

Health Insurance for the Elderly - Issues in Measurement Workshop, April 2003: Meeting Summary, Commissioned Papers and Discussants' Remarks

D.E.B. Potter and Jessica Vistnes and (Editors)

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Sponsored by:

**The Federal Interagency Forum on Aging Related Statistics  
and the Agency for Healthcare Research and Quality**

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D.E.B. Potter and Jessica Vistnes (editors)  
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## **ABSTRACT**

The *Health Insurance for the Elderly: Issues in Measurement Workshop* held April 29, 2003, was sponsored by the Federal Interagency Forum on Aging-Related Statistics (the Forum) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The workshop was designed to provide the Forum and Forum member agencies with expert advice to guide them on data activities related to health insurance for the elderly. This working paper -- *Health Insurance for the Elderly - Issues in Measurement Workshop, April 2003: Meeting Summary, Commissioned Papers and Discussants' Remarks* -- comprises the proceedings from the workshop. The proceedings include recommendations (by the commissioned paper authors, workshop discussants and meeting participants) on indicators of health insurance coverage for inclusion in the Forum's *Older Americans: Key Indicators of Well-Being* and highlight data gaps in the Federal Statistical System's measurement of health insurance for the elderly.

The first section of the proceedings summarizes the morning presentations by Mary Laschober (Overview of Health Insurance Options for the Elderly), Paul Fronstin (Employer-Sponsored Insurance), Tom Rice (Medigap), Carlos Zarabozo (Medicare Managed Care), Judy Kasper (Medicaid), Bruce Stuart (Prescription Drug Coverage), and Marc Cohen (Long-Term Care Insurance). This is followed by the two workshop commissioned papers: "Data Sources and Measures of Coverage and Benefits" by John Czajka and "Data Sources and Measures of Access and Affordability" by Deborah Chollet. Data sources discussed include the Medicare Current Beneficiary Survey (MCBS), the Medical Expenditure Panel Survey (MEPS), the National Health Interview Survey (NHIS) and the Health and Retirement Survey (HRS), among others. The next section contains the workshop discussants' written remarks; authored by Pam Farley Short, Melinda Beeuwkes Buntin and Jeannette A. Rogowski. An Epilogue (prepared by John Czajka) follows, focusing on the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA). Also provided are Appendices: the agenda for the meeting; a summary of the major data sources available to measure health insurance for the elderly, including web links to each data source's web page; biographical sketches of the workshop speakers; and glossary resources on health insurance terms, including those developed by the Federal Interdepartmental Committee on Employment-based Health Insurance Surveys.

This working paper -- *Health Insurance for the Elderly - Issues in Measurement Workshop, April 2003: Meeting Summary, Commissioned Papers and Discussants' Remarks* -- was edited by D.E.B. Potter and Jessica Vistnes.

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## Acknowledgements

The *Health Insurance for the Elderly: Issues in Measurement Workshop* held April 29, 2003, was sponsored by the Federal Interagency Forum on Aging-Related Statistics (The Forum) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The workshop and the subsequent proceedings would not have been possible without the efforts of many.

Planning for the meeting was provided by the Forum's health insurance working group whose members included D.E.B. Potter (Chair) and Jessica P. Vistnes, Agency for Healthcare Research and Quality; Ryan Helwig, Bureau of Labor Statistics; Franklin Eppig, Centers for Medicare & Medicaid Services; Robin Cohen and Margie Goulding, National Center for Health Statistics; Hunter McKay, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; Brian Harris-Kojetin, Office of Management and Budget; Charles T. Nelson, U.S. Census Bureau; Donald Stockford, Veterans Health Administration; and the Forum's Staff Director, Kristen Robinson, National Center for Health Statistics. Lori Whitten, Cygnus Corporation, Inc served as the Executive Secretary for the planning group.

The Forum would like to give special thanks to the commissioned paper authors John Czajka and Deborah Chollet; the discussants Pamela Farley Short, Melinda Beeuwkes Buntin and Jeannette A. Rogowski; the meeting presenters Mary Laschober, Paul Fronstin, Tom Rice, Carlos Zarabozo, Judy Kasper, Bruce Stuart and Marc Cohen; and the session chairs Steven B. Cohen and Jon R. Gabel for their enumerable contributions. Without their expertise and professionalism the meeting would not have been possible. Special thanks are also given to the meeting participants, far too numerous to mention, without whom a successful meeting would not have been possible.

The Forum is grateful to the Agency for Healthcare Research and Quality's Center for Financing, Access and Costs Trends for the financial support provided for the meeting. Special thanks are also given to the Bureau of Labor Statistics and staff for their hosting of the meeting at the Bureau of Labor Statistics' Conference Center, in Washington, D.C. The Forum is also indebted to Lori Whitten, Molly Wolfe, Raquel McConnico and Mary Bedford at Cygnus Corporation, Inc., who provided expert meeting support services.

## About The Workshop And This Report

The *Health Insurance for the Elderly: Issues in Measurement Workshop* held April 29, 2003, was sponsored by the Federal Interagency Forum on Aging-Related Statistics (Forum) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The purpose of the workshop was to inform the Forum and Forum member Agencies on data needs surrounding the measurement of supplemental health insurance for people age 65 and over.

Although most people age 65 and over receive their primary health insurance through Medicare, the services covered under Medicare Parts A and B are limited primarily to acute care services such as inpatient hospital care, physician visits, stays in skilled nursing facilities, and hospice care. To cover the remaining health care costs, Medicare enrollees can obtain supplemental health insurance either privately (e.g., employer-sponsored coverage or self-purchased Medigap) or publicly (e.g., Medicare HMO policies or Medicaid). Without this insurance, older Americans would be paying a higher percentage of their health care costs out-of-pocket.

The workshop was designed to provide the Forum and Forum member agencies with expert advice to guide them on data activities related to health insurance for the elderly. The short-term objectives were to: 1) to obtain information on emerging trends in supplemental health insurance, particularly with respect to the data needs and measurement issues, and 2) develop recommendations for a supplemental health insurance indicator(s) for the Forum's chartbook *Older Americans: Key Indicators of Well-Being*. Another objective was to identify any important holes in the information on supplemental insurance to set the stage for future discussion of a possible longer-term effort by Forum member agencies to try to improve the measurement of supplemental insurance.

The morning session of the workshop focused on providing an overview of coverage options and specific aspects of health insurance for the elderly. Each presenter addressed the following questions:

- What are the current issues related to coverage?
- What are the most likely future issues related to coverage?
- What should be measured?

Presenters reviewed employer-sponsored insurance, Medigap, Medicare managed care, Medicaid, prescription drug coverage, and long-term care. The question-and-answer period focused on technical clarifications.

The afternoon session centered on the presentation of two commissioned papers describing data sources and measures on (1) actual coverage and benefits and (2) the accessibility and affordability of coverage. The authors made recommendations on chartbook indicators related to insurance coverage and highlighted data gaps. Discussants



commented on the papers and remarked on the key issues presented. The workshop concluded with a facilitated discussion on the intersection of policy issues and data needs.

In addition to the invited presenters and Forum members' Agency staff, workshop participants included representatives from private and public organizations in the Washington, D.C., area with an interest in health care policy and insurance issues. Workshop attendees included representatives of the Congressional Budget Office, the Medicare Payment Advisory Commission, Actuarial Research Corporation, the Lewin Group, the National Association of Insurance Commissioners, the Urban Institute, the Commonwealth Fund, the Kaiser Family Foundation and research scientists involved with major surveys of the elderly population. Approximately 80 people attended the Workshop held at the Bureau of Labor Statistics Conference Center, Washington, D.C.

This working paper -- *Health Insurance for the Elderly - Issues in Measurement Workshop, April 2003: Meeting Summary, Commissioned Papers and Discussants' Remarks* -- comprises the proceedings from the workshop.

The first section of the proceedings summarizes the morning presentations by Mary Laschober (Overview of Health Insurance Options for the Elderly), Paul Fronstin (Employer-Sponsored Insurance), Tom Rice (Medigap), Carlos Zarabozo (Medicare Managed Care), Judy Kasper (Medicaid), Bruce Stuart (Prescription Drug Coverage), and Marc Cohen (Long-Term Care Insurance). Presenters reviewed the summary of their respective presentations prior to the release of these proceedings. The section concludes with a summary of the facilitated floor discussion that followed the presentations.

The next section contains the two commissioned papers, authored by John Czajka and Deborah Chollet, respectively. Prior to the workshop, earlier versions of the commissioned papers were reviewed by Pam Farley Short, Melinda Beeuwkes Buntin and Jeannette A. Rogowski, who served as workshop discussants, and by the Forum's health insurance working group. The papers were revised by the authors after the workshop and subsequently reviewed and edited by the proceedings' editors as necessary. The commissioned papers include some of the changes in questionnaire content that have occurred since the workshop was held in 2003.

The next section contains discussants' written remarks. The written remarks were based on an earlier version of the commissioned papers and the workshop presentations. The next section is a summary of the closing session and includes recommendations for future Forum chartbooks on *Older Americans: Key Indicators of Well-Being*.

The last section is an Epilogue (prepared after the workshop) and speaks to the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) and its potential impact on health insurance (and the measurement of health insurance) for the elderly.

The Appendices section contains: the agenda for the meeting; a summary of the major data sources available to measure health insurance for the elderly, including web links to

each data source's web page; biographical sketches of the workshop speakers; and glossary resources on health insurance terms, including those developed by the Federal Interdepartmental Committee on Employment-based Health Insurance Surveys.

Prior to the final release of the workshop proceedings, this working paper was reviewed by AHRQ senior staff as part of the AHRQ Working Paper peer review process. AHRQ Working Papers provide preliminary analysis of substantive, technical and methodological issues. They are distributed to share valuable experience and research. Comments are welcome and should be directed to the corresponding author of the section. The views expressed are those of the authors and no official endorsement by the Agency for Healthcare Research and Quality, the Department of Health and Human Services, or the member Agencies of the Federal Interagency Forum on Aging Related Statistics is intended or should be inferred.

Since the workshop was held, the Federal Interagency Forum on Aging-Related Statistics published a new version of *Older Americans: Key Indicators of Well-Being*. As a result of the *Health Insurance for the Elderly - Issues in Measurement Workshop* the Forum's recent publications include new indicators on health insurance coverage. For the most up to date version of the Forum's *Older Americans: Key Indicators of Well-Being*, or for more information about the Forum, see the Forum's web site <http://www.agingstats.gov>.

Web site addresses provided in these proceedings were valid as of March 7, 2006.

Comments on this working paper should be addresses to the corresponding author of the commissioned paper or to below:

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# **Summary of Morning Presentations**

## **Overview and Key Issues in Health Insurance Options for the Elderly**

*Lori Whitten, Cygnus Corporation, Inc*

Presentations prepared for the  
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## Morning Presentations

### Welcome and Introduction

*Speaker: Steven B. Cohen, Ph.D.*

*Director, Center for Financing, Access and Cost Trends, AHRQ*

Dr. Steven Cohen welcomed the participants and reviewed the agenda. He commented that the impetus for the workshop came from discussions among members of the Aging Forum about statistics that reflect the well-being of the elderly. The Aging Forum updates its indicators regularly and recognizes the increasingly important role of insurance and supplemental coverage for elderly as a quality-of-life issue. There is a need for Federal agencies to reassess data sources that inform health care policy, given the current context for health insurance coverage. The Federal statistical community needs to identify data gaps and determine how agencies might improve data sources to provide a more complete picture of health insurance for the elderly.

Dr. Cohen thanked the members of the workshop planning committee and acknowledged the Jackson Foundation for providing support for refreshments and Cygnus Corporation for providing logistical facilitation.

### Overview of Health Insurance Options for the Elderly

*Presenter: Mary Laschober, Ph.D.*

*BearingPoint, Inc.*

Dr. Mary Laschober described the Medicare program, including eligibility requirements, services covered, and expenditures. Medicare does not cover all health care services needed by the elderly and eligible disabled persons, and she reviewed options for supplemental insurance. Dr. Laschober also described the demographic characteristics of Medicare beneficiaries and reviewed the sources of payment for Medicare beneficiaries' medical services. Medicare is a complex program, and beneficiaries are often confused about their options and coverage. Unfortunately, beneficiary confusion about Medicare coverage affects the accuracy of self-reported data collected from national surveys. Verification of survey data using administrative claims data enhances the measurement of health insurance coverage.

Congress established the Medicare program in 1965 to protect the elderly (defined as individuals aged 65 years and older) from financial ruin due to high medical expenses. U.S. citizens or permanent residents are automatically eligible for Medicare benefits if they are aged 65 years or older and have paid into Social Security (or the Railroad Retirement Board retirement program) for 40 quarters. A U.S. citizen or permanent resident aged 65 years or older whose spouse or former spouse receives Social Security (or Railroad Retirement benefits) also is eligible for Medicare. Some individuals who do not meet these requirements can purchase Medicare coverage if they are U.S. citizens or legal residents who have resided in the United States for at least 5 years. The cost of purchasing Medicare is based on the number of quarters the individual has contributed to

Social Security. For example, the Part A premium in 2003 was \$174 per month for people contributing between 30 and 39 quarters and \$316 per month for people contributing fewer than 30 quarters.

In 2002, about 97 percent of the resident U.S. population aged 65 years or older were covered by the Medicare program (about 34.5 million people). Medicare benefits also cover some permanently disabled individuals under age 65 years and people with end stage renal disease, but the large majority of Medicare beneficiaries (85 percent) are elderly.

Medicare has three parts—Hospital Insurance (HI or Part A), Supplementary Medical Insurance (SMI or Part B), and Medicare+Choice (a managed care program or Part C). Medicare Part A provides hospital insurance and pays for care provided by inpatient hospitals, skilled nursing facilities, some home health care providers, and hospice care. Eligible persons are enrolled automatically at no cost. The HI Trust Fund, which is derived primarily from a payroll tax paid by workers and employers, finances Medicare Part A. Part A constituted about 51 percent of Medicare expenditures in 2002. Many are concerned about the financial strain on Medicare Part A. Demographic shifts, including the aging of the baby boom generation and a reduction in the worker-to-retiree ratio, have significant implications for the future financing of Medicare Hospital Insurance.

Medicare Part B covers physician services, rehabilitation therapy, outpatient hospital, diagnostic tests, some home health care, outpatient therapy, outpatient mental health, and most medical supplies and services. Individuals who are eligible for Part A are enrolled in Part B automatically unless they opt out of supplemental coverage. Individuals covered by Part B pay a premium (\$58.70 per month in 2003). The majority (95 percent) of new Medicare enrollees choose to keep Part B. Some data indicate that individuals who opt out of Part B do so because they do not understand Part B benefits and/or do not understand why they should pay a monthly premium for these benefits. The SMI Trust Fund—derived from a combination of beneficiary premiums, general tax revenues, and interest—finances Medicare Part B. In 2002, Medicare Part B expenditures constituted about 36 percent of the program's total expenditures, but the costs associated with supplementary medical insurance are rising at a faster rate than those of hospital insurance.

Medicare Part C, the Medicare+Choice (M+C) program, often offers enhanced benefits to beneficiaries who choose to enroll in an M+C plan when one is available in their area. Congress established the program under the Balanced Budget Act of 1997 to expand the types of private health plans available to beneficiaries. The Medicare program contracts with private managed care plans to provide Medicare Parts A and B services to Medicare beneficiaries. M+C plans are most often health maintenance organizations (HMOs), where beneficiaries covered under these plans are often limited to doctors in the HMO's network and service area (and a referral is usually needed to see a specialist). Under M+C demonstrations involving preferred provider organizations (PPOs),<sup>1</sup> a beneficiary can see any doctor in the PPO's network at any time (but costs are higher for non-

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<sup>1</sup> Not all PPOs, but most, are demonstration plans under the M+C program.

network provider visits). The M+C program also offers private fee-for-service plans. These plans cover services performed by any doctor willing to accept the plan's fees, terms, and conditions. Other managed care health plan options available in some areas through the M+C program include provider-sponsored organizations, PACE plans,<sup>2</sup> point-of-service plans, and medical savings accounts (no medical savings accounts have been offered to Medicare beneficiaries to date). The Medicare+Choice program accounted for 13 percent of Medicare expenditures in 2002.

Medicare expenditures in total comprised 19 percent of U.S. health care expenditures (or about \$247 billion) in 2002. To put Medicare expenditures in perspective, they represented 13 percent of the Federal budget in 2002 and 2.2 percent of the Nation's gross domestic product in 2000. The average expenditure amount per beneficiary was about \$9,573 in 1999. However, it is important to note that Medicare expenditures are concentrated on beneficiaries with the greatest medical need. Six percent of beneficiaries account for almost 50 percent of Medicare payments. Over the long term, per capita growth in Medicare spending has closely tracked that of private insurance. The Centers for Medicare & Medicaid Services (CMS) administers the program through contracts with private carriers and fiscal intermediaries, and local offices of the Social Security Administration (SSA) implement Medicare enrollment.

As noted previously, Medicare is not a comprehensive health care program. Beneficiaries pay deductibles, copayments, and coinsurance for both Part A and Part B services. For example, Part B has a \$100 per-year deductible, and beneficiaries must pay 20 percent coinsurance on Medicare-approved charges for most services. If the attending physician or other Part B provider does not accept Medicare assignment for the Medicare-covered service,<sup>3</sup> then the patient also is responsible for the amount above the Medicare-approved charge. Medicare does not cover some important medical services, such as most outpatient prescription drugs, long-term care (including custodial care at home or in a nursing home), routine examinations, or vision, dental, and hearing care. In 1999, for example, Medicare paid only 53 percent of Medicare beneficiaries' health care costs. Not including premium payments, beneficiaries themselves paid for almost one-fifth of their health care costs out of their own resources.

Because Medicare does not pay for all health services or all costs for Medicare-covered services, in 1999, beneficiaries aged 65 years and older spent a projected average of about \$2,430 (19 percent of their income) on health care needs. This figure excludes those needing home care or long-term care. A quarter of Medicare beneficiaries aged 65 years or older spent more than \$3,000 on out-of-pocket health care expenses. Out-of-pocket spending on prescription drugs represents a significant portion of the health care

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<sup>2</sup> PACE stands for "Program of All Inclusive Care for the Elderly." The PACE program is a unique capitated managed care benefit for frail elderly Medicare beneficiaries provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs.

<sup>3</sup> Part B providers who agree to accept the Medicare-approved amount as payment in full for the Medicare-covered service agree to "accept assignment" for that service.

expenditures borne by Medicare beneficiaries. In 2001, beneficiaries spent about \$848 on prescription medications, with 9 percent spending more than \$2,500.

To help protect beneficiaries from out-of-pocket health care costs not paid for by Medicare, most beneficiaries (87.5 percent of non-institutionalized beneficiaries in 1999) rely on supplemental insurance to fill gaps in Medicare's coverage. They obtain supplemental insurance from a variety of sources, but 12.5 percent had no insurance to supplement their Medicare benefits in the fall of 1999. In the fall of 1999, about 5.1 percent of those aged 65 years or older had health insurance coverage from a current employer. If a Medicare beneficiary (or his/her spouse) works beyond age 65 for an employer with 20 or more employees, by law the elderly employee must be offered the same health insurance package as all other employees. Employer-sponsored health insurance benefit plans are often more generous than Medicare (e.g., cover routine dental and vision care). If an individual accepts the employer's insurance and joins Medicare, Medicare is the secondary payer. If the individual rejects the employer's offer of insurance, Medicare becomes the primary insurance program.

In the fall of 1999, about 28 percent of beneficiaries living in the community relied on retiree employer-sponsored coverage to supplement Medicare. This coverage is provided by a beneficiary's (or his/her spouse's) former employer or union. For retirees aged 65 years or older, retiree employer-sponsored insurance supplements Medicare benefits. Employee-sponsored retiree coverage acts as the primary payer for retirees under age 65. Employers have considerable flexibility in designing their retiree health benefits, which results in a wide variation in actual benefits and out-of-pocket expenses. Many companies require the beneficiary to pay a premium for this supplemental coverage, which in general though is more generous than Medigap or Medicare+Choice plans. Some employers contract with Medicare+Choice plans to provide retiree health benefits, which may be different from the Medicare+Choice plan benefits offered to other Medicare enrollees.

About 24 percent of non-institutionalized beneficiaries held an individually-purchased supplemental policy (i.e. Medigap plan) in the fall of 1999. Private insurance companies sell such plans to fill the "gaps" in Medicare. In 1992, the federal government mandated that only 10 standardized Medigap plans (A through J) could be sold in most States, with each plan offering a different set of benefits and varying in price. All plans with the same letter provide the same benefits regardless of the insurance company that is selling it. Some plans offer minimum coverage (e.g., Medicare Part A and/or Part B deductibles and coinsurance only), but others offer more extensive benefits (e.g., they pay for limited home care, some prescription drugs, Part B excess charges, and foreign travel emergencies). No Medigap plan covers long-term custodial care at home or in a nursing facility, vision or dental care, hearing aids, private-duty nursing, or unlimited prescription drugs. Any standardized policy may be sold as Medicare SELECT—a PPO for Medigap. Participants in Medicare SELECT must use specific hospitals and doctors to receive full benefits. Medigap plans offer an open enrollment period for those turning age 65 (and some special enrollment periods) when underwriting and coverage denial are not allowed. After the open enrollment period, companies may restrict coverage, deny coverage, or

base an individual's premium on his/her health status (i.e., underwrite the policy). Recent data indicate that about 5 percent of Medicare beneficiaries may be overinsured—that is, they keep their Medigap policy even after enrolling in an M+C plan so they can still retain their Medigap coverage if they leave the M+C plan.

About 17 percent of beneficiaries relied on Medicare+Choice (or another type of Medicare HMO that is not an M+C plan) for primary supplemental coverage in the fall of 1999. Private managed care companies contract with CMS to provide Parts A and B services to enrolled Medicare beneficiaries. Medicare pays M+C plans a fixed monthly payment per member to provide all services based on a county payment rate. To be eligible, one must have Medicare Parts A and B, live in the plan's service area, and not have end-stage renal disease or receive hospice care at the time of enrollment. Extra benefits covered might include prescription drugs, vision, hearing, or dental services, Medicare deductibles, and reduced copayments. M+C plans might offer these additional health services at no additional charge to the beneficiary or they might charge enrollees a monthly plan premium for these extra services. M+C plans are mainly offered in urban areas, although private fee-for-service plans and PPO demonstrations are expanding into rural areas.

About 11 percent of Medicare beneficiaries living in the community in the fall of 1999 relied on Medicaid for their supplemental insurance. These individuals are called "dual eligibles," because they are eligible for Medicaid benefits as well as the Medicare program. Some are eligible for their State's full set of Medicaid benefits if they meet their State's income, asset, or other eligibility requirements that apply to all individuals residing in the State. Those receiving full Medicaid benefits represent 42 percent of dual eligibles. Other Medicare beneficiaries are "dual eligibles" because their income qualifies them for one of the Medicare Savings Programs: under the Qualified Medicare Beneficiary (QMB) program, the State pays the beneficiary's Medicare Part A and B premiums, deductibles, and coinsurance amounts. QMBs have an annual income no higher than 100 percent of the Federal poverty level and many must meet the criteria of an asset test (if the State has not waived this requirement). QMBs represent 48 percent of dual eligibles. For Specified Low-Income Medicare Beneficiaries (SLMBs)—individuals with an annual income no more than 120 percent of the Federal poverty level and that meet the criteria of an asset test—the State pays Medicare Part B premiums. SLMBs represent 8 percent of dual eligibles. The Medicare Savings Programs also require limited State assistance for other low-income populations and some Medicare beneficiaries outside of the aged 65 years and older category (e.g., qualified disabled and working individuals).

State pharmacy assistance programs can be another source of supplemental benefits for Medicare beneficiaries. In 2000, 28 states offered assistance with outpatient prescription drug costs through coverage of copayments and deductibles is counted prices from participating pharmacies, or payment for certain drugs to poor and "near poor" beneficiaries. Some of these programs charge beneficiaries a monthly fee. In 2000, these programs covered about 1.2 million individuals representing 3 percent of Medicare beneficiaries. Approximately 1.6 million of the nation's federally recognized American



Indians and Alaska Natives obtain health care through the Indian Health Service. The Veterans Health Administration (VA) provides supplemental benefits to military veterans. Access to VA benefits are based on priority group, with the highest priority given to individuals with a service-connected disability. Medicare beneficiaries usually obtain health care services at a VA facility. In 2001, TRICARE for Life began offering supplemental insurance coverage for Medicare-eligible uniformed services retirees aged 65 years and older who have Medicare Part A and Part B. Some family members are also eligible for TRICARE for Life benefits, which include coverage for outpatient prescription drugs (but which do not include coverage for routine dental care, hearing aids, or eyeglasses). Single service insurance policies to supplement Medicare coverage may also be available for long-term care insurance, cancer care, dental care, and care for other specific health events.

