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Health Insurance And The Elderly
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Abstract: The effectiveness of proposed changes to the Medicare program depends on consumers’ responses to different market incentives, which vary according to the coverage the elderly possess to supplement their Medicare coverage. This DataWatch explores the extent of supplemental insurance among the elderly, based on a new data set from the Medicare Current Beneficiary Survey. Only 11 percent of Medicare beneficiaries have only Medicare as their source of coverage; the rest of the elderly population is covered by either private coverage (employer-sponsored retiree coverage or individually purchased coverage) or Medicaid. An increase in Medicare cost sharing would likely affect one-third of elderly beneficiaries, which calls into question the effectiveness of this approach to Medicare program reform.

Amidst rapidly rising costs, policymakers have proposed changes to the Medicare program. One key to evaluating these proposed changes is information on the current distribution and types of supplementary insurance that Medicare beneficiaries carry. The success of proposals to increase beneficiaries’ cost sharing, to restructure benefits, to modify the structure of private Medicare supplemental coverage, or to institute cost control programs aimed at Medicare providers depends on beneficiaries’ responses to the changed incentives. These responses in turn depend on the supplemental insurance that beneficiaries carry.

Over the years a system of private and public health insurance has developed to cover medical expenses not covered by Medicare. There are two main types of private health insurance for persons age sixty-five and older: employer-sponsored retiree insurance and individually purchased Medigap policies. On the public side, aged Medicare beneficiaries with low incomes and assets are entitled to benefits under Medicaid, the federal/state program to insure the poor.” For Medicare enrollees, these Medicaid benefits can be partial (covering only Medicare premiums, deductibles, and coinsurance) or complete (providing full coverage of services).

The interconnection of Medicare benefits with other forms of insurance makes reform of the Medicare system a tricky proposition. Consider, for

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example, the Medicare Catastrophic Coverage Act of 1988. That program established caps on beneficiary out-of-pocket spending and phased in coverage of outpatient prescription drugs under Medicare. The program was to be financed by new premiums and by higher taxes on upper-income elderly persons. Faced with an intense political backlash from this group, Congress repealed this legislation almost as soon as it was passed.

In retrospect, it appears that policymakers were not clearly aware of the supplementary insurance holdings of the elderly. The Medicare catastrophic benefits were much less generous than the subsidized employer-sponsored health insurance retirement benefits already held by a significant share of the elderly. Thus, despite being asked to pay additional premiums and higher taxes, many of the higher-income elderly would not be receiving any new insurance benefits. In this DataWatch we use the new Medicare Current Beneficiary Survey to measure the extent of supplementary insurance held by Medicare enrollees. This information should aid policymakers as they consider future reforms without repeating past mistakes.

**Data and methods.** The supplementary health insurance data are from the Medicare Current Beneficiary Survey (MCBS), a continuous panel survey of more than 12,000 aged beneficiaries living at home and in institutions. The survey is being directed by the Office of National Health Statistics within the Office of the Actuary in the Health Care Financing Administration (HCFA). The data in this report were prepared from a public use file that is available for general use. MCBS Round One survey data, collected from September through December 1991, have been linked to Medicare administrative bill records for calendar year 1991. This links information that can only be collected in the survey (for example, supplementary health insurance coverage) to Medicare bills that provide complete records of service use and program spending for each person in the survey. For Round One, 87 percent of the initial sample completed interviews.

<table>
<thead>
<tr>
<th>Distribution Of Elderly By Supplementary Insurance Status</th>
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Exhibit 1 shows the 1991 distribution of the elderly Medicare population by their supplementary insurance status as reported in Round One of the Medicare Current Beneficiary Survey. Elderly enrollees are defined to be those age sixty-five and older, regardless of their original reason for eligibility. About one of every nine Medicare beneficiaries age sixty-five and older have Medicare as their only form of health insurance. About 75 percent of elderly beneficiaries have some form of private insurance to supplement Medicare. One-third of the elderly supplement Medicare with employer-sponsored private insurance only. Another 36.8 percent of the elderly have
only individually purchased private policies to supplement Medicare. Five percent of the elderly have both types of insurance.

**Employer-sponsored insurance.** Although 38 percent of the elderly currently have employer-sponsored insurance, such benefits were not a common part of the average retirement benefit package prior to Medicare. In the 1970s and early 1980s employers rapidly expanded these benefits. Employers continue as primary health insurers for older persons who continue to work. When a person who is age sixty-five or older retires, Medicare becomes the primary health insurer and the former employer becomes a secondary payer.

Most retiree health plans continue health insurance benefits at the same level as those offered to current employees. This can be very advantageous to the elderly because the employer pays part or all of the premiums, and these plans often provide benefits that are not covered under Medicare, such as prescription drugs and stop-loss limits on large out-of-pocket expenditures. However, in many employer-sponsored plans members are still responsible for the lower of either Medicare or the private plan deductibles and coinsurance.

