MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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10:11 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
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JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Medicare supplemental markets: view from the field
-- Scott Harrison, Jill Bernstein, Sarah Lowery

DR. BERNSTEIN: Good afternoon. I'm going to briefly walk through the summary document that we sent you about the site visits that we did over the summer with the help of Mathematica Policy Research. Bob Hurley from Virginia Commonwealth University who worked on that project is also here and if you have any questions later about specifics on the site visits any of us has an equal chance of being able to answer them.

The objective of the site visits was to help us understand the factors that shape the different markets for supplemental insurance that we have seen across the country. We were looking for the sources of variation in order to understand what the implications of the variation in these different markets might be for Medicare beneficiaries and for Medicare policy now and in the near future. The sites that we went to were Atlanta, Long Island, Minneapolis-St. Paul area, the entire state of in Nebraska, and San Diego. These areas have approximately the same number of beneficiaries although their size varies considerably, and the distribution of different kinds of supplemental coverage also varies tremendously across these three areas.

Although Medicare is a national program with standard benefits, the array of products that beneficiaries use to supplement Medicare are shaped in large measure by local factors. For the purposes of summarizing what we learned on the site visits we have divided these into four sets of issues which I'll talk about briefly. One is state regulation and oversight. Second is the organization and history of the local systems. We also looked at the nature and concentration of employer-sponsored retiree health benefits in each of these areas. Finally, we looked at the interaction of privately-funded supplemental products with publicly-funded products, particularly for low income beneficiaries.

We discussed the issues of state and local regulation with a variety of people in each of these sites, and I'm going to move from specific issues up to more general issues. A major topic that comes up, particularly in states that have not made changes in excess of the National Association of Insurance Commissioners model regulations is access to supplemental insurance for disabled beneficiaries under the age of 65. To of the states we visited don't have any special provisions for extra open enrollment or guaranteed issue. Three of them do.

This is an issue which is still in play. California only increased protections for beneficiaries under 65 a couple years ago. They had a special open enrollment period and they're going to have another one starting in January because evidently no one was aware of the first one. They were kind of concerned about that.

As it turns out, the Medicare+Choice program is what brought

this issue into special light in a number of these states. There was some hope on the part of the beneficiary advocate community that M+C programs would provide an option for people who couldn't get supplemental insurance. This turned out not to work out very well. In the two states that didn't have special provisions the M+C market never really developed all that much and there was never a great deal of enrollment for people under 65. Now that the availability of M+C programs in both Nebraska and the Atlanta area is quite limited impact, we're back to the same position we were at before which is an issue of some concern for the beneficiary community.

Moving to the next area, there are really basic differences in the way Medigap insurance in particular looks in states. Minnesota is a waiver state and its products are actually quite different from the national products in some substantive ways. In particular, the structure of the drug benefit that's available in Minnesota Medigap is a little bit more generous than anything that's available under H, I, and J. It's expensive, but there are also differences in the way Minnesota Medigap is structured in terms of the select policies so that there are options available to beneficiaries in Minnesota for coverage which includes drug coverage that are more accessible, evidently, than they are nationally. Twice as many people who buy Medigap in Minnesota get a drug coverage version than is true for the benefit in the other states.

DR. REISCHAUER: But isn't that because it's one of the three states that was excluded from the requirements--

DR. BERNSTEIN: Right.

DR. REISCHAUER: --and they have to keep the plans that were defined as of the early 1990s?

DR. BERNSTEIN: They made the reforms right before the OBRA reforms and they basically went through the same process, they just came up with a slightly--they believe that their structure was superior to what NAIC came up with so they didn't switch to the NAIC option. Their actuaries have some very interesting insights into what they think they did, although they're not taking credit for it being entirely on purpose but it seemed to have worked out pretty well.

Medigap is the basic form of coverage in Minnesota. The M+C rate is not that high and there's very little employer coverage there compared to some other urban areas that would be comparable to Minneapolis. So it is a big deal there.

New York is also a heavily regulated state under the regular system but New York has pure community rating and open enrollment and guaranteed issue. There are less policies sold in New York, and they're not cheap but we didn't hear any complaints when we were there about the availability of Medigap from beneficiaries or from regulators.

