Medicare Supplemental Coverage in Minnesota

December 2002

MINNESOTA MDH DEPARTMENT OF HEALTH

Health Economics Program

Health Policy and Systems Compliance Division
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Executive Summary

Medicare provides health care coverage for almost all of the elderly, some disabled people under age 65, and people with permanent kidney failure. However, Medicare has relatively high deductibles and coinsurance and does not cover certain health care goods and services such as prescription drugs or dental care. Many Medicare beneficiaries have additional health insurance to pay for the cost sharing and services that Medicare does not cover.

This report describes the demographic characteristics of the Medicare population and provides information on supplemental insurance coverage for Medicare beneficiaries in Minnesota and the United States. All Minnesota results presented in this report are based on data collected from the 2001 Minnesota Health Access Survey. Results presented in this report for the United States are based on data collected from the 1998, 1999, or 2000 Medicare Current Beneficiary Survey (MCBS). Only the results from non-institutionalized beneficiaries are presented.

How Are Medicare Beneficiaries in Minnesota Different From the National Average?

Medicare beneficiaries in Minnesota differ in someways from the national average. In general, beneficiaries in Minnesota are similar to the national average in terms of age, gender, and health status. However, for all other demographic characteristics, Minnesota beneficiaries are different from the national average:

- Minnesota beneficiaries are more likely to be married or never married and less likely to be divorced, widowed, or separated;

- Minnesota beneficiaries are more likely to be white;
- In general, Minnesota Medicare beneficiaries have higher educational attainment;
- In general, Minnesota beneficiaries have higher household incomes; and
- Fewer Medicare beneficiaries live in metropolitan areas in Minnesota compared to the national average.

What is of Interest Regarding Supplemental Insurance Coverage?

- The proportion of Medicare beneficiaries without supplemental coverage is relatively the same in Minnesota and the United States; however, Minnesota beneficiaries are less likely to have coverage through a government program, employer, or Medicare HMO and more likely to have an individually purchased Medigap policy to supplement Medicare.
- Employers are scaling back on retiree health benefits and enrollment in Medicare HMOs is declining.
- Almost half of Minnesota's beneficiaries who do not have supplemental insurance coverage could potentially be eligible for full Medical Assistance benefits or financial assistance with Medicare cost sharing through other Medical Assistance programs.
- In Minnesota, populations of color, low-income beneficiaries, and the disabled are significantly more likely to lack supplemental insurance compared to the Medicare population as a whole.

What is of Interest Regarding Prescription Drug and Dental Coverage?

- Medicare beneficiaries in Minnesota are more likely to lack prescription drug coverage than the national average. In Minnesota, 49.9% of beneficiaries lack prescription drug coverage, compared to 37.7% nationally.
- One reason for the relative lack of prescription drug coverage in Minnesota is that the sources of supplemental insurance coverage are different in Minnesota compared to the national average. In general, beneficiaries covered by employer retiree health plans and Medicare HMOs are more likely to have prescription drug coverage than beneficiaries with Medigap policies.
- Approximately one-fifth of beneficiaries without prescription drug coverage could potentially be eligible for coverage through Medical Assistance or Minnesota's Prescription Drug Program.
- In Minnesota, older beneficiaries, populations of color, and middle-income beneficiaries are more likely to lack prescription drug coverage compared to the Medicare population as a whole.

- Most Medicare beneficiaries do not have additional insurance that pays for dental care. In Minnesota, 76.1% of non-institutionalized Medicare beneficiaries lack dental coverage.

If current trends continue, the lack of supplemental coverage, particularly for prescription drugs and dental services, will likely increase for Medicare beneficiaries in Minnesota and at the national level over the next several years. If employers continue to scale back on retiree health benefits and if enrollment in Medicare HMOs continues to decline, beneficiaries may begin to lose access to lower cost supplemental coverage and may be forced to purchase higher cost Medigap policies or forgo supplemental insurance. In the coming years, Minnesota may be faced with more Medicare beneficiaries who have financial barriers to accessing health care. This is particularly worrisome for some rural areas of the state where Medicare beneficiaries comprise a larger proportion of the population. It will be important to monitor changes in supplemental insurance coverage to determine the impact of these changes on access to health care and out-of-pocket health care spending for Medicare beneficiaries.

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1 Introduction

Medicare is a federal health insurance program that covers nearly all people age 65 and older, some disabled people under the age of 65, and people with permanent kidney failure. In 2001, roughly 660,000 Minnesotans were enrolled in Medicare, representing approximately 13% of the state's population.[1]

Medicare coverage consists of two parts: Part A, the hospital insurance (HI) component, and Part B, the supplemental medical insurance (SMI) component. Part A covers inpatient hospital care, inpatient skilled nursing care, home health care, and hospice care. Part A is financed primarily by a payroll tax paid by both employers and employees; however, beneficiaries are required to pay various deductibles and coinsurance. Elderly beneficiaries age 65 and older are automatically enrolled in Part A if they receive Social Security benefits or Railroad Retirement cash benefits. Other elderly persons over age 65 who are not automatically enrolled in Part A may enroll in Part A by paying the full actuarial cost of Medicare coverage or the Part A premium. A small percentage of beneficiaries buy into Part A coverage.[2]

Part B covers physician services, outpatient hospital services, and other health services such as laboratory and diagnostic tests. Part B is financed by a combination of beneficiary premiums ($54 per month in 2002) and general revenue. Beneficiary premiums account for 25% of Part B spending. Under Part B, beneficiaries are required to pay an annual $100 deductible and 20% of all medically necessary services. Part B is an optional program, but nearly all Medicare enrollees who are eligible for Part A also enroll in Part B. In Minnesota, 95% of beneficiaries enrolled in Part A are also enrolled in Part B.[3]

Compared to private health insurance, Medicare has relatively high deductibles and coinsurance and does not cover routine physical exams, outpatient prescription drugs, dental care, eyeglasses, hearing aids or routine hearing loss exams. As a result, many Medicare beneficiaries obtain additional health insurance coverage through either private or public sources to pay for the cost sharing and services that Medicare does not cover. This report describes the demographic characteristics of the Medicare population and provides information on supplemental insurance coverage for Medicare beneficiaries in Minnesota and the United States. This report also details the supplemental insurance coverage of various subgroups of Minnesota Medicare beneficiaries. The findings presented in this report pertain only to non-institutionalized Medicare beneficiaries.

Data Sources

All Minnesota results presented in this report are based on data collected from the 2001 Minnesota Health Access Survey conducted by the Minnesota Department of Health in collaboration with the University of Minnesota School of Public Health. The 2001 Minnesota Health Access Survey was a stratified random digit dial telephone survey of non-institutionalized Minnesota residents. Surveys similar to the 2001 survey were conducted in 1990, 1995, and 1999; however, the 2001 survey is the only survey that included questions on Medicare supplemental insurance coverage, prescription drug coverage, and dental coverage. Over 27,000 Minnesotans, including 5,400 Medicare beneficiaries, were surveyed in 2001.

Results presented in this report for the United States are based on data collected from the 1998, 1999, and 2000 Medicare Current Beneficiary Survey (MCBS). The MCBS is an in-person survey of a representative sample of the Medicare population. The MCBS is conducted under the direction of the Centers for Medicare and Medicaid Services (CMS). Approximately 16,000 Medicare beneficiaries are surveyed each year. The MCBS surveys both institutionalized and non-institutionalized Medicare beneficiaries. However, for this report, only the results from non-institutionalized beneficiaries are presented so as to provide an accurate comparison to Minnesota figures.

Outline of This Report

This report is divided into various chapters. The report is organized as follows:

- Chapter 2 provides information on the characteristics of Medicare beneficiaries in Minnesota and the United States;
- Chapter 3 details the sources of supplemental insurance coverage for Medicare beneficiaries in Minnesota and the United States, describes the types of public and private sources of supplemental coverage, describes the characteristics of Medicare beneficiaries that lack supplemental coverage in Minnesota, and provides the sources of supplemental insurance coverage for various subgroups of Minnesota Medicare beneficiaries;

- Chapter 4 details the sources of prescription drug coverage for Medicare beneficiaries in Minnesota and the United States, describes the characteristics of Minnesota Medicare beneficiaries who lack prescription drug coverage, and provides the sources of prescription drug coverage for various subgroups of Minnesota Medicare beneficiaries;
- Chapter 5 details the sources of dental coverage for Medicare beneficiaries in Minnesota;
- Chapter 6 concludes the report with a summary of the findings and their implications for health policy in Minnesota and the United States.

2 Characteristics of Medicare Beneficiaries

This chapter describes and compares the demographic characteristics of Medicare beneficiaries in Minnesota and the United States. Table 2-1 provides information on the characteristics of non-institutionalized Medicare beneficiaries in Minnesota and the United States.

Demographically, Medicare beneficiaries in Minnesota differ in a number of ways from the national average. In general, beneficiaries in Minnesota are similar to the national average in terms of age, gender, and health status. Both in Minnesota and nationally, approximately 13% of beneficiaries are disabled and under the age of 65, a majority of beneficiaries are female, and approximately one-fourth of beneficiaries rate their health as fair or poor. However, for many other demographic characteristics, Minnesota beneficiaries are distinctly different from the national average. As shown in Table 2-1, Minnesota Medicare beneficiaries are different from the national average in the following ways:

- Minnesota beneficiaries are more likely to be married or never married and less likely to be divorced, widowed, or separated;
- Minnesota beneficiaries are more likely to be white;
- In general, Minnesota Medicare beneficiaries have higher educational attainment;
- In general, Minnesota beneficiaries have higher household incomes; and
- Fewer Medicare beneficiaries live in metropolitan areas in Minnesota compared to the national average.

As shown in the next chapters, these differences in demographic characteristics have an impact on the sources of supplemental coverage for Medicare beneficiaries in Minnesota and the United States.

Table 2-1

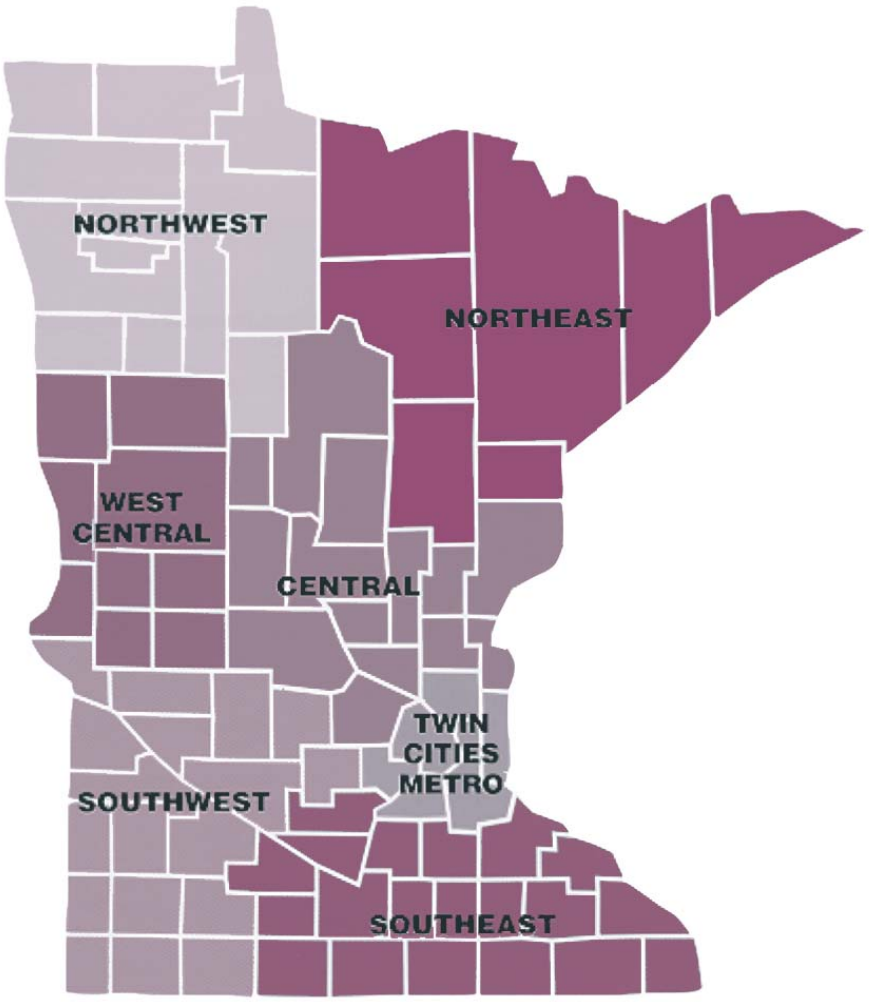
Characteristics of Non-Institutional Medicare Beneficiaries

