Cost of Uncovered Services Adds to Beneficiaries' Financial Burden

Medicare does not cover some services that are commonly included in private insurers' benefit packages. The most notable omission in Medicare's benefit package is coverage for outpatient prescription drugs. This benefit is available to most active workers enrolled in employer-sponsored plans. More than 95 percent of private employer-sponsored health plans for active workers cover prescription drugs, typically providing comprehensive coverage with relatively low cost-sharing requirements.

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. The average beneficiary in 2000 is estimated to have incurred about $3,100 in out-of-pocket expenses for health care—an amount equal to about 22 percent of the average beneficiary's income.[10]

Some beneficiaries potentially face much greater financial burdens for health care expenses. For example, 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 in 2000. Low-income single women over age 85 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.[11] These percentages are expected to

[9]The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*.

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

[11]Maxwell, Moon, and Segal.

increase over time as Medicare premiums and costs for prescription drugs and other health care goods and services rise faster than incomes.

Medigap Policies Address Some Medicare Shortcomings But Are Expensive

While more than one-fourth of beneficiaries have Medigap policies to fill Medicare coverage gaps, these policies can be expensive and provide only limited protection from catastrophic expenses. Medigap drug coverage in particular offers only limited protection because of high cost sharing and low coverage caps.

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 offering a choice among 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 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 a Medigap policy, demonstrating the value of this coverage to the Medicare population.

Medigap Policies Can Have High Cost

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

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

Medigap plan	Covered lives (percentage)	Average annual premium earned per covered life
A	2.7	$877
B	8.0	$1,093
C	15.9	$1,151
D	3.8	$1,032
E	1.5	$1,067
F	23.4	$1,217
G	1.5	$980
H	1.5	$1,379
I	1.5	$1,704
J	2.7	$1,669
Pre-standard (policies originally sold before July 31, 1992)	32.9	$1,573
Plans in states exempt from plan standards[a]	4.5	$1,405
Total[b]	**100.0**	**$1,322**

[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 NAIC do not include plan type for policies representing less than 9 percent of Medigap policy covered lives, with an average paid premium of $1,016. These plans are not included in the plan distribution or average premiums reported in the table.

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

Premiums also vary widely across geographic areas and insurers. For example, average annual premiums in Massachusetts ($1,915) were 45 percent higher than the national average. While varying average premiums may reflect geographic differences in terms of 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. For example, in Nevada, plan A premiums for a 65-year-old ranged from $446 to as much as $1,004, depending on the insurer. Similarly, in Florida, plan F premiums for a 65-year-old male ranged from $1,548 to $2,123; and in Maine, plan J premiums ranged from $2,697 to $3,612.[12]

[12]Premium quotes for policies available in 2000 and 2001 from most recently available state guides for consumers on Medigap policies.

Medigap policies are becoming more expensive. One recent study reports that premiums for the three Medigap plan types offering prescription drug coverage (H, I, and J) have increased the most rapidly—by 17 to 34 percent in 2000. Medigap plans without prescription drug coverage rose by 4 to 10 percent in 2000.[13]

A major reason premiums are high is that a large share of premium dollars are used for administrative costs rather than benefits. 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.[14] The share of premiums spent on benefits varies significantly among carriers. The 15 largest sellers of Medigap policies spent between 64 and 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. Also, 98 percent of Medicare fee-for-service funds are used for benefits.

Remaining Gaps Leave Beneficiaries at Significant Risk

While Medigap policies cover some costs beneficiaries would otherwise pay out of pocket, Medigap policies have limits and can still leave beneficiaries exposed to significant out-of-pocket costs. Medigap prescription drug coverage in particular leaves beneficiaries exposed to substantial financial liability. Prescription drugs are of growing importance in medical treatment and one of the fastest growing components of health care costs. Medigap policies with a drug benefit are the most expensive yet the benefit offered can be of limited value to many beneficiaries. For example,

- Medigap policies offering drug coverage typically cost much more than policies without drug coverage—the most popular plan with prescription drug coverage (plan J) costs on average $450 more than the most popular plan without drug coverage (plan F)—although the benefit is at most $1,250 or $3,000, depending on plan type, and

[13]Weiss Ratings, "Prescription Drug Costs Boost Medigap Premiums Dramatically," March 26, 2001, at http://www.weissratings.com/NewsReleases/Ins_Medigap/20010326Medigap.htm.

