MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 25, 2003
9:04 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Implications for beneficiaries and policy reform of supplemental insurance
-- Scott Harrison, Jill Bernstein

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Our first topic for this morning is the implications for beneficiaries and policy reform of supplemental insurance market variation. It's a good way to start the day.

DR. BERNSTEIN: Good morning. We'd like to spend a few minutes today reviewing the June chapter on markets that beneficiaries use to supplement Medicare coverage. Briefly, we'd like to do three things. We'd like to talk a minute or two about what the goals of the chapter are, and how the chapter fits into our broader plan for looking at how markets work or don't work for beneficiaries. Next, Scott will go over some of the findings from work we've been doing in the last couple weeks that's been incorporated into this draft of the chapter. And finally, we'd like to use the time available to get your comments, suggestions, et cetera, on the draft chapter. There are no recommendations in this chapter but we do discuss some issues that might lead to the development of recommendations drawing on the additional research and analysis we plan to do this summer and fall.

There are two reasons why we think it's important to understand how markets for supplemental insurance products work. First, the chapter lays out significant variations in state regulatory policies and some federal policies as well. States can play a large role in Medigap markets and in how different kinds of health organizations that are allowed to bear risk or to contract with organizations that bear risk, do those things, and in the ways that low income beneficiaries are able to supplement Medicare through Medicaid or sometimes through other programs such as prescription drug programs. A better understanding of how law and regulations affect market entry and exit, and how they affect beneficiaries' access to markets could help to identify ways to reduce barriers to, or to encourage participate in Medicare markets.

Second, understanding how market competition works helps us to focus on specific structural factors like demographics and economic structures that affect the choices that beneficiaries have now. This could be important for thinking through how future market-based reforms might actually play out in different areas and for different beneficiary groups.

The revised chapter draft includes some new sections that introduce broad issues that we would like to address in greater detail in the work that we are going to be doing. In the draft, these sections are currently labeled policy directions. We need your input regarding whether these are the right directions.

One set of design issues revolves around the concept of level playing fields. This gets to questions about what different types of supplements actually offer in the way coverage and benefits, and how beneficiaries can be helped to make informed decisions among alternates. For example, how much standardization of benefits or standardization of the ways in which benefits and coverage are described is desirable or needed for beneficiaries to be able to make useful choices? Or, can beneficiaries make good choices among alternatives if the rules governing market entry, exit, and withdrawal, and from enrolling and disenrolling from plans vary among the product types?

These design issues are tied up with questions about who's responsible for the regulation and oversight of Medicare-related insurance products, how much federal preemption of state law is needed to ensure equity and access to insurance, or in the types of coverage that are offered across states, or for different beneficiary populations? Who will be responsible for oversight, consumer education, consumer protection, quality oversight for different kinds of plans if the roles of private markets as a source of coverage for beneficiaries expands?

A lot of these issues are extremely complicated and we don't have enough time to get into them now but we do need your thoughts about what we need to do over time.

Scott is going to walk you through some of the additional analysis we've done that can help us focus on some of these issues now.

DR. HARRISON: Last time I showed you some insurance coverage patterns by state. This time we're going to go and look at some different variables but still bring the state back in. While state differences were clearly apparent, we know that many states include multiple markets. One way to look at markets below the state level is to divide the state markets into urban and rural areas. The 2001 current population survey, or the CPS, the data which forms the basis for most of the tables here. Medicare managed care data come from the CMS administrative data, and both these data sets can be split easily into urban and rural components. Unfortunately, above CPS sample sizes are not large enough to evaluate urban-rural differences within each state and therefore we need to group states in order to get adequate sample sizes.

This slide shows that there are differences at the national level between urban and rural insurance patterns. Urban-dwelling beneficiaries are more likely to have employer-sponsored supplemental coverage and be enrolled in Medicare managed care options, and less likely to purchase Medigap than their rural counterparts.

We checked to see if the national level differences between urban and rural insurance patterns break down at the state level. We hypothesized that if insurance markets are influenced by state characteristics, both the urban and rural markets within a state should be affected by state policies. To test this hypothesis we examined states that were high or low in market penetration for different insurance types to see if they were high or low in both the urban and rural areas. To get adequate sample sizes for this analysis we grouped states together that were particularly high or low for the share of a given product, and I showed you those lists last time.