	MN	US
Age		
0-64	13.7%	13.4%
65-74	47.6%	46.0%
75-84	31.1%	31.1%
85+	7.7%	9.4%
	100.0%	100.0%
Gender		
Male	42.1%	44.4%
Female	57.9%	55.6%
	100.0%	100.0%
Marital Status		
Married	61.1%	53.5%
Divorced/Widowed/Separated	29.9%	40.1%
Never Married	9.0%	6.4%
	100.0%	100.0%
Race/Ethnicity		
White only, non-Hispanic	94.6%	79.6%
Black only, non-Hispanic	1.4%	9.3%
American Indian only, non-Hispanic	0.7%	-
Asian only, non-Hispanic	1.0%	-
Hispanic	1.7%	7.2%
Other	0.6%	3.8%
	100.0%	100.0%
Educational Status		
0-12 years, no diploma	19.7%	33.0%
High school graduate	37.8%	29.1%
Some college/tech school	23.8%	20.9%
College graduate or more	18.7%	17.0%
	100.0%	100.0%
Household Income as % of Poverty Guidelines		
0 to 100%	10.9%	23.0%
101 to 200%	29.0%	29.1%
201 to 300%	24.9%	19.4%
301 to 400%	13.8%	11.6%
401%+	21.5%	17.0%
	100.0%	100.0%
Geography		
Metropolitan Area (MSA counties)	59.6%	76.0%
Rural Area	40.4%	24.0%
	100.0%	100.0%
Northwest	4.9%	-
Northeast	8.9%	-
West Central	6.1%	-
Central	11.9%	-
Southwest	8.1%	-
Southeast	16.6%	-
Twin Cities	43.5%	-
	100.0%	
Health Status		
Excellent	14.2%	14.1%
Very Good	27.6%	25.8%
Good	33.0%	31.2%
Fair	17.5%	19.4%
Poor	7.7%	9.6%
	100.0%	100.0%

Minnesota results are from the 2001 Minnesota Health Access Survey
United States results are from the 2000 Medicare Current Beneficiary Survey (MCBS), Westat Inc., "Characteristics and Perceptions."

Figure 2-1

Geographic Regions in Minnesota



3 Supplemental Coverage

As noted in Chapter 1, Medicare does not cover routine physical exams, outpatient prescription drugs, dental care, eyeglasses, hearing aids or routine hearing loss exams. Beneficiaries are required to pay deductibles and coinsurance for many of the services that Medicare does cover. As a result, many Medicare beneficiaries obtain additional insurance to cover the services and costs that Medicare does not cover. This chapter provides information on the types of supplemental insurance coverage obtained by Medicare beneficiaries and the characteristics of beneficiaries who do not obtain supplemental coverage.

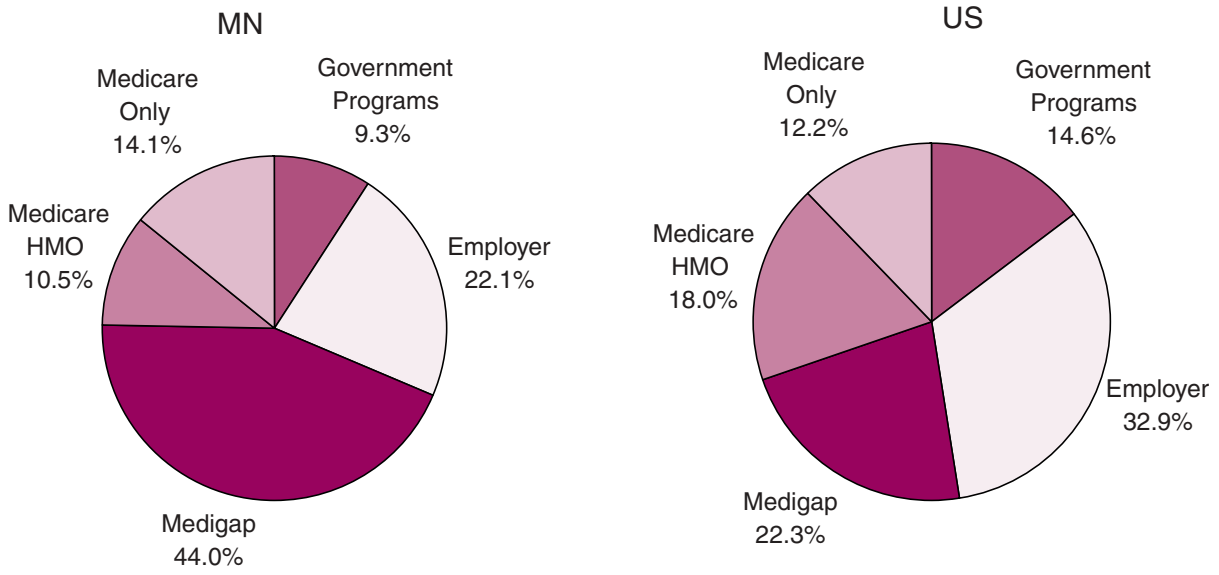
Sources of Supplemental Coverage

Most Medicare beneficiaries obtain additional coverage through the private market or government programs to cover the services and costs that Medicare does not cover. In Minnesota, 76.6% of non-institutionalized Medicare beneficiaries have some form of private insurance coverage to supplement Medicare, 9.3% are covered by government programs (Medical Assistance, VA, MCHA, etc.), and 14.1% lack additional coverage to supplement Medicare. A large number of beneficiaries purchase a Medigap policy (44.0%), while the others with private supplemental coverage purchase an HMO product (10.5%) or receive coverage through their employer as a retirement benefit (22.1%).

Nationally, 73.2% of non-institutionalized Medicare beneficiaries have some form of private coverage, 14.6% are covered by government programs, and 12.2% rely on Medicare alone. A large portion of beneficiaries have employer coverage (32.9%), while the remaining beneficiaries with private supplemental coverage either purchase a Medigap policy (22.3%) or an HMO product (18.0%). Figure 3-1 compares the supplemental insurance coverage of Medicare beneficiaries in Minnesota and the United States.

Figure 3-1

Sources of Supplemental Insurance Coverage
for Non-Institutional Medicare Beneficiaries, MN and US



Minnesota results are from the 2001 Minnesota Health Access Survey

United States results are from the 2000 Medicare Current Beneficiary Survey (MCBS), Westat Inc., "Characteristics and Perceptions."

Note: Government programs may not be directly comparable between Minnesota and the United States as the Minnesota survey did not specifically ask about enrollment in Medical Assistance programs such as QMB, SLMB, QI-1 or QI-2. These people may be classified in Government Programs or as Medicare Only in Minnesota. Beneficiaries enrolled in these Medical Assistance programs represent approximately 1% of the Minnesota Medicare population.

Note: Medicare supplemental insurance coverage for Minnesota is slightly different from that reported in Health Economics Program, Minnesota Department of Health, "Minnesota's Uninsured: Findings From the 2001 Health Access Survey," April 2002 due to additional cleaning of the survey data.

Employer Coverage and Retiree Benefits

Medicare beneficiaries may have additional insurance through a current employer or through a former employer as a retirement benefit to cover the costs and services that Medicare does not cover. Minnesota Medicare beneficiaries are less likely to have employer coverage than the national average. Figure 3-1 shows that 22.1% of non-institutionalized Medicare beneficiaries in Minnesota have employer coverage, compared to 32.9% nationally.

At first glance, it seems unusual that Medicare beneficiaries in Minnesota are less likely to have supplemental employer coverage than the national average. Minnesota has historically had one of the highest rates of employer coverage among the non-elderly population and one might assume that this would apply to the Medicare population as well. However, Minnesota Medicare beneficiaries are demographically different from the national average and this may partially explain why benefici-

aries in Minnesota are less likely to have employer coverage. Table 2-1 shows that a smaller share of Minnesota's Medicare beneficiaries live in metropolitan areas than the national average. Metropolitan areas generally have more large employers than rural areas and large employers are more likely to offer retiree health benefits than small employers. A 2001 national survey found that 64% of employers with 5,000 or more workers, 37% of employers with 1,000 to 4,999 workers, 31% of employers with 200 to 999 workers and only 3% of employers with less than 200 workers offered retiree health benefits.[4]

The prevalence of retiree health coverage has been declining over the past decade. From 1991 to 1999, the share of large employers with 5,000 or more workers offering retiree health benefits declined from 80% to 66%.[5] The decline in retiree health benefits in the early 1990s has been attributed to new accounting standards that required employers to disclose the liability of future retiree health benefits in their balance sheets.[6] The recent decline in retiree health benefits has been attributed to rapidly rising health care costs and a worsening economy.[7] Recent research suggests that retiree health benefits may continue to decline in the near future. Results from a 2001 survey indicate that 9% of employers with 200 or more workers who currently offer retiree health benefits plan to eliminate the benefits within the next two years. In addition, 72% of employers reported that they intended to make changes in the benefits or cost sharing levels for retirees within the next two years.[8] If current trends continue, it is reasonable to expect that retiree health benefits will continue to erode both in Minnesota and at the national level over the next few years.

Medicare HMO

HMO or managed care plans contract with Medicare to provide services to Medicare beneficiaries. Contracted plans must provide all Medicare covered services for a fixed capitated payment or for actual cost.[9] These plans provide a range of benefits and services through a network of physicians, hospitals, and other providers. These health plans must also cover the deductibles and coinsurance that beneficiaries are responsible for; however, the plan may charge a premium for this coverage and for other additional covered benefits and services. Currently, Medicare beneficiaries continue to pay the Part B premium while enrolled in an HMO product; however, in 2003, reduced Part B premiums can be offered as an extra benefit by Medicare HMO plans.

Medicare HMO enrollment is low in Minnesota compared to the national average. In Minnesota, 10.5% of non-institutionalized Medicare beneficiaries are enrolled in self-purchased Medicare HMO plans, compared to 18.0% nationally.[10] Although Minnesota's Medicare HMO enrollment is low relative to the national average, this was not always the case. Minnesota had one of the highest Medicare HMO enrollment rates in the country in the early 1990s. In the early 1990s, approximately 20% of beneficiaries in Minnesota were enrolled in Medicare HMOs. At this same time, only 6% of beneficiaries were enrolled in Medicare HMOs at the national level.[11] Medicare HMO enrollment in Minnesota was higher than the national average in the early 1990s because Minnesota had a long history with managed care and HMOs were well poised to enter the Medicare market.

In the mid 1990s, Medicare HMO enrollment grew rapidly at the national level and declined in Minnesota. There are various reasons for the decrease in Medicare HMO enrollment in Minnesota. The primary reason is that Minnesota Medicare HMO plans receive low capitated payments relative to other states. Currently, the Medicare HMO payment rate for most Minnesota counties outside of the Twin Cities metropolitan area is $500.37 per month, which is the lowest payment rate available. The payment rate for counties in the Twin Cities metropolitan area is $553.04. Medicare HMO payments have been based on historical Medicare fee-for-service payments and these payments have been low in Minnesota compared to other states; this is why Minnesota receives the lowest or "floor" payment rate for most counties today. Over time, regional variations in payments are expected to decline because Medicare is starting to phase in a payment system that blends national and county-level costs and raises payments to rural and other low-cost counties.[12] The low payment rates have led some Medicare HMO plans to withdraw from the market. Other reasons for the decline in Minnesota may include reluctance by beneficiaries to enroll in a Medicare HMO that may withdraw from the market in the next year or benefit changes, such as restrictions on prescription drug utilization.

In some parts of the country, Medicare HMO enrollment is high because HMO payment rates are high and beneficiaries receive extra benefits for little or no extra cost. For example, in Dade County, Florida, HMO payments are 67% higher than for most Minnesota counties and beneficiaries receive coverage for routine physical exams, outpatient prescription drugs, dental care, and eyeglasses or contacts for $0 premium and little cost sharing. In Hennepin County, Minnesota, beneficiaries can receive some of the same services through Medicare HMOs, but they must pay a relatively high premium. Table 3-1 compares the benefits of Medicare HMO plans in Dade County, Florida and Hennepin County, Minnesota and the cost to enrollees.