We also saw differences in the regulatory climate that affects supplemental products. Some states are very happy with the existing set of standardized policies and don't want any changes to it and are very resistant to the introduction of innovative benefits. Other states are much more laissez faire and believe that the basic rules cover the options and if it's

okay with the national system, it's okay with them. California is the prime example there. There are a lot of different things going on in California and I'll come back--but the insurance options in California are more diverse than they are in other standardized states.

In the broadest level, some of the state regulations actually affect who can participate in the M+C market and what insurers can do. In Minnesota for-profit organizations can't find health plans, PPOs or M+C or any kind of managed care plan, so there are contracting arrangements with commercial vendors that have established contracting intricacies there that have affected the way they go forth with things like PPOs.

New York has a rule about insurers not doing out-of-state business which would be an issue, and California's prohibition of corporate practice of medicine has had an effect on the way physician groups have organized themselves there, which in turn has an effect on who participates and what kind of managed care arrangement or insurance arrangement.

Moving to the local delivery systems. It's kind of obvious to say that managed care and M+C options look different in markets where integrated care and HMOs are a way of life versus markets where they're not, but they're more fine-tuned differences that stem from that kind of basic difference across the places that we went to. The four metro areas that we visited are about the same size in Medicare population but they have very different kinds of health care provider organizations, physician groups, relationships with hospitals, et cetera. M+C options fit in some of them and they don't fit very well in some of these other places.

Both Minneapolis and San Diego have strong managed care organizations and have had high penetration rates in managed care in the commercial market for decades. In Minneapolis, pretty much everyone we talked to told us about the region's strong commitment to integrated care and to quality initiatives and to strong relationships between providers and health plans and so forth. In San Diego, the physician groups are clearly committed to contracting with health plans and capitated arrangements still actually work there, and there are a lot of people who are committed to sustaining those relationships. Beneficiaries also are very loyal to managed care in San Diego even though the quality of the M+C benefits has deterioriated somewhat over time.

Some of the points that are listed in the sub-bullets there are--contrary to popular opinion, rules of thumb don't always apply because of these differences in local delivery systems. As I said, in San Diego some provider organizations really like capitated arrangements. In Minnesota we talked to plans who said they had put together rural networks and they planned to put together more rural networks in adjoining states. In other urban areas it seemed to be virtually impossible to put together networks that could participate in PPOS or in MedicareSelect plans. Atlanta was one example and Long Island is another.

Finally, history and cultural or whatever you want to call it, makes a difference in some of these areas. Beneficiaries in some of these markets were very happy about the coming of managed

care, M+C programs, and very unhappy when things didn't work out the way they wanted them to and the plans, particularly in Atlanta, just disappeared. It's almost personal. People are very skeptical, including the people who work in the counseling organizations about managed care and its ability to ever serve these people's needs so they're going to be skeptical when anything new comes along.

The issue of employer-sponsored insurance came up a couple times this morning. Again, despite the fact that it is clearly true that there's a decline in retiree benefits, it's still important in some of these markets, in Long Island in particular, there are big variations across the industry groups and the public versus private sector with regard to these benefits, but across all of them we heard very mixed views about how--on the one hand these things remain important. They're important to the beneficiaries. They're important to the employers. All of them are concerned about cost. All of them are concerned about, in particular, prescription drug benefits and the cost of those plans.

One thing that we heard about that's important is the extent to which, in an effort to reduce costs or liability in employee benefits in general, employers in both the public and private sector can move retirees into their own risk pool, which reduces the increase in cost for the working population but leads to fairly steep premium increases for the retirees and may cause them to drop coverage.

So we have to be very skeptical now when you look at the offer--percentage of employers who say they're offering coverage to retirees masks the fact that, first of all, some of the retiree premiums are very, very high in some of these programs, and in some of these programs employers are no longer able to contribute at all to the retiree population. They offer the plans because they're group plans and group plans have distinct advantages, mainly in terms of being able to craft benefits more flexibly than you can in the individual market. In many cases, the retiree plans are the only--provide a way of offering a much better drug benefit than you can buy through H, I, or J and there isn't much else out there except for some generic-only plans.

Finally, employer-sponsored insurance still has a big effect in some areas on local health plans. In some markets contract plans for M+C through employers constitute one-third or more of the business that some of the M+C plans are involved with.