Dr. Laschober described the demographic characteristics of Medicare beneficiaries in 2001. More than half (57 percent) of beneficiaries were female, and 19 percent self-identified as belonging to a racial or ethnic minority group. The fastest growing group of beneficiaries is those aged 85 years or older, representing 11 percent of all beneficiaries in 2001. The health status of beneficiaries varies, with 13 percent categorized as disabled or having end-stage renal disease and 28 percent reporting their health as only fair or poor. Six percent of beneficiaries resided in long-term care facilities (most in nursing homes). The majority (77 percent) of beneficiaries lived in urban areas. A significant proportion of beneficiaries (40 percent) had an income at or below 200 percent of the federal poverty level. A critical policy issue is the lack of prescription drug coverage: for example, approximately 38 percent of Medicare beneficiaries had no type of outpatient prescription drug benefits in the fall of 1999.

Dr. Laschober referred the participants to various Henry J. Kaiser Family Foundation materials ([www.kff.org](http://www.kff.org)) and the CMS Web sites ([www.cms.hhs.gov](http://www.cms.hhs.gov) and [www.medicare.gov](http://www.medicare.gov)) for additional information on Medicare and supplemental insurance.

### **Retiree Health Benefits: Savings Needed To Fund Health Care in Retirement**

*Presenter: Paul Fronstin, Ph.D.*

*Employee Benefit Research Institute (EBRI)*

Dr. Paul Fronstin described current trends in employment-based retiree health benefits and presented EBRI's retiree health savings model, which estimates the amount of savings an individual or couple will need to purchase health benefits on retirement. He briefly reviewed options for public policy and the implications for workers.

Fewer employers offer retiree health benefits than in the past. The shift in employer-sponsored retiree health insurance benefits started in the early 1990s, after a major change in the accounting standards for post-retirement benefits other than pensions. The standards required companies to include the expense of such benefits in their profit and loss calculations, thereby negatively shifting companies' views on offering retiree health insurance. Companies began to perceive offering retiree health benefits as a long-term

liability. Combined with the increasing cost of providing such benefits (due to increasing health care costs and longer life expectancies), the new accounting standards markedly changed the benefits offered by employers. In 1997, 20 percent of employers in the private sector offered retiree health benefits. This number fell to 11 percent in 2000. When employers do offer such benefits, retirees are paying more for both benefits and health care services. Employers are reaching spending caps for health insurance benefits and are attempting to reduce the expense in a number of ways. They are increasing the age and service requirements for retiree benefit eligibility and eliminating retiree health benefits for new hires. Some employers are taking defined contribution approaches or adopting access-only plans, which allow employees to buy into the health plan but do not provide retirees with a subsidy.

Retirees are assuming an increasing amount of their health insurance and expenses, yet tax treatment of these expenses is different from that of an active employee. Employers can claim health insurance costs as a business expense, and such benefits are not counted towards employee taxable income. For the active employee, the employer's and in some cases the employee's contributions are not counted toward taxable income. Some active employees who pay out-of-pocket expenses can do so out of flexible spending accounts (if their employers offer such a plan), which permit payment of such expenses on a pretax basis. Retirees face a different situation. Employer-sponsored retiree health insurance is not counted as taxable income for the employee, although it is a deductible business expense for employers. Yet, retirees making premium contributions and paying out-of-pocket health care expenses must meet the 7.5 percent adjusted gross income test to deduct these expenses from taxable income. However, only the portion spent above the 7.5 percent level is tax deductible.

As indicated in Dr. Fronstin's presentation, Medicare benefits are not comprehensive. Major issues include the lack of a prescription drug benefit and long-term care coverage. Medicare has no out-of-pocket maximum, and deductibles and copays can be significant. For example, the deductible for days 1–60 of inpatient care is \$840. Medicare beneficiaries pay a \$210/day copay for days 61–90, a \$420/day copay for days 91–150, and the full cost thereafter. Concerns about the financing of the Medicare Trust Fund are widespread. As a result, future retirees may be responsible for even greater cost sharing.

Because Medicare covers only 53 percent of the health care costs of the elderly population, many individuals purchase Medigap insurance. The 10 standardized plans do not offer much flexibility for consumers to tailor insurance to meet individual needs. Medigap Plan I—the most frequently offered plan with some prescription drug coverage—pays a maximum of \$1,250 per year for prescriptions. This plan pays a maximum of \$1,600 per year for at-home recovery care, does not cover nursing after 100 days, pays no hospital expenses after the lifetime reserve is depleted, and limits lifetime foreign care payments to \$50,000. Medigap plan availability varies geographically, and not all 10 plans are available in each State.

Clearly, individuals will need to save a considerable amount of money for health care expenses on retirement. EBRI developed a retiree health savings model to help people

estimate how much they will need, based on various assumptions related to insurance premium levels (i.e., the individual's source of insurance and the benefits covered), annual premium increases, and age at the time of death. Model users also can assume retirement age, rates of return on savings, out-of-pocket expenses, and Medicare Part B premium amount. Dr. Fronstin showed the amount of savings needed for employment-based retiree benefits and for Medigap coverage, given various assumptions about rates of return on investments (4 percent), employment-based premiums, and out-of-pocket expenses. For example, the savings needed by employment-based benefits for a person retiring at age 65 in 2003 (including premiums and Medicare Part B premiums) would be \$62,000, assuming a 7 percent annual increase in costs and death at age 80. If the current rate of a 14 percent annual increase in health care costs holds, the same individual would need \$100,000 assuming death at age 80. The savings needed for Medigap coverage for a person retiring at age 65 in 2003 (including premiums and Medicare Part B premiums) would be \$115,000, assuming a 7 percent annual increase in costs and death at age 85. If the current rate of a 14 percent annual increase in health care costs holds, the same individual would need \$230,000, assuming death at age 85.

Individuals will need to consider other factors when estimating the amount of savings needed for health care insurance on retirement. A lower return on investments than assumed in the model would require a higher level of savings. Another important consideration is the amount of out-of-pocket expenses, given substantial individual market variation in benefits. Individuals who take advantage of group coverage purchasing power will realize substantial benefits in terms of lower needed savings.

A public policy change on tax treatment of health care insurance and expenses might help the elderly. Possible beneficial changes might include allowing retirees to exclude their contributions toward health insurance from taxable income. Extending flexible spending accounts to retirees would help the elderly pay out-of-pocket health care expenses. Finally, retirees would benefit from a policy allowing tax-free distributions from retirement plans (e.g., 401K plans) for qualified health insurance and health care service expenses. A combination of these policy changes would maximize assistance to the elderly. For example, the savings needed for employment-based benefits for an individual retiring in 2003 at age 65 would be \$73,000 (assuming that the 14 percent annual increase in health care costs eventually decreases to 5 percent), if the age of death is 80 years. The \$73,000 needed, given no tax deductibility, decreases to \$62,000 if premiums were tax deductible. The savings amount needed decreases further to \$58,000 if individuals could deduct premiums and use tax-free distributions from savings plans to pay for health insurance and health care expenses.

Other options for public policy changes that might alleviate the financial burden on the elderly population include the expansion of public programs. Expanding the eligibility to purchase Medicare, prescription drug coverage, changing the eligibility age, and reducing the Medicare out-of-pocket maximum would improve the situation for retired individuals. Another option is employer mandates for the provision of retirement health care benefits.

Public education is key to ensuring that people have sufficient savings for health care costs on retirement. Workers need to understand the available options and consider their health status and potential out-of-pocket expenses when planning for retirement. To fully grasp the savings amount required, individuals should consider how pre-existing conditions affect insurance availability and calculate their personal life expectancy.

In conclusion, Dr. Fronstin stressed that if the current trends continue, few future retirees will qualify for subsidized retiree health benefits. Workers retiring today will need a large sum of money, depending on factors such as age at time of retirement, age at death, and return on investment. An individual's insurance premium and benefits covered, insurance premium inflation rates, and age effects on insurance also determine the savings amount required for health care on retirements. Future retirees will need even more money to cover their health insurance and health care expenses. The projections and assumptions presented actually underestimate the amount needed, because they do not account for the long-term care that many will need. Even for access-only plans, retirees realize substantial savings from employment-based plans compared with individual market plans. In response to the need for higher savings amounts on retirement, labor market dynamics may change. Workers might defer retirement age beyond the time planned originally. Current data demonstrate that the labor force participation rate among males aged 60–64 years is already increasing (reversing a prior trend).

Dr. Fronstin referred the participants to the following EBRI Web sites, which offer visitors the facility to model the savings amount needed for health insurance and health care costs upon retirement:

- [www.ebri.org](http://www.ebri.org)
- [www.ourhealthbenefits.org](http://www.ourhealthbenefits.org)
- [www.choosetosave.org](http://www.choosetosave.org)
- [www.asec.org](http://www.asec.org)

## **Medigap**

*Presenter: Tom Rice, Ph.D.*

*University of California at Los Angeles*

Dr. Tom Rice discussed measurement issues in Medigap insurance coverage. He presented key questions as a framework for his presentation.

*Who has Medigap coverage? Who does not?* As Dr. Laschober's presentation indicated, survey data provide good information on the prevalence of coverage among the elderly and the characteristics of individuals with and without coverage. Generally, the information on Medigap coverage is reliable. However, survey respondents might not know whether they own a Medigap product as defined by the research community. Investigators have changed the definition of Medigap products to only include individually purchased policies. Researchers do not consider employer-based coverage,

participation in an HMO, or stand-alone policies (e.g., those covering only long-term care; cancer policies) as Medigap products, but respondents probably do not make these distinctions.

*What benefits are contained in Medigap?* Unfortunately, the data on the benefits offered by Medigap policies owned by elderly individuals are not very good. Dr. Rice commented that information on Medigap benefits held represents the largest data need in this area. Surveys report on a limited number of benefits covered by Medigap policies (e.g., prescription drugs and nursing home coverage). The information collected is probably not accurate because respondents are not aware of the benefits offered under their policies. As an example of the need to enhance the data, Dr. Rice focused on determining the number of elderly people with prescription drug coverage. Consumer surveys have typically reported that 20–30 percent of Medigap owners have prescription drug coverage. However, the actual figure is more likely about 10 percent. Data from the National Association of Insurance Commissioners (NAIC) show that 8 to 9 percent of standardized Medigap policies in force for 2001 were plans H, I, or J. The discrepancy between the 20–30 and 10 percent estimates are not due to high rates of prescription drug coverage before standardization of Medigap plans. In 1991, the year before standardization, only 13–14 percent of Medigap policies offered drug coverage. Several data enhancements are ongoing. For example, CMS now asks MCBS survey respondents to distinguish drug coverage and drug discount cards offered through various state pharmacy assistance programs. Improved data are an essential aspect of the debate on a Medicare drug benefit.

Less is known about other benefits, so the data needs on the specific benefits held by Medigap policy owners are significant. NAIC might provide more accurate information on benefits, because it counts the number of Medigap policies (distinguishing plan letter A–J) sold by the insurance industry annually. There are some concerns with this potential approach to obtaining benefit data. NAIC data do not include individual information, which precludes linkage to enrollee characteristics. The data also are limited because they do not provide information on individual policy premiums. Although NAIC does calculate average premiums, researchers desire information at the individual level. The NAIC database does not include some large insurance carriers and is costly for non-academic researchers (\$2,500 per year).

*What does Medigap cost beneficiaries?* Information on policy premiums is available from consumer surveys and from state insurance department Web sites. These surveys provide reasonable estimates from policies that consumers have purchased. Although most state web sites offer premium information, not all states post policy premium data. CMS's web site, Medigap Compare, does not provide premium information itself but rather links to state insurance department sites.

*What does Medigap cost Medicare?* Medigap affects Medicare costs, because Medicare subsidizes Medigap premiums by inducing greater utilization. Medicare covers most of the increased utilization resulting from Medigap in a ratio of 4 to 1. It can be useful to estimate the subsidy and determine how much Medicare bears the cost of extra

utilization. One can estimate the subsidy from generally available information by estimating the impact of policy ownership on utilization (controlling for other factors). Dr. Rice suggested that knowing the magnitude of Medicare's subsidy of Medigap is an important area for future research and might provide a basis for critical policy decisions (e.g., taxation of Medigap).

*How does ownership of a Medigap policy affect health status?* It is important to analyze the increased utilization brought about by Medigap coverage—the extra services used as a result of owning a Medigap policy. Further, it is critical for the field to determine how Medigap services affect the health status of the beneficiary. Researchers might obtain such information from the medical literature or from national surveys containing health status information. Endogeneity, the effect an individual's health status has on the amount of coverage they seek, is a major challenge to this important area of investigation. The extra services used as a result of Medigap ownership might be related to the tendency for individuals with a need for more health services to buy Medigap policies. Although there are many confounding variables, it is critical to understand the relationship between supplemental insurance coverage and health status.

*Is the protection provided by Medigap adequate?* Analysts can estimate the cost implications of the inadequacies of Medigap coverage. One approach is to develop utilization profiles of individuals with hypothetical diseases. An alternative approach is to use national surveys to examine out-of-pocket costs for people who own different types of supplemental coverage (controlling for other factors). Endogeneity presents a challenge to analysts taking these approaches.

### **Medicare+Choice: Access and Benefits**

*Presenter: Carlos Zarabozo*

*Centers for Medicare & Medicaid Services*

Mr. Carlos Zarabozo described the Medicare+Choice program including enrollment requirements, access among the Medicare population, and the effect of geography on access. He explained the benefits offered by the program, changes in coverage, and premiums. Mr. Zarabozo identified the demographic profile of Medicare+Choice enrollees and future directions for the program.

The Balanced Budget Act of 1997 (BBA) introduced the Medicare+Choice program as a replacement for the Medicare private health plan program in existence since 1985, the year in which Medicare implemented the risk contracting provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, only Federally-qualified health maintenance organizations (HMOs) or a similar type of entity, competitive medical plans, could have Medicare risk contracts. The BBA extended Medicare to include “coordinated care plans,” defined as HMOs, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). Although the BBA also specifically authorized coordinated care plans to have point-of-service (POS) options, Medicare had already permitted POS plans under TEFRA. The BBA also

authorized medical savings account demonstration programs and introduced private fee-for-service plans into the Medicare program.

In the Medicare+Choice program, private health plans enter annual contracts with Medicare on a risk basis. The number of risk contracts and associated enrollment has decreased steadily to 148 contracts enrolling 11 percent of the population in 2003 from a peak of 309 contracts enrolling 16 percent of the population in 1999.

Medicare beneficiaries with Part A and B of Medicare who reside in the service area of a health plan and do not have end-stage renal disease are eligible to enroll in Medicare+Choice. The percentage of the Medicare population with access to at least one Medicare+Choice plan—including private fee-for-service plans—increased between 1993 and 2000 (from 49 to 84 percent), but that figure has dropped over the past 3 years to 79 percent. Access to Medicare coordinated care plans has declined from a high of 74 percent of the total Medicare with access to at least one plan in 1998, to 59 percent in 2003. Furthermore, the number of coordinated care plan options also has fallen recently. For example, the percentage of the Medicare population with four or more coordinated care plan options decreased from 50 in 1998 to 16 percent in 2003. Residents of rural areas do not have the same level of access to Medicare+Choice coordinated care plans as those who live in urban areas (about 13 percent compared with 72 percent respectively), and the choice of plans in rural areas is more limited.

Plans participating in Medicare+Choice are required to provide the Medicare benefit package. They may charge a premium in lieu of cost sharing for Medicare-covered services (e.g., in lieu of Medicare's 20 coinsurance for physician services). Plans may also have a combination of a premium and cost sharing for Medicare-covered services. CMS sets a dollar limit on a Medicare+Choice plan's cost sharing for Medicare-covered services, representing the actuarial value of cost sharing that Medicare beneficiaries face in fee-for-service Medicare. However, the limit does not apply to the premium charged by private fee-for-service plans. For private fee-for-service plans, the limit applies only to any actual cost sharing (on a service by service basis) that the plan imposes.

The majority of Medicare+Choice plans provide their enrollees with extra benefits. Such benefits include reduced cost sharing for Medicare-covered services (as is the case with "zero premium" plans that have no premium charge for enrollees), as well as the provision of extra health care benefits at no charge to enrollees. Perhaps the most significant extra benefit that plans provide is the coverage of outpatient drugs not covered by Medicare.

The coverage of extra benefits has changed since the inception of Medicare+Choice in 1997. Both cost sharing and premiums have increased, and some benefit erosion has occurred. For example, while in the early years of the TEFRA program, plans generally did not provide drug coverage, by 1998 the majority of plans provided generous drug coverage. However, the most recent trend has been towards reducing drug coverage. The percentage of the Medicare population with access to any coordinated care plan with drug coverage has fallen from 65 percent in 1999 to 50 percent in 2003. If PPO

demonstration plans and private fee-for-service plans are included, 60 percent (an additional 10 percent) of the Medicare population had access to a private plan with drug coverage in 2003. The level of drug benefits is diminishing, with the number of enrollees with no dollar caps on generic and brand-name drug coverage (i.e., unlimited drug coverage) declining significantly, and the percentage of beneficiaries with only generic drug coverage increasing.

Most people who enroll in Medicare+Choice are lower-middle- to middle-income beneficiaries reporting better health status. Hispanics are more likely to be Medicare+Choice enrollees than participants in fee-for-service plans. African Americans enroll in Medicare+Choice at a level similar to fee-for-service enrollment levels. Disabled individuals tend to enroll in fee-for-service plans at a higher level than coordinated care plans (about 18 percent of the fee-for-service population are beneficiaries entitled to Medicare because of disability (under age 65) compared with about 7 percent in private plans).

In the near term, analysts of the Medicare+Choice will examine disenrollment patterns and the effects of premium and cost sharing changes on beneficiary decisions to disenroll from plans or to newly enroll. There also is interest in enrollment patterns for the PPO demonstration plans and various other types of plans (including private fee-for-service plans and “sub-zero” plans, which are plans that offer a reduction in a beneficiary’s Medicare Part B premium as an extra benefit). The decreasing prevalence of employer-sponsored retiree health insurance highlights the need to monitor the status of employer Medicare+Choice arrangements. Investigators should examine the impact of general Medicare reforms, particularly the addition of a Medicare drug benefit and Medigap reform. Analysts also might identify the effects of competitively determined premiums and benefits on the Medicare+Choice program.

Mr. Zarabozo referred the participants to the following sources for more information on the Medicare+Choice program:

- Medicare Compare (or Health Plan Management System [HPMS])
- CMS Plan Information Control System (PICS)
- Medicare Current Beneficiary Survey
- Adjusted community rate proposals submitted by plans (proprietary information)
- Monthly reports (enrollment, plan characteristics), penetration reports, geographic service area reports (posted at [www.cms.gov](http://www.cms.gov))
- Actuarial Research Corporation survey data (one-time only on employer group enrollment, individual choices)
- Consumer Assessment of Health Plans Surveys, Health Outcomes Surveys, disenrollment surveys
- Physician incentive plan reporting
- CMS/SSA enrollment databases



## **Medicaid Coverage Among Elderly People**

*Presenter: Judith D. Kasper, Ph.D.*

*The Johns Hopkins University Bloomberg School of Public Health*

Dr. Judith Kasper explained the importance of data on the elderly Medicaid population, described the characteristics of dual enrollees (individuals eligible for both Medicare and Medicaid health benefits), and identified key measures that will inform policy on health insurance for the elderly.

The nation invests a great deal of resources in both the Medicare and Medicaid programs. The Medicaid population is vulnerable and has extensive health care needs. Many Medicaid beneficiaries are disabled, and almost 25 percent reside in nursing homes. Half of poor Medicare beneficiaries are dual enrollees. State and Federal Governments share the responsibility for dual enrollees. For all these reasons, this population is of special interest in current health policy discussions.

A higher percentage of dual enrollees are over age 85 (17 percent) compared with the Medicare and general U.S. population (12 and 2 percent respectively). Dual enrollees represent 19 percent of Medicaid enrollment and 35 percent of Medicaid expenditures. In both the over-age-65 and over-age-85 categories, a higher percentage of dual enrollees reside in nursing homes compared with other Medicare beneficiaries. The percentage of dual enrollees over age 85 in nursing homes is 55 percent compared with 13 percent of other Medicare beneficiaries. More dual enrollees have fair/poor health status and a higher number of limitations in activities of daily living compared with other Medicare beneficiaries. Finally, a higher percentage of dual enrollees are poor, with 71 percent having an annual income of less than \$10,000.

Medicare beneficiaries can be eligible for Medicaid through several pathways, based on income eligibility and an asset limit. By law, certain individuals are entitled to Medicaid. Individuals with an income at or below 73 percent of the Federal poverty level (the level for Social Security Insurance [SSI] income eligibility) and assets up to \$2,000 are eligible for wrap-around Medicaid benefits and Medicare Part B premium and cost sharing through the SSI Cash Assistance pathway. However, States may set lower levels (invoking the 209b option) and have the authority to expand the income level for SSI Cash Assistance to 100 percent of the Federal poverty level. Individuals categorized as QMBs with an income at or below 100 percent of the Federal poverty level and assets up to \$4,000 are eligible for Medicare Part B premium and cost sharing. Individuals categorized as SLMBs with an income at 100–120 percent of the Federal poverty level and assets up to \$4,000 are eligible for the Medicare Part B premium.

Medicare beneficiaries may be eligible for Medicaid if they are medically needy—individuals who spend their income down to a specified level and assets up to \$2,000—but the benefits may be more limited than those provided under SSI Cash Assistance. Individuals in institutions with an income at or below 300 percent of the SSI level and assets up to \$2,000 are eligible for wrap-around Medicaid benefits and Medicare Part B premium and cost sharing under the Special Income Rule for Nursing Home Residents.

Individuals who would be eligible if they resided in an institution but remain in the community are eligible for home- and community-based services.

To address policy issues for dual enrollees, analysts need to monitor use and expenditures to determine the unmet needs of this resource-intensive and vulnerable population. Good information is needed about Medicaid coverage, because the program fills in Medicare's gaps. For example, information on copayments/deductibles and services not covered by Medicare (especially long-term care and medications) would be instrumental in improving Medicaid's services. Analysts should monitor the effects of state policy changes driven by budget constraints. For example, budget constraints might result in gains in community-based care options or reduced access to vital services (e.g., medications). Investigators should examine the effects of such state policy changes on health outcomes and family functioning.

Given the informational needs described above, a key measurement issue is identifying elderly dual enrollees. The identification of elderly dual enrollees through surveys is problematic for several reasons. Respondents tend to underreport Medicaid because they confuse it with Medicare. Survey participants are generally unable to identify themselves as a QMB or SLMB and may not be aware of the sources of their Medicaid eligibility such as the HCBS waivers. Determining whether individuals have full Medicaid benefits also is complicated. Many people receiving full benefits do not receive SSI, including some nursing home residents, and persons covered under home- and community-based waiver programs.

Another key measurement issue is obtaining information on home- and community-based long-term care. Long-term care provides a wide range of services that includes in-home personal care, home and vehicle modifications, assistive devices, respite services for caregivers, case management, and psychiatric rehabilitation. Analysts need information on the use of these services and sources of payment to assess the role of Medicaid, and the overall effectiveness and costs of long-term care services.

The current approaches to measurement link survey data and Medicare enrollment files for the elderly population, which facilitates the identification of dual enrollees. Although surveys are a source of information on Medicaid-covered services and sources of payment, it currently is not feasible to link national, population-based survey data and Medicaid files. Current measurement approaches have not solved the problem of identifying different eligibility groups (e.g., QMB, SLMB, and full benefits).

### **Trends in Prescription Coverage of Medicare Beneficiaries, 1996 to 2000: It Depends on How Benefits are Measured**

*Presenter: Bruce Stuart, Ph.D.*

*University of Maryland School of Pharmacy*

Published estimates of the proportion of Medicare beneficiaries with various types of prescription coverage vary widely. The discrepancies are not due to different data sources—virtually all estimates are based on the MCBS. Wide discrepancies arise

because there is no standardized method for measuring prescription coverage in the MCBS.

Dr. Bruce Stuart described the various approaches that analysts use to measure beneficiary drug coverage using MCBS data and demonstrated the differences in estimated coverage rates for 1996 and 2000 based on the various approaches. He discussed the policy implications of using the various measurement methods. It is important to note that all coverage estimates derived from the MCBS address the non-institutionalized Medicare population. Although there is some information on Medicare beneficiaries in nursing homes, there is a general lack of data on insurance coverage for elderly individuals in institutions.

Estimates of prescription drug coverage among Medicare beneficiaries are highly sensitive to basic measurement issues. The duration of coverage affects estimates. In 2000, 21 percent of non-institutionalized Medicare beneficiaries had no drug coverage, 18 percent had part-year coverage, and 61 percent had full-year coverage. The percentage of non-institutionalized Medicare beneficiaries with drug coverage in the fall is lower than those covered at anytime during the year (e.g., 62 compared with 74 percent in 1999). Point estimates for the fall rounds are available through the MCBS Access to Care files. Multiple-round estimates (over three rounds of the survey) are also available from the MCBS Cost and Use files. Multiple-round estimates are used to construct annual coverage estimates. It is possible to develop longer-term duration of coverage estimates by linking two or more years of MCBS Cost and Use files.