Table 3-1

Comparison of Medicare HMO Plans in 2002

County	Medicare Payment	Premium	Enrollment	Plan Availability	Prescription Drug Benefits
Dade County, Florida	$834.20/month	$0 per month for plans with prescription drugs	46% of Medicare beneficiaries are enrolled in county	13 products from 11 health plans	11 of 13 products and all 11 health plans offer prescription drugs, $3000 to $4000 annual limit with no limit on generic drugs
Hennepin County, Minnesota	$553.04/month	$89 to $389 ($202 average) per month for plans with prescription drugs	27% of Medicare beneficiaries are enrolled in county	9 products from 3 health plans	4 of 9 products and all 3 health plans offer prescription drugs, $400 to no annual limit on all prescription drugs

Data Sources: June 2002 CMS Medicare Managed Care State/County Market Penetration data file and Medicare Health Plan Compare from Medicare.gov

Although certain parts of the country currently have high Medicare HMO enrollment, the United States Congressional Budget Office (CBO) estimates that enrollment will decline by almost 40% over the next ten years.[13] Part of the reason for the predicted decline in enrollment is the continued

withdrawal of HMO plans from Medicare. In 1998, 346 HMO plans participated in Medicare; in 2002, the number dropped to 153 plans.[14] Another reason for the predicted decline in Medicare HMO enrollment is the decrease in benefits offered by the plans making them less attractive to beneficiaries. For example, in 2001, 18% of plans with prescription drug benefits only covered generic drugs; today, the percentage has increased to 51%.[15] Over the same time period, the percent of Medicare HMO enrollees in plans with no premium fell from 80% to 40%.[16]

Medigap

Medigap policies are different from Medicare HMO plans because they only provide coverage for services not covered by Medicare. Medicare HMO plans and Medigap policies are similar in that they cover many of the deductibles, coinsurance, and services not covered by traditional Medicare.

As shown in Figure 3-1, almost half (44.0%) of Minnesota's non-institutionalized Medicare population is covered by an individually purchased Medigap policy, compared to 22.3% at the national level. It is likely that more Medicare beneficiaries in Minnesota are covered by Medigap policies compared to the national average because of lower Medicare HMO enrollment and less employer retiree coverage in Minnesota.

The State of Minnesota requires insurance companies that sell Medigap coverage to offer two standardized policies (Basic and Extended Basic). Basic policies cover 100% of Medicare Part A and B expenses and co-payments except the Part A and Part B deductibles, 100% of immunization and routine screening procedures for cancer, 80% of emergency foreign travel care, and 50% of most outpatient mental health services. Beneficiaries may add on optional riders to cover prescription drugs and the expenses not covered by the Basic policy for an additional cost. Extended Basic policies cover all payments and services provided by the Basic policy and the optional riders. Extended Basic policies also have a $1,000 annual limit on the amount of money a beneficiary pays for covered medical expenses. Once this limit is reached, the policy will pay for 100% of all covered expenses.

Minnesota beneficiaries may also purchase Medicare Select policies. Medicare Select policies cover the same expenses and co-payments as Basic and Extended Basic Medigap policies. The policy pays for these benefits as long as the beneficiary obtains care through a network of healthcare providers. In other words, Medicare Select policies are Medigap policies that are purchased from managed care plans. Premiums for Medicare Select policies and Medicare HMOs tend to be lower than those charged for Basic and Extended Basic Medigap policies because Medicare Select and Medicare HMOs limit the places where a beneficiary can get care to a specified network of providers. Table 3-2 provides a comparison of Medigap, Medicare Select, and Medicare HMO premiums.

Table 3-2

2002 Minnesota Premium Comparison

Policy/Plan Type		Monthly Premium
Medigap		
	Without Drugs, Basic	Average: $89 Range: $57 to $145
	With Drugs, Extended Basic	Average: $470 Range: $320 to $673
Medicare Select		
	Without Drugs, Basic	Average: $117 Range: $102 to $140
	With Drugs, Extended Basic	Average: $425 Range: $396 to $455
Medicare HMO		
	Without Drugs	Average: $84 Range: $42 to $132
	With Drugs	Average: $202 Range: $89 to $389

Data Source: Minnesota Department of Commerce
Medigap and Medicare Select premiums are for non-smokers

Government Programs

Government programs to supplement Medicare include Medical Assistance (MA) Programs, Veterans Affairs (VA) and other military health care programs, and state-specific programs such as the Minnesota Comprehensive Health Association (MCHA) for beneficiaries with pre-existing conditions who cannot get private coverage. Although there are a variety of government programs, Medical Assistance is the largest source of government coverage and will be discussed in more detail below.

Various Medical Assistance programs are available to low-income Medicare beneficiaries to help reduce the financial burden imposed by cost sharing requirements under Medicare. Low-income beneficiaries may be eligible for full Medical Assistance benefits, the Qualified Medicare Beneficiary (QMB) or Service Limited Medicare Beneficiary (SLMB) programs, or the Qualifying Individual 1 or 2 (QI-1 or QI-2) programs. Over 90% of beneficiaries with Medical Assistance have full benefits.[17] Table 3-3 describes the benefits and eligibility requirements for these Medical Assistance programs.

Table 3-3

Minnesota Medical Assistance Programs for Medicare Beneficiaries

Program	Benefits	Income Requirement	Asset Requirement
Full Medical Assistance	Full Medical Assistance benefits, Medicare cost sharing, and Medicare premiums.	<100% FPL, In 2002, less than $8,868 for individuals or $11,940 for a married couple per year.	Less than $3,000 for individuals or $6,000 for married couples.
Qualified Medicare Beneficiary (QMB)	Medicare cost sharing and premiums	<100% FPL, In 2002, less than $8,868 for individuals or $11,940 for a married couple per year.	Less than $10,000 for individuals or $18,000 for married couples.
Service Limited Medicare Beneficiary (SLMB)	Medicare Part B Premium	<120% FPL, In 2002, less than $10,632 for individuals or $14,328 for a married couple per year.	Less than $10,000 for individuals or $18,000 for married couples.
Qualifying Individual 1 (QI-1)	Medicare Part B Premium	<135% FPL, In 2002, less than $11,964 for individuals or $16,128 for a married couple per year.	Less than $10,000 for individuals or $18,000 for married couples.
Qualifying Individual 2 (QI-2)	Part of Medicare Part B Premium	<175% FPL, In 2002, less than $15,516 for individuals or $20,904 for a married couple per year.	Less than $10,000 for individuals or $18,000 for married couples.

Data Source: Minnesota Department of Human Services

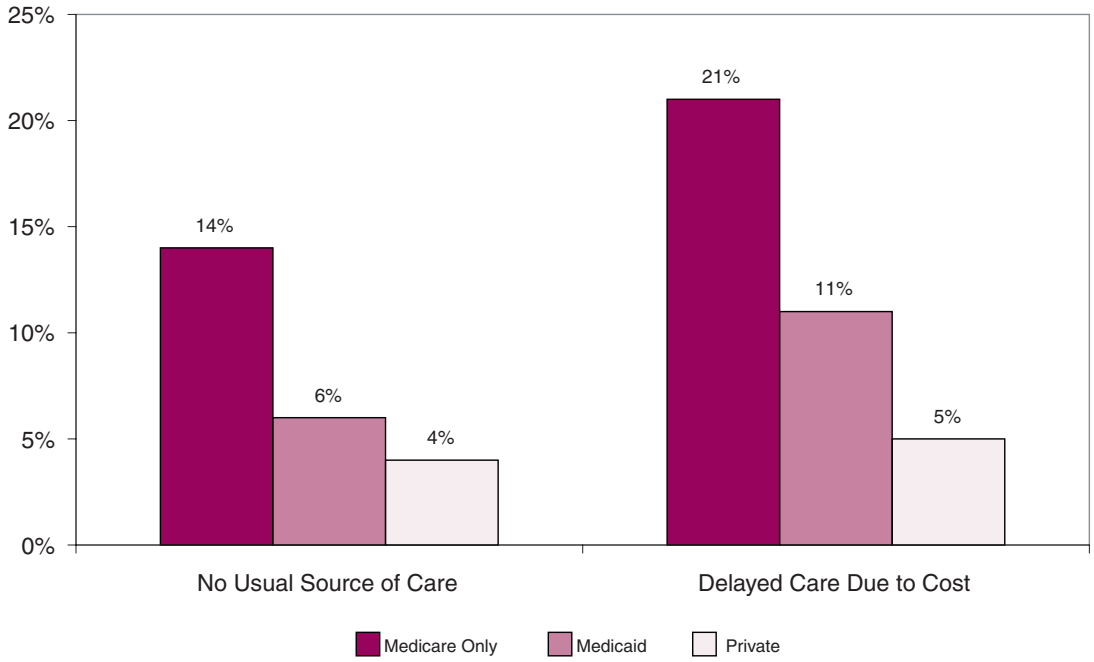
Government programs cover fewer non-institutionalized Medicare beneficiaries in Minnesota than the national average. Figure 3-1 shows that government programs cover 9.3% of Minnesota beneficiaries and 14.6% of beneficiaries at the national level. Minnesota Medicare beneficiaries are less likely to be covered by government programs than the national average for several reasons. First, as shown in Table 2-1, Minnesota Medicare beneficiaries have higher household incomes than the national average, which means that beneficiaries in Minnesota are less likely to be eligible for government programs. Second, a larger percentage of the population with Medical Assistance is institutionalized in Minnesota compared to the national average. In 1999, 47.2% of low-income elderly Minnesotans received Medical Assistance and resided in a nursing home compared to 29.9% nationally.[18] In addition, 51.9% of spending on Medical Assistance in Minnesota was spent on long-term care in 1999 compared to 34.6% nationally.[19] Since the data presented in Figure 3-1 is based on non-institutionalized Medicare beneficiaries, a greater percentage of Minnesota's Medicare beneficiaries with Medical Assistance would be excluded from the results compared to beneficiaries with Medical Assistance at the national level.

Characteristics of Beneficiaries with Medicare Only

As shown in Figure 3-1, 14.1% of Minnesota beneficiaries and 12.2% of beneficiaries at the national level do not have coverage to supplement Medicare. Beneficiaries who lack additional insurance are not covered for health care goods and services such as dental care or prescription drugs and are responsible for unlimited amounts of Medicare cost sharing. On average, Medicare pays for half of the health care goods and services used by beneficiaries; supplemental coverage and out-of-pocket payments cover the rest.[20] Medicare beneficiaries without supplemental coverage potentially face substantial barriers to accessing health care. As shown in Figure 3-2, beneficiaries who only have Medicare coverage are more likely than those with additional private or Medicaid coverage to not have a usual source of care and to delay care due to cost.

Figure 3-2

Access to Care for Non-Institutional Medicare Beneficiaries



Data Source: 1999 Medicare Current Beneficiary Survey (MCBS), The Henry J. Kaiser Family Foundation, "Medicaid's Role for Low-Income Medicare Beneficiaries," January 2002.

Table 3-4 shows the characteristics of Minnesota Medicare beneficiaries who have Medicare as their only source of insurance coverage. Compared to Minnesota's total non-institutionalized Medicare population, Minnesota beneficiaries who have Medicare alone are more likely to:

- Be under the age of 65 (36.0% compared to 13.7%);
- Not be married (51.2% compared to 38.9%);
- Be non-white (17.5% compared to 5.4%);
- Lack a high school diploma (28.8% compared to 19.7%); and
- Have a household income below 200% of the poverty level (56.8% compared to 39.9%).