Another unique example is the TriCare for Life program which is an employer-sponsored plan from the Department of Defense which covers supplemental benefits and offers an optional free--it doesn't cost anything to join it--drug program for military retirees. When that came online a little over two years ago in San Diego it affected about 14 percent of the Medicare beneficiaries living there. Thousands of people left their existing plans, dropped either M+C coverage or Medigap coverage. A major insurer in Atlanta also told us 10,000 of their members dropped Medigap when TriCare for Life came online. So these organizations do affect each other.

On a sadder note, in Minnesota--it doesn't affect

Minneapolis as much as the state as a whole, large declines in coverage for iron and steelworkers as a result of plant closings has led to really interesting competition among Medigap and M+C plans in that state as well.

We also talked about some of these low income programs this morning so I'll just go over this really quickly. The supplemental coverage offered through the full Medicaid program varies substantially across states; has a big impact on beneficiary access to coverage. The income limits in Georgia are less than half of the income limits in Minnesota, which has the highest. Asset levels vary considerably across these states as well.

For the Medicare savings programs, that would be QMB and SLIMB, QI1 program, the income is set nationally so those are the same but again the state asset requirements come into play. There's even more variability when it comes to the prescription drug benefits available for low income beneficiaries. Georgia has a program which basically helps people get private sector drug assistance, whereas Nebraska has no program at all; New York has a very popular program called EPIC which many of you know about, which provides coverage to people of low and moderate income levels. It's a very large program, and given the support that it has in the state and the commitment that the state has made to us, we heard a lot of people there say that they were actually concerned that changes in national policy could be detrimental to the people of New York because it could leave them with something worse than what they have now.

The last thing I'll mention even more briefly is that the dual eligible issue is clearly important in all of these areas. In most of the states, dual eligibles are not generally in managed care because it's optional and it's very difficult to coordinate benefits, particularly drug benefits. However, the MSHO program, Minnesota Senior Health Options in Minnesota is a fully integrated waiver program that combines Medicare and Medicaid benefits into a single funding stream, and a lot of folks there are actually in managed care. The plans that are participating in that think there's a tremendous potential for better care and more coordinated care and efficiencies, and later this year other staff will be getting back to you on some of the issues regarding dual eligibles and some of what's going on with them.

Looking to the future. One common theme that we heard and what we emphasized in the report is that generally across all the five sites we went to, as different they were, the Medigap market is seen as a stable thing. The insurance regulators, the insurance companies and beneficiaries know what the rules are. They generally understand them. They had very few complaints about regulation, and it was striking to us that this is just as true in New York or in Minnesota as it was in places where there was very little regulation in comparison. Knowing what the rules are with these products is very important to people.

There's a growing tension, however, as some of the forms of Medigap and different sorts of Medicare+Choice products evolve, as benefits have eroded and cost-sharing has increased

Medicare+Choice plans begin to look a little bit more like Medigap products. Medigap providers for their part, particularly in places where they're being more innovative or trying to come up with ways of addressing the prescription drug needs of their clients and also trying to deal with cost by using high deductible plans.

They're also adding benefits like homeopathic medicine or the prevention programs or exercise programs that attract different groups of beneficiaries so that in some places like California it's really hard to figure out what these products are, whether they're Medigap or whether they're Medicare+Choice. Those differences are important because they're regulated differently. The open enrollment season issues are different, and the community rating provisions are different, and the re-entry into the market are affected by different federal and state protections.

A number of the beneficiary folks we talked to in California were really beginning to have trouble trying to figure out what to tell their clients. In terms of Medigap alone, the SHIP was unable to provide price information on alternative Medigap products because the system is so complicated, there's so many different options and they're so hard to compare to each other that they had basically lost the ability to help the people that called them to get that kind of information. It's also not available on the state insurance department web site, the pricing information, because they can't keep track of it either.

I just want to go through one really quick example of how some of this plays out by using an example that was raised with us a number of times in different states and that has to do with the regulation of private fee-for-service plans, which are very, very much like other Medicare+Choice plans with a couple of unique distinctions. Like Medicare plans, you can't deny people entry based on any kind of personal--age or health or whatever. No difference for smokers or nonsmokers like there can be in other insurance. They have the same open enrollment, guaranteed renewal rules as other M+C plans. They are M+C plans. They have benefits similar to other M+C plans. To the extent that they have--you can set up a different systems of copayments. They cover some non-Medicare services. They offer some kinds of discounts for things like sometimes hearing aids, sometimes prescription drugs, out-of-area coverage. They look a lot like other M+C plans. They also look a lot like some of the Medigap plans that are available out there.