Estimates of prescription drug coverage among Medicare beneficiaries also are affected by the strength of self-report data compared with inferences drawn from service activity. The MCBS asks detailed questions about Medicare supplemental health insurance for up to five private plans. It collects data on start and end dates and whether the plan provides prescription benefits. Some beneficiaries report that they have coverage but are unsure of the source. Others report that they have no coverage, but a review of their service-summary data on self-reported medication events suggests third-party payment. When the percentage of beneficiaries with coverage is measured using the MCBS plus service-summary data, the proportion is higher compared with data collected from only the survey.

Whether beneficiaries with multiple policies are counted also complicates the estimates of prescription drug coverage. Although most beneficiaries with drug benefits rely on a single source of coverage with defined periods of entitlement (67 percent in 2000), some beneficiaries rely on two or more sources of prescription coverage with overlapping periods of entitlement.

Beneficiaries with sequential coverage move from one to another source of benefits with or without a gap in coverage. Other beneficiaries have sporadic coverage—they make occasional use of one or more sources of drug benefits with unknown periods of entitlement. Another group of beneficiaries reports having private drug coverage, yet there is no evidence of a specific payer from the service summary records. In 2000, 12

percent of non-institutionalized Medicare beneficiaries had multiple sources of coverage or ill-defined coverage. This percentage is significant enough to affect estimates of prescription drug coverage.

New retirees are increasingly at risk for lack of prescription drug coverage. Employer-sponsored health insurance is generally considered the most stable form of private prescription coverage for eligible Medicare beneficiaries. The number of employers offering retiree coverage is declining, yet overall rates of employer-sponsored health insurance reported in the MCBS have remained stable. This seems like a paradox, but it reflects two offsetting demographic trends —declining retiree coverage among younger Medicare beneficiary population (ages 65–69) and increasing rates of coverage among older beneficiaries (an artifact of the very low rates of retiree coverage among decedents). The percentage of the younger Medicare beneficiary population with retiree health insurance, and drug coverage in particular, fell by about 5 percent from 1996 to 2000. Dr. Stuart noted that almost all of the declines in prescription drug coverage occurred among males receiving health benefits from their own policies. The data indicate that many men in the younger Medicare beneficiary population now have prescription drug coverage from their spouses. The overall decline in employer-sponsored health insurance among retirees and the need for prescription drug coverage have significant implications for workforce trends.

### **Long-Term Care Insurance: The Data Challenge**

*Presenter: Marc A. Cohen, Ph.D.*

*LifePlans, Inc.*

Dr. Marc Cohen summarized the current information on long-term care insurance and the long-term care insurance market. He highlighted data challenges regarding benchmarking of market growth, claims payments, and policyholders. Good data in this area rely on the advancement of accurate tracking mechanisms. The field seems to be moving in the right direction, but demographic trends indicate a need to facilitate the accurate measurement of long-term care coverage.

Long-term care insurance policies typically reimburse the costs associated with skilled and custodial care services performed by a variety of providers, such as nursing homes and assisted living centers, home care agencies, and adult day care. Most long-term care insurance is sold to individuals, but employment-based plans are growing dramatically. Currently, long-term care policies feature reimbursement of the costs of chronic care in both institutional settings and home and community-based care. Beneficiaries have access to a pool of benefits based on measurable and observable levels of disability. Most policies include inflation-protection features and care management and make lifetime coverage available. Insurers are moving toward rate guarantees and the stabilization of rates.

The long-term care insurance market is growing rapidly. To date, companies have sold more than 8 million policies and an estimated 7 million individuals have long-term care

coverage. The premium volume of long-term care policies is greater than \$5 billion per year. From 1987 to 2001, the annual rate of growth has been 18 percent. About 100 companies offer long-term care policies, so the market is competitive. However, the market is somewhat consolidated, with 20 companies accounting for more than 80 percent of policies. There have been more than 250,000 applications for the long-term care insurance program offered to Federal employees. Despite the growth of the private long-term care insurance market, these policies pay less than 10 percent of the U.S. long-term care costs.

The target market for long-term care insurance comprises middle- to upper-income elderly individuals who would not immediately qualify for Medicaid. This group represents between 25 and 35 percent of the elderly population. People who purchase long-term care insurance tend to have few available informal supports or worry about not having them at the potential time of need. A growing number of younger adults view long-term care insurance as an integral part of retirement planning. The optimum age for purchasing a long-term care policy is between age 55 and 60.

There is a great deal of untapped market potential for long-term care insurance, and analysts expect continued growth in sales. The current public policy environment encourages growth in the market. Given the demographic trends, long-term care insurance will play a growing role in financing the nation's health care costs. Until 2001, companies had paid out \$5.6 billion in long-term care claims. However, claims are now running at \$1 billion per year and growing rapidly.

The growing demand for long-term care insurance indicates a need to include it in the measurement of supplemental insurance coverage for the elderly. Private sources of information about long-term care insurance include industry associations such as the Health Insurance Association of America's annual surveys and sponsored studies. The Life Insurance Marketing Research Association also studies long-term care insurance activity. The Society of Actuaries sponsors various intercompany studies, and private research firms also investigate the dynamics of the long-term care insurance market. Public sources of information about long-term care insurance include specialized studies sponsored by the Department of Health and Human Services and the Robert Wood Johnson Foundation. Only one national survey, the Assets and Health Dynamics Among the Oldest-Old, focuses on long-term health insurance coverage. Unfortunately, the prevalence rates observed by this survey did not accord with data from insurers.

Estimating the prevalence for long-term care insurance policy ownership is challenging. Respondents often demonstrate confusion about their current coverage for long-term care. About 40 percent of individuals over age 55 believe, mistakenly, that their current health insurance pays for, or they do not know who would pay for, long-term care. Many respondents identified their health insurance carrier as their long-term care insurance provider even though many of the identified carriers did not provide the insurance. There also is confusion about the payer for services. The national records of insurance companies sometimes categorize a payment made to a beneficiary who then pays a provider as an "out-of-pocket" payment. Thus, it can be difficult to separate out what

beneficiaries actually pay for such services. Reliable payment data could come from industry claims payments, which are reported at the state level.

In conclusion, Dr. Cohen stressed that long-term care insurance is growing. There is a need to collect reliable and detailed information on the market, the product, and its uses. Current data collection efforts do not adequately capture prevalence data. Therefore, the field should identify the appropriate recurring national survey to address long-term care insurance coverage. Investigators might modify the survey to include questions specific to long-term care and develop a strategy to verify self-report data. The field will need to overcome challenges related to confusion about current coverage for long-term care. Public education on long-term care should make national data collection efforts more reliable.

### **Morning Question-and-Answer Session and Discussion**

Dr. Steven Cohen asked Dr. Fronstin about the uncertainty bounds on premium estimates for the EBRI model presented. Dr. Fronstin replied that model developers did not have time to generate a data set on Medigap premium estimates. Rather, they selected certain states for specific purposes. The model is available on the Web so users can enter different premium estimates into the model. The AARP health care Web site provides useful premium information for different markets. Dr. Cohen asked for clarification as to whether the current proposed individual tax credits for retiree contributions toward health insurance would assist Medicare beneficiaries with Medigap coverage. Dr. Fronstin commented that the proposals are designed to expand coverage among uninsured individuals and do not cover supplemental insurance.

In response to a participant's question, Dr. Rice noted that it is difficult to determine the extent to which drug coverage estimates reflect selective renewal of older Medigap policies (i.e., ones bought before plan standardization). It is possible that some proportion of Medicare beneficiaries hold policies from the prestandardization period, but the drug benefits from those policies were not generous so it is unlikely that most people would keep them.

The participants discussed the great need for accurate data on prescription drug coverage among the elderly. The current context for insurance coverage is dynamic, with many changes occurring in the past 5 years. Multiple sources of coverage for an individual present a challenge in the translation of data to policy. Knowing how individuals coordinate their insurance coverage would facilitate the creation of a database comprising multiple data sources. Analysts need access to a synthesis of all data sources to measure coverage in an environment of multiple coverage sources.

Dr. Steve Cohen stressed the need for more information on the interaction of policy and individual characteristics (e.g., socioeconomic status). Although there are several potential vehicles to advance such information, those vehicles have problems with scale and response rates. The field requires a creative approach to generating information that

will support policy analysis. Statistical standards would ensure the integrity of the data sources underlying policy.

Dr. Kasper emphasized the difficulty of keeping data systems current in a dynamic insurance environment. New Medicaid programs add to the complexity. For example, states may use savings from the Medicaid program to purchase drug coverage. Some states have done so, but others have not. Many states are implementing new programs, which has implications for insurance data systems.

Dr. David Weir noted that access to information on health care insurance and pension benefits is limited. Information on pensions can be obtained from firms, but federal rules restrict the disclosure of health insurance information. Dr. Fronstin commented that the level of access depends on the information sought. Although it is a slow process, researchers can obtain data from employers and financial service organizations on plan participants.

Dr. Scott Harrison, of the Medicare Payment Advisory Commission, asked Dr. Fronstin to estimate the percentage of non-public-sector employees with retiree health insurance coverage. Dr. Fronstin replied that such estimates were difficult to determine. Many individuals do not know whether they qualify for such benefits. Further, a dynamic workforce with a high job turnover contributes to a lack of awareness about benefits. However, most experts believe benefit knowledge will increase among workers. EBRI has not attempted to estimate the number of future workers without employer-sponsored retiree health insurance, but there is no doubt that the prevalence of such coverage will decrease. Dr. Harrison wondered if workers receive other benefits to compensate for the lack of a retiree health insurance benefit. Dr. Fronstin noted great variability among employer benefits. It is much easier for employers to cut retiree health insurance benefits for future retirees compared with current retirees who have promises of coverage in writing. In general, companies that have successfully cut health benefits among current retirees have not offered other benefits in compensation.

A participant commented that Medicaid eligibility is inconsistent across states. States differ in asset examination aggressiveness. Some elderly people deplete their assets to levels that make them Medicaid-eligible. Dr. Kasper acknowledged the state variation in Medicaid eligibility groups. Individuals who spend down their assets would fall into the medically needy category, yet only 36 states have Medicaid programs for this group. Dr. Kasper emphasized the need for longitudinal studies on the medically needy population. The MCBS and MEPS have followup periods of 3 and 2 years respectively, but longitudinal data are essential to understanding the relationship between health care insurance and asset depletion. Most studies on medically needy individuals focus on particular special populations.

Dr. Kasper also commented that state variation adds to the complexity of data collection and analysis. During times of budget constraints, states change their programs to address financial shortfalls. National population-based surveys are key insurance data sources,

but their samples are not drawn at the state level. Thus, analyzing the effects of different state policies is a challenge.

Dr. Rice focused on the data sources that permit analyses of prescription drug coverage adequacy. Most researchers use survey data and examine out-of-pocket expenditures as a measure of coverage adequacy. However, the appropriate interpretation of low-level expenditures is not clear. Drug coverage offered in the private market varies, and it is difficult to determine benefit generosity from out-of-pocket spending estimates. Additionally, the generosity of drug benefits has decreased over the past few years. Data systems must be able to measure the adequacy of coverage in an insurance context where quality is changing in a nonuniform way. A participant added that there is no consensus on the appropriate level of beneficiary burden for prescription drug costs.

Mr. Jon Gabel asked about the availability of data on the loss ratio and actuarial value of long-term care policies (i.e., the amount of benefits received from the policy compared with how much has been paid into it). Dr. Marc Cohen commented that such issues are regulated at the state level, thus data are available from NAIC. Most states require long-term care policies to pay a certain amount (usually 60–65 percent) of premiums out in benefits. Therefore, states require insurance companies to pay 60 to 65 cents in benefits for every dollar paid in premiums. Loss ratios are public information, but as lifetime ratios, they are difficult to determine.

A participant inquired about the gender difference in prescription drug coverage among new retirees aged 65–69 years. Dr. Stuart commented that the data showing constant coverage for women but not men were preliminary. His research team is following up on some well-known changes in labor market participation rates among individuals aged 65–69 years. He remarked that their goal is to develop additional data sources that predict who receives benefits and the sources of those benefits.

Dr. Marsha Gold focused on the implications of part-year insurance coverage as reported in the MCBS. Generally, Medicare beneficiaries do not change policies, so it is possible that some are reporting part-year coverage because they have reached their benefit limit rather than because they lack coverage. Dr. Stuart commented that the only way to obtain information on the duration of coverage is to compare plan start and end dates. Although those two data elements are not validated, the start- and end-date patterns seem to reflect actual changes in coverage (i.e., changing plans and gaps in plans). The most common days for changes are at the end and middle of the year when people are allowed to change their plans. Further, the shifts correlate with payment data. People change health insurance plans more frequently than most policymakers think. Mr. Zarabozo added that many beneficiaries in the Medicare+Choice program disenroll rapidly, which might account for some of the observed coverage instability.

Dr. Steve Cohen thanked the presenters for crystallizing the major policy issues and identifying data needs. He encouraged them to contribute recommendations for Chartbook health insurance indicators during the afternoon session.



**Afternoon Session**  
**Commissioned Papers, Discussants' Remarks**  
**And Closing Comments**

*Jon R. Gabel, M.A., Health Research and Educational Trust (Session Chair)*  
*John L. Czajka, Ph.D., Mathematica Policy Research, Inc. (Paper Author)*  
*Deborah J. Chollet, Ph.D., Mathematica Policy Research, Inc. (Paper Author)*  
*Pamela Farley Short, Ph.D., The Pennsylvania State University (Discussant)*  
*Jeannette Rogowski, Ph.D., RAND (Discussant)*  
*Melinda Beeuwkes Buntin, Ph.D., RAND (Discussant)*

Mr. Jon Gabel introduced the panel members and described the afternoon agenda. The facilitated discussion focused on short- and long-term data needs and measurement issues facing the Federal statistical system. Panelists and participants from Forum member agencies discussed data activities related to health insurance for the elderly. Conference organizers intended the discussion to assist the Forum in developing recommendations for health insurance coverage measures for its Chartbook.

# Data Sources and Measures of Coverage and Benefits

*John Czajka, Mathematica Policy Research*

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AHRQ Working Papers provide preliminary analysis of substantive, technical and methodological issues. The papers are works in progress and have not undergone a formal external peer review. They are distributed to share valuable experience and research. Comments are welcome and should be directed to the authors. The views expressed are those of the authors and no official endorsement by the Agency for Healthcare Research and Quality, the Department of Health and Human Services, or the member Agencies of the Federal Interagency Forum on Aging Related Statistics is intended or should be inferred.

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## Introduction

In striking contrast to the 12 percent of children and 50 percent of poor full-time workers who lack any form of health insurance, the very low uninsured rate among the nation's elderly population, measured at 1 percent in recent surveys, attracts little attention.<sup>1</sup> Indeed, it is quite common for health policy researchers to report uninsured rates that exclude the population 65 and older. Yet this low uninsured rate among the aged draws attention away from two important facts: (1) not all of the aged are covered by Medicare, and (2) most of those who *are* covered find it necessary to supplement their Medicare coverage with one or more other forms of insurance.

This paper examines issues related to the measurement of health insurance coverage and benefits among older Americans, reviews the most promising data sources, and presents recommendations regarding the specification of indicators of coverage and the establishment of priorities for data development. These recommendations are addressed to members of the Federal Interagency Forum on Aging-Related Statistics (The Forum), which sponsored the paper. The next section presents basic information on health insurance among the elderly and discusses implications for measuring coverage and benefits. We then give an overview of the principal data sources on health insurance for this population. Next we assess what these data can tell us about health insurance for the elderly and present some illustrative statistics. Finally, we present recommendations for possible expansion of the indicators of health care used in the Forum's chart book on older Americans and discuss priorities for data development to better address the measurement needs that we have identified.

## Health Insurance Coverage and Benefits Among The Elderly: Implications for Measurement

Persons who have established eligibility for social security or railroad retirement benefits at age 65 become eligible for Medicare, whether or not they elect to begin receiving retirement income. With Medicare eligibility they are entitled to receive Hospital Insurance (HI), also known as Part A, at no cost and can purchase Supplemental Medical Insurance (SMI), or Part B, at a low monthly premium, which is deducted from their retirement income checks if they receive them. Aged citizens and permanent residents who are not eligible for Medicare can buy into Part B with a larger premium, and those who do so can also purchase the Part A coverage that they were not entitled to receive for free. Previous estimates indicate that, including those who buy in, between 95 and 97 percent of the aged are covered by Medicare.

A comparison of the most recent decennial census data and Medicare administrative data for the same period is consistent with these estimates. Of the 35.0 million elderly U.S. residents enumerated in the 2000 census, Medicare administrative data indicate that 33.5 million or 95.9 percent were covered by Part A or B, and 31.8 million, or 90.9 percent, were covered by both

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<sup>1</sup> Estimates are from the March 2002 Current Population Survey (U.S. Census Bureau 2002).

(Table 1).<sup>2</sup> The flip side is that 4.1 percent of the aged were either ineligible or chose not to purchase the Medicare coverage that was available as a buy-in, and another 3.8 percent limited their Medicare coverage to the Hospital Insurance that was provided at no cost.

## **Medicare and Supplemental Coverage**

While 90.9 percent of the aged carry full Medicare coverage, Medicare benefits are significantly more limited than the benefits that younger persons obtain from their private and government health plans. In addition to paying higher coinsurance and deductibles and, in some cases, doctors' charges above Medicare-approved amounts, Medicare beneficiaries receive fewer services. In particular, Medicare does not cover most outpatient prescription drugs; nor does it cover general preventive care, both of which are common features of health insurance coverage among the nonelderly.<sup>3</sup> And while relatively few plans routinely provide younger persons coverage for dental and vision care, hearing aids, and long-term care, their exclusion from Medicare coverage is far more significant because of the larger fraction of Medicare beneficiaries who have need for such services.

Because of these limitations in what Medicare covers, most aged Medicare beneficiaries supplement their Medicare coverage with additional coverage—principally from private sources. In doing so they have a number of options. They can purchase, from private insurers, “Medigap” policies that supplement the basic Medicare coverage in various ways. There are 10 standard Medigap policies, which are identified by the letters A through J, and an individual insurer may offer one or more of these plans.<sup>4</sup> Table 2 summarizes basic features of these plans, which enrolled about 11 million Medicare beneficiaries in 2001. Note that only three plans provide prescription drug coverage, and only two plans cover general preventive care.

An alternative to purchasing a Medigap policy, depending on where a person lives, is to enroll in a managed care plan that provides the basic Medicare benefits with reduced coinsurance costs and deductibles and may include additional services. The Balanced Budget Act of 1997 established the Medicare+Choice program, which formalized arrangements that were developed as demonstrations between the Medicare program and a number of Health Maintenance Organizations (HMOs) and encouraged the provision of Medicare services through other types of managed care organizations. Enrollment in Medicare+Choice, which encompasses nearly all of the managed care offered under Medicare, reached 6.3 million in 1999 but then fell off, dropping below 5 million by 2002 (Gold 2003).

Elderly persons who are still employed may choose to remain covered by private insurance obtained through their employers. In addition, some employers provide health insurance benefits to their retirees. Medicare assumes the role of secondary insurer as soon as these employees and

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<sup>2</sup> These estimates assume that all decedents have been removed from the Medicare counts. If some decedents remain, the estimates will overstate Medicare coverage by a slight amount.

<sup>3</sup> Coverage for routine mammography screenings was introduced in 1991. Coverage was extended in 1997 to include a set of additional specific preventive services—mostly related to cancer screening (Social Security Administration 2001).

<sup>4</sup> A substantial fraction of Medicare beneficiaries with Medigap coverage still have policies that predate these 10 standard plans.

retirees become eligible while the private plan remains the primary insurer. What this means to the employee or retiree will depend on the individual plan. For example, aged military retirees may qualify for TRICARE for Life, which Congress legislated in 2000 and which provides particularly good benefits, including prescription drug coverage. Other retiree plans may not be as generous.

Low-income aged may qualify for Medicaid, which provides nursing home coverage and prescription drug coverage to dual eligibles in most states. Nursing home residents with sufficiently low income but with assets above a state limit may have to spend down their assets to qualify for the nursing home benefits. Some states supplement their Medicaid programs with their own health insurance programs that have higher eligibility levels but provide less generous benefits—often limited to specific services. A number of states have pharmaceutical programs for the low-income aged, for example.

### **Elderly Persons without Medicare Coverage**

The 4 percent of elderly persons without Medicare coverage are ineligible because they or their spouses accumulated too few credits for employment covered by the social security, railroad, or civil service retirement systems. In addition, they were either ineligible to buy in to coverage, being neither citizens nor permanent residents, or elected not to do so—perhaps because of the cost or because they had other coverage. Survey data suggest that 20 to 25 percent are uninsured, although there is reason to suspect that this may be an underestimate, as we discuss below.<sup>5</sup> For the remainder, the private or public coverage that they purchase or qualify to receive constitutes their primary insurance.

### **Implications for Measurement**

To provide an adequate summary of health insurance coverage among the elderly requires that we know, first, who has Medicare coverage and who does not. Among those who do have Medicare coverage, we need to know who has both Part A and Part B and who has only one of the two—particularly just Part A. It would also be useful to know who among those with Part B acquired such coverage by buying in rather than qualifying for retirement benefits.

Next, we would like to know how many Medicare beneficiaries elected to supplement their coverage with additional coverage from another source—and what source. How many chose to purchase a Medigap plan, and how many opted instead to enroll in a managed care plan under Medicare+Choice? What fraction of beneficiaries qualified to receive supplemental coverage under Medicaid or a state plan, and what fraction obtained coverage through an employer (current or former) or a direct purchase?

Among those *without* Medicare coverage, how many were ineligible to buy in, and how many were eligible but chose not to do so? How many of each group obtained coverage from another source, and how many were simply uninsured? For those who obtained coverage, how were the

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<sup>5</sup> The March 2002 Current Population Survey estimated an uninsured rate of .8 percent among the elderly. The 1999 National Health Interview Survey estimated 1.0 percent.

sources of coverage distributed, and how did this distribution differ across the two groups? In particular, how important was Medicaid?

For those with Medicare and those without, what did their basic and supplemental coverage provide? In particular, how often did it include prescription drug benefits, and what did these benefits cover? How often were expenses for long-term care covered; what did this coverage include; and how did this vary across plans?

### **Integration Issues**

Finally, with many of the aged holding coverage from two or more sources, and some receiving their health care benefits from facilities operated by the Department of Veterans Affairs, the integration of services becomes an issue that is present to only a very limited degree among the nonelderly population, where it occurs mainly among couples with both partners holding family coverage. Are there factors that affect awareness of or full utilization of benefits? Estimates of how many older persons have coverage from various combinations of sources would reveal the potential for such issues to develop.

## **Principal Data Sources on Health Insurance For The Elderly: An Overview**

There are a number of federal and privately sponsored surveys that collect data on a recurring basis on the health insurance coverage of the aged population. Most of these surveys cover the general population, but some have a much narrower focus that gives prominence to the aged. We reviewed all of these surveys for their ability to provide the information on health insurance coverage and benefits outlined in the preceding section. From these surveys, we identified four that collect much of the information that we discussed. These four surveys are the Medicare Current Beneficiary Survey, the Health and Retirement Study, the National Health Interview Survey, and the Medical Expenditure Panel Survey. Surveys judged less useful for examining the health insurance coverage and benefits of the elderly were the March supplement to the Current Population Survey, the Survey of Income and Program Participation, the Community Tracking Study, the Panel Study of Income Dynamics, and the National Long-term Care Survey.<sup>6</sup>

Administrative data from the Medicare program also have a role to play in assessing the health insurance coverage of the elderly. These data are a source of very precise estimates of the number of aged who are enrolled in the Medicare program, the type of coverage they hold, the basis for their eligibility, and their ages and geographic dispersion. Medicare also collects voluminous cost and payment data. Data from Medicare administrative records are routinely linked to sample members in the Medicare Current Beneficiary Survey to enrich the database for analysis and provide a resource for validating and editing a number of the data items collected in the personal interviews.

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<sup>6</sup> The National Long-term Care Survey, which collects data from a sample of aged Medicare beneficiaries with chronic functional impairments, is particularly well suited to research on the health care needs and services received by older persons with disabilities.

## **Considerations Regarding Survey Samples**

In addition to the survey content, the quality of the questions used to elicit the information collected from the respondents, the mode of administration, and whether responses are validated in any way, several characteristics of a survey sample are important in assessing the overall strength of the survey as a source of estimates of the health insurance coverage of the elderly. These include the size of the elderly sample (number of observations 65 and older), whether or not the institutional population is included, the response rate among the elderly and, closely associated, the coverage of this population. The size of the elderly sample is either readily available or can be estimated with reasonable accuracy from the total sample size and an independent estimate of the aged share of the survey universe. Similarly the inclusion of the institutional population, who made up about 5 percent of the elderly at the time of the 2000 census, is easily discerned from the survey description. Elderly response rates and population coverage are not usually reported, however. The overall response rate may provide a good indication, but to the extent that the aged are more cooperative than younger sample members, the overall response rate will tend to underestimate the elderly response rate.