Table 3-4

Characteristics of Minnesota Medicare Beneficiaries Without Supplemental Coverage, 2001

	MN Beneficiaries Without Coverage	All MN Beneficiaries
Age		
0-64	**36.0%**	13.7%
65-74	**28.7%**	47.6%
75-84	26.6%	31.1%
85+	8.7%	7.7%
	100.0%	100.0%
Gender		
Male	43.7%	42.1%
Female	56.3%	57.9%
	100.0%	100.0%
Marital Status		
Married	**48.8%**	61.1%
Divorced/Widowed/Separated	34.9%	29.9%
Never Married	**16.3%**	9.0%
	100.0%	100.0%
Race/Ethnicity		
White only, non-Hispanic	**82.5%**	94.6%
Black only, non-Hispanic	**5.0%**	1.4%
American Indian only, non-Hispanic	1.5%	0.7%
Asian only, non-Hispanic	**5.3%**	1.0%
Hispanic	4.5%	1.7%
Other	1.3%	0.6%
	100.0%	100.0%
Educational Status		
0-12 years, no diploma	**28.8%**	19.7%
High school graduate	35.4%	37.8%
Some college/tech school	21.6%	23.8%
College graduate or more	14.3%	18.7%
	100.0%	100.0%
Household Income as % of Poverty Guidelines		
0 to 100%	**20.3%**	10.9%
101 to 200%	**36.5%**	29.0%
201 to 300%	19.5%	24.9%
301 to 400%	**8.3%**	13.8%
401%+	**15.5%**	21.5%
	100.0%	100.0%
Geography		
Metropolitan Area (MSA counties)	60.7%	59.6%
Rural Area	39.3%	40.4%
	100.0%	100.0%
Northwest	5.8%	4.9%
Northeast	7.1%	8.9%
West Central	5.3%	6.1%
Central	**17.3%**	11.9%
Southwest	7.1%	8.1%
Southeast	12.0%	16.6%
Twin Cities	45.4%	43.5%
	100.0%	100.0%
Health Status		
Excellent	15.0%	14.2%
Very Good	23.0%	27.6%
Good	34.6%	33.0%
Fair	16.9%	17.5%
Poor	10.5%	7.7%
	100.0%	100.0%

Bold indicates significant difference at 95% level from all Medicare beneficiaries

Half of Minnesota Medicare beneficiaries with Medicare as their only source of coverage are low income and could potentially be eligible for a Medical Assistance program, assuming that they meet the asset requirements. Over half (56.8%) of beneficiaries with Medicare as their only source of coverage have household incomes below 200% of the federal poverty level. The 20.3% of beneficiaries with household incomes below 100% of the federal poverty level could be eligible for full Medical Assistance benefits or the QMB program. Both of these programs pay for all Medicare cost sharing and the Part B premium. Full Medical Assistance also covers health care goods and services such as dental care and prescription drugs. Many of the 36.5% of beneficiaries with household incomes between 100% and 200% of the federal poverty level could be eligible for coverage for part or all of their Part B premium through the SLMB, QI-1, or QI-2 programs. An estimated 48.5% of Minnesota Medicare beneficiaries who lack coverage to supplement Medicare are potentially eligible for a Medical Assistance program.[21]

Enrollment in a Medical Assistance program could greatly improve access to health care and reduce the financial burden imposed by Medicare for beneficiaries without supplemental coverage. As shown in Figure 3-2, enrollment in a Medical Assistance program could improve access to health care for beneficiaries with Medicare only. Medicare beneficiaries covered by Medical Assistance are significantly less likely than those with Medicare alone to lack a usual source of care or delay care due to cost.

Sources of Supplemental Coverage by Demographic Groups

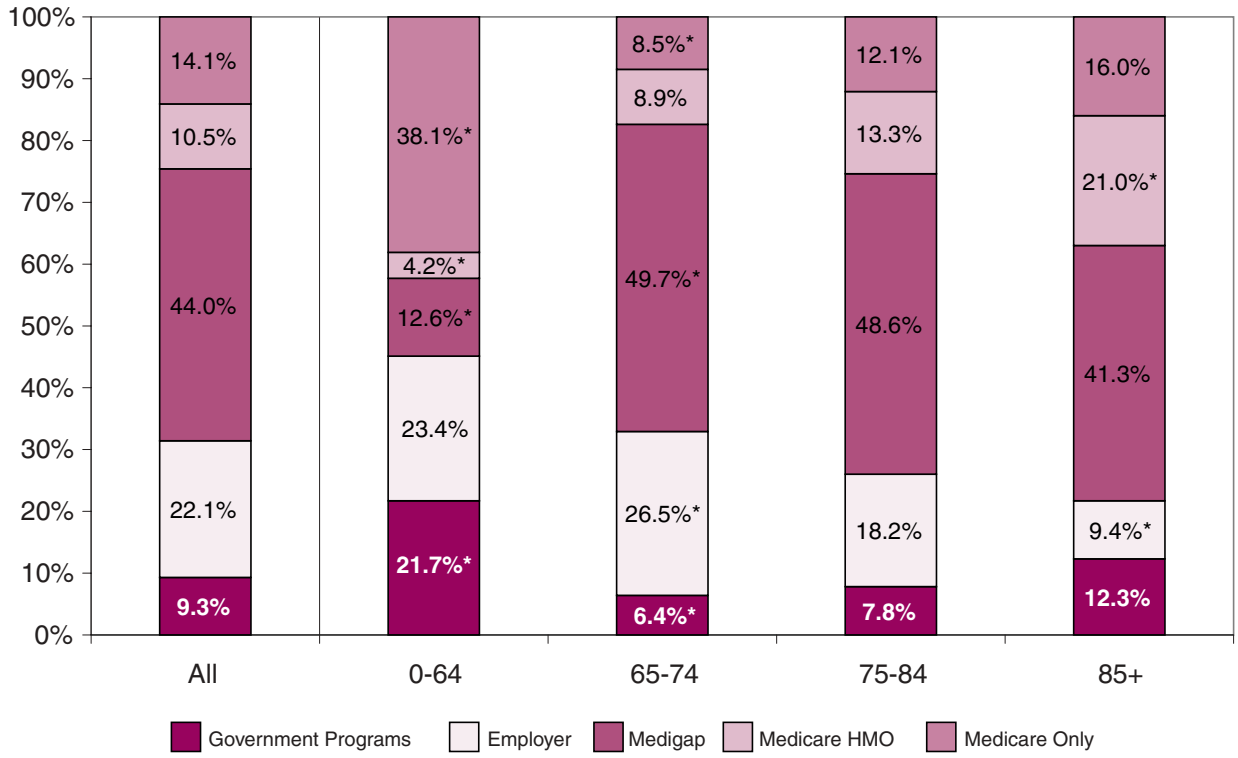
Most Minnesota Medicare beneficiaries have additional insurance to supplement Medicare through government programs or the private market. However, the sources of supplemental coverage vary by age, gender, race/ethnicity, income level, and geography.

Age

Figure 3-3 shows that the sources of supplemental insurance vary greatly by age. Disabled beneficiaries under age 65 are much more likely to have Medicare alone or be covered by a government program than older beneficiaries. Disabled beneficiaries are also less likely to be covered by Medigap policies or Medicare HMO plans than older beneficiaries. For beneficiaries over age 65, lack of supplemental coverage increases with age as does enrollment in government programs and Medicare HMOs. Employer coverage and enrollment in Medigap policies decrease with age in Minnesota. Research at the national level finds that Medigap enrollment increases with age and that Medicare HMO enrollment decreases with age. One reason for the difference between Minnesota and the nation may be explained by the history of Medicare HMO enrollment. Medicare HMO enrollment peaked in the early 1990s in Minnesota and in the late 1990s at the national level; this may explain why older beneficiaries are more likely to have HMO coverage in Minnesota and younger beneficiaries are more likely to have HMO coverage nationally.

Figure 3-3

Sources of Supplemental Coverage by Age, MN 2001



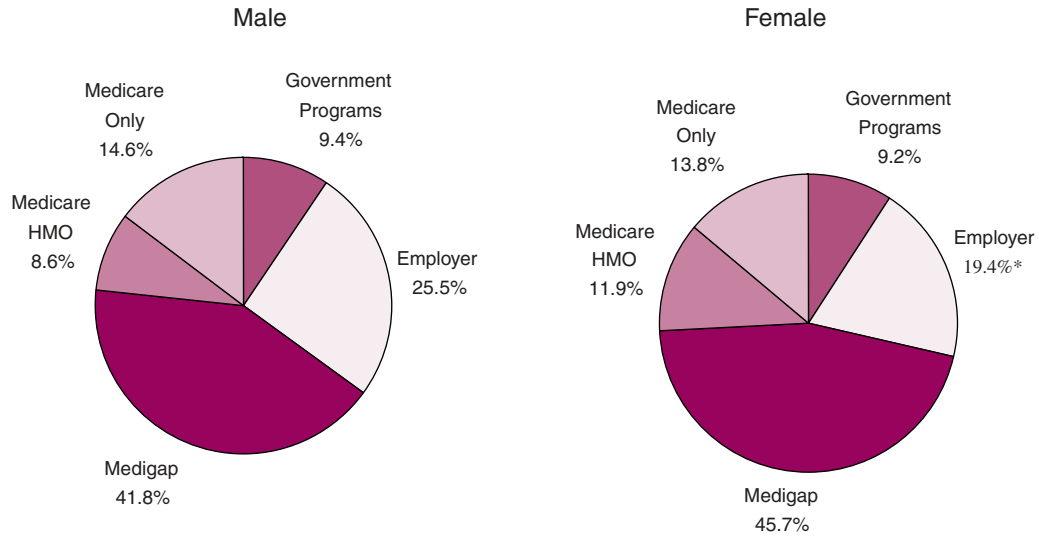
*Indicates significant difference at 95% level from all Medicare beneficiaries

Gender

Figure 3-4 shows that there are few gender differences in the sources of supplemental coverage for Medicare beneficiaries in Minnesota. The only statistically significant difference between men and women is that women are less likely to have employer retiree health benefits than men. One reason for this difference may be that women in this age cohort were less likely than men to have participated in the workforce.

Figure 3-4

Sources of Supplemental Insurance Coverage by Gender, MN 2001



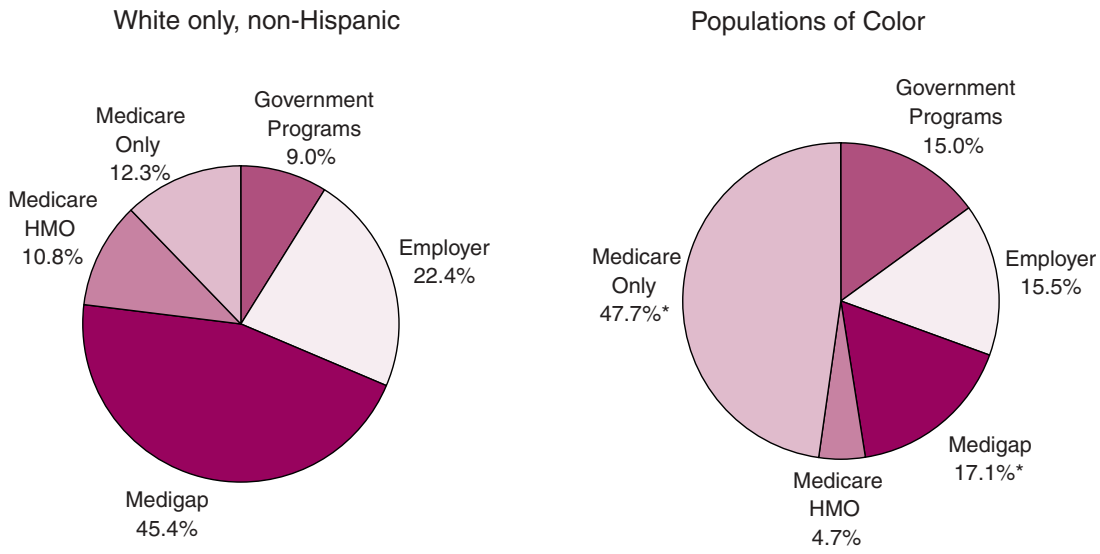
* Indicates significant difference at 95% level from Male

Race/Ethnicity

There are some dramatic differences in the types of supplemental coverage by race/ethnicity. Figure 3-5 shows that populations of color are significantly more likely to rely on Medicare alone and less likely to have a Medigap policy than the white population.