For example, here we grouped those six states -- the six states are Iowa, Kansas, Montana, Nebraska, North Dakota and South Dakota. They were found to have the highest penetration of Medigap coverage so that's the high group. The low group is 10 states, Alaska, California, D.C., Georgia, Hawaii, Nevada, New Mexico, New York, Vermont, and West Virginia. That’s the low group. This table shows that the states that had relatively high Medigap penetration had relatively high Medigap penetration in both the urban areas and in the rural areas. For each other type of Medicare supplemental insurance, Medicaid, employer-sponsored, and Medicare managed care, we found that, as we do here, that the penetration rate for the high groups are at least twice as high as the low groups for both urban rural areas. So these findings strongly suggest that at least some state market characteristics

transcend urban-rural differences between states.

Another way to look at some substate markets is to examine insurance coverage at the metropolitan area level. Unfortunately, the CPS sample size only lets us look at a limited number of metropolitan areas. You have a table in the meeting materials that show the variation among the twelve metropolitan areas that had the largest CPS sample sizes. Sometimes those aren't the biggest cities. I think what CPS does is, if you take a lot from one city in a state, you don't take a lot from a second city in a state because you're trying to get state sizes about right.

I wanted to look at different metropolitan areas within the same state and of the 12 with a sample size of the least 200 only one pair of metropolitan areas were within one state. That was Miami and Tampa, Florida. This table compares Miami and Tampa, and they look very different in regard to each type of coverage. A simple explanation for some of the difference is that 21 percent of Miami's senior population lives under the poverty level and in Tampa that rate is only about half that, 11 percent. I think this shows that while state factors are important, local market conditions can vary and need to be kept in mind.

Let me quickly tell you how you to read these tables. You can't apply sophisticated mathematical formulas like addition on them. The columns don't add. CPS asks a question, do you have this, that, or other, and you can have more than one. So the last column there is the any fee-for-service supplemental, combines those three plus another. So if you had at least one of those you'd show up in the last column.

We hypothesized that supplemental insurance coverage varies by age, which may be a simple proxy for health status. We broke the population into three age groups, under 65, which are the disabled, 65 to 76, and over 76. We broke it at 76 instead of 75 because those over 76 are old enough to have prestandard Medigap.

We found that those under 65 were much more likely to receive benefits from Medicaid. Those in the 65 to 76 age group were the most likely to be covered by employer supplemental insurance. And those over 75 were most likely to have Medigap coverage. The disabled were the most likely not to have any fee-for-service style supplemental coverage. Unfortunately, we don't have the managed care information by age so we have to do without them for this. Those in the middle age group were the most likely to have at least one type of fee-for-service supplemental coverage.

We were able to examine some state regulatory policies with the age group data. We grouped the 14 states that mandated, prior to 1988 -- this is 2001 data -- guaranteed issue for Medigap policies for the disabled. We found that overall those states had slightly higher Medigap participation rates among the disabled, but the difference in participation rates between the aged and the disabled did not close any.

When we looked at the state level we found that the guaranteed issue states had both relatively high and relatively low rates of participation among the disabled. However, of the seven states that had disabled Medigap coverage reach as high as 15 percent penetration, five of those states did have mandates and one other had recently enacted a mandate. The conclusion we draw is that mandated guaranteed issue for the disabled is not sufficient to ensure higher Medigap coverage, but it may be an important factor facilitating access.

We also examined states that required community rating for

Medigap to test the hypothesis that the community rating would increase Medigap participation for the oldest group and lower it for those in the younger aged group because of the implied cross-subsidy that you get in community rating. We could not find any relationship for the eight states that required community rating, although as a group the overall Medigap participation was slightly lower in those states than in the nation as a whole.

That's what we've found so far and would welcome your comments.

MR. FEEZOR: A couple of comments. First off, I thought the chapter was done quite well, given a rather complicated regulatory and product diversity subject. A couple of things. I think we probably need to make more explicit in our conclusion that any move to make for an effective public-private partnership in dealing with post-65 coverages will require an explicit coordination of policy both across state and federal, and between legislative and executive or regulatory. We say that and the difficulty of the analysis that we bring up I think leads to that conclusion but we need to make it, I think, a little more explicit.