Population coverage refers to the completeness of the sample frame and the listing of individuals within housing units. Omissions from either will contribute to an understatement of the population. Coverage is sometimes assessed, if at all, by comparing population controls used in weighting to preliminary survey estimates of the population (broken down by age, race, and sex, typically) immediately prior to the application of these controls. Caution is advised in interpreting such coverage estimates, however. The demographic characteristics of nonrespondents are often not known, making the nonresponse adjustment process less than perfect, and this may result in coverage estimates that overstate or understate the survey coverage of particular demographic groups.

## **Medicare Current Beneficiary Survey (MCBS)**

The MCBS is an ongoing survey of a representative sample of Medicare beneficiaries. The survey is longitudinal, with an overlapping panel design. A new panel is introduced each fall, drawn from the administrative records of Medicare beneficiaries enrolled as of January 1. The members of each panel are interviewed 12 times over a four-year period. The survey collects data on the expenditures and sources of payment for services; health insurance coverage; changes in health status; and the impact of program changes. Data released from the survey utilize the overlapping panel design by including information collected from all four panels active at one time. Administrative data from Medicare records are combined with the survey data in order to assemble the most accurate information available on beneficiary status and a number of outcome variables (Centers for Medicare & Medicaid Services 2002). Plan names are collected for all forms of insurance coverage, creating at least the possibility of editing coverage and adding plan characteristics.

Because the MCBS sample is drawn from Medicare records, undercoverage is not an issue. But as a survey of beneficiaries, the MCBS does not represent non-beneficiaries—an estimated 4 percent of the aged, as we have noted. Furthermore, while coverage is not a problem, nonresponse is an issue that had to be addressed. The survey sample is sized to take into account both the initial nonresponse and the cumulative attrition due to refusals, loss of contact, and

mortality. Each new panel includes about 6,000 members in order to maintain an ongoing annual sample of more than 16,500 interviewed beneficiaries (of whom about 14,000 are aged) spread across the four panels. The rotating panel design eliminates a potential trend bias from the cumulative nonresponse *within* panels.

The survey is conducted under contract by Westat. Interviews are conducted in person with laptop computers, using the Computer Assisted Personal Interviewing (CAPI) methodology. Beneficiaries living in institutional settings are included in the initial sample, and institutionalized sample members are included in all interview rounds, with facility staff providing the responses to a separate interview protocol. The survey also includes periodic supplements designed to address specific analytic issues, as funds permit. Data from the survey are released in two types of files: (1) an Access to Care file, which includes health insurance coverage and other data collected in the fall of each year (rounds 1, 4, 7, and 10 for the four panels) and is representative of those enrolled *continuously* during the year and (2) a Cost and Use file, which contains one, two, and three years of data from the four panels and is representative of those *ever* enrolled during the year.

### **Health and Retirement Study (HRS)**

The HRS, which is also a panel study, is sponsored by a consortium of federal agencies led by the National Institute on Aging and is conducted by the Institute for Social Research at the University of Michigan. The HRS began with a sample of households containing at least one individual born between 1931 and 1941. Sample members were first interviewed in 1992 and have been reinterviewed every two years since. A second cohort of “war babies,” born 1942 to 1947, was added in 1998. A companion survey, the Asset and Health Dynamics Among the Oldest Old Survey (AHEAD), was started in 1993 with a sample of persons born in 1923 and earlier. A third HRS cohort of “children of the depression,” born from 1924 through 1930, was introduced in 1998 to fill the gap, and all of the cohorts have since been shifted to the same interview schedule to facilitate pooling of the data across cohorts. With these additions the HRS/AHEAD sample is representative of the U.S. resident population born before 1948—that is, 50 and older in 1998. Sample members will be interviewed every two years. The sample interviewed in 2000 included between 11,000 and 12,000 persons 65 and older. Response rates of eligible individuals in the first round of interviews ranged between 70 and 82 percent over the four cohorts. The response rates for reinterviews have been between 92 and 95 percent.

Over time the representativeness of the HRS sample will diminish slightly, as there is no mechanism for adding birth cohort members who migrated to or returned to live in the U.S. after the sample for that cohort was drawn. In addition, people who enter institutions are retained in the sample but are not interviewed for as long as they remain institutionalized. But in 2004 a sample of persons born in the six years preceding 1948 will be added to the survey, and this type of expansion will be made every six years so that at each such point the sample will represent the population 50 and older.

As the name suggests, health is a major focus of the HRS, and the survey has collected detailed information on health insurance coverage since the earliest interviews. The health insurance section was expanded significantly for the 2002 survey. The HRS has benefited from comparatively low item nonresponse, and has used the method of “unfolding brackets” to obtain



approximate dollar amounts for expenditure, income, and asset items for which the respondents could not provide answers to the initial questions. Its strong data on income and wealth make the HRS particularly well suited to analyses of the economics of health insurance coverage among the aged (and the near aged as well).

### **National Health Interview Survey (NHIS)**

The NHIS is an annual survey of about 40,000 households drawn to represent the civilian noninstitutionalized population of the U.S. The survey is administered over the course of a year using independent weekly samples so that it can provide unbiased estimates of the incidence and prevalence of many health conditions. Data are collected by the Census Bureau with in-person interviews using CAPI, which was introduced as part of a major redesign in 1997. The NHIS has collected data on health insurance coverage every year since 1989, with less regular data collection dating back to 1960 (Cohen 2000).

A comparative strength of the NHIS is its high response rate. Even with recent declines, interviews are collected from over 90 percent of the eligible sample households, and item nonresponse to the health insurance questions is only 1 percent. Another strength is the use of reported health insurance plan names to edit the reported sources of health insurance coverage and improve the classification of managed care. With the low nonresponse, annual frequency, high quality coverage data, and a representative elderly sample of about 11,000, the NHIS provides a good source for monitoring the health insurance coverage of the entire elderly population. Its extensive data on health conditions will also support detailed analysis of the relationship between health insurance coverage and health care needs.

### **Medical Expenditure Panel Survey (MEPS)**

Cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and NCHS, MEPS consists of three component surveys: (1) a household component (HC), which is representative of the civilian, noninstitutionalized population of the U.S.; (2) a medical provider component, which collects information from medical providers identified by household survey respondents in order to validate and supplement the data reported by those respondents; and (3) an insurance component (IC), which collects data from a representative sample of insurers (Cohen 1997). The initial MEPS in 1996 included a fourth component, which collected information on nursing home residents from a representative sample of nursing homes, but this component has not been repeated. The household component and the insurance component are relevant to measuring the health insurance coverage of the elderly.

**The MEPS-HC consists of a series of independent, annual panels that run about two-and-a-half years in length. This overlapping panel design improves the precision with which MEPS can produce not only cross-sectional estimates but calendar year longitudinal estimates as well. Public use files combine the overlapping rounds of consecutive panels, which approximately doubles the sample size relative to a single panel and, as we noted with the MCBS, eliminates the effects of attrition bias on estimates across years. Data are released in the form of cross-sectional “point-in-time” files, which include fairly limited variables, and longitudinal full year files. For example, the 2002 file released in July 2003**

**contains data collected in round 1 of panel 7 and round 3 of panel 6. The full year files (there are several) for 2001, which were released later in 2003, contain calendar year data collected in rounds 1, 2, and 3 from panel 6 and in rounds 3, 4, and 5 from panel 5. MEPS-HC sample sizes declined during the late 1990s but have returned to their 1997 levels, with each panel including about 7,000 households. The point-in-time and full year files contain data for about 35,000 persons, nearly 4,000 of them aged.**

The MEPS-HC sample is drawn from households that responded to the previous year's NHIS. The NHIS records provide a rich source of additional data on sample households prior to their selection into MEPS. A drawback of subsampling NHIS respondents to obtain the MEPS sample is that the unit nonresponse to the NHIS, low as it is, is built into the MEPS sample, compounding the nonresponse to MEPS itself. The cumulative response rate to the first round MEPS interview in the spring of 1996 was 78 percent (Vistnes and Monheit 1997). Response rates have dropped slightly since then. The 1999 panel achieved a response rate of 73 percent in the first round (Rhoades and Chu 2000).

As the name suggests, the major focus of MEPS is medical expenditures. The HC collects two full calendar years of expenditure data with five in-person interviews and a sixth, very brief interview conducted by telephone. Health insurance coverage is a high priority area, given its relevance to medical expenditures, and MEPS collects detailed health insurance data for the entire two-year reference period. Each interview collects information on the coverage held by household sample members since the last interview (or, in round one, the beginning of the first calendar year). Like the MCBS, the HC interviews are conducted by Westat using the CAPI methodology.

The MEPS-IC is a survey of employers and insurance providers. It collects information on the health insurance plans that are offered to employees and, for the provider sample, individuals who purchase coverage directly. The instruments include questions relating to coverage provided to retirees as well as current employees.

## **What Can the Data Tell Us About Health Insurance for the Elderly?**

Interest in the health insurance coverage of the elderly ranges across several dimensions. To adequately address the needs of policymakers and researchers, our data sources must be able to answer the following kinds of questions:

- Who has what coverage and benefits?
- What are the demographic and economic characteristics of those who have and those who do not have particular types of coverage and benefits?
- How have coverage and benefits changed, and what is their current trend?

- To what extent do individuals maintain their coverage and benefits over time?
- What role does geography play in the availability of supplemental coverage?

We compare the coverage and benefits data collected by the four surveys and then consider to what extent these surveys enable users to address the additional questions.

## Coverage and Benefits

All four of the surveys identify Medicare enrollees and capture Part B coverage (Table 3). Three of the four—all but the HRS—capture Part A as well. For the HRS, most of the missing Part A coverage can be inferred from the overall Medicare indicator and the reported Part B coverage. We say “most” because persons who buy in to Part B may choose not to purchase Part A. The NHIS and MEPS have a different limitation. Part A and Part B are determined from the respondent’s Medicare insurance card, and if this is unavailable—as it was for about 20 percent of Medicare beneficiaries in the 2000 NHIS—no information is obtained.

Only the MCBS obtains the information needed to differentiate between enrollees who are automatically eligible for Medicare and those who buy in. These data are taken directly from Medicare administrative records, and their accuracy is presumably very high. The other three surveys capture the receipt of social security benefits, which can serve as a proxy for eligibility—but with limitations. Social security benefit receipt among persons 65 and older will identify most but not all of the elderly who are eligible for Medicare. Furthermore, social security benefits are subject to misreporting, which introduces additional error into the estimates of eligibility. The substitution of administrative data on social security benefit receipt, which may be possible for the HRS, addresses the possible misreporting of this proxy for Medicare eligibility but not the other limitations.

All four surveys capture the presence or absence of Medigap coverage, and all but the NHIS obtain the plan letter, but the quality of reported plan letters is not high, and none of the surveys collects information on older plans.<sup>8</sup> The MCBS, the NHIS, and MEPS identify enrollment in a Medicare+Choice plan. While the HRS does not identify such coverage explicitly, it can approximate such enrollment with the information reported on managed care, as HMOs and PPOs account for most of the plans offered through Medicare+Choice.

Both the MCBS, and beginning in 2004, the NHIS ascertain whether the respondent is entitled to VA care.<sup>9</sup> The MCBS also captures both the use of and expenditures for VA services. If a

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<sup>8</sup> The MCBS finds that a majority of those who report Medigap coverage cannot provide a valid plan letter. MEPS also obtains a lot of responses outside the A to J range.

<sup>9</sup> As late as 2003, the NHIS listed "military health care/VA" and "TRICARE/CHAMPUS/CHAMP-VA" as two of the possible choices in response to a question asking what kind of health insurance or health care coverage each family member had. While persons with access to VA care might be picked up by the first category, persons with more comprehensive military coverage not identified as TRICARE, CHAMPUS, or CHAMP-VA could be included as well. Beginning in 2004, the NHIS includes a single category for military health care as a source of

respondent is eligible for VA services, the MCBS will probe to determine if each reported medical services was provided by a VA facility or physician.

With respect to additional data on coverage and benefits (Table 4), all four surveys identify whether or not Medicare coverage is obtained through an HMO, but only the MCBS distinguishes risk HMOs from non-risk HMOs. This is done with Medicare administrative data. MEPS asks respondents who report coverage through an HMO to identify the HMO from a list of Medicare HMOs in their area. This information is stored but not coded. All but MEPS identify PPO plans and whether they include point of service options, with the MCBS providing the most explicit and, possibly, the most accurate identification of such plans.

Medicaid is an important source of supplemental coverage for low-income beneficiaries, and managed care is playing an increasingly more significant role in the delivery of Medicaid services. All four surveys identify Medicaid HMOs explicitly, with the HRS and NHIS capturing somewhat more detail on other types of managed care for private plans.

With respect to prescription drug coverage, the MCBS, HRS, and MEPS obtain general reports of such coverage without probing for coverage limits, coinsurance or other costs. Medigap plan letters, collected by all but the NHIS, can indicate whether such coverage was obtained from Medigap and, if so, what such coverage includes, but as we have noted, the reliability of the reported plan letter is low. The NHIS obtains reports of prescription drug coverage only if such coverage is reported in a single service plan.

Long-term care insurance is reported in the MCBS and the HRS both as a stand-alone and as part of a comprehensive private plan. MEPS captures nursing home coverage as part of a private plan as well. As with drug coverage, the NHIS captures long-term care insurance only if it is reported as a single service plan. Also like prescription drugs, none of the four surveys collects information regarding the scope of the coverage, which varies widely across plans.

## **Data to Address Additional Questions**

### *Demographic and Economic Characteristics*

All four of the surveys capture standard demographic characteristics. The NHIS and MEPS, because they include the full household as sample members, have more extensive data on nonelderly members (other than spouses) than the HRS and the MCBS, but all four capture family and household composition. Economic characteristics are strong in both the HRS and MEPS, which capture assets as well as income. The MEPS devotes a substantial number of questions to income and assets. The HRS has considerably fewer asset questions, but its estimates of net worth, based on questions used in the PSID, compare favorably to those obtained for elderly persons in the PSID and the Federal Reserve Board's Survey of Consumer Finances. Neither the NHIS nor the MCBS collects any information on assets, and their income data are very limited.

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coverage but follows up with questions that allow the respondent to identify one or more specific types of military health care, including VA.

### *Change in Coverage and Benefits Over Time*

In selecting all of the surveys that we examined, it was a prerequisite that they provide repeated measures over time. The MCBS, MEPS, and the NHIS can provide nationally representative annual estimates because new samples are drawn each year. The HRS was designed with a different purpose than cross-sectional representation, but it, too, will be able to provide reasonably representative estimates of changes in patterns of coverage over time, given the introduction of six new birth cohorts every six years. Its limitations in this regard are its exclusion of immigrants and persons returning to the U.S. after the selection of each group of cohorts plus the attrition that the panel will experience over time.

### *Continuity of Coverage and Benefits*

It is coincidental that three of the four surveys are longitudinal because all four were selected on the basis of their data on coverage and benefits. Yet the longitudinal aspect of their designs is critical to being able to provide data on the continuity of coverage and benefits among individuals. Do individuals change their coverage and, if so, why do they do so? MEPS will support estimates of continuity over a two-year period, and the MCBS will allow estimates of continuity over a period of up to four years. The HRS is open-ended, so it will support long-term analysis of changes in coverage, which is particularly important for investigating the impact of new policies affecting coverage, as interventions may take several years to achieve their full effects. At the same time, however, the two-year span between interviews limits the HRS's utility for analysis of short-term impacts of changes in coverage and benefits.

### *Geography*

Geographic location or, in particular, state of residence, is an important component of any measure of health insurance coverage. Plans vary across states, so knowing each respondent's state of residence can be informative with respect to the characteristics of both private and public plans. Such information can also help with validation as well. If a respondent reports plan features that do not exist in the state, the responses can be edited. Of the four surveys, however, only the MCBS includes a state identifier in its public use files. State identifiers are suppressed in the public use files for the HRS, NHIS and MEPS in order to protect the confidentiality of the respondents, and it is unlikely that this will be changed. Users can make arrangements to work with non-public use MEPS and NHIS data in a secure site maintained by their sponsoring agencies, but this can be cumbersome and costly. All analysis of microdata utilizing the state identifiers or any information derived from them (including plan characteristics) must be conducted on-site. We are not aware of any option to obtain state identifiers for the HRS.

## **Estimates of Coverage and Benefits**

This paper was not intended to develop new estimates of coverage and benefits among the elderly, but for illustrative purposes we have assembled two tables that address key aspects of supplemental coverage. The first shows the extent to which Medicare beneficiaries draw on

supplemental sources for their health insurance coverage. The second shows where Medicare beneficiaries obtain at least some coverage for the outpatient prescription drugs that are not covered by Medicare.

## **Supplemental Coverage**

All but 10 percent of aged Medicare beneficiaries in 1999 had some form of supplemental coverage beyond basic fee-for-service Medicare Part A and/or B (Table 5). The reliance on supplemental coverage varied little by age group, but the sources differed.<sup>10</sup> Persons 65 to 74 were more likely to have employer-sponsored private insurance (37 percent including the 5 percent who also purchased additional private coverage directly) and more likely to be enrolled in a risk HMO (21 percent) than older beneficiaries. Beneficiaries 85 and older were the least likely to be enrolled in a risk HMO or to have employer-sponsored private coverage and the most likely to have purchased individual private coverage (34 percent) or be covered by Medicaid (13 percent). Nevertheless, the differences across age groups are not as striking as the similarities. Even among beneficiaries 85 and older, 30 percent still had employer-sponsored insurance—only 7 percentage points lower than beneficiaries 65 to 74, who were much more likely to be still employed.

## **Prescription Drug Coverage**

Including the non-aged with disabilities, nearly three-quarters (73 percent) of Medicare beneficiaries had at least some level of outpatient prescription drug coverage in 1998 (Table 6). While employer-sponsored insurance was the dominant source of prescription drug coverage, accounting for nearly 14 million of the 35.5 million who had supplemental insurance, the fraction of beneficiaries with prescription drug coverage was essentially the same (roughly 90 percent) among those who were enrolled in any form of supplementation other than individually purchased coverage. Beneficiaries with individually purchased coverage were less than half as likely (43 percent) to have any kind of prescription drug coverage.

## **Recommendations**

Our recommendations regarding the data we have discussed address possible expansion of the Forum's chart book on older Americans and future data development.

### **Expanding the Chart Book Indicators?**

The chart book, *Older Americans 2000: Key Indicators of Well-being*, includes seven health care indicators, but none of these involves health insurance coverage. Does our review of supplemental coverage provide grounds for expanding this set of indicators to include at least one measure of coverage? We believe that it does. Specifically, the large fraction of older Americans who supplement their Medicare coverage with one or more other forms of coverage

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<sup>10</sup> Entries in Table 5 were calculated from Table 1.6 in a 1999 compilation published by CMS. Standard errors were reported in the published table, but standard errors for the statistics reported in Table 5 cannot be derived from those values. Because of this, the text highlights the largest differences.

suggests a statistic or set of statistics worth charting. We expect that both the overall percentage who choose to supplement their coverage and how they elect (or are able) to do so will change over time, which makes this a useful indicator to watch.

The fact that five of the seven current indicators refer to Medicare beneficiaries, and we have just proposed a sixth, invites us to consider whether there might also be grounds for developing an indicator based on the four percent of older Americans who are not covered by Medicare. While the argument for such an indicator is a reasonable one, however, the small size of this population prevents our saying anything interesting about its composition or characteristics that would be sufficiently reliable statistically to produce a good indicator. The NHIS, for example, might have no more than 500 observations on this population while the MEPS would have about 160 (and the MCBS, of course, would have none). Compounding this problem is the fact that household surveys may very well underrepresent segments of this population, which would introduce a bias into estimates of the characteristics of this group. Until both problems can be solved in some way, we recommend against attempting to develop an indicator based on the aged who lack Medicare coverage.

### **Longer Term Priorities for Data Development**

The highest priority for improving the data on health insurance benefits among the elderly is an area of data development that has been a top priority among researchers for many years but one with which little progress has been made. There continues to be a need to find effective ways to incorporate information on the benefits included under private and public insurance plans into the key person-level databases. This would provide researchers direct access to the data they need to analyze the heterogeneity of benefits among the insured elderly. Variation in benefits is almost certainly greater among this population than among younger persons, so the potential value that would come from improving these data is correspondingly greater as well.

Public plans provide a good place to start. For Medicaid and many state-only plans, it may be sufficient to know a beneficiary's state of residence in order to attribute the details of the coverage that such plans provide. Similarly, much can be determined about Medigap policies from their plan letter and their state.<sup>11</sup> At present, however, state data are available from only the MCBS, and this is unlikely to change in the near future. Including direct measures of state plan characteristics as an alternative to the state identifiers on public use files from the other three surveys is not a realistic alternative, as the uniqueness of particular benefit combinations would reveal the state identities that their suppression was intended to protect. But perhaps the surveys' sponsoring agencies could contribute to the development of either a limited set of benefit codes, that would provide useful information without uniquely identifying states, or a more extensive set of codes that they could add to their restricted-use files, sparing researchers the need to create their own codes independently.

Coding the benefits data from private plans is a much more substantial undertaking. We have noted the low reliability with which respondents with Medigap coverage can report their plan letters. What is needed here is a new approach, perhaps building on the successes that some surveys have had with coding information from plan descriptions. Both MEPS and the

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<sup>11</sup> Three states deviate from the benefit packages summarized in Table 2.

Community Tracking Study have obtained benefits data in this manner, and the information has proved useful to analysts, but in neither case did this become a routine component of data collection. A greater contribution from the respondent may ultimately be essential. Ascertaining what additional data on benefits are most critical and how much of this respondents are likely to know are key steps in the path toward capturing useful benefits data.

Other improvements in our data resources are suggested by the pattern of missing or qualified Xs in Tables 3 and 4. For example, both NHIS and MEPS could obtain more complete information on enrollment in Medicare Parts A and B by directly asking respondents what type of coverage they have if they cannot produce their Medicare cards.

Lastly, while the fraction of elderly persons who lack Medicare coverage is small, and survey estimates suggest that most of these have other coverage, we could stand to learn more about this population. For example, to what extent is the lack of both Medicare and other coverage associated with undocumented immigration or, more broadly, employment not reported to the Social Security Administration? And what role does survey undercoverage play in hiding, in effect, some of the immigrant population from our view? To address these questions will require new data collection or a creative approach to combining information from existing data sources, as the answers cannot be obtained from any single survey or administrative database at present.

## **Conclusion**

Acknowledging the role of supplemental coverage among Medicare beneficiaries is a partial step toward attaining a more comprehensive understanding of the health insurance coverage of the elderly. The limitations of Medicare coverage create the need to understand how the aged supplement their Medicare coverage—or substitute other coverage if they cannot qualify for Medicare. But the benefits provided by supplemental coverage vary widely. We need to set our sights on developing a more complete description of the aged population's health insurance coverage that takes account of what, precisely, is included in the plans in which the elderly enroll.



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TABLE 1

## MEDICARE AGED BENEFICIARIES, JULY 2000, BY TYPE OF MEDICARE COVERAGE

| Type of Medicare Coverage | Number<br>of<br>Beneficiaries<br>(1,000s) | Percent<br>of<br>Total<br>Beneficiaries | Percent<br>of<br>Aged<br>Population |
|---------------------------|---|---|-------------------------------------|
| Part A and/or Part B      | 33,548                                    | 100.0                                   | 95.9                                |
| Part A                    | 33,130                                    | 98.8                                    | 94.7                                |
| Part B                    | 32,235                                    | 96.1                                    | 92.1                                |
| Part A and Part B         | 31,816                                    | 94.8                                    | 90.9                                |
| Part A alone              | 1,313                                     | 3.9                                     | 3.8                                 |
| Part B alone              | 419                                       | 1.2                                     | 1.2                                 |

SOURCE: Centers for Medicare & Medicaid Services, July 1, 2000 Medicare enrollment data and U.S. Census Bureau (2001).

TABLE 2  
BENEFITS INCLUDED IN 10 STANDARDIZED MEDIGAP PLANS, A THROUGH J

| Benefit                                     | A | B | C | D | E | F    | G   | H     | I     | J        |
|---|---|---|---|---|---|------|-----|-------|-------|----------|
| Basic benefits <sup>a</sup>                 | X | X | X | X | X | X    | X   | X     | X     | X        |
| Part A inpatient hospital deductible        |   | X | X | X | X | X    | X   | X     | X     | X        |
| Part A skilled nursing facility coinsurance |   |   | X | X | X | X    | X   | X     | X     | X        |
| Part B deductible                           |   |   | X |   |   | X    |     |       |       | X        |
| Foreign travel emergency                    |   |   | X | X | X | X    | X   | X     | X     | X        |
| At home recovery                            |   |   |   | X |   |      | X   |       | X     | X        |
| Part B excess charges                       |   |   |   |   |   | 100% | 80% |       | 100%  | 100%     |
| Preventive care                             |   |   |   |   | X |      |     |       |       | X        |
| Prescription drugs                          |   |   |   |   |   |      |     | Basic | Basic | Extended |

SOURCE: Centers for Medicare & Medicaid Services (2003).