Figure 3-5

Sources of Supplemental Insurance Coverage by Race/Ethnicity, MN 2001



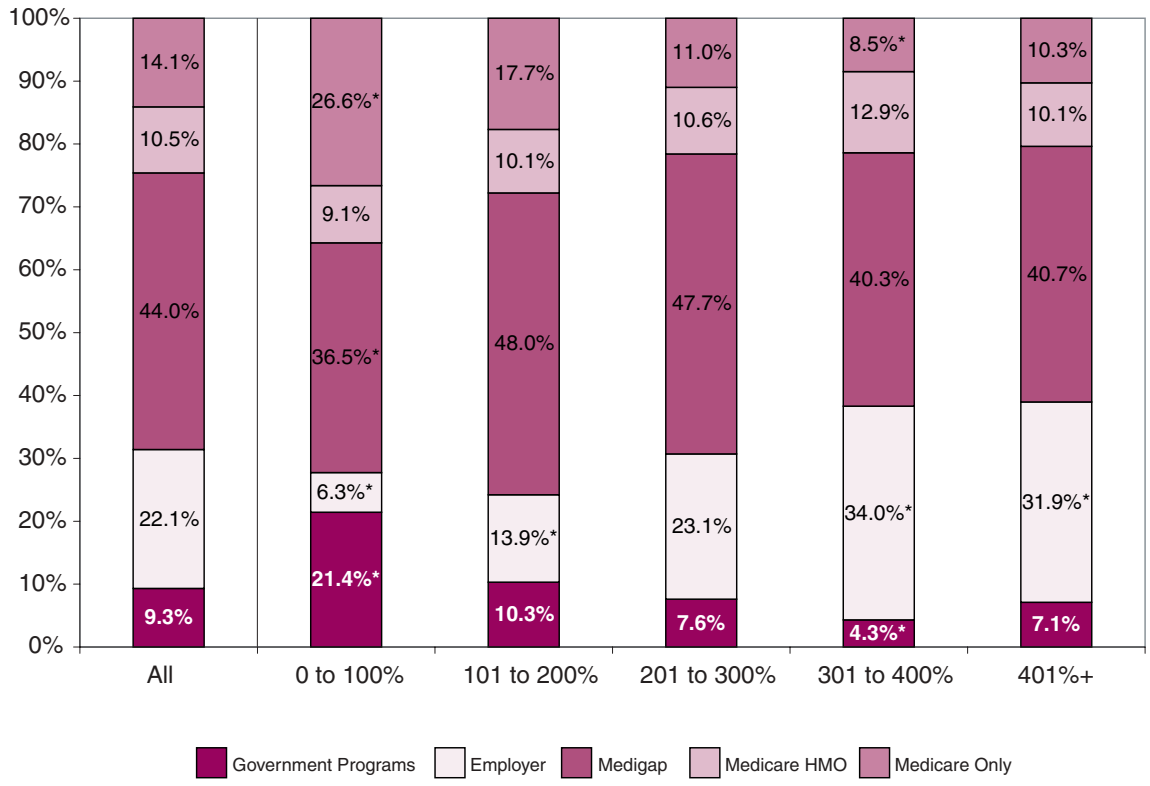
* Indicates significant difference at 95% level from White only, non-Hispanic

Income Level

Figure 3-6 shows that supplemental insurance coverage varies by income. In general, low-income beneficiaries are more likely than higher income beneficiaries to be covered by Medicare alone or to have additional coverage through a government program and less likely to have coverage through a private source. Low-income beneficiaries are more likely to be enrolled in government programs because they are more likely to be eligible for income-based Medical Assistance programs than higher income beneficiaries. Beneficiaries with low incomes are less likely to be covered by private insurance and more likely to have Medicare alone because they may find private insurance unaffordable and they are generally less likely to have worked for an employer who offers retiree health benefits.

Figure 3-6

Sources of Supplemental Coverage by Income^ Level, MN 2001



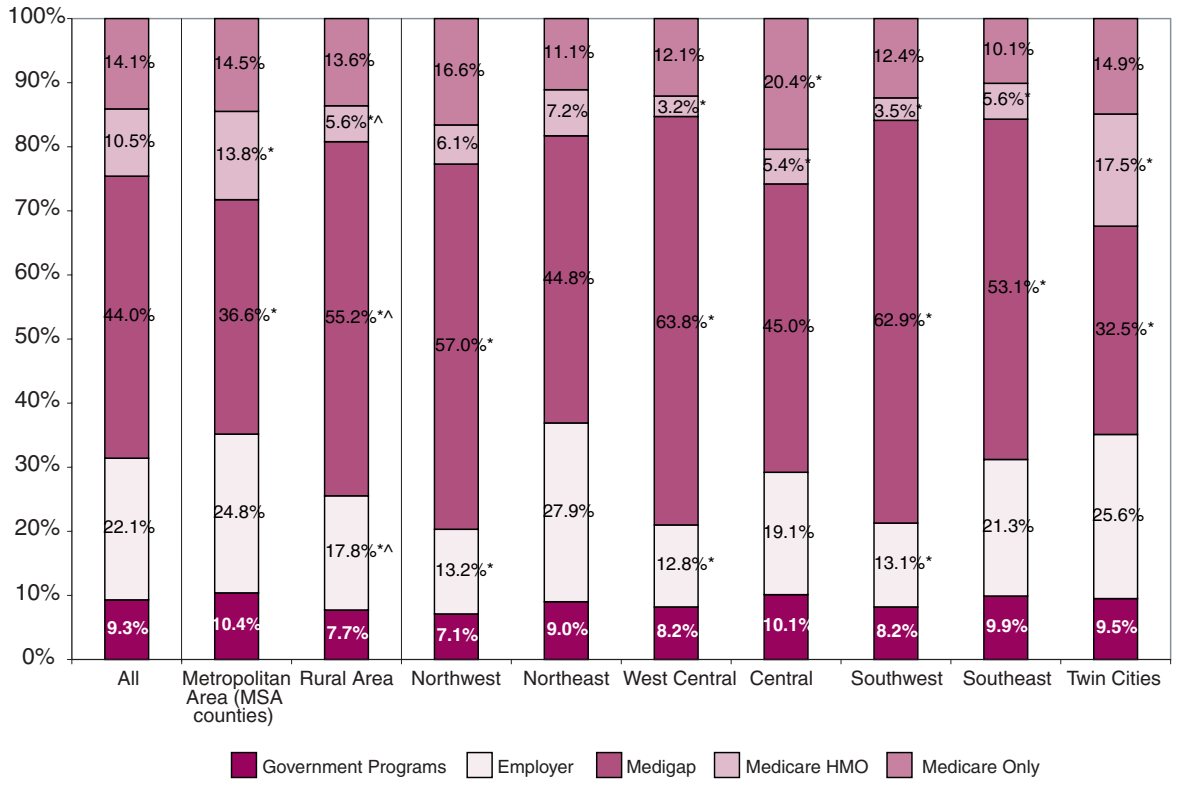
* Indicates significant difference at 95% level from all Medicare beneficiaries
^ Income in relation to Federal poverty guidelines

Geography

As shown in Figure 3-7, beneficiaries in rural and metropolitan areas of Minnesota are generally the same in terms of supplemental coverage through government programs and lack of supplemental coverage. However, the source of private coverage for rural and metropolitan beneficiaries is different. Medicare beneficiaries in rural areas of Minnesota have significantly higher enrollment in Medigap policies and lower enrollment in Medicare HMOs and employer coverage than beneficiaries in metropolitan areas of the state. These differences likely exist for two main reasons: first, few Medicare HMO plans are available in rural areas of the state; and second, large employers, who are more likely to offer retiree health benefits, are generally located in metropolitan areas.

Figure 3-7

Sources of Supplemental Coverage by Geography, MN 2001



^ Indicates a significant difference between Rural and Metropolitan Area at 95% level
* Indicates significant difference at 95% level from all Medicare beneficiaries

Figure 3-7 shows that the sources of supplemental insurance coverage vary throughout the regions of the state. Most of the geographic variation in supplemental insurance coverage is due to variation in the sources of private coverage. In general, the western regions of the state have more Medigap coverage and less employer coverage than the eastern regions of the state. This is likely due to the fact that there are more large employers in the eastern half of state in Duluth, St. Cloud, Rochester, and the Twin Cities compared to the western half of Minnesota. Medicare HMO enrollment is relatively high in the Twin Cities and low in the other regions of the state because Medicare HMO plans are primarily available in the Twin Cities area.

4 Prescription Drug Coverage

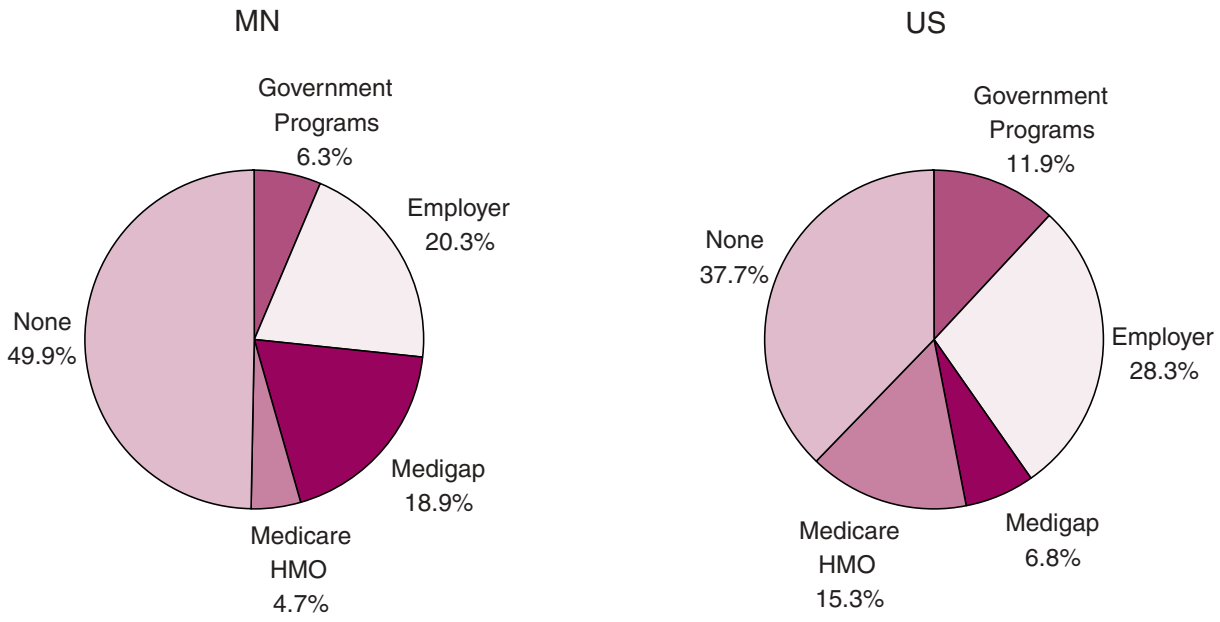
Medicare does not provide coverage for outpatient prescription drugs. Beneficiaries must pay for prescription drugs out of their own pockets or they can obtain supplemental coverage to pay for part or all of their prescription drug costs. The rising cost of prescription drugs and the declining enrollment in employer retiree health coverage and Medicare HMO plans has made prescription drug coverage a key issue for beneficiaries and policy makers in recent years. This chapter provides information on the sources of prescription drug coverage for Medicare beneficiaries and the characteristics of beneficiaries who lack coverage for prescription drugs.

Sources of Prescription Drug Coverage

The sources of drug coverage for Minnesota beneficiaries are different from those of beneficiaries at the national level. More Minnesota Medicare beneficiaries lack prescription drug coverage than the national average. Figure 4-1 shows that 49.9% of Minnesota beneficiaries lack prescription drug coverage, compared to 37.7% of beneficiaries nationally.

Figure 4-1

Sources of Prescription Drug Coverage for Non-Institutional Medicare Beneficiaries, MN and US



Minnesota results are from the 2001 Minnesota Health Access Survey

United States results are from the 1999 Medicare Current Beneficiary Survey (MCBS), Laschober et al., "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," Health Affairs, February 2002.

Note: Government programs may not be directly comparable between Minnesota and the United States as the Minnesota survey did not specifically ask about enrollment in the Prescription Drug Program and the United States numbers include state prescription drug programs. These people may be classified in Government Programs or as Medicare Only in Minnesota. Beneficiaries enrolled in the Prescription Drug Program represent less than 1% of the Minnesota Medicare population.