Second, I wonder if a couple of paragraphs in terms of the pre-65 retiree population, either in terms of its growth, its predicament as being probably the least sought-after group in the private insurance market, and its implications for Medicare supplemental might not be worth it on that. So I would offer that as something to think about if it could be incorporated at this date without too much trouble. Scott and Jill, I mention the comment, we probably need to be a little clearer on the Taft-Hartley plans, that they have a different regulatory structure than what you laid out in here in terms of complaints.

Then the other thing we probably do need to mention since we have, in some other chapters or some other products have talked about the seniors counseling program which does enjoy some federal funding, we probably need to reference that. I think it's about page nine or 10 where we talk about the difficulty of getting information and comparison basis.

Then that leads to the final thing that I think the chapter dealt well with but again maybe needs to be made more explicit, and that is that I think there are -- the reforms that happened in the current Medicare Choice mind-set showed two very different constructs or ideas or approaches to what is best for consumers.

One is where you're trying to standardize so that you can -- standardize the benefits so that you in fact can produce value and comparability, and the other which assumes that you want greater latitude and flexibility, and that individuals are enlightened to do that on their own. I don't know that we've ever really quite reconciled those, or whether they would be reconciled, but I think that shows two very different approaches that are probably a decade apart, and to some degree have some of their lineage perhaps to the more traditional indemnity side, the Medicare supp side versus managed care, the newer entities that are out now in terms of the MCOs that offer the latter.

Other than that, I thought it was -- I've got some edits that I'm going to share with the group, but I thought it was a good job.

MS. ROSENBLATT: I agree, I thought it was a good chapter and I think it made the point well, as Allen said, it really made the point well about the complexity of this market, particularly with the first chart in there, that narrative chart.

The comment you made, Scott, about community rating, and

this may be beyond the scope of this chapter but I think you just made the point that in the states that require community rating that the penetration of Med supp is actually lower. It's my guess that that's because the overall premium rates, both to the young and old, are higher because of the effect of community rating. Now I don't know if you've got time to look at that, but it might be worth just making a comment that this could be due to the overall effect community rating on the premium.

I want to echo the point Allen just made on standardization. I sort of feel like this is lecture number three from Alice Rosenblatt, but I'm always in favor of innovation in the marketplace and have always believed that the OBRA attempt to standardization, while it may have made explaining benefits harder, it probably prevented companies from coming out with innovative products. I think that Scully has recently been promoting that. You had some sentences in here that made it sound like there wasn't much going on, and I think we've got a product in California that is getting a lot more enrollment than we thought it was going to get because it's one of those special product kind of things. I can't describe the benefits to you, but if you wanted to pursue it I could give you the name of somebody at Wellpoint to talk to.

Just a minute thing on the narrative chart that I referred to where you're talking -- it's on the first page of it where you're talking about the employer-sponsored plans. One other thing you should add to the last row there is that the employer-sponsored plans have the ability to vary the retiree contributions so that they can impact what their cost is by passing more cost on to the employee or retiree, so that helps them out.

Then the last thing that wasn't mentioned that I always think should be mentioned, particularly looking forward, is FAS 106. As companies have had to recognize this liability on their balance sheets, many companies have scaled back benefits or -- I think it further makes the point that you're trying to make that as we look out there's a whole group of people that don't have -- the percent of the population that has the employer-provided benefit I think is going to really drop and part of the causative effect is FAS 106.

MR. FEEZOR: On that, Alice, I think there is a difference between access to employer-based retirement coverage and the actual contribution. They're two very different things and certainly the employer contribution is going to be going down rather markedly I think over time. I hope I'm wrong but I suspect not from everything I've seen.

MS. BURKE: The first is really a question and it relates to the points that Allen and Alice have made. How current is the data on retiree coverage?

DR. BERNSTEIN: The CPS data is 2001.

MS. BURKE: Because my sense is, and I think Allen just pointed it out, that there's an increasing difference in access and actual take-up, in part because of the decline in employer coverage in terms of the cost of those benefits that is shifting that I suspect is going to increase. I think some sensitivity to that as has been suggested I think makes a lot of sense because I think we're clearly seeing a move on that side of the market.