Currently none of them have networks, which does make them different from other M+C plans. But the other difference that has insurance regulators concerned is that nobody reviews their rates. CMS by law doesn't review the rates of private fee-for-service plans, and states are preempted by federal law from reviewing the rates that are offered by these plans.

The concern of the regulators is that these are insurance products that are licensed to do business in their state, beneficiaries buy them the way they would any other Medicare product but it looks more like they're buying Medigap than M+C. But if the plans raise their rates substantially over time but

don't leave the area, then the beneficiary might be in a difficult situation because they don't have--if the plan still exists they don't have the same rights as they would if the plan just disappeared and they would have automatic reinstatement rights for Medigap under federal law--I mean, M+C under federal law.

If an M+C plan disappears and there are no other M+C options, a person has certain rights to reenter the Medigap market, which is true of these plans. But if the plan is still there but offering a very high rate, this puts them in a different position. In a state like Minnesota where they are very careful about regulating everything, this is causing a great deal of consternation.

DR. ROWE: Can you say that again? I got a little confused.

DR. BERNSTEIN: I think I said it wrong. If you're in an M+C plan and it disappears, it withdraws from your area, there are federal protections for reentering the Medigap market. You're allowed within certain number, a 60-day window or something, you're allowed to reenter the market and buy certain of the Medigap plans without underwriting. Since private fee-for-service is an M+C plan it counts in there, so in many rural counties of Minnesota it's the only M+C option--actually Minnesota is a bad example. They have M+C everywhere. In many areas of many rural states it's the only option that's there. So if one private fee-for-service plan comes in and it's charging $70 a month for a benefit and then it leaves--

DR. ROWE: You can't afford that so you drop that but you don't have this reentry eligibility.

DR. BERNSTEIN: Right, because there's still an M+C plan. You can go back to regular Medicare but you can't get Medigap.

DR. ROWE: Why can't you buy Medigap? Is there a law against it?

DR. BERNSTEIN: It depends on the state rules. After the 60--

DR. ROWE: You can never buy back in?

DR. BERNSTEIN: No, you can buy it but there are different rules in every state. You don't get guaranteed issue. In New York it doesn't make any difference because it's community rated and open enrollment, but other states you can't.

DR. ROWE: Tell me about the exceptions.

DR. BERNSTEIN: This is complicated, but the bottom line is, private fee-for-service looks like M+C but you don't have the same--nobody is reviewing the rates. That's what gets people upset and that could have an impact on beneficiaries if that's all that's available.

DR. ROWE: I don't understand. It seems to me that you are implicitly suggesting--you're kind of a born regulator. You're implicitly suggesting that what you should do is have some people review these rates. Why don't you solve the problem the other way and put in a regulation that gives these people the right to access Medigap at those rates, rather than create another bureaucracy reviewing all these rates? Wouldn't that fix the problem a little easier?

DR. BERNSTEIN: I'm not sure that the states want--I'm not

proposing or was not building to a recommendation that they review the rates. I'm saying that the regulators don't know what to do with these products that look sort of like Medigap and sort of not like Medigap, and kind of like M+C but not exactly like M+C. They have a lot of questions.

DR. ROWE: And they want to review the rates. You're saying, why can't we review the rates for these policies in this state that people are buying? I'm just saying there's another solution to the problem that would be much simpler and less bureaucratic.

DR. BERNSTEIN: I don't think the regulators in other states will want to review them. I think Minnesota like to review things. In fact they review things they're not even allowed to review.

MS. BURKE: Jill, can I just ask one further question on the structure of these plans? You indicate that there's no rate review. Are there similar to the normal insurance structure in most states as to reserve requirements or any of those kinds of issues?

DR. BERNSTEIN: They have to be licensed by the states so it depends on the state's rules.

MS. BURKE: So it's just a function of that. So it may or may not.

DR. BERNSTEIN: Right.

MR. FEEZOR: Indirectly it may.

MR. SMITH: Purveyors are subject to normal insurance department regulations. What they're selling isn't but the sellers are.

MR. HACKBARTH: So the finances of this particular plan, is the premium appropriate for the costs, are not subject to state review but the overall financial stability of XYZ health insurer is because it's a state-licensed entity. That's a threshold requirement for participating in Medicare is that they're a state-licensed--

DR. BERNSTEIN: Right, they have to qualify to be a Medicare contractor, so they have to meet those requirements.