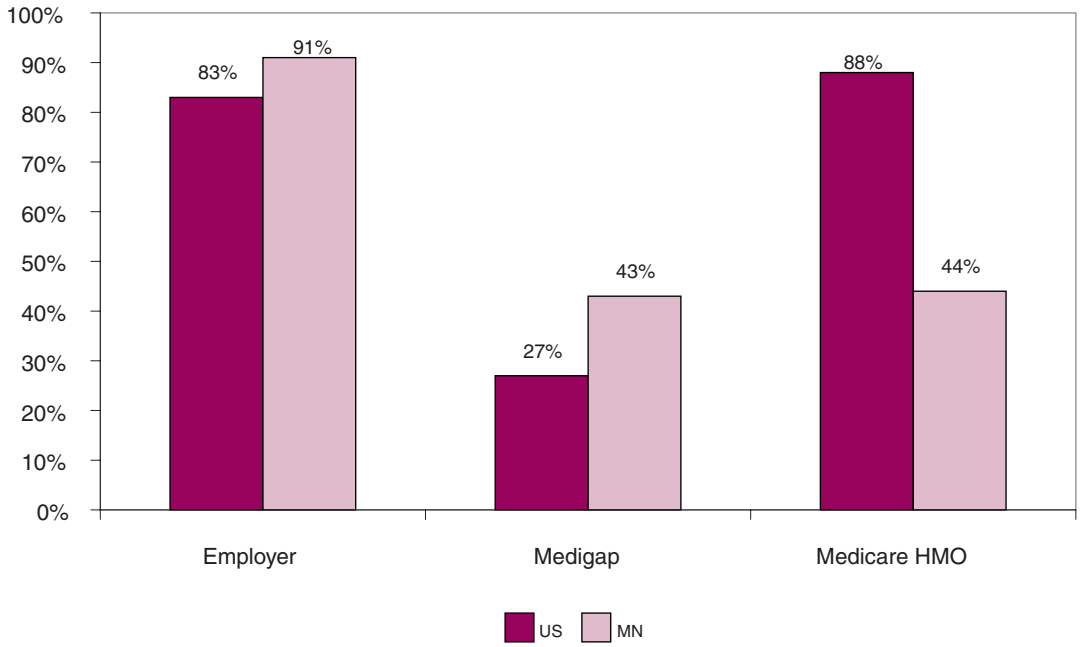
Note: Lack of prescription drug coverage for Minnesota is slightly different from that reported in Health Economics Program, Minnesota Department of Health, "Minnesota's Uninsured: Findings From the 2001 Health Access Survey," April 2002 due to additional cleaning of the survey data.

There are several reasons why Minnesota Medicare beneficiaries lack prescription drug coverage at higher rates compared to the national average. The primary reason is that the sources of supplemental insurance coverage in Minnesota are different from the national average. As shown previously in Figure 3-1, Minnesota has much lower rates of supplemental coverage through government programs, employer coverage, and Medicare HMOs and a higher rate of Medigap coverage than the national average. At the national level, beneficiaries enrolled in government programs, employer coverage, and Medicare HMOs are much more likely to have prescription drug coverage than beneficiaries with Medigap policies. Over 90% of beneficiaries covered by Medical Assistance receive full benefits that cover the cost of prescription drugs.[22] Nationally, 83% of beneficiaries with employer coverage, 88% of beneficiaries enrolled in a Medicare HMO, and only 27% of beneficiaries with a Medigap policy have coverage for prescription drugs. Another reason for the lower rate of prescription drug coverage in Minnesota is that beneficiaries in Medicare HMOs are less likely to have cov-

erage for prescription drugs in Minnesota than at the national level. While 88% of beneficiaries enrolled in Medicare HMOs at the national level have prescription drug coverage, only 44% of beneficiaries in Minnesota have prescription drug coverage. Figure 4-2 provides a comparison of prescription drug coverage by private source of supplemental coverage for Minnesota and the United States.

Figure 4-2

Beneficiaries With Prescription Drug Coverage by Private Supplemental Coverage



Minnesota results are from the 2001 Minnesota Health Access Survey.

United States results are from the 1999 Medicare Current Beneficiary Survey (MCBS), Laschober et al., "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," Health Affairs, February 2002.

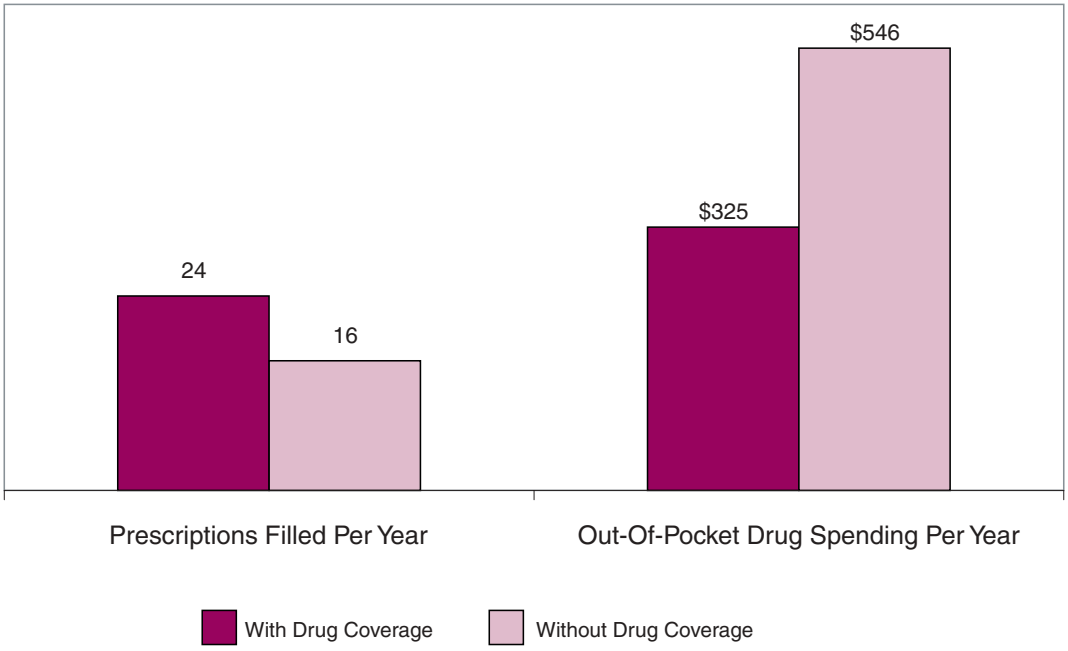
Figure 4-2 shows that there are some differences between Minnesota and the nation that have kept Minnesota from having even more beneficiaries without prescription drug coverage. Medicare beneficiaries with employer coverage or Medigap policies are more likely to have prescription drug coverage in Minnesota than at the national level. While 83% of beneficiaries with employer coverage at the national level have prescription drug coverage, 91% of beneficiaries with employer coverage in Minnesota have prescription drug coverage. Although only 27% of beneficiaries with a Medigap policy have prescription drug coverage nationally, 43% of beneficiaries with a Medigap policy have prescription drug coverage in Minnesota.

Characteristics of Beneficiaries Without Prescription Drug Coverage

As shown in Figure 4-1, 49.9% of Minnesota beneficiaries and 37.7% of beneficiaries at the national level do not have prescription drug coverage. Medicare beneficiaries who lack prescription drug coverage potentially face high costs and difficult utilization choices. Figure 4-3 shows that beneficiaries without prescription drug coverage fill fewer prescriptions and face higher out-of-pocket costs than those who have drug coverage.

Figure 4-3

Prescription Drug Utilization and Out-Of-Pocket Costs for Medicare Beneficiaries



Data Source: 1998 Medicare Current Beneficiary Survey (MCBS), Poisal, J.A. and Murray, L., Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage, Health Affairs, March/April 2001.

Table 4-1 shows the characteristics of Minnesota Medicare beneficiaries who do not have prescription drug coverage. Compared to all of Minnesota's non-institutionalized Medicare beneficiaries, Minnesota beneficiaries who lack prescription drug coverage are more likely to:

- Be over age 75 (45.9% compared to 38.8 %);
- Lack a high school diploma (25.2% compared to 19.7%); and
- Have a household income between 101% and 200% of the federal poverty level (35.5% compared to 29.0%).

Table 4-1

Characteristics of Medicare Beneficiaries Without Prescription Drug Coverage, Minnesota 2001

	MN Beneficiaries Without Coverage	All MN Beneficiaries
Age		
0-64	12.5%	13.7%
65-74	**41.6%**	47.6%
75-84	**36.0%**	31.1%
85+	9.9%	7.7%
	100.0%	100.0%
Gender		
Male	42.2%	42.1%
Female	57.8%	57.9%
	100.0%	100.0%
Marital Status		
Married	58.0%	61.1%
Divorced/Widowed/Separated	32.4%	29.9%
Never Married	9.5%	9.0%
	100.0%	100.0%
Race/Ethnicity		
White only, non-Hispanic	93.9%	94.6%
Black only, non-Hispanic	1.3%	1.4%
American Indian only, non-Hispanic	0.8%	0.7%
Asian only, non-Hispanic	1.6%	1.0%
Hispanic	2.0%	1.7%
Other	0.5%	0.6%
	100.0%	100.0%
Educational Status		
0-12 years, no diploma	**25.2%**	19.7%
High school graduate	38.0%	37.8%
Some college/tech school	21.8%	23.8%
College graduate or more	15.0%	18.7%
	100.0%	100.0%
Household Income as % of Poverty Guidelines		
0 to 100%	11.5%	10.9%
101 to 200%	**35.5%**	29.0%
201 to 300%	25.7%	24.9%
301 to 400%	11.1%	13.8%
401%+	**16.2%**	21.5%
	100.0%	100.0%
Geography		
Metropolitan Area (MSA counties)	56.9%	59.6%
Rural Area	43.1%	40.4%
	100.0%	100.0%
Northwest	**6.3%**	4.9%
Northeast	8.2%	8.9%
West Central	7.0%	6.1%
Central	13.1%	11.9%
Southwest	8.9%	8.1%
Southeast	15.1%	16.6%
Twin Cities	41.4%	43.5%
	100.0%	100.0%
Health Status		
Excellent	14.4%	14.2%
Very Good	26.7%	27.6%
Good	33.0%	33.0%
Fair	17.8%	17.5%
Poor	8.1%	7.7%
	100.0%	100.0%

Bold indicates significant difference at 95% level from all Medicare beneficiaries

A large portion of Minnesota Medicare beneficiaries who lack prescription drug coverage have low incomes. Slightly less than half (47.0%) of beneficiaries without prescription drug coverage have household incomes below 200% of the federal poverty level. An estimated 20.6% of those who lack drug coverage are potentially eligible for prescription drug coverage through Medical Assistance or Minnesota's Prescription Drug Program.[23]

Minnesota's Prescription Drug Program helps the low-income elderly and disabled pay for their prescription drugs. The Prescription Drug Program pays for necessary prescription drugs after an enrollee pays a $35 monthly deductible. To be eligible for the Prescription Drug Program, Medicare beneficiaries must have a household income below 120% of the federal poverty level ($10,632 for individuals and $14,328 for a married couple per year in 2002), meet an asset requirement ($10,000 or less for individuals and $18,000 or less for married couples), not have prescription drug coverage within four months of applying, and be enrolled in or applying for the QMB or SLMB programs.