**Individually purchased insurance.** Individually purchased coverage is the most common form of Medicare supplementary insurance coverage; 41.8 percent of the elderly held such coverage in 1991. Individual Medigap policies can vary widely in their coverage. However, all policies are required to cover all Medicare coinsurance costs except coinsurance for skilled nursing facility (SNF) stays. Nevertheless, the typical Medigap plan usually

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**Exhibit 1**  
Supplementary Health Insurance For Medicare Elderly, 1991

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Source: Medicare Current Beneficiary Survey, Round One data.  
Note: The “other” category includes Medicare enrollees who have public insurance other than Medicaid and enrollees who are unable to specify whether their private coverage is employer-sponsored or individually purchased.
covers all coinsurance costs under Medicare, including SNF coinsurance and the Part A (hospital insurance) deductible. Some Medigap plans cover the Part B (supplemental medical insurance) deductible as well, thereby wrapping around Medicare to eliminate virtually all point-of-service cost sharing. However, the typical Medigap plan does not cover balance-billing amounts by physicians and other Part B providers. These are amounts above Medicare-approved charges on claims where providers have not agreed to accept the Medicare-approved amount as full payment. In addition, unlike many employer-sponsored health plans, the typical Medigap plan does not cover outpatient-sponsored prescription drugs or other services not covered by Medicare, nor does it place a catastrophic cap on health spending for an individual.

**Medicaid eligibles**, Nearly 12 percent of the elderly were eligible for both Medicare and Medicaid in 1991. These are persons who have qualified for cash payments from public assistance programs such as Supplemental Security Income (SSI), who qualify as medically needy under guidelines in their state, or who receive more limited Medicaid benefits as qualified Medicare beneficiaries. Medicare is the primary payer for these persons for the services it covers. The state Medicaid program typically buys in, that is, pays the Medicare Part B premium for these persons and pays all Medicare cost-sharing amounts. Fully qualified dual enrollees are entitled to any additional Medicaid services offered in their state, such as coverage for prescription drugs and long-term care.

**Comparison With Past National Health Surveys**

In addition to knowing the current share of elderly persons with a particular type of insurance, it is helpful to know if this share has been growing or decreasing over time. Exhibit 2 shows distributions of elderly persons by insurance status as reported from major surveys over the past fifteen years: published data from the National Medical Care Expenditure Survey (NMCES), the National Medical Care Utilization and Expenditure Survey (NMCUES), the Survey of Income and Program Participation (SIPP), and the National Medical Expenditure Survey (NMES). A consistent share of about 20 percent of elderly persons had only Medicare insurance coverage between 1977 and 1984; however, this share dropped to 11 percent in 1987. By 1991 the share of elderly with Medicare only was also just over 11 percent, according to the new Medicare Current Beneficiary Survey. This confirms that there has been a sharp drop in the share of Medicare-only persons in the past decade. The share of elderly persons with private supplementary insurance increased from 65 percent in 1977 to 75 percent in 1987. However, this upward trend appears to have
### Exhibit 2

<table>
<thead>
<tr>
<th>Survey</th>
<th>Total</th>
<th>Private coverage</th>
<th>No private coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Employer-sponsored</td>
<td>Individually purchased</td>
</tr>
<tr>
<td>1977 NMCES</td>
<td>100.0</td>
<td>65.2</td>
<td>23.7</td>
</tr>
<tr>
<td>1980 NMCUES</td>
<td>100.0</td>
<td>64.9</td>
<td><em>a</em></td>
</tr>
<tr>
<td>1984 SIPP</td>
<td>100.0</td>
<td>70.0</td>
<td>29.8</td>
</tr>
<tr>
<td>1987 NMES</td>
<td>100.0</td>
<td>75.4</td>
<td>34.8</td>
</tr>
<tr>
<td>1991MCES</td>
<td>100.0</td>
<td>74.8</td>
<td>38.0</td>
</tr>
</tbody>
</table>


Note: Previous surveys did not publish a separate share of persons with both types of private insurance. The 1991 MCBS 5 percent share of persons with both types of private insurance has been added into the employer-sponsored share to make comparisons easier.

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leveled off at 75 percent in 1991.

**Employer-sponsored insurance.** The share of persons with employer-sponsored retiree benefits increased from 24 percent in 1977 to 35 percent in 1987. This share continued to increase to 38 percent in 1991 (including persons with both types of private insurance). This translates into an average increase of about 1 percent per year over the past fifteen years.

Financial Accounting Standards Board (FASB) Rule 106, which was first released in 1989 and will apply to most corporations in 1993, will require corporations to report future obligations for employee and retiree health care expenses as current liabilities on their balance sheets. Most of these expenses are currently unfunded liabilities, and the new rule is expected to affect firms’ asset values and profit levels adversely. There is concern that the new financial reporting requirements will cause employers to withdraw support for retiree health benefits. The historically high 38 percent share does not suggest any less employer support through 1991.

**Individually purchased plans.** The share of persons with individually purchased plans hovered around 40 percent between 1977 and 1987. This share remained stable at 41.8 percent in 1991.