So as we develop--we're going to give you a final report on the site visits and we're going to look at some of these other issues further, so I just basically have two questions for you. One is whether there are particular topics that were raised in the material we sent, or elsewhere, that you think we should be pursuing? And secondly, whether you would be interested in us looking at potential policy changes that might improve beneficiaries' ability to meet their supplemental needs.

MR. SMITH: Jill, thank you. I found this fascinating at the last meeting when we looked at the site visits and the mailing materials. I found it fascinating but not very satisfying, in that the question, so what, never got raised in any useful way. Does the structure of the supplemental market end up costing beneficiaries differentially out-of-pocket? Does it affect utilization? Does the structure of the market affect health outcomes to the extent that we know?

It's interesting that Minnesota and New York continue to be heavy-handed regulators and Jack would prefer to be in Nevada,

but so what? Is the experience of one of Jack's policyholders in New York significantly better, significantly worse, significantly more expensive? Do they buy less supplemental health care than folks in a difficult market? It's hard to even begin to think about answers to the questions you raise at the end without knowing whether or not this stuff matters.

DR. BERNSTEIN: One of the reasons that we did this is because when we did the national overview it was clear that it did matter. There a lot more people in some of these states that don't have any supplemental coverage than in others. In previous work we've tried to look at whether having different kinds of supplemental insurance makes a difference in terms of the way people use services. We haven't done that again recently, but that was going to be part of what we'd like to do in the future.

We're particularly interested in looking at what the decline in employer-sponsored benefits actually means, and where do these people go, and what are their options, but haven't yet figured out a good way of getting the data to track some of that. So those are all really important issues that we'd like--and that's one of the reasons that we wanted to talk to you today is to get some ideas about what particular directions you'd like us to go in.

MR. SMITH: In general I'd be more interested in what kind of services do they consume and how much do they have to pay for them, rather than what the architecture of their supplemental choice is.

DR. BERNSTEIN: Every year in the context chapter do an analysis of out-of-pocket spending and we do that by different type of supplemental coverage.

MR. SMITH: Incorporating some of that in here would be--

DR. BERNSTEIN: We did that last year and we're doing that again for the context chapter this year. We're also developing a chapter for the June report looking specifically at beneficiary resources and liabilities, basically looking at what they're spending for health care, and how they're paying for it, and how that's changed over time.

MR. SMITH: Looking that in terms of the differences in supplemental marketplaces?

DR. BERNSTEIN: That will be one of the things that's in there.

MR. HACKBARTH: Whether the different regulatory regimes are good or bad depends in part on who you are as a beneficiary and what you're expected expenditures are, what your health status is.

DR. BERNSTEIN: Actually, one of the things that will be in the report that we haven't had a change to talk about is the natural experiment in San Diego when almost 50,000 people went from having just military retiree coverage, which wasn't very good, to having TriCare for Life coverage, which is very good and has a very good drug benefit. We have yet to figure out how to get hard data on this, but there was a lot of anecdotal evidence that their use of services has changed dramatically as a result of having different kinds of supplemental. They're using a lot more services.

So it is an issue. Again, on Long Island more than 60 percent of the people, according to CPS, have supplemental coverage through their employer. Utilization patterns there are very difficult than they are in San Diego or Minneapolis.

MR. HACKBARTH: One of the interesting things that I read on this subject, I think it was Kaiser Foundation report that looked at different markets and looked at the options available to certain hypothetical beneficiaries with different conditions and associated health care costs, and said, what are the total health care costs for this hypothetical 80-year-old frail female, or a 65-year-old healthy male in different markets, when you take into account the premiums plus the out-of-pocket expenditures? It was very interesting and enlightening. Huge differences; huge differences.

MR. FEEZOR: Glenn, I think you and Dave probably at your last question framed what really we should be focusing more on in our analysis of this. I bear some responsibility because Jill and Scott had asked my opinion from my days 15 years ago as a regulator about what were the right market and some of the nuances.

In retrospect, I am concerned about two or three things about our work thus far. Out of the five sites we picked, three are in notoriously unique states in the terms of the regulatory environment. That is Minnesota, that is New York, that is California. Two, I think three of those are out of the four or five who maintained a duality of regulatory oversight for a long time. Basically said that HMOs were not in the insurance business and that sort of thing. So in retrospect I worry about that.