<sup>a</sup> Includes: the cost of Part A coinsurance and 365 extra days of hospital care after Medicare coverage ends, the Part B coinsurance or copayment amount, and the first 3 pints of blood each year.

TABLE 3  
COLLECTION OF DATA ON MEDICARE AND SUPPLEMENTAL OR  
ALTERNATIVE COVERAGE: FOUR SURVEYS

| Source of Primary or Supplemental Coverage | MCBS           | HRS          | MEPS           | NHIS           |
|--|----------------|--------------|----------------|----------------|
| Medicare                                   | X <sup>a</sup> | X            | X              | X              |
| Part A                                     | X <sup>a</sup> |              | X <sup>b</sup> | X <sup>b</sup> |
| Part B                                     | X <sup>a</sup> | X            | X <sup>b</sup> | X <sup>b</sup> |
| Eligible vs. Buy-in                        | X <sup>a</sup> |              |                |                |
| Medigap                                    | X              | X            | X              | X              |
| Plan Letter                                | X              | X            | X              |                |
| Medicare+Choice                            | X <sup>a</sup> | <sup>c</sup> | X              | X              |
| Medicaid                                   | X              | X            | X              | X              |
| Private                                    | X              | X            | X              | X              |
| Group                                      | X              | X            | X              | X              |
| Non-group                                  | X              | X            | X              | X              |
| Military                                   | <sup>d</sup>   | X            | X              | X              |
| Other Public                               | X              | X            | X              | X              |
| Entitled to VA Care                        | X <sup>e</sup> |              |                | X <sup>f</sup> |

SOURCE: Survey instruments for the four surveys.

<sup>a</sup> Obtained from Medicare administrative records.

<sup>b</sup> Obtained from Medicare card presented by respondent; not collected if

the respondent was unable or unwilling to produce the card.

<sup>c</sup> Not identified explicitly, but most participation in M+C can be inferred from reported enrollment in a Medicare HMO or PPO.

<sup>d</sup> Not reported as a separate source; may be included in other public.

<sup>e</sup> Those who reported having served in the Armed Forces are asked if they have received health care or health services through the Department of Veterans Affairs or V.A. since the reference date. This is separate from and generally less comprehensive than health insurance coverage described as military and provided by the Department of Defense.

<sup>f</sup> Beginning in 2004, the NHIS identifies "VA" as a distinct type of military health care. Previously, VA health care was combined with military health care not reported as TRICARE, CHAMPUS, or CHAMP-VA.

TABLE 4

## COLLECTION OF ADDITIONAL DATA ON COVERAGE: FOUR SURVEYS

| Additional Data<br>on Coverage | MCBS           | HRS            | MEPS           | NHIS           |
|--------------------------------|----------------|----------------|----------------|----------------|
| Medicare Managed Care Type     |                |                |                |                |
| HMO                            | X              | X              | X <sup>d</sup> | X              |
| Risk vs. non-risk              | X <sup>a</sup> |                |                |                |
| POS option                     | X              | X              |                |                |
| PPO                            | X <sup>a</sup> | X <sup>b</sup> |                |                |
| Prescription drug coverage     | X              | X              | X              | X <sup>c</sup> |
| Long-term care insurance       | X              | X              | X              | X <sup>c</sup> |

SOURCE: Survey instruments for the four surveys; Poisal and Murray (2001).

<sup>a</sup> Obtained from Medicare administrative records.

<sup>b</sup> Reduced fee for doctors on list; no explicit mention of PPO.

<sup>c</sup> Captured only for persons who first report having a single service plan.

<sup>d</sup> In 2004, the MEPS questionnaire was changed. The question now ascertains if the individual was enrolled in a managed care plan, but not the particular type of plan.

TABLE 5

SUPPLEMENTATION OF BASIC MEDICARE SERVICES BY TYPE OF SUPPLEMENTAL COVERAGE  
FOR NON-INSTITUTIONALIZED, AGED MEDICARE BENEFICIARIES, 1999

| Supplemental Coverage                    | Total<br>Aged | 65-74  | 75-84  | 85+   |
|--|---------------|--------|--------|-------|
| Total Number (1,000s)                    | 32,996        | 17,520 | 11,960 | 3,516 |
| Total Percent                            | 100.0         | 100.0  | 100.0  | 100.0 |
| Medicare Risk HMO                        | 19.2          | 20.8   | 18.1   | 14.9  |
| Medicaid                                 | 9.0           | 8.5    | 8.5    | 12.9  |
| Employer-sponsored private insurance     | 30.9          | 32.2   | 30.4   | 26.2  |
| Individually-purchased private insurance | 25.1          | 21.6   | 28.6   | 30.8  |
| Both types of private insurance          | 4.8           | 4.7    | 5.1    | 3.7   |
| Other                                    | 1.4           | 1.6    | 1.0    | 1.8   |
| Medicare fee-for-service only            | 9.6           | 10.6   | 8.2    | 9.8   |

SOURCE: 1999 MCBS, Centers for Medicare & Medicaid Services.

TABLE 6

DRUG COVERAGE AMONG NONINSTITUTIONALIZED MEDICARE AGED AND DISABLED  
BENEFICIARIES, BY SUPPLEMENTAL INSURANCE COVERAGE, 1998

| Supplemental Insurance Coverage              | Total<br>Beneficiaries<br>(1,000s) | Percent<br>With Drug<br>Coverage | Percent<br>Without Drug<br>Coverage |
|--|------------------------------------|----------------------------------|-------------------------------------|
| All  | 38,109                             | 73                               | 27                                  |
| No supplemental coverage (Medicare FFS only) | 2,602                              | 0                                | 100                                 |
| Any supplemental coverage                    | 35,507                             | 78                               | 22                                  |
| Medicare risk HMO                            | 6,282                              | 92                               | 8                                   |
| Medicaid                                     | 5,026                              | 89                               | 11                                  |
| Employer-sponsored <sup>a</sup>              | 13,770                             | 90                               | 10                                  |
| Individually purchased only                  | 8,999                              | 43                               | 57                                  |
| All other                                    | 1,431                              | 89                               | 11                                  |

SOURCE: Poisal and Murray (2001).

<sup>a</sup> Includes those with both employer-sponsored and individually purchased coverage.

# Data Sources and Measures of Access and Affordability

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## Introduction

An estimated 61 percent of Medicare beneficiaries over age 65 had health insurance from a private source in 1999 – from a current employer, a past employer, or an individually purchased plan (CMS 2001). For the vast majority of the elderly with private insurance or Medicaid, the coverage supplements traditional Medicare and is “second payer” for Medicare-covered services. For persons who are enrolled in a Medicare+Choice plan, supplemental private insurance is presumably rare, although there may be reasons that the elderly would have supplemental private coverage even in that circumstance.

As health care costs have risen, both the importance and cost of supplemental coverage also have risen. The growing cost of supplemental coverage may have caused some employers to abandon offers of coverage for retirees. It may also have caused Medicare beneficiaries to drop coverage that is available, or to alter their coverage to reduce their contribution or premium.

This paper considers what available survey data can reveal about elderly Medicare beneficiaries’ access to health insurance coverage to supplement Medicare benefits and the affordability of that coverage. For the purpose of this paper, access is defined as the offer of coverage distinct from the actual purchase or take-up of coverage.

Affordability is a more complex issue, encompassing at least three considerations: personal income, the price of coverage, and the value of coverage (considering both benefits covered and cost sharing for covered benefits). This paper focuses on the price of coverage available either to persons with coverage or to those without coverage. Price is defined as either what covered participants actually pay for coverage or (consistent with the concept of access) the market price of available coverage regardless of whether coverage is taken.

The following four sections of this paper consider (1) employer sponsored coverage for elderly workers and retirees – including military coverage; (2) private Medigap coverage; (3) Medicare managed care; and (4) private coverage for long term care. Each section first reviews emerging issues of concern to public policy makers and then considers the information national surveys – including household and employer – or by administrative data offer to inform these issues. Finally, the paper then turns to recommendations in two areas: expansion of the Chart Book indicators of well-being among older Americans (Federal Interagency Forum on Aging Related Statistics, *Older Americans 2002: Key Indicators of Well Being*); and longer-term priorities for data development.

Two household surveys – the Health and Retirement Study (HRS) and the Medicare Current Beneficiary Survey (MCBS) are of particular relevance to questions of access to insurance and affordability.<sup>1</sup> One other survey, the Medical Expenditure Panel Survey

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<sup>1</sup> Other national surveys judged less useful in measuring both access and affordability include the Current Population Survey (CPS), the National Health Interview Survey (NHIS), the Survey of Income and Program Participation (SIPP) the Community Tracking Study (CTS), the Panel Study of Income Dynamics (PSID), and National Long-Term Care Survey (NLTCS).

(MEPS) is of particular interest because of the ability it offers to measure the level of premiums relative to insured expenditure at the individual or household level – an issue that is developed in the concluding section of the paper.

The basic features of the national household surveys considered here are described in a companion paper and appendix (Czajka, J. and Appendix 2 in these *Proceedings*, respectively) and so are not reviewed again here. Discussion related to the HRS in each section below describes the information to be obtained in 2004, based on an expanded household sample and the preliminary survey instrument as of January 30, 2003.<sup>2</sup>

## **A. Employer-Sponsored Coverage**

Employer-sponsored coverage for retirees is, to many, considered an optimal way to obtain coverage to supplement Medicare. Provided as a group plan, it is presumed that the administrative costs of employer-sponsored coverage are much less than direct-marketed individual plans and, therefore, that the value (measured as medical benefits paid) per premium dollar is higher. These plans generally provide coverage mirroring that for active workers, with Medicare as first payer. For elderly workers who remain employed, federal law (the Age Discrimination in Employment Act, ADEA) protects their eligibility for employer-sponsored coverage as for any other employee.<sup>3</sup>

### **1. Issues and Concerns**

The growing cost of employer-sponsored health insurance benefits, a series of court rulings protecting retirees' contractual rights to continued benefits, and a change in the way that employers must account for future retiree health insurance obligations<sup>4</sup> have all corresponded to a decline in the rate at which employers offer retiree health insurance and the terms of offer when it is made available. Changes in the terms of offer include

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<sup>2</sup> The HRS survey instrument was significantly expanded in 2002 to include more extensive questioning about health insurance coverage. In 2004, the population sample also will be expanded, making it representative (with some caveats) of the population over age 50 at each point.

<sup>3</sup> Although for active workers with employer coverage (and with Medicare), Medicare is second payer.

<sup>4</sup> Financial Accounting Statement No. 106 (FAS 106), approved by the Financial Accounting Standards Board (FASB) in December 1990, requires most private companies to record unfunded retiree health benefit liabilities on their financial statements for fiscal years after Dec. 15, 1992, in accordance with generally accepted accounting principles. FAS 106 requires employers to accrue and expense future claims payments as well as actual paid claims. By affecting companies' calculation of profit, recognition of retiree health liabilities provides a strong incentive for companies to limit future expenses. In 2004, the Governmental Accounting Standards Board (GASB) directed state and local governments to document in their financial statements the full cost of health benefits for current and future retirees beginning July 1, 2007. Local officials report that the ruling (known as GASB 45) "could lead to reduced benefits for retirees." (Bill Turque, Washington Post, January 30, 2006, page B01).

increases in participant contributions for coverage, increases in service requirements for coverage,<sup>5</sup> and reductions in the range of plan options available to retirees.

A 2001 district court interpretation of ADEA further narrowed the ability of employers to differentiate retiree health insurance benefits for retirees who are Medicare-eligible versus those who are not.<sup>6</sup> This ruling in effect restricts employers from requiring (older) Medicare-eligible retirees to pay a greater portion of their total cost of health insurance (including payment of Medicare Part B premiums) than younger retirees and from offering different plan options (e.g., only HMO coverage) to Medicare-eligible retirees.

As health care costs are again rising in excess of wages and pension payments, it seems likely that the offer of retiree health insurance will continue to decline, the terms of offer will continue to narrow, and the cost to retirees will rise. In 2000, an estimated 62 percent of large firms offered health insurance benefits to Medicare-eligible retirees, compared to 80 percent in 1991 (Fronstin 2001). Among large employers that offered retiree health benefits to Medicare-eligible retirees, approximately one third required retirees to pay the full cost of coverage in 2000 (Wm. A. Mercer, 2001). A similar percentage of large employers limited their obligations to a defined-dollar contribution irrespective of the cost of the plan; beyond that limit, retiree contributions rise directly with further increases in the cost of the plan (Hewitt Associates 2001).

## 2. Household Surveys

While the major national household surveys identify current coverage from a present or past employer, two are attuned specifically to retirees and may offer a richer context for understanding coverage choices: the Health and Retirement Study (HRS), the Medicare Current Beneficiary Survey (MCBS). These surveys also offer information about the dollar amount that covered retirees contribute for coverage. Other major household surveys, such as the MEPS, also contain information on retirees' premium contributions for coverage.<sup>7</sup>

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<sup>5</sup> In 2000, 49 percent of large employers reported that they required at least 10 years of service and attainment of age 55 to qualify for retiree health insurance benefits; in 1996, just 35 percent required as much as 10 years of service (McArdle et al. 2000).

<sup>6</sup> *Erie County Retirees Association v. Erie County Employees' Retirement Board*, 140 F. Supp. 2d 466, 474 (April 16, 2001). This ruling applies only to employers located in the Third Circuit, including Pennsylvania, New Jersey, Delaware, and the Virgin Islands. On August 20, 2001 the U.S. Equal Employment Opportunity Commission (EEOC) rescinded Section IV (B) of EEOC Compliance Manual Chapter on "Employee Benefits" regarding the Age Discrimination in Employment Act (ADEA) and (retiree) health insurance benefits (<http://www.eeoc.gov/policy/docs/benefits-rescind.html>). In March 2005, the AARP won a Federal court decision to block the rule. The issue is still under appeal. For a summary of the litigation over the EEOC ruling see *Law and the Workplace*, Vol. XIV, Fall/Winter 2005, p. 7-8, Proskauer Rose LLP, [www.proskauer.com](http://www.proskauer.com).

<sup>7</sup> Although the sample size for the population 65 and older is smaller in the MEPS, than in the HRS and MCBS.

a. *The Health and Retirement Study (HRS)*

The HRS survey instrument asks about current coverage from the respondent's current employer, and separately about coverage from a past employer, a spouse's current employer, or a spouse's past employer. If a spouse is not covered by the respondent's plan, it asks whether the spouse was eligible to be covered. In addition, it asks whether respondents participating in an HMO had to join in order to obtain benefits from another supplemental plan (for example, a drug benefit), indicating whether their enrollment decision was forced by the terms of their retiree coverage. Finally, it asks how much the covered individual contributes for coverage and how much, using its characteristic "unfolding brackets" approach to elicit a response. The HRS includes various questions about the form and extent of benefits covered (e.g., whether the plan is an HMO or uses a preferred or required panel of providers), but most other questions related to benefit design are so broad that they probably are unhelpful in understanding why participants' contributions to a retiree health insurance plan would vary.

The HRS also asks a number of questions about prospective eligibility for retiree health insurance of respondents under age 65.<sup>8</sup> However, it asks about eligibility for coverage not taken or reasons for not accepting coverage only if either current coverage does not cover a spouse or if the respondent is employed but not covered by their employer. Similarly, the HRS asks whether the respondent is currently covered by TRI-CARE, CHAMPUS, CHAMP-VA, or any other military plan (separately or in addition to Medicare or Medicaid), but it does not ask about eligibility for coverage that is not taken.

b. *The Medicare Current Beneficiary Survey (MCBS) and the Medical Expenditure Panel Survey (MEPS)*

The MCBS and the MEPS share much in common. Like the HRS, the MCBS and the MEPS are panel surveys. The MCBS uses a longitudinal, overlapping sample of Medicare beneficiaries, questioning each panel 12 times over a 4-year period. The MEPS uses a longitudinal, overlapping sample of the civilian non-institutionalized population, questioning each panel five times over a two year period.

Like the HRS, the MCBS offers information about private insurance options not taken only with respect to coverage from a current employer. The MEPS contains information on why workers were not eligible for health insurance offered by their employer. The longitudinal structure of these surveys offer at least a glimpse of changes in retiree coverage that relate to affordability.

The MCBS and the MEPS ask whether the sample person(s) is currently covered by a supplemental plan, whether the plan is an HMO, whether it was obtained from a current

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<sup>8</sup> For respondents younger than age 65 with coverage from a former employer, the HRS asks whether the coverage could be continued until age 65, and separately whether it could be continued after age 65. If the respondent is currently employed, the HRS asks whether coverage could be extended to age 65 if they left that employer now, and (separately) whether it could be continued after age 65. Each of these questions is asked again with respect to coverage for the respondent's spouse.

or (separately) a former employer or a deceased spouse's employer, how much the respondent (or primary insured person) pays for coverage, and whether a current or former employer contributes to the cost of coverage.<sup>9</sup> The MCBS also contains a question for individuals' whose coverage has changed from the prior interview, asking why the change occurred. Response categories for this question include "too expensive" and "could not afford premiums, deductibles, or copayments."

### 3. Employer Surveys

Several private surveys of employers have asked about retiree health insurance benefits – whether coverage is offered and the terms of offer to retirees. Because these surveys are private, the data are proprietary although tabulations of the data have been made public. The MEPS-Insurance Component (MEPS-IC) is an annual survey of employers, sponsored by the Agency for Healthcare Research and Quality (AHRQ) and conducted by the U.S. Bureau of the Census.

With respect to measuring access to coverage or affordability among current retirees each of these surveys offers the same dilemma: it is impossible to relate information about changes in offer or participant cost to the number of current retirees affected. However, each offers information that may be useful in understanding how important it is and will be to ask clearer questions about access (not just current coverage). They also suggest the potential value of asking clearer questions about participant cost sharing (not just contributions to premium) to understand affordability.

Among the ongoing private employer surveys is the Employer Health Benefits Survey, conducted by Kaiser Family Foundation and the Health Research and Education Trust (KFF/HRET).<sup>10</sup> The KFF/HRET survey has been conducted each year since 1999, and follows a longer series of surveys conducted by KPMG periodically between 1988 and 1998. The survey instrument includes questions about health insurance benefits for active workers, as well as a series of questions about benefits available to pre-65 and Medicare-eligible retirees. The sample frame includes all nonfederal employers, including private employers, state governments and local governments. It is stratified by employer size and industry, whether the employer's workforce is unionized, and geographic region.

The KFF/HRET survey asks about current offer as well as recent changes in retiree benefits. The latter include changes in the share of premium paid by retirees, elimination of retiree coverage for new hires or employees not yet retired, and changes in cost sharing

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<sup>9</sup> The MCBS also asks a separate panel of questions about enrollment in a Medicare HMO – including whether a current or past employer contributes to premiums, and whether an employer paying the premiums is the most important reason for their participating in a Medicare HMO.

<sup>10</sup> William A. Mercer, Inc. also conducts an annual survey of employer health plans, and asks a series of questions about retiree health insurance benefit offer, terms of offer, and retiree contributions for coverage. The Mercer survey uses an augmented convenience sample which consists heavily of large firms. Mercer also has developed several metropolitan-area samples to develop estimates for those locales.

for prescription drugs. The survey instrument also includes questions about changes that responding employers expect to make over the next two years, including changes in cost sharing for prescription drugs, the share of premiums paid by retirees, or elimination of coverage for current or future retirees or for new hires.

The MEPS-IC, conducted since 1996, is a national survey of establishments that collects information on employer sponsored health insurance. Among the data collected are active employment, active enrollments, active plans, active plan enrollments, premiums, employer and employee contributions, self funding information and plan characteristics. Also collected are data that describe the employer, such as, firm size, industry, general wage levels, percentages of part time employees and presence of unions. Retiree information collected includes whether health insurance is being provided to some current retirees above and below the Medicare eligibility age, whether the same coverage is provided for new retirees, enrollments, enrollments, premiums and contributions for retirees above and below the Medicare eligibility age.

The MEPS-IC has a sample of over 47,000 business establishments and governments and covers all US employers except the Federal Government. The response rate is over 80%. Samples sizes currently are large enough to produce estimates for all 50 states and the District of Columbia. Results from the survey are used to support National Health Account Estimate made by the Centers for Medicare and Medicaid Services and Gross Domestic Product Estimates made by the Bureau of Economic Analyses.

## **B. Medigap Insurance**

Federal law standardizes the design of all newly issued Medigap products as well as Medigap insurer practices regarding issue of new coverage.<sup>11</sup> Insurers may continue to renew nonstandard products issued before July 1992, but otherwise they may sell only 10 standard products. These products are designed to eliminate the redundant coverage that insurers and agents had marketed to the elderly, and to promote competition in the Medigap market. Under federal law, all Medigap insurers must sell the most basic Medigap product (Plan A), and in addition may sell any of the 9 more comprehensive products defined in law. In 1999, 64 percent of Medigap policyholders were one of the 10 standard policy designs; 33 percent were prestandard, and 3 percent were HMO contracts as Medigap policyholders.

Federal law requires Medigap insurers to sell all of the standard products that they offer to any applicant at age 65 (guaranteed issue) and to renew any policy in force except for nonpayment of premiums (guaranteed renewal). After age 65 (unless further constrained

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<sup>11</sup> OBRA-90 standardized Medigap policies and practices in nearly all states. Only Massachusetts, Minnesota and Wisconsin regulate Medigap plans under a waiver of Federal law. Each has a different set of standard policy options. Massachusetts has three standard policies, one of which covers prescription drugs. In Minnesota, prescription drug coverage is sold either as an optional rider to the basic policy, or as a covered expense in extended basic policies. In Wisconsin, the basic benefit covers prescription drugs with a \$6,250 drug deductible; additional drug coverage may be purchased as an optional rider.

by federal law), Medigap insurers may underwrite coverage. That is, they may deny coverage to high-risk applicants and price coverage according to their assessment of the applicant's risk and various other rating factors (such as age and geographic location) unless restricted by state law.

Most Medigap insurers sell only a few of the 10 standard policy forms (though all must offer plan A). It is unclear from any available data whether all plans are available to Medicare beneficiaries from some Medigap insurer in every geographic location. But it is clear that individuals who would want to change plan types could have very little choice of plan type from their current insurer, and they would be underwritten if they attempted to change insurers.

Medigap insurers rate Medigap coverage in any of three ways: by age at issue or attained age, or they may community rate. Various state legislatures have felt strongly enough about Medigap rating practices to require all insurers to rate using one of these rating methods, but there is no consensus among the states about which preferred.<sup>12</sup> Under federal law, all insurers must community rate (that is, they may not rate to reflect health status) at first issue; the states generally prohibit insurers from underwriting for health status at renewal.

## **1. Issues and Concerns**

While insurers have been able to issue only standardized products since mid-1992, in 1999 one-third of policies currently in force were prestandard – that is, policyholders had continuously renewed them for at least 7 years. Some of these policies may cover very limited expenditures for prescription drugs (the prestandard AARP policy limited prescription drug coverage to \$500 per year). This may explain why some elderly have retained prestandard policies in lieu of foregoing drug coverage (in standard plans A through G) or purchasing a standard policy that offers more (though still very limited) coverage for drugs (standard plans H, I, or J), presumably at a much higher price. However, other aspects of the Medigap market suggest that there is very little movement of policyholders among plans, suggesting that the elderly may review coverage infrequently, or that underwriting after age 65 may restrict Medigap policyholders' ability to change plans.

Available price information also suggests that there may be remarkably little competition in the Medigap market – even for Medicare beneficiaries at age 65, but also after age 65. Polling the available rates in the Medigap market within metropolitan areas, Weiss

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<sup>12</sup> Entry-age rating front-loads premiums in order to achieve lower cost increases over the life of the policy. Because attained-age premiums are not front-loaded, they may be lower than entry-age rates at age 65 (all else being equal), but they may rise more steeply over the policyholder's lifetime. Community-rated policies (such as those marketed through AARP) average the cost of coverage over the whole group (irrespective of health status) and they also may soften or eliminate the age gradient. Thus, community-rated policies may be either more or less expensive at age 65 than policies priced on an entry-age (front-loaded) basis, but they probably are less expensive in later years than an attained-age-rated policy. Of 43 states that responded to a NAIC survey in 1999, six states prohibited Medigap insurers from using entry-age rating, ten prohibited attained-age rating, and eight required community rating (NAIC, 2000).

Ratings, Inc. (2002) found wide variation in premiums for identical plan designs available at to 65-year old men. Average premiums for standard products also vary widely across states (for both new issue and renewals combined), suggesting that many Medigap policyholders may be unknowledgeable about available alternatives or unable (given market underwriting) to change insurers to obtain a lower price for coverage (Chollet and Kirk 2001).