Sources of Prescription Drug Coverage by Demographic Groups

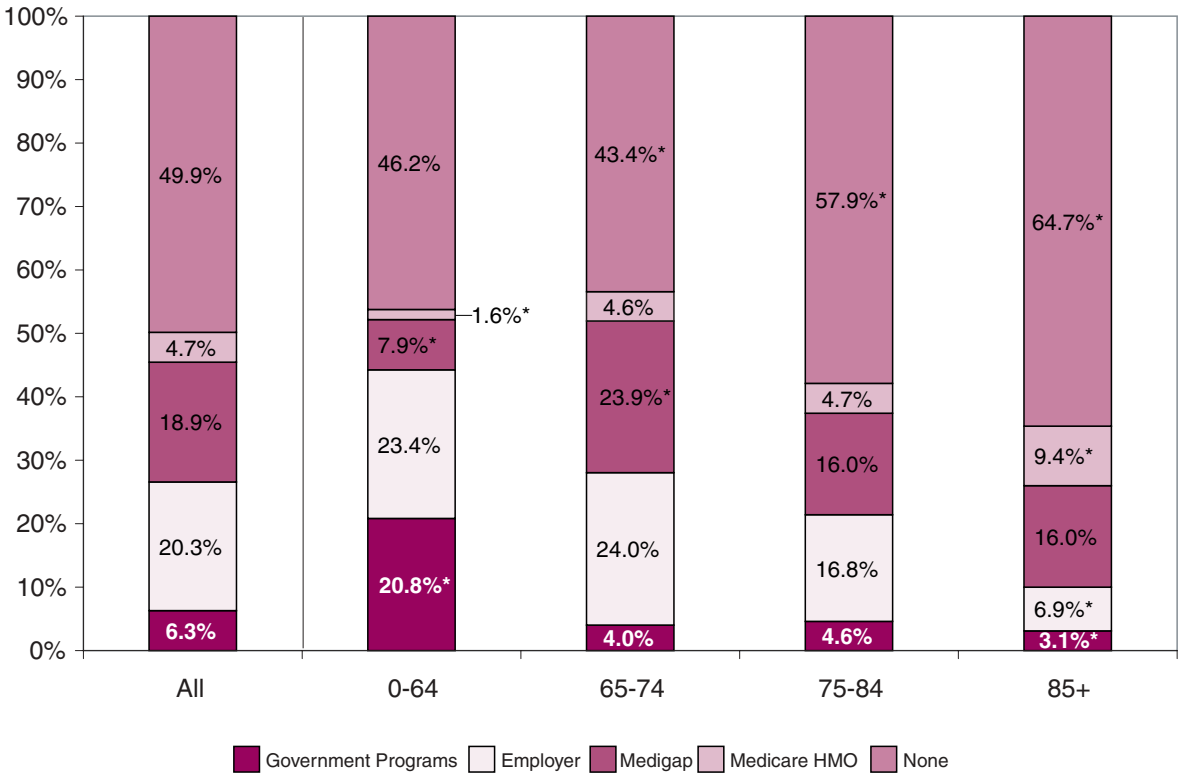
Half of Minnesota's Medicare beneficiaries have prescription drug coverage, but the percentage of beneficiaries who lack drug coverage varies among demographic groups. The sources of prescription drug coverage for Minnesota Medicare beneficiaries vary by age, gender, race/ethnicity, income level, and geography.

Age

Figure 4-4 shows that the sources of prescription drug coverage vary by age. Although disabled beneficiaries are much more likely to lack supplemental coverage than older Medicare beneficiaries, they are not more likely to lack prescription drug coverage. Disabled beneficiaries under age 65 are much more likely to have prescription drug coverage through a government program than older beneficiaries. Disabled beneficiaries are less likely to have drug coverage through Medigap policies or Medicare HMO plans than older beneficiaries. Prescription drug coverage through employer health benefits and Medigap policies decreases with age in Minnesota for those over age 65. Lack of prescription drug coverage increases with age as does enrollment in Medicare HMOs.

Figure 4-4

Sources of Prescription Drug Coverage by Age, MN 2001



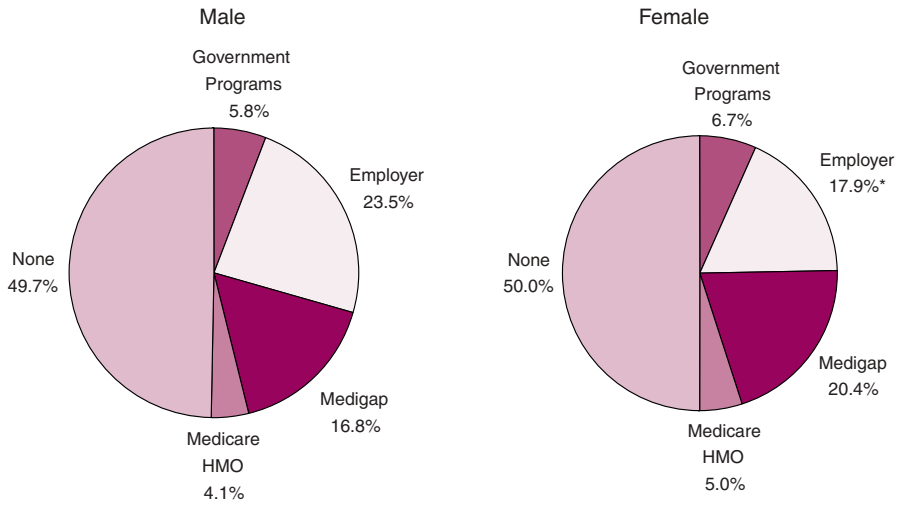
* Indicates significant difference at 95% level from all Medicare beneficiaries

Gender

Figure 4-5 shows that there are few gender differences in the sources of prescription drug coverage for Medicare beneficiaries in Minnesota. The only statistically significant difference between men and women is that women are less likely to have drug coverage through employer retiree health benefits than men, which is consistent with the fact that women are less likely to have supplemental coverage through an employer.

Figure 4-5

Sources of Prescription Drug Coverage by Gender, MN 2001



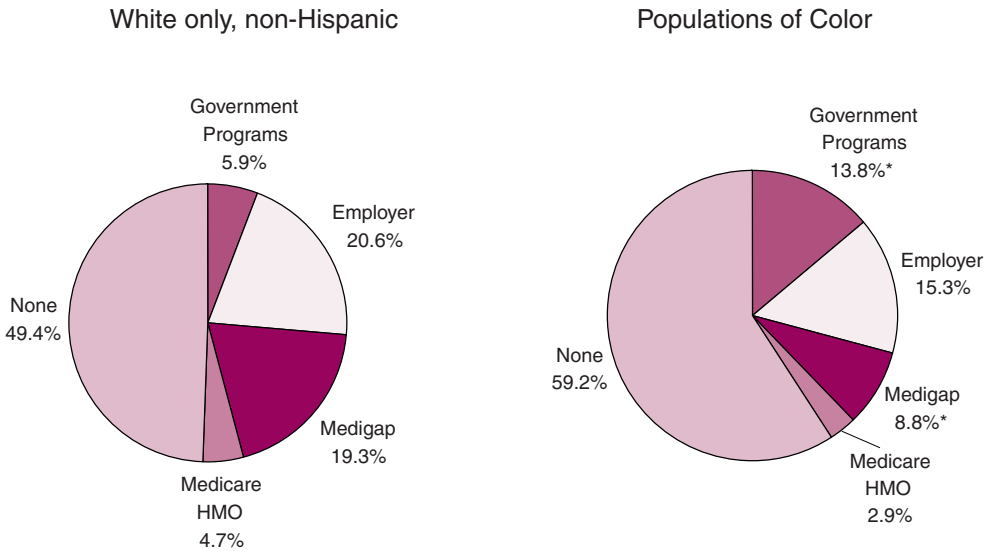
* Indicates significant difference at 95% level from Male

Race/Ethnicity

There are differences in the types of supplemental coverage by race/ethnicity. Figure 4-6 shows that populations of color are more likely to lack prescription drug coverage or get coverage through a government program and less likely to get drug coverage through a Medigap policy than the white population.

Figure 4-6

Sources of Prescription Drug Coverage by Race/Ethnicity, MN 2001



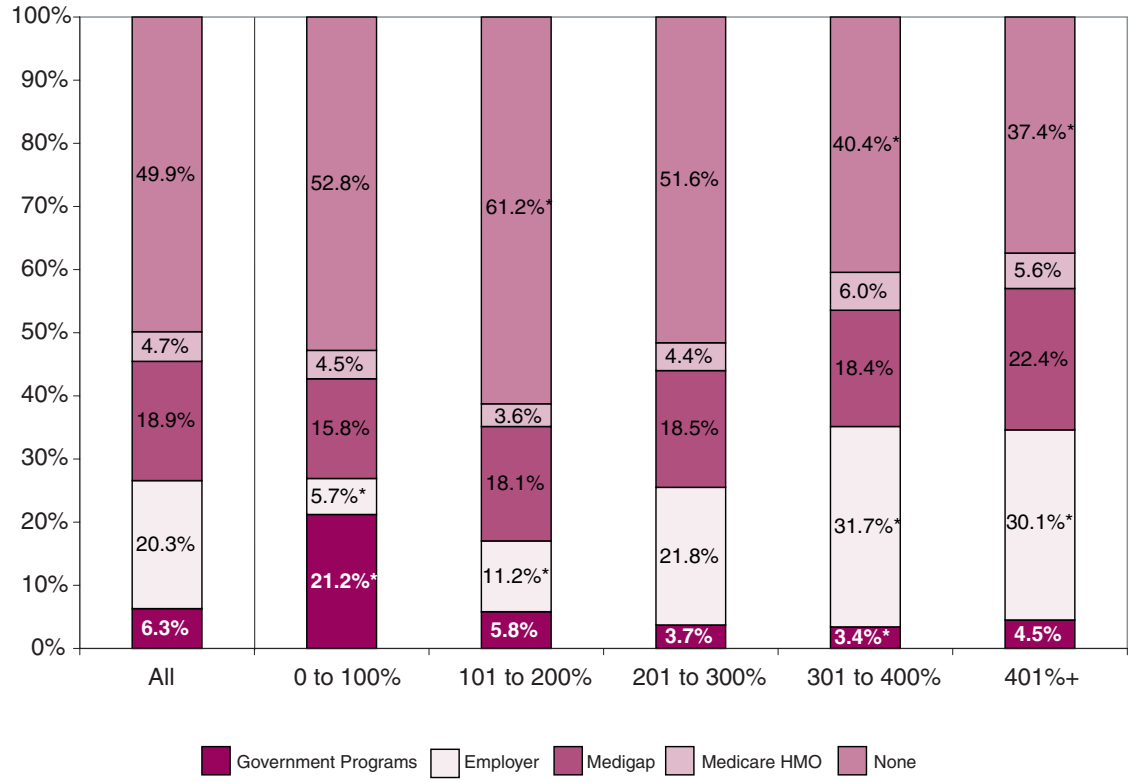
* Indicates significant difference at 95% level from White only, non-Hispanic

Income Level

Figure 4-7 shows that the sources of prescription drug coverage vary by income. Middle-income beneficiaries are more likely than lower or higher income beneficiaries to lack prescription drug coverage. Lower income beneficiaries are more likely to have drug coverage through a government program and less likely to have coverage through an employer than higher income beneficiaries.

Figure 4-7

Sources of Prescription Drug Coverage by Income^ Level, MN 2001



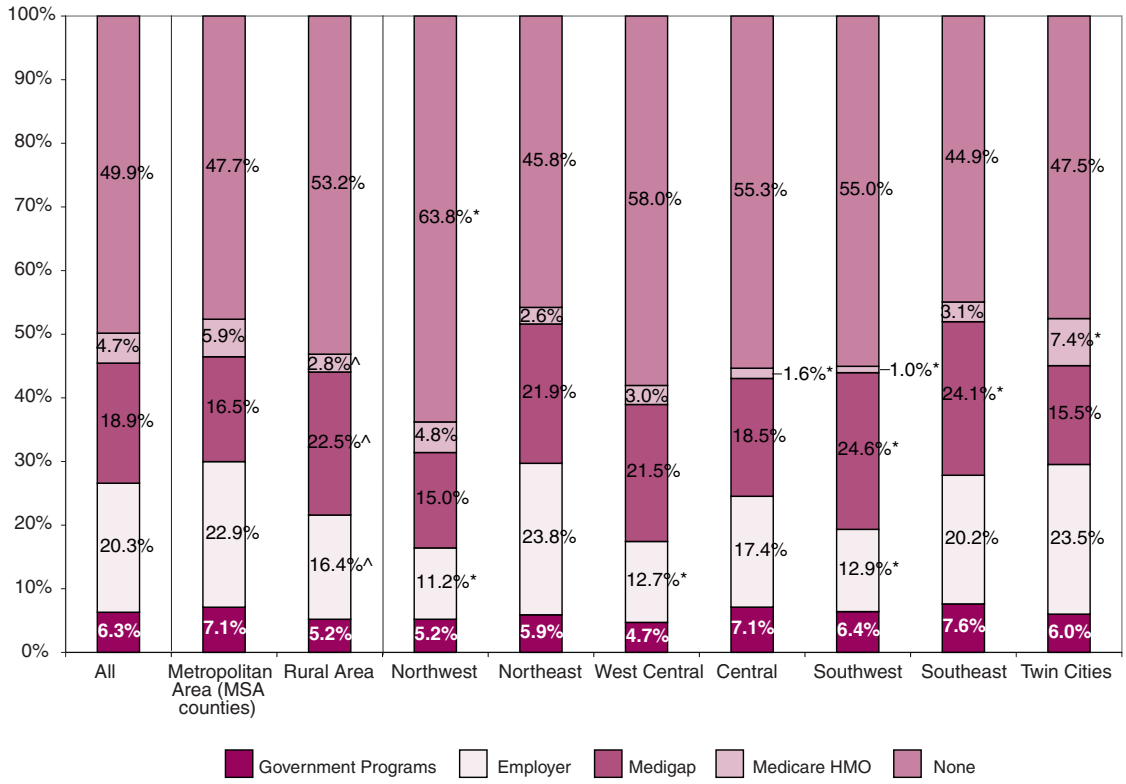
^ Income in relation to Federal poverty guidelines
* Indicates significant difference at 95% level from all Medicare beneficiaries

Geography

As shown in Figure 4-8, the sources of prescription drug coverage for rural and metropolitan beneficiaries are different. Medicare beneficiaries in rural areas of Minnesota are more likely to have drug coverage through a Medigap policy and less likely to have drug coverage through a Medicare HMO or employer retiree health plan than metropolitan beneficiaries.