[14]Federal law requires Medigap plans to spend at least 65 percent of premiums on benefits for policies sold to individuals, and 75 percent for policies sold to groups.

- under the Medigap plan with the most comprehensive drug coverage, type J, a beneficiary would have to incur $6,250 in prescription drug costs to get the full $3,000 benefit, because of the plan's deductible and coinsurance requirements.

The high cost and limited benefit may explain why more than 90 percent of beneficiaries with one of the standardized Medigap plans purchased standard Medigap plans that do not include drug benefits.[15] Further, 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 in most states. Insurers may then either deny coverage or charge higher premiums, especially to Medicare beneficiaries with any adverse health conditions.

The Medigap standard prescription drug benefit differs greatly from that typically offered by employer-sponsored plans for active employees or Medicare-eligible retirees. The Medigap prescription drug benefit has a $250 deductible, requires 50 percent coinsurance, and is limited to $1,250 or $3,000 depending on the plan purchased. In contrast, employer-sponsored plans typically require small copayments of $8 to $20 or coinsurance of about 20 to 25 percent, depending on whether the enrollees purchase generic brands, those for which the plan has negotiated a price discount, or other drugs. Further, few employer-sponsored health plans have separate deductibles or maximum annual benefits for prescription drugs. These plans may also offer enrollees access to discounted prices the plans have negotiated even when the beneficiary is paying the entire cost.

First-Dollar Coverage Through Medigap Distorts Medicare's Cost Control Features

Even though Medicare's original design has been criticized as outmoded, it included various cost-sharing requirements intended to encourage prudent use of services. These requirements have also traditionally been features of private insurance. However, Medigap's first-dollar coverage—the elimination of any deductibles or coinsurance associated with the use of specific services—undermines this objective. All standard Medigap plans

[15]While less is known about the benefits offered by prestandardized plans that were sold prior to 1992—representing about 30 percent 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.

cover hospital and physician coinsurance, while nearly all beneficiaries with standardized Medigap plans purchase plans covering the full hospital deductible, and most purchase plans covering the full skilled nursing home coinsurance and part B deductible. First-dollar coverage reduces financial barriers to health care, but it also diminishes beneficiaries' sensitivity to costs and could thus increase unnecessary service utilization and total Medicare program costs.

A substantial body of research clearly indicates that Medicare spends more on beneficiaries with supplemental insurance relative to beneficiaries who have Medicare coverage only. For example, an analysis of 1993 and 1995 data found that Medicare per capita expenditures for beneficiaries with Medigap insurance were from $1,000 to $1,400 higher than for beneficiaries with Medicare only. Medicare per capita spending on beneficiaries with employer-sponsored plans was $700 to $900 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) relative to beneficiaries who did not have supplemental insurance, but were otherwise similar in terms of age, sex, income, education, and health status.[16] Service use among beneficiaries with employer-sponsored supplemental insurance (which often reduces, but does not eliminate, cost sharing) 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.

[16]"Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," Christensen and Shinogle, *Health Care Financing Review*, Fall 1997.

Concluding Observations

As Congress continues to consider proposals to reform Medicare, it is important to examine all facets of the program and how they relate to other coverage that beneficiaries may have. Current Medicare cost-sharing provisions do not reflect common insurance practices that have evolved over time to promote prudent use and protect beneficiaries from catastrophic care costs. Medigap policies also fail to provide the comprehensive coverage needed by some beneficiaries. In addition, by offering first-dollar coverage, they may undermine incentives for prudent use of Medicare services. In light of how prevailing private sector coverage and practice have evolved, reconsideration of coverage and cost-sharing policies, both within the Medicare program and within any supplemental options that may be available, would be valuable to improve both coverage for beneficiaries and the financial health of the Medicare program.

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

GAO Contacts and Staff Acknowledgments

For more information, regarding this testimony, please contact me or Laura Dummit at (202) 512-7114. Rashmi Agarwal, Susan Anthony, James Cosgrove, Paul Cotton, John Dicken, and Carmen Rivera-Lowitt also made key contributions to this statement.