## 2. Household Surveys

All national household surveys of the population over age 65 obtain sufficient information about coverage to infer whether elderly individuals have individually purchased Medigap coverage. Most also seek information about the cost of those policies. However, two national surveys ask additional questions that may help to address public policy concerns about competition in the Medigap market – specifically, access to new coverage after age 65.

### a. *The Health and Retirement Study (HRS)*

The HRS asks about respondents over age 65 about individually purchased coverage and also the cost of coverage to policyholders. However, HRS asks two additional questions of interest. It asks individuals enrolled in managed care whether they were enrolled principally because they could not obtain Medigap coverage – a question that may suggest problems of access. Also the HRS asks all respondents enrolled in a Medigap plan how long they have held their current policy – a question that could help in understanding the relationship between mobility among Medigap carriers and premium levels – that is, whether there is competition in the Medigap market.

### b. *The Medicare Current Beneficiary Survey (MCBS)*

The MCBS also asks respondents about coverage from a Medigap plan, attempts to identify the plan type (A through J), and asks about premium payments. However, it asks virtually no questions that would help to identify or interpret problems of access or affordability for Medigap policyholders. Only one question in the MCBS instrument could hint at underwriting problems in the Medigap market: whether the most important reason that an individual joined a Medicare HMO<sup>13</sup> related to an inability to buy a Medigap plan. However, responses to this question are ranked, so that if the respondent identifies any of eleven other reasons as more important, the respondent is not asked about the difficulty of obtaining a suitable Medigap plan.<sup>14</sup>

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<sup>13</sup> MCBS has an unusual advantage in obtaining accurate information about HMO enrollment, in that it can be linked to Medicare records. Household surveys asking type of plan in which respondents are enrolled have yielded rates of HMO enrollment that are infeasible.

<sup>14</sup> In addition to the HRS and MCBS, the Medical Expenditure Panel Survey (MEPS) obtains information about individual coverage purchased by Medicare beneficiaries. MEPS asks both insured and uninsured respondents if they ever had been denied coverage because of health problems, but it does not ask when the denial occurred, for what type of product, or under what circumstances.



### **3. Administrative Data**

Every state requires health insurers to report extensive information about their Medigap business in that state. This information includes premiums earned and medical claims paid for the reporting year by standard policy form, as well as the number of policyholders covered in each policy form. Medigap insurers also must report the amount of premiums for new policies sold in the three prior years, thus indicating the extent to which they have been actively selling coverage versus renewing old business. While these data offer a much more detailed picture of Medigap markets than available household survey data, they also are very limited. They offer a much clearer picture of access for Medicare beneficiaries at age 65 (when all Medigap policies are guaranteed issue), albeit at the state level, not at the local market level. They enable calculation of average premiums, but they offer no information on actual rates or method of rating. Finally, they include the number of policyholders, but no information about the demographics of policyholders or the length of time that policyholders have renewed coverage. Consequently, they offer an intriguing glimpse of the market, but ultimately answer very few questions about how well the Medigap market serves Medicare beneficiaries.

### **C. Medicare Managed Care**

Introduced in 1997, the Medicare+Choice program (M+C) introduced major changes in Medicare managed care.<sup>15</sup> M+C expanded the types of managed care organizations eligible to contract with Medicare, changed the way they are paid, instituted greater quality assurance and improvement requirements, and increased the information offered to beneficiaries about their coverage choices.

#### **1. Issues and Concerns**

Expanding access to a choice of M+C plans and maintaining stable access to these plans are key concerns of the Medicare program, as is maintaining affordable premiums for participation. Before 1997, enrollment in Medicare managed care was growing steadily, although most participating HMOs offered only supplemental coverage (such as prescription drugs) at a low monthly premium, primarily in urban areas. In 1997 and the years that followed, many managed care organizations left the program. In 1999, 407 thousand Medicare beneficiaries were affected by plan withdrawals; this number rose to 934 thousand in 2001, and remained at 536 thousand in 2002. In 2002, 17 percent of affected beneficiaries had no alternative M+C option in their market area (Gold and McCoy 2002). In most rural counties, Medicare beneficiaries still do not have access to a Medicare managed care plan.

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<sup>15</sup> With the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare+Choice program (M+C) was renamed the Medicare Advantage (MA) program.

Many of the managed care plans that remained in the M+C program raised premiums and reduced benefits. Average monthly premiums rose 16 percent between 2002 and 2003 (to \$37 per month), while the percent of M+C enrollees with prescription drug coverage dropped from 72 percent to 69 percent. In 2003, 60 percent of plans cover only generic drugs, compared to 55 percent in 2002 and 19 percent in 2001 (Achman and Gold 2003). Voluntary disenrollment from M+C plans, while fairly low (approximately 4 percent in 2001) was nearly twice as high as in 1998 (2.1 percent). Nearly half of Medicare beneficiaries who withdrew from an M+C plan (45 percent) returned to traditional Medicare (Gold and McCoy 2002). These beneficiaries have constrained options for reenrolling in a Medigap plan to supplement Medicare benefits.<sup>16</sup>

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 changed the playing field for private plans participating in the Medicare program. MMA substantially raised monthly payment rates in 2004 and 2005 in an effort to stabilize the market and stem eroding benefits. In 2004, Medicare Advantage (MA) plans generally used the new funds to reduce premiums, restore brand-name drug coverage, or both (Achman and Harris 2005).

## **2. Household Surveys**

Many (if not all) of the national household surveys of the population over age 65 obtain sufficient information about coverage to infer whether elderly individuals have HMO coverage. They also allow the data user to distinguish between whether the respondent's HMO coverage is a benefit of present or past employment or an individual purchase, and they seek information about the cost of those policies. However, both the HRS and the MCBS ask more extensive questions about Medicare HMO enrollment.

### *a. The Health and Retirement Study (HRS)*

The HRS asks a number of questions about HMO enrollment that drive at questions of access and affordability. Of respondents enrolled in a Medicare (or Medicaid) HMO, it asks how long they have been enrolled in that specific HMO, and how much the respondent pays to participate net of deductions from their Social Security benefit. HRS also asks about recent exit (in the last two years) from a Medicare HMO and why. Responses include access to providers and services, as well as increased cost, that the plan encouraged them to leave, and that the plan itself became unavailable.

### *b. The Medicare Current Beneficiary Survey (MCBS)*

The MCBS also asks about enrollment in a Medicare HMO, and confirms whether the respondent has changed plans since the previous interview. It asks participating respondents the most important reason that they (and/or their spouse) joined the Medicare

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<sup>16</sup> Under federal law, Medigap insurers may deny beneficiaries exiting M+C plans (or employer-sponsored retiree coverage) coverage in any policy form except A, B, C or F (none of which cover prescription drugs). They also may deny applicants any policy except A if more than 63 calendar days have elapsed since disenrolling from an M+C plan.

HMO; the first optional response category is lower cost. Among respondents who had been covered by a Medicare managed care plan at the previous interview (or who refute Medicare's records indicating that they still are enrolled in a Medicare Managed Care plan), it asks the most important reason for disenrollment; optional response categories include "too expensive," "the plan went out of business or stopped Medicare coverage," and that the plan corporately changed ("plan name changed or plan was bought by/merged with another managed care plan"). MCBS also asks about coverage by any other Medicare managed care plan since the last interview.

If the respondent is not enrolled in a Medicare managed care plan, the MCBS asks if the respondent had ever heard of such a plan; whether such a plan is available locally; and whether the respondent would prefer to have any, more, or different Medicare managed care plans available to them. Respondents also are asked about their satisfaction with the information available to them to make health coverage choices.

### **3. Administrative Data**

CMS maintains Medicare Compare, a database that provides information about available M+C plans by market area, as well as the benefits they provide. When merged with enrollment numbers from CMS's State/County/Plan Market Penetration file, this information can yield area-specific estimates of enrollment and disenrollment by plan feature, as well as enrollment-weighted estimates of plan features and changes within and across service areas.<sup>17</sup>

Once these data are merged to be useful in understanding local changes in the M+C program that affect beneficiaries, they offer considerable information about access to a local plan. Medicare Compare also offers information about offers and premium levels for individual Medicare beneficiaries by local area, although it is not generally accessible as a research database.

## **D. Long-Term Care Insurance**

Despite decades of private long-term care insurance marketing, very little long-term care is yet privately insured. In 1999, Medicaid paid for half of the long-term care services used by Medicare beneficiaries, and beneficiaries paid 41 percent out-of-pocket. Less than 10 percent was paid by all other third-party payers combined, including private insurance (CMS, June 2002).

### **1. Issues and Concerns**

Access to long-term care is a significant and growing issue for the United States, as the baby boom ages, the elderly population's life expectancy increases, and the need for long term care services accelerates. The prevalence of moderate to severe and irreversible

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<sup>17</sup> For example, see Gold and Achman (2001) and Achman and Gold (2002).

dementia increases exponentially with advancing age, as does the prevalence of disabling physical problems such as osteoarthritis, osteoporosis, diabetes, severe hearing and vision impairment, and Parkinson's disease. Estimates of the baby boom's future need for long-term care swamp those of current demand, as both a larger elderly population – and a larger share of them very old – require therapeutic and personal care services that Medicare does not cover.

While the prevalence of long-term care purchase has remained low, it is expected to increase at least moderately over the next decade, as the baby boom pays greater attention to financing retirement, including health care and long-term care. Long-term care policies, like a large share of Medigap policies, typically are priced on an entry-age basis, but they have a larger asset component than entry-age Medigap policies. Policyholders are encouraged to buy policies much before they are likely to use long-term care services, and to maintain coverage (paying regular premiums to the same carrier) for many years – 30 years or more for a woman who buys a long-term care policy at age 51.

Policyholders who allow their policy to lapse (for nonpayment of premiums) lose not only current coverage, but also the asset value of their policy. They might look to buy another policy, but could pay a much higher premium associated with entering coverage at an older age.

This structure of pricing makes both the stability of coverage and indexation of benefits extremely important. If elderly policyholders finally fail to maintain coverage – neglecting to pay regular premiums because of reduced income, confusion, or illness – they are likely to lose longstanding coverage at irreplaceable prices, just as their need for long term care materializes. If benefits are not indexed appropriately to the cost of care, most of the value of a policy held over 30 or 40 years could erode – so that the policy would become increasingly inadequate as the policyholder's probability of needing care rose.

## **2. Household Surveys**

The HRS asks respondents about coverage for long term care. The HRS asks about whether the policy covers institutional care, care at home, or both; how much respondent pays for coverage; whether the respondent's spouse also is covered; whether benefits are indexed; and the premium amount. It also asks whether the respondent ever had claimed payment for long-term care services under the plan, and whether the policyholder had ever been cancelled or let a policy lapse because payments were too high (or they no longer needed coverage).

## Recommendations

### 3. Expanding the Chart Book Indicators

The chart book, *Older Americans 2000: Key Indicators of Well-Being*, currently contains no measures of health insurance coverage, access to coverage, or affordability. It includes estimates of health-related expenditures by age (from the Consumer Expenditure Survey), but does not differentiate expenditures for premiums from direct (out of pocket) expenditures for health care services.<sup>18</sup>

The companion paper prepared for this Workshop (Czajka, 2006) suggests that private supplemental insurance is sufficiently prevalent and important to elderly Medicare recipients to warrant the addition of at least one indicator – measuring coverage by source of coverage. While that indicator would indeed be most fundamental, two others would also be very useful in assessing the elderly population’s well-being: direct payment (or contributions) for premiums as a proportion of (1) total health care expenditures and (2) personal income, among individuals that have supplemental private coverage. These measures would help to track changes in the value of coverage per premium dollar paid, and also the affordability of coverage as health care costs and premiums continue to rise.

### 4. Longer-Term Data Development

Our review of the current national household surveys indicates that they offer extremely little information about access to coverage (versus current coverage status) or options for alternative coverage. While it may be infeasible to obtain extensive information from respondents about insurance options not taken, it would be valuable to understand somewhat more about the respondent’s choice set. For example, respondents without retiree coverage might be asked whether they had in the last year looked or applied for (alternative) coverage and if so, whether they had been accepted or denied coverage. If they were accepted, they might be asked why they chose not to take that coverage.

Problems of access are likely to differ among the major sources of supplemental coverage – retiree health coverage, Medigap coverage, and Medicare Advantage. But for each type of coverage, access problems are likely to be regional or local in nature – related to local labor markets and compensation norms, state regulation of insurance, managed care penetration, and insurance market structure. While geographic indicators create notorious problems of confidentiality for small samples, it may be very difficult to understand problems of access to insurance viewed only at a national level. Thus, to understand trends in private coverage, surveys based on samples representative at a market level (like the RWJF Community Tracking Survey) might offer the best information for understanding Medicare beneficiaries’ access to coverage. Linked to

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<sup>18</sup> Since the Workshop was held *Older Americans 2002: Key Indicators of Well-Being* has been re-published. See the web site of the Federal Interagency Forum on Aging Related Statistics for the most up-to-date information (<http://www.agingstats.gov>).

local-market (or even state-level) administrative data measuring the supply of coverage, such information could offer a very rich picture of access.

Several surveys – notably the HRS and MCBS, but also SIPP, MEPS, and NHIS – obtain information about premium or contribution levels. However, differences in premiums paid are impossible to interpret without also knowing the proportion of health care expenditures that the policy covered or did not cover or, at minimum, some of the basic design features of the plan. Policies that cover fewer services or narrowly limit coverage, given the level of premium they require, may be as unaffordable as policies that cost much more but also cover more. A conventional accounting measure of insurance value is the ratio of benefits returned for premiums paid. While not all surveys are designed to capture health expenditure data, those that are (such as MEPS) are uniquely positioned to understand affordability much more clearly than information about only premiums and income permit. Efforts to collect policy booklets (such as MEPS did in 1996 and BLS had done for its discontinued Employee Benefits Survey) are more arduous, but may be worthwhile periodically to establish and update benefits benchmarks.

Like changes in access, changes in the value of coverage might be best understood at a state or local level—where survey findings might translate to public policy. However, MEPS relies on a relatively small population sample – related to the complexity and cost of capturing expenditure information. Even so, greater attention to developing even national estimates of benefits changes, by type and source of coverage, would offer substantially more information about the affordability of coverage, and affordability trends, than is available today.

Finally, it would be of considerable interest to obtain information from more than one source about whether elderly Americans hold long-term care insurance and some features related to the adequacy of coverage. At minimum, it would be useful to know whether the policy value was indexed, what event (e.g., one or more ADL impairments) would trigger payment, whether individuals hold more than one policy, and (if no coverage) reasons for not having purchased long-term care coverage. As the baby boom enters old age, a more detailed understanding of the demand for long-term care coverage will become increasingly important in developing national policy for financing their care.

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## Discussant's Remarks

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## Discussant's Remarks

The two papers written by John Czajka and Deborah Chollet offer an excellent description of the data that are available to describe the health insurance of elderly Americans. Czajka's overview concentrates on actual coverage and benefits, while Chollet's concentrates on the availability and affordability of health insurance choices for people over age 65. In that sense, using concepts suggested 25 years ago by Andersen and Aday for thinking about access to health care,<sup>1</sup> one might say that Czajka describes realized access to health insurance while Chollet describes potential access.

Looking beyond realized access to potential access is just as important in studying health insurance as health care itself. Health insurance patterns among the elderly are the net result of two factors: (1) the menu of insurance options that are available to each person through public and private sources, and (2) the decisions made by each person in choosing from those options.

There are a number of good reasons for distinguishing between potential and realized access in collecting data about the health insurance of elderly Americans. First, characteristics of the plans chosen by elderly consumers are not necessarily a good indication of the choices that were available in the first place. For example, average premiums will be lower for actual coverage compared to available coverage, if buyers are attracted to plans with lower premiums. Also, because potential access accounts for the number and affordability of the alternatives available to consumers, it is a good indicator of the competitiveness of health insurance markets. After all, where enrollees are locked into their current plans because of the uneven geographic distribution of Medicare + Choice products, for example, or by individual health problems that a new insurer would refuse to cover, incumbent plans are freer to charge higher prices or skimp on service. Finally, empirical studies that are aimed at predicting the effect of policy changes on insurance purchases are likely to reach false conclusions if they fail to account for differences in the choices that different people could make.

Both Czajka and Chollet give particular emphasis to data that are available from household surveys. However, as both mention, relevant data can also be obtained from other sources, including administrative sources and employer surveys. Probably the most important administrative source is the Medicare program itself. Czajka makes use of administrative data from the Medicare program to compare the number of elderly Medicare enrollees to the number of elderly Americans, thereby calculating the number of elder people without Medicare. In addition, state Medicaid agencies have information about their enrollees and report some of it to the federal Center for Medicare and Medicaid Services. As Chollet notes, there are regulatory databases with information about Medigap products that private insurers must submit to state insurance commissioners. Finally, with about a third of beneficiaries currently supplementing Medicare with insurance obtained from employers, according to the figures in Czajka's

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<sup>1</sup> R. Andersen and L.A. Aday, Access to medical care in the U.S.: Realized and potential. *Medical Care* 16(7): 533-46, July 1978.

paper, employer surveys are another source of information about the health insurance of older Americans.

Czajka offers a useful list of high-priority questions regarding health insurance for the elderly:

- Who has what coverage and benefits?
- What are their demographic and economic characteristics?
- How have coverage and benefits changed?
- How continuous are coverage and benefits?
- What role does geography play?

To this list, Chollet essentially adds two more:

- What health insurance choices are available to the elderly?
- How affordable are these choices?

Household surveys are better suited to answering some of these questions than others. In the rest of my comments, I will discuss the relative strengths and weaknesses of household surveys, administrative data, and employer surveys in obtaining different types of data regarding the health insurance of the elderly. I will also suggest that we need these data for at least four different uses. When I array the available data against the uses of data, I conclude that there are important limitations in the availability of data for some purposes. However, some of these limitations may be difficult to overcome.

As shown in Table 1, household surveys that ask about expenditures, as well as those that ask about insurance, are relevant in measuring health insurance. In particular, health care expenditures that are *not* paid by insurance, but are paid out-of-pocket, are a good summary indication of the overall generosity of an insured person's coverage (or, more exactly, its inverse). Out-of-pocket expenditures are especially meaningful as a measure of insurance generosity when expressed as a share of total health care expenditures, as advocated by Chollet, or as a measure of affordability when expressed as a share of income. Indeed, when analysts have had access to detailed health insurance provisions, they have used the information to calculate the share of total expenses that would be paid out of pocket in order to compare and summarize across a wide variety of policies<sup>2</sup>

Household respondents can provide reasonably good information about the sources of their insurance (for example, whether obtained from a current or former employer or directly from an insurance company). Over time, survey researchers have also developed acceptable approaches for identifying HMO enrollees in household surveys. Most household surveys also ask about covered services, particularly whether a person has insurance that covers prescription drugs. Expenditure surveys ask primarily about out-of-pocket expenses for health care and insurance premiums. The Medical Expenditure Panel Survey obtains information about total health care expenditures by supplementing

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<sup>2</sup> P.F. Short and J. Banthin, New estimates of the underinsured younger than 65 years. *JAMA* 274(16):1302-06, October 25, 1995.

household reports with data obtained from the sample's health care providers, and the Medicare Current Beneficiary Survey combines household reports with Medicare claims to estimate total health care expenditures.

Household respondents cannot reliably describe their health insurance arrangements in any detail. Nor can they provide reliable data concerning the total cost of health insurance that is partly (or entirely) financed by employers. Household respondents are unlikely to know or remember much about the options that they did not select. Consequently, as indicated in detail in Table 1, administrative sources and employer surveys are virtually the only sources of detailed data concerning plan types and provisions, premiums for employer-sponsored insurance, and options or potential access.

Corresponding to the columns of Table 1, there are at least four major uses for data concerning the health insurance of elderly Americans. The data are needed to monitor trends and to identify significant disparities across the population. Data are also needed for policy analyses and to estimate behavioral parameters (such as the responsiveness of health insurance choices to premium or benefit differences). From left to right across the table, these uses demand increasingly more of the data. To monitor trends requires only that health insurance data be collected consistently and repeatedly. Consequently, trends are available for every type of data shown in the table.

To monitor disparities, health insurance data must be linked to individual characteristics or collected by geographic location, so the data available for this purpose are somewhat spottier. In particular, because administrative files contain only a limited set of individual characteristics (such as age) and employer surveys have no individual information, there is little information about individual disparities regarding aspects of health insurance that can only be monitored through these sources. On the other hand, because most surveys are not designed with samples large enough to make estimates for local areas, administrative sources are the main source of detailed information regarding geographic disparities. In addition, confidentiality concerns limit the release of survey data files with identifiers for geographic areas as small as states or metropolitan areas.

Like the monitoring of disparities, policy simulations require health insurance data that are linked to individual and geographic characteristics. However, policy analyses usually require many data elements of both types, in order to model the health insurance changes in the policy proposal and the number and characteristics of people who would be eligible for or affected by the policy. Luckily, it is often enough to get these relationships right "on average," so policy simulations sometimes use imputation or statistical matching to merge data originally collected from multiple sources. However, the feasibility and quality of these merges is limited by the lack of individual characteristics in data obtained from administrative records and employers and the lack of detailed geographic information in household surveys.

Behavioral analyses also require a large number of health insurance details (to describe "the behavior") and a large number of individual details (to describe the decision-maker and the decision-making context). However, for this purpose, all of the details for

specific individuals must be linked together correctly. Errors or random variation in associating factors predicting behavior with the behavior itself will bias estimates of behavioral effects towards zero. No data source allows analysts to model the behavior of elderly individuals as they select a specific health insurance plan, described in terms of its price and benefit provisions, from an explicit set of alternatives (with their prices and benefit provisions). Nor are there data to support modeling of expenditures, the supplementation of Medicare from all sources, or other topics mainly covered in household surveys at the market level.

Selective changes to existing data sources and creative use of available data could overcome some of these limitations. Out-of-pocket expenditures can often serve as a good substitute for detailed descriptions of plan benefits that cannot be obtained from household respondents. The utility of administrative data systems maintained by Medicare and Medicaid could be enhanced by adding a few more individual characteristics for direct analysis and statistical matching. Increasingly, statistical agencies are allowing users to link geographic identifiers to household surveys in controlled data centers. Multiple years of data can sometimes be combined to make estimates for smaller geographic areas. More can be done with statistical matching of data from different sources. Exact linkages of survey data with administrative records (for example, through the use of Social Security numbers) can also be pursued, although these linkages can be quite costly in terms of money and the timeliness of data. Exact linkages also raise confidentiality concerns and are prone to high levels of missing data when surveys are required to follow elaborate, legalistic procedures in asking respondents for permission to make the linkages.

I conclude that existing data systems already provide good coverage of trends and disparities in the health insurance of the elderly. However, while we have a good picture of realized access, our view of potential access is somewhat cloudier. I also believe that behavioral analyses involving large-scale, national data sources will always be severely constrained by the inability of household respondents to report on their actual coverage or options in any detail.

**Table 1. Availability of data from different sources, by type of data and uses**

| Type/source of data  | Uses of data |   |  |  |
|--|--------------|---|--|--|
|  | Trends       | Disparities   | Policy analyses  | Behavioral analyses                    |
| <b>Household Surveys</b>   |              |   |  |  |
| <b><u>Insurance</u></b>  | Yes          |   |  |  |
| All sources of insurance (Medicare, Medicaid, employer, Medigap)       |              | According to many individual characteristics                                  | Involving individuals, but not markets   | Involving individuals, but not markets |
| HMO enrollment   |              | Usually only for large geographic areas (census division, sometimes by state) |  |  |
| Covered services   |              |   |  |  |
| <b><u>Expenditures</u></b>   | Yes          |   |  |  |
| Out-of-pocket health care expenses                                     |              | According to many individual characteristics                                  | Involving individuals, but not markets   | Involving individuals, but not markets |
| Share of health expenses out of pocket                                 |              | Usually only for large geographic areas (census division, sometimes by state) | Difficult to account for changes in out-of-pocket expenses associated with policy-induced changes in utilization or insurance. |  |
| Out of pocket premiums   |              |   |  |  |
| Share of income for out of pocket premiums and/or health care expenses |              |   |  |  |
| <b>Administrative Data</b>   |              |   |  |  |
| <b><u>Public programs</u></b>  | Yes          |   |  |  |
| Program enrollment in aggregate and by type                            |              | Only for individual characteristics captured in enrollment files              | Involving markets, but not individuals   | Involving markets, but not individuals |
| Choices and premiums for Medicare + Choice by local area               |              | By geographic area  |  |  |

**Table 1. Availability of data from different sources, by type of data and uses (cont'd)**

| Type/source of data  | Uses of data |  |   |   |
|--|--------------|--|---|---|
|  | Trends       | Disparities  | Policy analyses                                     | Behavioral analyses                                 |
| <b>Administrative Data (cont'd)</b>  |              |  |   |   |
| <b><u>Insurance regulation</u></b>   | Yes          |  |   |   |
| Medigap enrollment by plan type and prices   |              | By state   | Unlikely  | Unlikely  |
| <b>Employer Surveys</b>  |              |  |   |   |
| Enrollment, premiums, covered services, benefit provisions of current retirees         | Yes          | By employer characteristics                                  | Involving employers, but not individuals or markets | Involving employers, but not individuals or markets |
| Options (premiums, covered services, benefit provisions) available to current retirees |              | Not by individual characteristics                            |   |   |
| Retirement benefits promised to active workers   |              | Usually only for very large geographic areas (census region) |   |   |

# **Discussants' Remarks: Gathering Critical Information about the Health Coverage of the Elderly**

*Melinda Beeuwkes Buntin and Jeannette A. Rogowski, RAND*

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## **Discussants' Remarks: Gathering Critical Information about the Health Coverage of the Elderly**

Knowledge about the health insurance coverage, use of health care services, and health status of the elderly is critical for policymakers and providers. Much of the information that policymakers currently rely on comes from national surveys. But both decision makers and researchers are concerned that current knowledge levels are inadequate. Both groups have expressed a strong interest in gathering more information about consumers, utilization, and outcomes. In this context, the Federal Interagency Forum on Aging-related Statistics workshop fostered an important discussion about the key indicators of trends in health and health insurance for the elderly.