**Medicare and Medicaid.** The share of persons who are eligible for both Medicare and Medicaid decreased slightly from about 11 percent in 1977 to
about 8 percent in 1987. In 1991 it increased to 11.9 percent. There is a likely reason for this increase. The new category of qualified Medicare beneficiaries was added to Medicaid in 1989; its addition would be expected to increase the number of dually eligible persons in 1991.12

Policy Implications

One reliable, if politically difficult, way to reduce the aggregate demand for health services by the Medicare population would be to increase point-of-service cost sharing for Medicare-covered services.13 The effectiveness of such a strategy depends on a number of factors. One fundamental factor is the share of the Medicare population that would have to pay any increased Medicare cost sharing. Using the current distribution of the Medicare population by their supplementary insurance holdings, we can estimate the likely share of the Medicare elderly who would be directly affected by increased cost sharing. The 11.4 percent of the population who do not have private or public supplementary insurance clearly would be subject to any increase in Medicare cost sharing. It is equally clear that those with individually purchased insurance (41.8 percent) would not be directly affected by an increase in cost sharing. Similarly, persons with Medicaid coverage (11.9 percent) would be protected from increased Medicare cost sharing.

Most of the elderly with employer-sponsored insurance (38 percent) are theoretically responsible for the lower of either Medicare or their private plan deductibles and copayments. However, whether the beneficiary actually pays depends on the method employers use to coordinate their benefits with Medicare payments.14 Further, an increase in Medicare deductibles and copayments would apply only to those persons whose employersponsored insurance had deductibles and copayments that were greater than Medicare's new levels.

Under the most sweeping assumption (that all beneficiaries with employer-sponsored insurance would pay), an increase in Medicare cost sharing would apply to nearly half of elderly beneficiaries. Under more realistic assumptions about levels of private plan deductibles and methods of payment coordination with Medicare, an increase in Medicare cost sharing would probably apply to about one-third of elderly beneficiaries under current supplementary insurance arrangements. Thus, it seems that an attempt to reduce demand for health services by Medicare enrollees through the imposition of more point-of-service cost sharing on Medicare-covered services would be blunted by supplemental health insurance for roughly two-thirds of the Medicare population.
NOTES


5. The Medicare Current Beneficiary Survey Round One public use tape and documentation are available for purchase from the U.S. Department of Commerce, National Technical Information Service, Springfield, Virginia 22161. The item number for the data tape plus documentation is PB93-50062. Documentation alone is item number PB93-100287. General questions about the survey should be addressed to Frank Eppig, Project Director, Medicare Current Beneficiary Survey, Office of National Health Statistics, Office of the Actuary, Health Care Financing Administration, Room L-1, EQ-OS, 6340 Security Boulevard, Baltimore, Maryland 2 1207.


9. NMCS data for 1977 are from Cafferata, Private Health Insurance Coverage of the Medicare Population, Tables 1 and 2; NMCUES data for 1980 are from Garfinkel and Corder, Supplemental Health Insurance Coverage, Table 2; SIPP data for 1984 are from L. Del Bene and D.R. Vaughan, “Income, Assets, and Health Insurance: Economic Resources for Meeting Acute Health Care Needs of the Aged,” Social Security Bulletin (Spring 1992): 3-25; NMCS data for 1987 are from Monheit and Schur, Health Insurance Coverage of Retired Persons, Table 5; and Medicare only and Medicare/Medicaid shares are from D.C. Lefkowitz and A.C. Monheit, Health Insurance, Use of Health Services, and Health Care Expenditures, National Medical Expenditure Survey Research Findings 12, HCPR Pub. no. 92-0017 (Rockville, Md.: U.S. Public Health Service, December 1991), Table 1.

10. Other sources currently report higher shares with Medicare only. One policy analysis model uses a 21 percent share of Medicare enrollees (including the disabled) with Medicare coverage only. CBO, Restructuring Health Insurance for Medicare Enrollees. Others who tabulate Current Population Survey (CPS) data estimate the Medicare-only share at 22 percent. K.R. Levit et al., “Changes in Americans’ Health Insurance
Coverage, 1980-1991” (forthcoming). The CPS is a household survey and, unlike the MCBS, excludes persons who are in institutions and long-term care facilities. In the CPS, which is primarily an employment survey, one respondent answers for all members of the household, including any elderly members. By contrast, the MCBS is an interviewer-administered health survey of Medicare beneficiaries only. The primary respondents are the beneficiaries themselves or their spouses. If the sample person is not able to respond, the survey insists on proxy respondents with direct knowledge of the sample person’s health and finances. Direct interviewing of elderly persons about their supplemental insurance is usually the more accurate survey method.


12. In addition, participation in public programs such as Medicaid may have been under-reported on past surveys. We used official Medicaid enrollment records in addition to survey reports to determine Medicaid eligibility. Persons shown to have coverage but who did not report it on the survey have been added into the Medicaid counts for 1991.