Figure 4-8

Sources of Prescription Drug Coverage by Geography, MN 2001



^ Indicates a significant difference between Rural and Metropolitan Area at 95% level
* Indicates significant difference at 95% level from all Medicare beneficiaries

Figure 4-8 also shows that the sources of prescription drug coverage vary throughout the regions of the state. In general, beneficiaries living in the western regions of the state are more likely to lack prescription drug coverage and less likely to have drug coverage through an employer than beneficiaries living in the eastern part of the state.

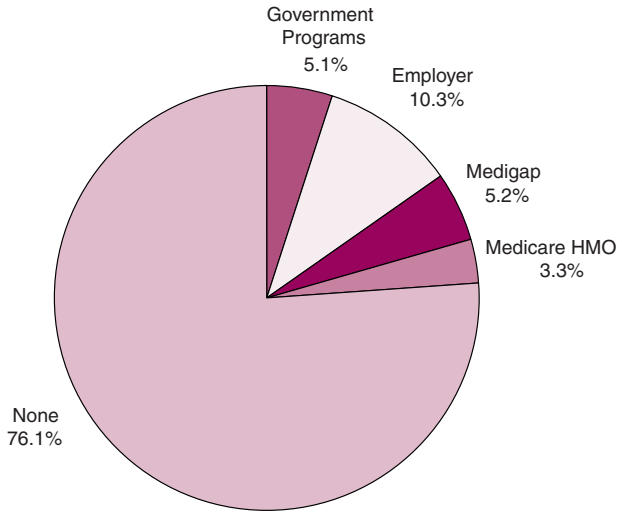
5 Dental Coverage

Medicare does not provide coverage for most dental care. Beneficiaries must pay for dental care on their own or they can get supplemental coverage to pay for it. Dental care is often ignored by the elderly, as they have more pressing chronic health concerns. However, as dental advances enable the elderly to keep their teeth into their later years, it is likely that the need for ongoing dental care to prevent and treat dental disease will increase.[24] This chapter provides information on the sources of dental coverage for Medicare beneficiaries.

Most Medicare beneficiaries do not have additional insurance to pay for dental care. In Minnesota, 76.1% of non-institutionalized Medicare beneficiaries lack dental coverage, while 5.1% get coverage through a government program, 10.3% get coverage through an employer, 5.2% have dental coverage through a Medigap policy, and 3.3% have coverage through a Medicare HMO. Medicare beneficiaries who lack dental coverage are less likely to get dental care than those who have dental coverage. In 1998, only 23.6% of Medicare beneficiaries who rely on Medicare alone had at least one dental visit, while 42.5% of all Medicare beneficiaries had at least one dental visit. [25]

Figure 5-1

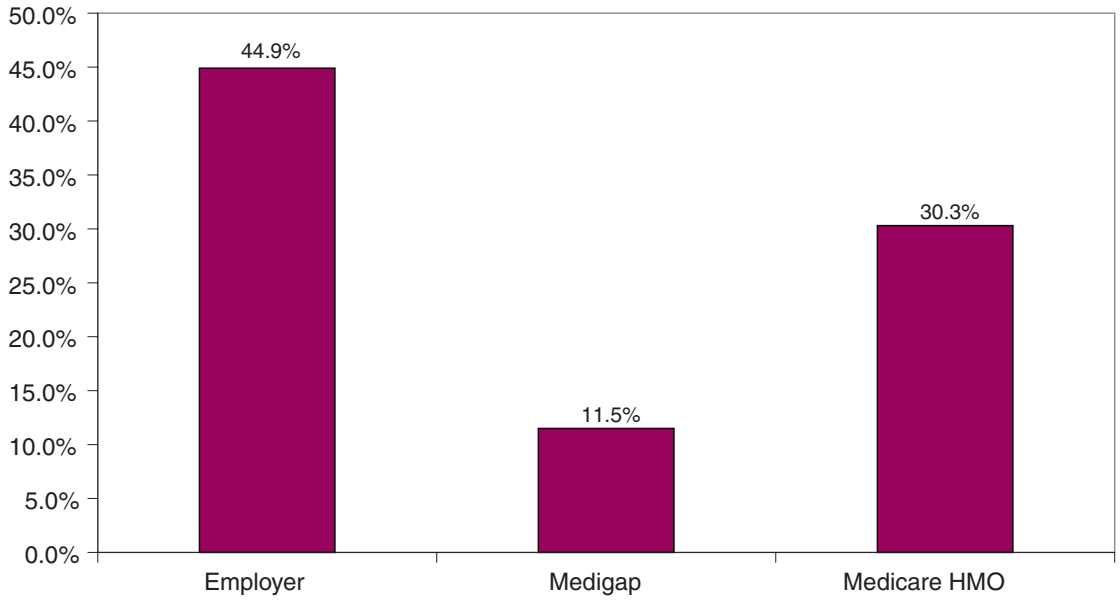
Sources of Dental Coverage, MN 2001



Of those who have dental coverage, many are covered through an employer. This is primarily because those with employer coverage are more likely to have dental coverage than those who have another source of private supplemental coverage. Figure 5-2 shows that 44.9% of beneficiaries with employer coverage, 30.3% with a Medicare HMO, and 11.5% with a Medigap policy have dental coverage.

Figure 5-2

Beneficiaries With Dental Coverage by Private Supplemental Coverage, MN 2001



Many Medicare beneficiaries lose dental coverage when they retire. However, even before retirement, a large portion of people lack dental coverage. In Minnesota, 28.3% of the non-elderly lack dental coverage, while only 6.0% lack health insurance coverage.[26]

6

Summary and Conclusion

Because of Medicare coverage limits and high cost sharing, supplemental insurance is vital to ensuring access to health care for Medicare beneficiaries. Beneficiaries without supplemental insurance to pay for the gaps in Medicare coverage are less likely to have a usual source of care, more likely to delay care due to cost, fill fewer prescriptions, have fewer dental visits, and face higher out-of-pocket health care costs than those with supplemental insurance.

The sources of supplemental insurance and the goods and services provided by these supplemental plans vary for Medicare beneficiaries in Minnesota and the United States. The proportion of Medicare beneficiaries without supplemental coverage is relatively the same in Minnesota and the United States; however, Minnesota beneficiaries are less likely to have coverage through a government program, employer, or Medicare HMO and more likely to have a Medigap policy to supplement Medicare. The differences in the sources of supplemental coverage help to explain the relative lack of coverage for prescription drugs and dental care in Minnesota. Beneficiaries covered by employer retiree health plans and Medicare HMOs are more likely to have coverage for goods and services such as prescription drugs and dental care than beneficiaries with Medigap policies.

If current trends continue, the lack of supplemental coverage overall and coverage for prescription drugs and dental care will likely worsen for beneficiaries in Minnesota and at the national level over the next several years. If employers continue to reduce or eliminate retiree health benefits and if enrollment in Medicare HMOs continues to decline, beneficiaries will lose access to lower cost health coverage and may be forced to purchase higher cost Medigap policies or forgo supplemental insurance. In the coming years, Minnesota may be faced with more Medicare beneficiaries who have financial barriers to accessing health care.

Minnesota also faces disparities in supplemental insurance coverage. Populations of color and rural residents are more likely to lack supplemental insurance and coverage for prescription drugs than the white population and metropolitan residents. Rural residents are also more likely to have higher cost Medigap policies than metropolitan residents because they lack access to lower cost Medicare HMOs and employer retiree health benefits. Disparities in supplemental coverage also exist by age. Lack of supplemental insurance and lack of coverage for prescription drugs increases with age. In addition, disabled beneficiaries are much more likely to lack supplemental coverage than older beneficiaries. This is worrisome as health care needs and costs generally increase with age and disability.

Some Minnesota Medicare beneficiaries who lack supplemental insurance may be eligible for supplemental coverage or financial assistance with Medicare cost sharing through existing public programs. Almost half of Minnesota's Medicare beneficiaries who do not have supplemental insurance coverage could potentially be eligible for full Medical Assistance benefits or financial assistance with Medicare cost sharing through other Medical Assistance programs, assuming they meet the asset requirements. Approximately one-fifth of beneficiaries without prescription drug coverage could potentially be eligible for coverage through Medical Assistance or Minnesota's Prescription Drug Program.

As employer coverage for retiree health benefits and Medicare HMO enrollment continues to decline, it will be important to track changes in supplemental insurance coverage for Minnesota Medicare beneficiaries. Further research and monitoring will be needed to determine the impact of changes in supplemental insurance coverage on access to health care and out-of-pocket health care costs for Medicare beneficiaries in Minnesota.

Endnotes

1. Centers for Medicare and Medicaid Services (CMS), Medicare County Enrollment as of July 1, 2001, October 29, 2002.

2. CMS. People who pay a premium for Medicare Part A are over the age of 65 and neither they nor their spouse paid Medicare taxes for at least 40 quarters or 10 years.

3. CMS, Medicare State Enrollment for HI and SMI, 2001.

4. The Henry J. Kaiser Family Foundation, Health Research and Education Trust, and The Commonwealth Fund, "Erosion of Private Health Insurance Coverage for Retirees," April 2002.

5. Hewitt Associates, "The Implications of Medicare Prescription Drug Proposals for Employers and Retirees," July 2000.

6. Newman P., The Henry J. Kaiser Family Foundation, "The Future of Retiree Health Benefits: Challenges and Options," November 2001.

7. The Henry J. Kaiser Family Foundation, Health Research and Education Trust, and The Commonwealth Fund, "Erosion of Private Health Insurance Coverage for Retirees," April 2002.

8. Ibid.

9. There are generally two types of Medicare HMOs: risk and cost. Risk HMOs are paid on a capitated basis to provide Part A and B services to Medicare beneficiaries. Cost HMOs are initially paid a capitated amount to provide Part A and B services to Medicare beneficiaries, but final payment is determined on the basis of reasonable cost at the end of the year.

10. Minnesota HMO enrollment represents individually purchased plans only; HMO enrollment through Medical Assistance or an employer is not counted in this category, but instead counted under government programs or employer coverage. In addition, the denominator is non-institutionalized Medicare beneficiaries, instead of all Medicare beneficiaries. As such, the results do not match administrative HMO enrollment from the Centers for Medicare and Medicaid Services (CMS).

11. MDH Health Economics Program analysis of CMS December 1990 through December 2000 Medicare Managed Care State/County Market Penetration data files.

12. The Henry J. Kaiser Family Foundation, "Medicare+Choice," June 2002.

13. United States Congressional Budget Office (CBO), "Medicare Baseline," March 2002.

14. The Henry J. Kaiser Family Foundation, "Medicare+Choice," June 2002.

15. Ibid.

16. Ibid.

17. The Henry J. Kaiser Family Foundation, "Medicaid's Role for Low-Income Medicare Beneficiaries," January 2002.

18. AARP, "Across the States: 2000 Profiles of Long-Term Care Systems," 2000.

19. Ibid.

20. Westat, Inc., "Health and Healthcare of the Medicare Population," 1998.

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