At first glance, it might seem that the easiest way to increase our knowledge about elders' health care would be to expand existing surveys. Unfortunately, the current economic climate has made funders less willing to support expensive survey work. Further, data is becoming more difficult to collect as concerns grow about confidentiality and health care consumers and providers succumb to "survey fatigue." A different approach is needed. In order to expand the amount of information collected about insurance coverage and the health status of the elderly, the research community will need to take better advantage of the information collected about those topics for other reasons.

Workshop participants identified three broad categories of questions about health insurance coverage for the elderly. They are:

- What types of coverage do the elderly have?
- What are the characteristics of beneficiaries with each type of coverage?
- What are the benefits covered by these policies?

These are all important questions, and such information clearly needs to be collected about nationally representative samples of the elderly.

Of course, researchers and policymakers already have some information on these subjects. As Czajka and Chollet note in other papers in this volume, current national surveys do a good job of collecting information about the types of coverage held by the elderly. Surveys produce valuable information about enrollment in public programs such as Medicare and Medicaid and about privately purchased insurance – both individual coverage and employer-sponsored coverage. Surveys also quantify the extent to which the elderly are uninsured.

This is no surprise as surveys are well positioned to collect information about the characteristics of the elderly. They can collect detailed self-reported demographic data about respondents. Some surveys (e.g. the Health and Retirement Survey [HRS]) collect extensive information on income and assets, others collect information about out-of-pocket spending for a wide variety of health care services (e.g. the Medicare Current Beneficiary Survey [MCBS]). They also collect information about respondents' perceived access to care and unmet needs for care.



However, researchers and policymakers need access to more than just a description of the health insurance coverage of the elderly. It is vitally important to better understand how health outcomes relate to that coverage. Some of the data needed to address that question is already available. The national surveys of the elderly discussed at the workshop do collect good information about respondents' health status and functioning. This information includes self-reported health status, self-reported diagnoses, and self-reported functional limitations. All of the surveys will, therefore, support observational studies that correlate insurance coverage with health status.

Estimating a causal relation is difficult, however, due to the potential for endogeneity. These types of estimation problems have been successfully addressed in prior research on the use of medical services among the elderly by the use of historical information such as job histories to identify the effects of insurance coverage. A strength of longitudinal surveys such as the HRS and PSID is the direct observation of historical variables for respondents. For surveys that are not longitudinal in nature, this could be remedied by asking respondents a key set of historical questions.

Survey data about the health outcomes of the elderly could be improved in two other ways as well. First, living arrangements are an important indicator of health outcomes for the elderly. Elderly persons generally prefer to remain in their homes if possible, and thus a transition to assisted living or a nursing home can represent an undesired outcome of a health decline in and of itself. A transition out of independent living in the community can also capture an overall decline in functioning past a point where a person can care for himself or herself. It can thus serve as a summary measure of health status and indicate a key change in health status that may not be captured by diagnoses or even measures of activities of daily living. In addition, the aging of the population has led to an explosion in the range of housing arrangements available to elders. Better identification of the living arrangements of the elderly, and the supportive services available to them in those locations, would be a valuable addition to national surveys.

Second, the benefits provided by private health insurance plans are another area where improved data could be useful to researchers and policymakers. Given the debate about adding prescription drug coverage to Medicare, more information about the drug coverage and the use of pharmaceuticals by the elderly is needed to both shape federal policy and to track the effects of such coverage if it is offered. The other characteristics of supplemental insurance, especially managed care plans and employer-sponsored policies that differ from the standard Medigap policies, are also poorly understood. Agreement about a standard set of key characteristics of these plans would facilitate uniform data collection in this area. Offers of employer-sponsored retiree insurance that are turned down are another important dimension of coverage that should be added to national surveys— and one that only surveys can track (Chollet, 2003).

In an era of diminishing resources and response rates it is not feasible to simply add questions to existing surveys. In order to collect information in these new areas,

therefore, researchers need to look aggressively for ways to get the most information out of our limited budgets and time with respondents.

One way to do this is to take greater advantage of existing administrative data sources that can be linked to national surveys. Data from Medicare and Medicaid administrative records as well as data collected about Medicare HMOs could be linked to survey responses. Social Security and public employee retirement benefit programs could provide data. The VA and the Department of Defense could also theoretically provide data. Linking information from these sources to data collected using surveys would reduce the amount of time that surveys must devote to collecting that information.

Linked data from federal sources alone could provide information about personal characteristics, health status, health care use, and many sources of coverage. Most of the elderly are covered by Medicare, so basic information about their demographics is available in enrollment records. Social Security records contain data on income and earnings histories. These records may, in fact, be more useful than current self-reported income among the elderly who may have low incomes but large assets such as an unmortgaged home. Medicare claims records can provide diagnostic information and information about types and amounts of care accessed. In addition, new patient assessment instruments, such as the Minimum Data Set for nursing home residents (MDS), are being collected by the Centers for Medicare and Medicaid Services. These assessments capture information about patients' health status and functioning, and are filled out for all residents of Medicare- or Medicaid-certified nursing homes, not just those whose care is paid for by public programs. The Centers for Medicare and Medicaid Services has also developed a centralized dataset that includes Medicaid claims for beneficiaries in all 50 states. Finally, nearly a third of Medicare beneficiaries with supplemental coverage get it through Medicaid or a Medicare HMO. A significant fraction supplement Medicare with VA, military retiree, or public employee retirement programs. Enrollment in these sources of supplemental coverage and the benefits covered under them can be collected from government agencies.

Linkages of this sort are feasible. Indeed, there are good precedents for them. The MCBS has always incorporated Medicare claims and administrative data into its public use files. The HRS has recently completed a successful effort to link Medicare claims to its survey responses. In order to do this it obtained permission to link the records from respondents. New CMS repositories of Medicaid data and nursing home patient assessment data will make linking these additional sources of administrative easier than it might have been in the past.

In summary, surveys are absolutely necessary for collecting certain types of information — including many of the new data elements suggested at the workshop. However, they are expensive to field, place a burden on respondents, and are increasingly suffering from declining response rates. In addition, federal funding for expansions of these surveys is unlikely, so adding new questions will likely need to be balanced by eliminating others.

Administrative data sources contain much of the information that researchers and policymakers seek about insurance coverage held by the elderly. They also contain largely untapped information about health status and functioning. Linking these data sources to national surveys would be a wise investment and could free up respondent time and survey resources for other items that only surveys can collect.

## Closing Comments

### Questions-and-Answers

Dr. Thesia Garner expressed concern about privacy and the use of administrative data. Dr. Chollet noted that some administrative data sets are audited, but other data are suspect. Confidentiality issues depend on who matches the data and who has control over matched data. Source organizations can sequester databases and require researchers to use the data only in that setting. Generally, if the reasons for matching the data are compelling, the means for preserving confidentiality are compelling. Respondents are increasingly reluctant to give Social Security numbers, which are required for matching data. Dr. Buntin noted that respondents are more likely to provide Medicare numbers, which permits data linking. Dr. Judith Kasper commented on the technical difficulty of data matching. Fortunately, there is an established system for matching data and maintaining confidentiality through the use of data centers. A participant pointed out that providing a Social Security number and permitting a researcher to match your data are two different issues. It might be possible to match data using the last four digits of a Social Security number.

Dr. David Weir remarked that more detailed consent forms reduce the response rate, and respondents do not necessarily feel more secure with more information. In general, survey response rates are declining, and empirical work is needed to determine the causal factors. Dr. Short suggested that researchers should consider carefully the occasions when linked data really are necessary. Data matching is not always essential, and there are many research questions for which obtaining an average estimate and a sense of the larger correlations is sufficient.

Dr. Bruce Stuart remarked that the need to link data depends on their use. For policy research and some behavior research, data linking is critical. He observed that although the discussion has focused on insurance coverage, one way to achieve coverage for more elderly individuals is to reduce the transaction price. For example, drug discount cards often offer significant savings and confer value. Such programs might provide the services elderly people need without being insurance coverage per se. Lower prices are a substitute for insurance, and those interested in improving coverage among the elderly should consider alternative options.

Dr. Marsha Gold commented on the need to consider the effect of health care system changes on administrative data sources. Administrative data on cost and use represent a relatively small piece of the data, but they are growing in importance. Federal agencies should consider coordinating data collection in a special sample survey. Such a survey would rotate through special questions asked every few years.

## Recommendations and Facilitated Discussion

Dr. Czajka made the following recommendations for expanding the Chartbook indicators:

- *Include as an indicator the percentage of Medicare beneficiaries who supplement their coverage and in what ways*—This indicator would highlight the limits of Medicare and would probably show a significant change over time.
- *Include as an indicator the coverage of persons without Medicare*—Such an indicator would complement the current composition of the Chartbook. However, samples of about 500 may not support analyses of interest with sufficient precision. Another potential problem is that survey undercoverage may be concentrated in this segment.

Dr. Czajka presented the following recommendations for data development priorities:

*Incorporate more information on benefits into person-level databases*—Although researchers have considered this a priority for many years, the obstacles have been difficult to overcome. To advance the issue, perhaps Federal agencies might lead an effort to identify what has worked, what has not worked, and what could work to enhance the insurance information in person-level databases.

*Fill the data gaps identified in the four key data sources for Medicare and supplemental insurance coverage among the elderly*—It would be particularly helpful if both NHIS and MEPS obtained more complete information on whether individuals participate in Medicare Parts A and B. The NHIS should collect information on the Medigap plan letter and its associated enrollment.

*Learn more about the population without Medicare and identify additional data needs to advance our understanding of this group*—Analysis of this population might reveal that undocumented immigration plays a role in lack of insurance coverage. Advancing this issue will probably require novel approaches to survey research.

Dr. Chollet supported Dr. Czajka's recommendations for the Chartbook indicators and added the following:

- Current health insurance coverage by source (especially retiree health insurance benefits)
- Premiums paid as a percentage of total health expenditures and personal income (i.e., financial burden on households)

Dr. Chollet recommended the following data development priorities:

- To better measure access:
  - Examine new coverage in the last year and the type of coverage taken up
  - Ask whether coverage was offered or denied
  - Determine the respondent's reasons for purchase/acceptance or rejection

- To better measure affordability (the most proximate data need):
  - Examine the premium paid per total expenditures for health care
- To better understand the impact of geography on access and affordability of health insurance among the elderly population, obtain regional, State, and market estimates.

### *Facilitated Discussion*

Because identifying an individual's state raises confidentiality concerns, Dr. Gold suggested categorizing states according to coverage availability and market characteristics. Such categorization might provide the necessary contextual variables without privacy violations. Dr. Jennifer Madans, Associate Director for Science at NCHS, noted that the number of useful categories would be too large. Unfortunately, it does not take much information to identify a state. Dr. Gold remarked that an interagency group might work on the issue.

Several researchers commented that the amenities at and remote access to federal data centers could be improved. Obtaining access to the centers present practical and budgetary challenges to many investigators.

A participant noted that survey respondents are often not accurate when they describe their insurance coverage. The field should develop a framework for addressing this issue and other challenges to conducting surveys on insurance. Dr. Steve Cohen commented that the data sources vary in accuracy. Substantive information is available to assess the accuracy of expenditure surveys. Generally, reports of insurance use and high-level coverage are fairly accurate, although the reports of benefit details are questionable. Administrative data can produce national estimates to benchmark survey results.

### **Conclusion**

Ms. D.E.B. Potter, Chair of the Workshop Planning Committee, thanked the participants. She remarked that the Planning Committee would distribute the two commissioned papers with discussant comments incorporated. Dr. Steve Cohen expressed special appreciation to the speakers and thanked all participants for their contributions to a productive discussion.

## Epilogue

### Passage of the Medicare Modernization Act (MMA)

*John Czajka, Mathematica Policy Research*

Paper prepared after the  
Health Insurance for the Elderly: Issues in Measurement Workshop, April 2003

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## Epilogue

On December 8, 2003, just seven months after the Workshop, the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173). The changes introduced into Medicare by the MMA will affect aspects of the health insurance coverage of the elderly discussed at the Workshop. Most notably, Title I of the Act establishes a significant prescription drug benefit that becomes available to Medicare beneficiaries on January 1, 2006. Identified as Part D, the new program is open to Medicare beneficiaries who are entitled to Part A or enrolled in Part B. Participants in Part D pay a discounted monthly premium, currently priced at just under \$37.<sup>1</sup> Low-income beneficiaries pay lower premiums and lower coinsurance costs. In addition, the prescription drug coverage provided under Medicaid to full-benefit dual eligibles was converted to a Medicare drug plan.

Title II of the MMA replaces the Medicare+Choice program (Part C) with the new Medicare Advantage (MA) program, intended to provide beneficiaries with greater access to coordinated private plans—particularly regional PPOs. Enrollees in MA are able to obtain Part D or even more comprehensive drug coverage through their individual plans. Medigap drug coverage was affected as well. The limited prescription drug coverage that was provided to beneficiaries holding Medigap plans H, I, and J is no longer offered to new enrollees in those plans, and it is anticipated that many enrollees will elect to replace their existing drug coverage with the more comprehensive and less costly Part D. Lastly, a separate retiree subsidy will enable employers and unions to provide prescription drug coverage to retirees at lower costs than they paid previously.

The changes introduced by the MMA will generate new data needs as well. It will be important to know which Medicare beneficiaries are enrolled in Part D or obtaining an equivalent or even greater level of coverage under an MA plan. Furthermore, knowing that a Medicare beneficiary is enrolled in one of Medigap plans H, I, or J will no longer be sufficient to document that individual's drug coverage. The enrollment date will be needed to determine whether drug coverage is included in the plan. The prospective changes to private plan offerings under MA will increase the importance of documenting both access to such coverage and the types of plans in which Medicare beneficiaries choose to enroll.

To the extent that beneficiaries' choices are documented in the Medicare administrative files, this information will become available to the MCBS. The other surveys, however, will have to develop new questions to capture these same aspects of coverage that the MCBS can obtain from administrative data, and all of the surveys—including the MCBS—will be tasked to develop additional questions to capture nuances of coverage and, especially, access, that are not recorded in the administrative files.

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<sup>1</sup> Current information on Part D premium costs is available from the Official U.S. Government Site for People with Medicare (<http://www.medicare.gov/>).



## **Appendix 1:**

### **Agenda for the Health Insurance for the Elderly: Issues in Measurement Workshop, April 29, 2003**

## Health Insurance for the Elderly: Issues in Measurement Workshop

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Bureau of Labor Statistics Conference Center, 2 Massachusetts Avenue, NE, Basement–Floor G, Washington, D.C.  
April 29, 2003

### FINAL AGENDA

- 8:30–9:00 a.m.** Continental Breakfast
- 9:00–9:10** Welcome and Introduction  
*Chair of Morning Session: Steven B. Cohen*  
*Agency for Healthcare Research and Quality*
- 9:10–9:30** Overview of Health Insurance Options for the Elderly  
*Mary Laschober, BearingPoint, Inc. (formerly KPMG Consulting)*

*INDIVIDUAL TALKS TO FOCUS ON THE FOLLOWING QUESTIONS FOR SPECIFIC TOPICS:  
Present issues related to coverage? Future issues? What should be measured?*

- 9:30–9:45** Employer-sponsored insurance  
*Paul Fronstin, Employee Benefit Research Institute*
- 9:45–10:00** Medigap  
*Tom Rice, University of California at Los Angeles*
- 10:00–10:15** Medicare Managed Care  
*Carlos Zarabozo, Centers for Medicare and Medicaid Services*
- 10:15–10:30** Medicaid  
*Judy Kasper, Johns Hopkins University*
- 10:30–10:45** Break
- 10:45–11:15** Q&A/Discussion
- 11:15–11:30** Prescription drug coverage  
*Bruce Stuart, University of Maryland*
- 11:30–11:45** Long-term care  
*Marc Cohen, LifePlans Inc.*
- 11:45 – 12:15 p.m.** Q&A/Discussion

**(Agenda continued)**

**12:15–1:30**

Lunch (*on your own*)

Chair of Afternoon Session: *Jon Gabel*  
Health Research and Educational Trust

**1:30–2:30**

Presentation and Discussion of Commissioned Paper #1—  
Data sources/measures on actual coverage and benefits  
*John Czajka, Mathematica Policy Research*

Discussants: *Pamela Farley Short, Pennsylvania State University*  
*Jeannette A. Rogowski, RAND*  
*Melinda Beeuwkes Buntin, RAND*

**2:30–2:45**

Break

**2:45–3:45**

Presentation and Discussion of Commissioned Paper #2—  
Data sources/measures on accessibility and affordability  
*Deborah Chollet, Mathematica Policy Research*

Discussants: *Pamela Farley Short, Pennsylvania State University*  
*Jeannette A. Rogowski, RAND*  
*Melinda Beeuwkes Buntin, RAND*

**3:45–5:00**

Facilitated discussion on the intersection of policy issues and data needs

**5:00**

Adjourn

## **Appendix 2:**

### **Summary of Major Data Sources Available To Measure Health Insurance for the Elderly**

# Summary of Major Data Sources Available to Measure Health Insurance for the Elderly

Web site addresses provided in this Appendix were valid as of March 7, 2006.

## Federal Sources

### Agency for Healthcare Research and Quality (AHRQ)

#### *Medical Expenditure Panel Survey*

The Medical Expenditure Panel Survey (MEPS) is an ongoing annual survey of the civilian noninstitutionalized population that collects detailed information on health care use and expenditures (including sources of payment), health insurance, income, health status, access, and quality of care. MEPS, begun in 1996, is the third in a series of national probability surveys conducted by the Agency for Healthcare Research and Quality on the financing and use of medical care in the United States. To yield more complete information on health care spending and payment sources, followback surveys of health providers are conducted for a subsample of events in MEPS.

#### *Medical Expenditure Panel Survey–Household Component (MEP–HC)*

The HC collects data on a sample of families and individuals across the Nation, drawn from a nationally representative subsample of households that participated in the prior year's NCHS National Health Interview Survey. The objective is to produce annual estimates for a variety of measures of health status, health insurance coverage, health care use and expenditures, and sources of payment for health services. These data are used to generalize to people in the civilian noninstitutionalized population of the United States, as well as to conduct research in which the family is the unit of analysis. The panel design of the survey, which features several rounds of interviewing covering 2 full calendar years, makes it possible to determine how changes in respondents' health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. Because the data are comparable to those from earlier medical expenditure surveys, it is possible to analyze long-term trends.

#### *Medical Expenditure Panel Survey–Insurance Component (MEP–IC)*

The IC consists of two subcomponents, the household sample and the list sample. The household sample collects detailed information on the health insurance held by and offered to respondents to the MEPS HC.<sup>1</sup> The number of employers and union officials interviewed varies from year to year, as the number of respondents in the previous year's HC varies. These data, when linked back to the original household respondent, allow for the analysis of individual behavior and choices made with respect to health care use and spending. The list sample consists of a sample of business establishments and governments throughout the United

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<sup>1</sup> The MEPS IC linked to the MEPS Household Survey is conducted periodically and was conducted in 1996-1999 and again in 2001.

States. From this survey, national, regional, and State-level estimates (for almost all States each year) can be made of the amount, types, and costs of health insurance available to Americans through their workplace.

For more information, contact: MEPS Project Director  
Phone: (301) 427-1656  
E-mail: [mepspd@ahrq.gov](mailto:mepspd@ahrq.gov)  
Internet: <http://www.meps.ahrq.gov>

## **Bureau of Labor Statistics (BLS)**

### *Current Employment Statistics (CES)*

Each month the Current Employment Statistics (CES) program surveys about 160,000 businesses and government agencies, representing approximately 400,000 individual worksites, in order to provide detailed industry data on employment, hours, and earnings of workers on nonfarm payrolls.

For more information, contact: U.S. Bureau of Labor Statistics, Division of Current Employment Statistics  
Phone: (202) 691-6555  
Email: [cesinfo@bls.gov](mailto:cesinfo@bls.gov)  
Internet: <http://www.bls.gov/CES>

### *National Compensation Survey (NCS)*

The NCS provides data on employer expenditures for wages, salaries, and benefits, as well as details of employer-provided benefits. Data are shown by sector of the economy (private industry, and State and local government), occupational groups, selected worker characteristics (such as full time and part time, and union and nonunion), and establishment characteristics (such as number of employees and geographic area). NCS benefits measures cover the incidence and detailed provisions of selected employee benefit plans. Data are presented as the percentage of employees who have access to, or participate in, a broad selection of prevailing benefits. Limited provision data are available for benefits such as leave (paid vacations, and holidays), disability insurance (short-term and long-term), and life insurance. NCS provides extensive provision data for two major benefit areas: (1) health insurance and (2) retirement (both defined-benefit and defined-contribution plans) (Source: [http://www.bls.gov/opub/hom/homch8\\_a.htm](http://www.bls.gov/opub/hom/homch8_a.htm)).

For more information, contact: U.S. Bureau of Labor Statistics, Office of Compensation and Working Conditions  
Internet: <http://www.bls.gov/ncs/home.htm>

### *Employee Benefits Survey (EBS)*

This survey has been discontinued. For additional information see “*Employee Benefits Survey: A BLS Reader* (February 1995) - (only in hard copy) (Source: <http://www.bls.gov/ncs/ebs/home.htm>).

### **Centers for Disease Control and Prevention (CDC)**

#### *Behavioral Risk Factor Surveillance System (BRFSS)*

The BRFSS is a telephone survey conducted by the health departments of all states, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam with assistance from CDC. The BRFSS is the largest continuously conducted telephone health surveillance system in the world. States use BRFSS data to identify emerging health problems, to establish health objectives and track their progress toward meeting them, and to develop and evaluate public health policies and programs to address identified problems. The BRFSS is the primary source of information for states and the nation on the health-related behaviors of adults. States collect data through monthly telephone interviews with adults aged 18 years or older. BRFSS interviewers ask questions related to behaviors that are associated with preventable chronic diseases, injuries, and infectious diseases (Source: [http://www.cdc.gov/NCCDPHP/aag/aag\\_brfss.htm](http://www.cdc.gov/NCCDPHP/aag/aag_brfss.htm)).

For more information, contact: BRFSS  
Internet: <http://www.cdc.gov/brfss/index.htm>

### **Centers for Medicare and Medicaid Services (CMS)**

#### *Medicare Current Beneficiary Survey (MCBS)*

The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to help the Centers for Medicare & Medicaid Services (CMS) administer, monitor, and evaluate the Medicare program. The MCBS collects information on health care use, cost, and sources of payment; health insurance coverage; household composition; sociodemographic characteristics; health status and physical functioning; income and assets; access to care; satisfaction with care; usual source of care; and how beneficiaries get information about Medicare.

MCBS data enable CMS to determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and noncovered services; develop reliable and current information on the use and cost of services not covered by Medicare (such as prescription drugs and long-term care); ascertain all types of health insurance coverage and relate coverage to sources of payment; and monitor the financial effects of changes in the Medicare program. Additionally, the MCBS is the only source of multidimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services and information about the Medicare program. The MCBS sample consists of Medicare enrollees in the community and in institutions.

The survey is conducted in three rounds per year, with each round being 4 months in length. MCBS has a multistage, stratified, random sample design and a rotating panel survey design.

Each panel is followed for 12 interviews. In-person interviews are conducted using computer-assisted personal interviewing. Approximately 16,000 sample persons are interviewed in each round. However, because of the rotating panel design, only 12,000 sample persons receive all three interviews in a given calendar year. Information collected in the survey is combined with information from CMS administrative data files and made available through public-use data files.