The other just passing note to Alice's point about the value of standardization or the ability to compare, that in fact was at the heart of much of what occurred in OBRA, and prior to OBRA. It came out of, in part, a fear of the failure of the beneficiary

to fully access information that allowed them to make a reasonable comparison and really understand, and that there was a great deal -- I don't want to use the word subterfuge, but there was a fair amount of confusion in terms of what in fact they were purchasing.

So I think while I wouldn't disagree with you that there is value in being able to be flexible, I think we ought not lose sight of the problems that led to a lot of the work that was done at the time. Again, not in a way to be paternalistic that people can't make choices, but there really was enormous difficulty at the time in terms of people being able to understand what it is that was being put before them and make reasonable decisions. So in the desire to be flexible and to be responsive to a market environment, I don't want to lost sight of the fact that there was a reason that led us to the kinds of changes that were made, even further back when we did some of the original Baucus stuff. I think there were real issues there that we ought not lose sight of.

DR. REISCHAUER: At the risk of inciting Alice here, I thought this was all very good and comprehensive and I learned a lot, but we didn't preface it by saying, this is really a second-best, if not third-best, solution to a problem. Supplemental insurance exists because the Medicare benefit package, unlike most employer-sponsored packages, is inadequate. Various entities, employers, states, individual insurance market, have tried to fill this gap. But what we have is a complex, inefficient response --

MS. ROSENBLATT: I agree.

DR. REISCHAUER: Why did I come today?

[Laughter.]

DR. REISCHAUER: The comment on what's happening to the employer-sponsored market really suggests that over time the employer-sponsored component will become more like Medigap, in the sense that the participants will pay a higher fraction and there will be more restraints on it. I just have to take one dig about innovation here. I think, if I remember correctly the minutia in this chapter there was an example which HCFA had turned down somebody's innovative suggestion that the benefit package include pregnancy benefits.

MR. HACKBARTH: It's not worthy of a response.

DR. REISCHAUER: I thought that was innovation.

MR. HACKBARTH: Going back to Bob's first point, I agree with that. I think that early in the chapter it might be useful again to make that point. As I recall, we labored over some very artful language to that effect in the June 2002 report on assessing the Medicare benefit package. Just lift that and plant it here.

MS. RAPHAEL: The other part I thought was interesting that I'd just like to see highlighted, when you did a comparison of the beneficiary costs under all these different options, I thought that was particularly important. I certainly didn't realize the differences there.

DR. BERNSTEIN: We could put in a separate chart the pulled that out of the big chart if you think that would be a good idea. We've also run that separately by health status and that's also informative so we can put that in if you want.

MS. RAPHAEL: That would be useful.

MR. DURENBERGER: My comment was the same as Bob's. This is a very exciting chapter, this work, and when it's put together with the report, which preceded my coming on board last summer,

it is very, very important product coming out MedPAC. But in order to get the attention of people other than the usual readers of MedPAC reports it really needs to get set up the way Bob suggested, and maybe even more frankly as opposed to artfully, whatever that may mean, and tied back. There is a phrase which says, previous MedPAC reports have documented the importance -- it would be helpful to restate it. Not the whole report, but just restate what it is that MedPAC said in the past and then flow from that the fact that this will examine both the variation in products and the variation in markets, and then aim to go to some specific studies and so forth.

MR. HACKBARTH: When you think of the time and energy and expense that goes into just trying to understand this market, regulate it, and all of the uncertainty about the implications of different forms of regulation, it really is an incredibly inefficient way to provide these benefits to Medicare beneficiaries.

MR. SMITH: I agree with that. I learned a lot from this chapter in each of its iterations and I much appreciate it. I think it would be useful, sort of building on Bob's point, sizing this market. The share of total health care expenditures that is paid for in this market is always a surprise to people. So making the point that not only is it, at best, second-best because of the inadequacy of the benefit package, but it is a big chunk of total health care expenditures for Medicare beneficiaries.

MR. HACKBARTH: Any other comments, suggestions?

Okay, thank you.