Also in retrospect as I look--we looked largely at urban markets, with the exception of all of Nebraska, and we got all of Nebraska in order to get equal numbers I guess, or equal size markets.

DR. BERNSTEIN: No, we wanted to go to a state that was rural; someplace that was rural.

MR. FEEZOR: In retrospect, even that one I worry a little bit about the presence of Mutual of Omaha being so very, very strong early in the supplemental market, though they may not be anymore. So you may want to just touch base or do a couple of quick and dirty conversations with some other less urban states to see if there's some--to verify what you found in Nebraska.

By the way, parenthetic, I think what will be interesting, Jill's point on the evolution of a lot of the Medicare+Choice products to look more like Medigap and Medigap to mimic some aspects of some of the Medicare+Choice products despite different regulatory--Jack may bear it out and I'm sorry Alice isn't here, but an awful lot of the--because of what seems to be the intransigence of the division of managed health care in California almost every HMO that I know is in fact filing dual license. They in fact are filing HMO look-alike products under a department of insurance license in order to have greater flexibility in their benefit design and so forth.

Then just one other observation. Because it is probably a more static market now maybe this is not as important, but I

think it's hard to look at what happens in the Medicare supplemental market generally without looking and giving some credence--and it's very tough thing to do market by market--by looking a little more carefully at the distribution mechanism by which those products are sold, looking at the compensation or the reimbursement, whether it's a captive sales force, independent agent, does that commission pan out over two years? Even though some of the Medigap reform efforts limited some of that variation, I think that's important. Then ultimately, and the point was made in this paper, how the regulatory construct fits with where there are some regional or local payment and physician network practices and attitudes are awfully important.

Two other just quick points. There was a new study that's just been released. I haven't had a chance to see it on public entity retiree.

DR. BERNSTEIN: I've got it.

MR. FEEZOR: Okay, just wanted to make sure you'd seen that.

Then finally, I don't know who's doing the actuarial work for TriCare for Life, but the future cost of that--I see a lot of snickers. I may be stepping into it, but it won't be the first time nor the last. But the unfunded liabilities, not only--Jill's point on the number just in San Diego, but even within the CalPERS program when people began to say, when we move to just a 10 or--in fact most of our retirees in the CalPERS program pay very little; certainly the state retirees. But even when we start talking about a pay increase out-of-pocket on premiums for the retirees, I had a significant number, hundreds that actually bolted from an almost free retiree coverage in CalPERS to TriCare for Life. If I could have been a little more selective about which ones left me that wouldn't have been all bad from my perspective, but I really do worry about who's tracking that from the federal government standpoint.

DR. REISCHAUER: By the time the bill comes in Arnold will be president and he'll handle that issue.

[Laughter.]

DR. BERNSTEIN: I just wanted to mention that the full report has a lot of the detail that we haven't been able to talk about including the agents. There's much more richness but it was hard to--we'll get a lot of that stuff to you.

DR. WAKEFIELD: I take the point that some of these examples might be little bit on extreme ends or atypical examples, but frankly, I liked that read. I agree, if you can, to deal some maybe more run-of-the-mill markets or circumstances into the mix might be helpful. But I thought this was pretty illuminating. The variation was striking to me, and I found that to be helpful. I did have the same reaction and why I asked to be called on was because I wanted to raise David's point, which he already raised and that was, I had some difficulty connecting this to the beneficiary at the end of the day. But you answered that. If we can deal that content back in here, I really interested in, recognizing all of this then, what's the link to out-of-pocket expenses, for example, to beneficiaries? How are they impacted by these kinds of variations? Because I actually found this quite helpful, but that was the piece I was still missing. And I

heard your answer, you're coming back and that's going to be dealt back in again. So basically that question was already raised.

I do have a different question though on--I also had a second question on private fee-for-service. Is it still the case, Jill, that these tend to be primarily in rural areas? At least the first one out of the box was. Is that still the case or are we seeing them equally distributed in urban and rural areas? Just out of curiosity.

DR. HARRISON: Next presentation will have a table that will show you that.

DR. REISCHAUER: When we do whatever we do in this area I hope we don't lose sight of what I think should be the message of MedPAC, and that is because employment conditions and health markets and the regulatory framework and Medicaid policy vary tremendously from area to area or state to state, the availability of supplemental insurance will be unequal and it will be inequitable with respect to cost, availability, structure, generosity, everything.

The right way or only way to solve this problem is to expand the basic Medicare package so that it constitutes a package that the vast majority of the elderly and disabled regard as adequate and they don't need two health insurance policies. We two years ago wrote something about that, about how one could do that. But we'll be here 50 years from now talking about the strangeness and the inequities that exist and how you might tinker around the edges and make some of it, the repercussions a little better than they otherwise would be, but you'll come nowhere near to solving the basic problem unless you expand the coverage of the basic Medicare benefit.

DR. HARRISON: The one thing that we really found was the search for drugs was very important in all of the markets. People stay in retiree plans where they have to contribute lots of money only because they're going to get drugs out of it that they can't get elsewhere.

DR. REISCHAUER: But as soon as we cover drugs we're going to worry about catastrophic.

DR. HARRISON: Right. I'm just saying, an example of what we found from the case studies is that drugs are swinging a lot of the decisions that are going on here. I don't know that we have a lot else that we saw.

DR. ROWE: Just three quick points. One is, I thought the stuff at the end of the chapter on how the Medigap policies seemed to be turning into M+C and M+C seemed to be turning into Medigap and it was getting to be a blur of the distinction yet they were regulated very differently was interesting. One of your questions is, are there particular topics, and you didn't talk about that much in the presentation but I thought that was interesting. Maybe if there was some sort of a table or something that showed the direction that each product was going and how they were trying to get--they seemed to be converging, I thought that was interesting.

Second is, I think you should say something to distinguish corporations that are putting in policies that individuals who

are not yet hired or who may be hired but not yet retired will lose certain benefits versus actually reducing the benefits of currently retired people, because they're two very different things. There are a lot of companies that are saying, no more X for retirees after next year or something like that, or two or five years from now or a sliding scale, because they don't want people to rush out and retire. But that's not influencing the market now because that company's retirees still have benefits. That's one subset.

Then there are the subset of people who actually are having their benefits reduced in retirement while they're retired and I think it's not obvious from what you presented about that.

The third is just a quick question. When you were in Minnesota, whether the proximity to Canada had any effect on the search for drugs. We hear a lot about people going to Canada get drugs, and I just wondered if you had heard anything about that or saw anything in the market up there that was different than in North Carolina or something like that.

DR. BERNSTEIN: Yes. There's a very large program run by a nonprofit consumer group there that has a very large drug importation business going on. I think they're having a little bit of legal--

DR. ROWE: Are they licensed--

DR. BERNSTEIN: A little bit of legal issues going on there now, but it's a very big program. They sort of invented--they've one of the driving factors behind the entire national movement. It's a huge organization.

MS. DePARLE: When you say very large, Jill, what do you mean?

DR. BERNSTEIN: It's the Minnesota Senior Federation and has like 80,000 people who belong to it in Minnesota plus others. They have a professional full-time staff and it's a real place.

DR. ROWE: I was hoping that wasn't going to be the answer, but given that it is then I think Minnesota is particularly inappropriate for us to draw any conclusions from with respect to--while we're comparing, we're picking three different markets or four different markets and we're trying to see what's going on. Here we've got this one market with this huge drug importation--

DR. WAKEFIELD: I think more states are doing that. There's probably at least three or four states.

DR. ROWE: Three or four out of 50.

DR. WAKEFIELD: Ralph's saying 16 or 17 states.

MR. HACKBARTH: We need to keep moving here, I'm afraid. Carol has the last comment and then we need to move on.

MS. RAPHAEL: This is something I'd like to have you focus on. It's on the road to tinkering, to make this better in the interim. That's the young disabled, because we know they're growing in the Medicare population. We know there are real issues about access to Medigap. I think you highlighted last year or the year before. You make some very brief reference to it, but I'd like to really understand the Medigap market for the young disabled under 65.

DR. BERNSTEIN: I didn't do it this time because we had

talked about it in some earlier sessions. There's data--we've been looking at it and it will be discussed in the report.

Actually, if I can make a really brief comment about the site visits and where we went. Site visits are really--you can't generalize from them but they're really good at looking at things that are different. I think the methodological advantage we had here is, in a sense looking at extremes to get a sense of how things could play out. We will be very careful in trying any conclusions from these five weird places about national--we need national data to do that. We can't do that from these five places, but you can see some really interesting nuances that can play out in very different ways which we thought would be helpful.

MR. HACKBARTH: Thank you.