For more information, contact: MCBS Staff  
E-mail: [MCBS@cms.hhs.gov](mailto:MCBS@cms.hhs.gov)  
Internet: <http://www.cms.hhs.gov/mcbs>

The Research Data Assistance Center  
Phone: (888) 973-7322  
E-mail: [resdac@umn.edu](mailto:resdac@umn.edu)  
Internet: <http://www.resdac.umn.edu>

#### *CMS Medicare Administrative Data*

##### *Medicare Managed Care Market Penetration for All Medicare Plan Contractors - Quarterly State/County/Plan Data Files*

For more information, contact: Russell Hendel (extraction of data, production/ update of web file), Joanne Weller (contact for obtaining Zip-gender-age data\*1, liaison for CMS component responsible for payment files), James Dorsey (liaison for CMS component responsible for payment files)

Email: [Rhendel@Cms.Hhs.Gov](mailto:Rhendel@Cms.Hhs.Gov), [Jweller@Cms.Hhs.Gov](mailto:Jweller@Cms.Hhs.Gov), [Jdorsey1@Cms.Hhs.Gov](mailto:Jdorsey1@Cms.Hhs.Gov)  
Internet: <http://www.cms.hhs.gov/healthplans/statistics/mpscpt/>

#### *Medicare Compare*

A consumer database with detailed comparisons of the benefits, costs, consumer satisfaction survey results and standardized quality measures of available managed care plans across the country.

For more information, contact: CMS  
Internet: <http://www.medicare.gov/Download/DownloadDB.asp>

#### *Medicare Consumer Assessment of Health Plans Survey (Medicare CAHPS)*

An annual nationwide survey that is used to report information on Medicare beneficiaries' experiences with managed care plans. The results are shared with Medicare beneficiaries and the public.

For more information, contact: CMS  
Internet: <http://www.resdac.umn.edu/OtherDataSets/CAHPS.asp>,  
[http://www.cms.hhs.gov/ConsumerResearch/05\\_CAHPS.asp](http://www.cms.hhs.gov/ConsumerResearch/05_CAHPS.asp)



## **Department of Veterans Affairs (VA)**

### *National Survey of Veterans, 2001*

The 2001 National Survey of Veterans (NSV) is a multipurpose survey used primarily to describe characteristics of the veteran population and of users and nonusers of Department of Veterans Affairs (VA) benefit programs. Survey topics include sociodemographic and economic characteristics, military background, health status measures, and VA and non-VA benefits usage. NSV was conducted by telephone with approximately 20,000 veterans, and interviews lasted an average of 35 minutes. The target population is all veterans residing in households in the United States and Puerto Rico. Because of the aging of the veteran population and the sampling methodology, a large portion (40 percent) of the sample is of veterans age 65 and over. The Department of Veterans Affairs Web site provides many data tables that classify veterans by age, including the 65 and over age group.

For more information, contact: Susan Krumhaus

Phone: (202) 273-5108

E-mail: [Susan.Krumhaus@mail.va.gov](mailto:Susan.Krumhaus@mail.va.gov)

Internet: <http://www.va.gov/vetdata/surveyresults/index.htm>;

<http://www.va.gov/vetdata/surveyresults/index.htm>

### *Survey of Veteran Enrollees' Health and Reliance Upon VA, 2003*

The 2003 Survey of Veteran Enrollees' Health and Reliance Upon VA is the fourth in a series of surveys of veteran enrollees for VA health care conducted by the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), under multiyear OMB authority. Previous surveys of VHA-enrolled veterans were conducted in 1999, 2000, and 2002. All four VHA surveys of enrollees consisted of telephone interviews with stratified random samples of enrolled veterans. In 2000, 2002, and 2003, the survey instrument was modified to reflect VA management's need for specific data and information on enrolled veterans.

As with the other surveys in the series, the 2003 Survey of Veteran Enrollees' Health and Reliance Upon VA sample was stratified by Veterans Integrated Service Network, enrollment priority, and type of enrollee (new or past user). Telephone interviews averaged 12-15 minutes in length. In the 2003 survey, interviews were conducted during August-September 2003. Of approximately 6.7 million eligible enrollees who had not declined enrollment as of December 31, 2002, some 42,000 completed interviews in the 2003 telephone survey.

VHA enrollee surveys provide a fundamental source of data and information on enrollees that cannot be obtained in any other way except through surveys and yet are basic to many VHA activities. The primary purpose of the VHA enrollee surveys is to provide critical inputs into VHA Health Care Services Demand Model enrollment, patient and expenditure projections, and the Secretary's enrollment level decision processes; however, data from the enrollee surveys find their way into a variety of strategic analysis areas related to budget, policy, or legislation.

VHA enrollee surveys provide particular value in terms of their ability to help identify not only who VA serves but also to help supplement VA's knowledge of veteran enrollees' demographic characteristics, including household income, health insurance coverage status, functional status (ADL and IADL limitations) and perceived health status, their other eligibilities and resources, their use of VA and non-VA health care services and "reliance" upon VA, and their potential future use of VA health care services.

For more information, contact: Dee Ramsel, Ph.D.

Phone: (414) 384-2000, ext. 42353

E-mail: [dee.ramsel@med.va.gov](mailto:dee.ramsel@med.va.gov)

Internet: <http://www.va.gov/vetdata/healthcare/index.htm>

### **National Center for Health Statistics (NCHS)**

#### *National Health Interview Survey (NHIS)*

The National Health Interview Survey (NHIS), conducted by the National Center for Health Statistics, is a continuing nationwide sample survey in which data are collected during personal household interviews. Interviewers collect data on illnesses, injuries, impairments, and chronic conditions; activity limitation caused by chronic conditions; utilization of health services; and other health topics. Information is also obtained on personal, social, economic, and demographic characteristics, including race and ethnicity and health insurance status. Each year the survey is reviewed, and special topics are added or deleted. For most health topics, the survey collects data over an entire year.

The NHIS sample includes an oversample of black and Hispanic people and is designed to allow the development of national estimates of health conditions, health service utilization, and health problems of the noninstitutionalized civilian population of the United States. The response rate for the ongoing part of the survey has been between 94 percent and 98 percent over the years. In 1997, the NHIS was redesigned; estimates beginning in 1997 are likely to vary slightly from those for previous years. The interviewed sample for 2002 consisted of 36,161 households, which yielded 93,386 persons in 36,831 families.

For more information, contact: NHIS staff

Phone: (866) 441-NCHS

E-mail: [nchsquery@cdc.gov](mailto:nchsquery@cdc.gov)

Internet: <http://www.cdc.gov/nchs/nhis.htm>

### **National Institute on Aging (NIA)**

#### *Health and Retirement Survey/Assets and Health Dynamics Among the Oldest-Old (HRS/AHEAD)*

The Health and Retirement Study (HRS) is a national panel study conducted by the University of Michigan's Institute for Social Research under a cooperative agreement with the National Institute on Aging. In 1992, the study had an initial sample of over 12,600 people from the 1931-1941 birth cohort and their spouses. The HRS was joined in 1993 by a companion study,

Asset and Health Dynamics Among the Oldest Old (AHEAD), with a sample of 8,222 respondents born before 1924 who were age 70 and over and their spouses. In 1998, these two data collection efforts were combined into a single survey instrument and field period and were expanded through the addition of baseline interviews with two new birth cohorts: Children of the Depression Age (CODA—1924–1930) and War Babies (WB—1942–1947). Plans call for adding a new 6-year cohort of Americans entering their 50s every 6 years. In 2004, baseline interviews will be conducted with the Early Boomer birth cohort (1948–1953). The combined studies, which are collectively called HRS, have become a steady state sample that is representative of the entire U.S. population age 50 and over (excluding people who were resident in a nursing home or other institutionalized setting at the time of sampling). HRS will follow respondents longitudinally until they die (including following people who move into a nursing home or other institutionalized setting). All cohorts will be followed with biennial interviews.

The HRS is intended to provide data for researchers, policy analysts, and program planners who make major policy decisions that affect retirement, health insurance, saving, and economic wellbeing. The study is designed to explain the antecedents and consequences of retirement; examine the relationship between health, income, and wealth over time; examine life cycle patterns of wealth accumulation and consumption; monitor work disability; provide a rich source of interdisciplinary data, including linkages with administrative data; monitor transitions in physical, functional, and cognitive health in advanced old age; relate late-life changes in physical and cognitive health to patterns of spending down assets and income flows; relate changes in health to economic resources and intergenerational transfers; and examine how the mix and distribution of economic, family, and program resources affect key outcomes, including retirement, spending down assets, health declines, and institutionalization.

For more information, contact: Health and Retirement Study Staff

Phone: (734) 936-0314

E-mail: [hqsquest@isr.umich.edu](mailto:hqsquest@isr.umich.edu)

Internet: <http://hrsonline.isr.umich.edu>

#### *National Long-Term Care Survey (NLTCs)*

The National Long Term Care Survey is funded through a Cooperative Agreement (2 U01 AG0007198) between the National Institute on Aging (NIA) and Duke University's Center for Demographic Studies. It is a longitudinal survey designed to study changes in the health and functional status of older Americans (aged 65+). It also tracks health expenditures, Medicare service use, and the availability of personal, family, and community resources for caregiving. The survey began in 1982, and follow-up surveys were conducted in 1984, 1989, 1994, and 1999. A sixth follow-up survey will be conducted during 2004.

The NLTCs survey population consists of a sample of 35,000 people drawn from national Medicare enrollment files in 1982 that has been augmented with subsequent samples of approximately 20,000 Medicare enrollees obtained by adding 5,000 people passing age 65 between successive surveys done approximately every five years. This technique ensures a large, nationally-representative sample at each point in time. Both elderly in the community (including those not impaired) and those residing in institutions are represented in the samples.

The survey is administered by the U.S. Census Bureau using trained interviewers, and the response rate is above 95 percent for all waves.

Supplemental surveys consist of the Next-of-Kin, Caregiver, and Blood and Buccal surveys done under subcontract with ASPE and the Research Triangle Institute (RTI). (Source: <http://nltns.cds.duke.edu/>)

For more information, contact: Center for Demographic Studies, Duke University  
Email: [vwlewis@cds.duke.edu](mailto:vwlewis@cds.duke.edu)  
Internet: <http://nltns.cds.duke.edu/>

### **National Science Foundation (NSF)**

#### *Panel Study of Income Dynamics (PSID)*

The Panel Study of Income Dynamics (PSID) is a nationally representative, longitudinal study conducted by the University of Michigan's Institute for Social Research. It is a representative sample of U.S. individuals (men, women, and children) and the family units in which they reside. Starting with a national sample of 5,000 U.S. households in 1968, the PSID has reinterviewed individuals from those households annually from 1968 to 1997 and biennially thereafter, whether or not they are living in the same dwelling or with the same people. Adults have been followed as they have grown older, and children have been observed as they advance through childhood and into adulthood, forming family units of their own. Information about the original 1968 sample individuals and their current co-residents (spouses, cohabitants, children, and anyone else living with them) is collected each year. In 1990, a representative national sample of 2,000 Hispanic households, differentially sampled to provide adequate numbers of Puerto Ricans, Mexican Americans, and Cuban Americans, was added to the PSID database. With low attrition rates and successful recontacts, the sample size grew to almost 8,000 in 2003. PSID data can be used for cross-sectional, longitudinal, and intergenerational analyses and for studying both individuals and families.

The central focus of the data has been economic and demographic, with substantial detail on income sources and amounts, employment, family composition changes, and residential location. Based on findings in the early years, the PSID expanded to its present focus on family structure and dynamics as well as income, wealth, and expenditures. Wealth and health are other important contributors to individual and family well-being that have been the focus of the PSID in recent years.

The PSID wealth modules measure net equity in homes and nonhousing assets divided into six categories: other real estate and vehicles; farm or business ownership; stocks, mutual funds, investment trusts, and stocks held in IRAs; checking and savings accounts, CDs, treasury bills, savings bonds, and liquid assets in IRAs; bonds, trusts, life insurance, and other assets; and other debts. The PSID measure of wealth excludes private pensions and rights to future Social Security payments.

For information, contact:  
Frank Stafford  
Phone: (734) 763-5166

E-mail: [fstaffor@isr.umich.edu](mailto:fstaffor@isr.umich.edu) or [psidhelp@isr.umich.edu](mailto:psidhelp@isr.umich.edu)  
Internet: <http://psidonline.isr.umich.edu/>

## **U.S. Census Bureau**

### *Current Population Survey (CPS)*

The Current Population Survey (CPS) is a nationally representative sample survey of about 60,000 households conducted monthly for the Bureau of Labor Statistics (BLS) by the U.S. Census Bureau. The CPS core survey is the primary source of information on the labor force characteristics of the civilian noninstitutionalized population age 16 and over, including estimates of unemployment released every month by the BLS. Monthly CPS supplements provide additional demographic and social data. The Annual Social and Economic Supplement (ASEC), or March CPS Supplement, is the primary source of detailed information on income and poverty in the United States. The ASEC is used to generate the annual Population Profile of the United States, reports on geographical mobility and educational attainment, and detailed analyses of money income and poverty status.

### *Current Population Survey Insurance Verification Question (in the March Supplement of the Annual Social and Economic Supplement)*

The Annual Social and Economic (ASEC) Supplement provides the usual monthly labor force data, but in addition, provides supplemental data on work experience, income, noncash benefits, and migration. Comprehensive work experience information is given on the employment status, occupation, and industry of persons 15 years old and over. Additional data for persons 15 years old and older are available concerning weeks worked and hours per week worked, reason not working full time, total income and income components, and residence on March 1, 2004. Data on employment and income refer to the preceding year, although demographic data refer to the time of the survey (Source: <http://www.census.gov/aprd/techdoc/cps/cpsmar04.pdf>).

For more information regarding the CPS, its sampling structure and estimation methodology, see “Explanatory Notes and Estimates of Error.” (Explanatory notes and estimates of error. *Employment and Earnings* 51(1):269–86. U.S. Department of Labor, Bureau of Labor Statistics. January 2004).

For more information on the CPS, contact: Division of Labor Force Statistics Staff  
Phone: (202) 691–6378  
E-mail: [cpsinfo@bls.gov](mailto:cpsinfo@bls.gov)  
Internet: <http://stats.bls.gov/cps/home.htm>

### *Survey of Income & Program Participation (SIPP)*

The main objective of SIPP is to provide accurate and comprehensive information about the income and program participation of individuals and households in the United States, and about the principal determinants of income and program participation. SIPP offers detailed information on cash and non-cash income on a sub-annual basis. The survey also collects data

on taxes, assets, liabilities, and participation in government transfer programs. SIPP data allow the government to evaluate the effectiveness of federal, state, and local programs. The survey design is a continuous series of national panels, with sample size ranging from approximately 14,000 to 36,700 interviewed households. The duration of each panel ranges from 2 1/2 years to 4 years. The SIPP sample is a multistage-stratified sample of the U.S. civilian noninstitutionalized population. For the 1984-1993 panels, a panel of households was introduced each year in February. A 4-year panel was introduced in April 1996. A 2000 panel was introduced in February 2000 for 2 waves. A 3-year 2001 panel was introduced in February 2001.

The SIPP content is built around a "core" of labor force, program participation, and income questions designed to measure the economic situation of persons in the United States. These questions expand the data currently available on the distribution of cash and noncash income and are repeated at each interviewing wave. The survey uses a 4-month recall period, with approximately the same number of interviews being conducted in each month of the 4-month period for each wave. Interviews are conducted by personal visit and by decentralized telephone.

The survey has been designed also to provide a broader context for analysis by adding questions on a variety of topics not covered in the core section. These questions are labeled "topical modules" and are assigned to particular interviewing waves of the survey. Topics covered by the modules include personal history, child care, wealth, program eligibility, child support, disability, school enrollment, taxes, and annual income.

For more information, contact: Judith Eargle,  
Phone: (301) 763-3819  
Internet: <http://www.sipp.census.gov/sipp/>

## **Other Sources**

### **American Hospital Association (AHA)**

See the Health Research and Educational Trust.

### **The Commonwealth Fund**

The Commonwealth Fund has several ongoing surveys related to the elderly population. For information on their *Biennial Health Insurance Survey* and other Commonwealth efforts see <http://www.cmwf.org/>.

### **Health Research and Educational Trust (HRET)**

The Health Research and Educational Trust, a charitable trust of the American Hospital Association, has conducted the *Employer Health Benefits Annual Survey* since the late 1980's. For additional information see <http://www.hret.org/hret/index.jsp>.

## **Robert Wood Johnson Foundation (RWJ)**

*Center for Studying Health System Change, Community Tracking Study Surveys (CTS).*

The CTS includes periodic national surveys of households (including an insurer followback), physicians and employers. The survey samples are concentrated in 60 communities that were randomly selected to provide a representative profile of change across the U.S. Among these communities, 48 are "large" metropolitan areas (with populations greater than 200,000), from which 12 communities were randomly selected to be studied in depth. Those 12 communities have larger survey samples and also comprise the communities used for the site visits.

The survey data can be used to draw conclusions for the nation and for individual communities. Having data from multiple surveys for a common set of sites permits analysts to relate the individual-level measures obtained from one survey to market-level health system characteristics obtained from the other surveys. Note, however, that there are no links between any of the survey respondents in the household, physician and employer surveys (e.g., respondents to the Household Survey are not patients of physicians in the Physician Survey).

For more information, contact: the Center for Studying Health System Change

Phone: 202.484.5261

Email: [hscinfo@hschange.org](mailto:hscinfo@hschange.org)

Internet: <http://hschange.org/>

## **State Health Access Data Assistance Center, Coordinated State Coverage Survey (SHADAC)**

The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is funded by The Robert Wood Johnson Foundation to help states monitor rates of health insurance coverage and to understand factors associated with uninsurance. SHADAC provides targeted policy analysis and technical assistance to states that are conducting their own health insurance surveys and/or using data from national surveys.

For more information, contact: SHADAC

Phone: 612-624-4802

Email: [shadac@umn.edu](mailto:shadac@umn.edu).

Internet: <http://www.shadac.umn.edu/about/>

## **Henry J. Kaiser Family Foundation**

The Kaiser Family Foundation has several ongoing surveys related to the elderly population, including the *Kaiser/Hewitt Survey on Retiree Health Benefits*. For details on the survey and other Foundation efforts see <http://www.kff.org/>.

## **Appendix 3**

### **Biographical Sketches of Workshop Speakers**



# Health Insurance for the Elderly: Issues in Measurement Workshop

Co-sponsored by:

## Federal Interagency Forum on Aging-Related Statistics and the Agency for Healthcare Research and Quality

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April 29, 2003

Bureau of Labor Statistics Conference Center  
Washington, D.C.

### Biographical Sketches (in order of the speaker's presentation)

**Steven B. Cohen, Ph.D.**, is Director, Center Financing, Access and Cost Studies at the Agency for Healthcare Research and Quality (AHRQ). Dr. Cohen directs a staff of 50 highly trained and skilled economists, statisticians, social scientists, and clinicians in support health care policy and behavioral research. He received his M.S. and his Ph.D. in biostatistics from the University of North Carolina.

Dr. Cohen directs the Center's administration of surveys, including the Medical Expenditure Panel Survey. He has authored more than 100 journal articles and publications in the areas of biostatistics, survey research methodology, estimation, survey design, and health services research. Articles by Dr. Cohen have appeared in *Effective Clinical Practice*, *Inquiry*, and the *Journal of Rural Health*. In 1997, he was elected a Fellow of the American Statistical Association and awarded AHRQ's Health Policy Researcher of the Year.

**Mary A. Laschober, Ph.D.**, Senior Manager with the Health Economics Practice of BearingPoint in McLean, VA, for 5 years, is an economist with more than 11 years of experience in health policy analysis. Her work has concentrated on Medicare beneficiary information needs and communication strategies, Medicare managed care markets, the Medicare Savings Programs, and Medicare supplemental insurance coverage. Dr. Laschober has provided extensive analytical assistance to the Centers for Medicare & Medicaid Services (CMS) to examine the information needs of Medicare and Medicaid beneficiaries and to determine the most effective communication strategies for disseminating information to them. In addition to reports discussing implications for CMS's social marketing strategy, Dr. Laschober directed/authored summary reports for African American, Latino, Medicare/Medicaid "dual eligibles," and rural beneficiaries, as well as beneficiaries with low education or literacy skills and vision- or hearing-impairments.

Dr. Laschober's recent work includes a Kaiser Family Foundation-sponsored national survey to study the effects of the 1998 Medicare HMO withdrawals on involuntarily disenrolled Medicare beneficiaries, and an empirical assessment of trends in Medicare beneficiaries' supplemental insurance and drug coverage. Findings from both studies appeared in *Health Affairs (Millwood)*. For CMS, Dr. Laschober has been Principal Investigator for an analysis of enrollment and disenrollment reasons, patterns, and trends in the Medicare+Choice (M+C) program; the development of alternative M+C model standardized benefit packages; an evaluation of the new 2003 M+C Part B premium reduction benefit plans; a new national survey to better understand the experiences of beneficiaries newly enrolled in Medicare; and a Congressionally mandated study of projected beneficiary and Medicare program impacts from termination of the cost-contracting Medicare HMO program. For dually eligible beneficiaries, she conducted an evaluation of a CMS-sponsored pilot program to increase enrollment in the Medicare Savings Programs, produced an interactive CD-ROM of dual-eligible outreach and barrier reduction strategies, and a comparative profile of program participants and nonparticipants. She will soon be examining dually eligible beneficiaries' ratings of Medicare managed care plans using the MMC-Consumer Assessment of Health Plans Study data.

Before BearingPoint, Dr. Laschober was a Senior Economist at Westat, where she was co-lead in developing the charge and payment imputation methods for the Medicare Current Beneficiary Survey (MCBS). She also co-authored a study of the demand for out-of-network services by Medicare HMO enrollees, presented at the 1996

AHSR annual meeting, and produced an annual MCBS data compendium in *Health and Health Care of the Medicare Population*.

**Paul Fronstin, Ph.D.**, is a Senior Research Associate with the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute's Health Security and Quality Research Program. He has been with EBRI since 1993. Dr. Fronstin earned his Bachelor of Science degree in economics from SUNY Binghamton and his Ph.D. in economics from the University of Miami.

Dr. Fronstin's research interests include trends in employment-based health benefits, consumer-driven health benefits, the uninsured, retiree health benefits, employee benefits and taxation, and public opinion about health care. He has published in numerous journals, including *Health Affairs (Millwood)*, *EBRI Issues Brief*, and *Benefits Quarterly*. He currently serves on the steering committee for the Mellon College Retirement Project, the board of advisors for CareGain, and on the Maryland State Planning Grant Health Care Coverage Workgroup.

**Thomas Rice, Ph.D.**, is Professor of Health Services in the UCLA School of Public Health. Dr. Rice received his doctorate in economics at the University of California at Berkeley in 1982.

His areas of interest include health insurance, cost containment, Medicare, and the role of competition and regulation in health care markets. The second edition of his book, *The Economics of Health Reconsidered*, was published by Health Administration Press in 2003. From 1994 to 2000, he served as the editor of the *Medical Care Research and Review Journal*. His articles have been published in the *Journal of Health Economics*, *Health Affairs*, and the *Journal of the American Medical Association*. Dr. Rice has received the Young Investigator Award (1988) and the Article-of-the-Year Award (1998) from the Academy for Health Services Research and Health Policy (currently, AcademyHealth). He is chairing the 2003 Annual Research Meeting of AcademyHealth.

Dr. Rice served as Department Chair from 1996 to 2000. Before joining the faculty at UCLA in 1991, he was a faculty member at the University of North Carolina School of Public Health.

**Carlos Zarabozo** is currently (and since 1993) a Social Science Research Analyst in the Policy Planning and Analysis Group, Office of Research, Demonstrations and Information of the Centers for Medicare & Medicaid Services (CMS, formerly HCFA).

His primary areas of interest are Medicare managed care, general managed care and insurance issues, and Medicare reform proposals. Mr. Zarabozo has authored or co-authored various articles on managed care and drug benefits, which have appeared in *Health Care Financing Review* and *Health Affairs (Millwood)*. He was co-author of the Medicare managed care chapter in *The Managed Health Care Handbook* (Peter Kongstvedt, editor; numerous editions).

Mr. Zarabozo joined the Office in December of 1993. From 1991 through the end of 1993, he was Director of the policy office within HCFA's Office of Prepaid Health Care Operations and Oversight. From 1988 until 1991, he was Special Assistant to the Director of HCFA's Office of Prepaid Health Care (and successor organizations). From 1984 through 1988, Mr. Zarabozo was contract specialist in the Office of Prepaid Health Care, and in HCFA's San Francisco regional office. He has served as a consultant in health care reform for the Agency for International Development, the World Bank, and the Pan American Health Organization in the Czech Republic, Slovakia, Argentina, Chile, and Costa Rica.

**Judith D. Kasper, Ph.D.**, is a Professor in the Department of Health Policy and Management in The Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, and a Senior Research Associate in the Center for Health Services Research and Development. Dr. Kasper holds a Ph.D. in sociology from the University of Chicago.

Her research and teaching interests include health policy in disability and long-term care, assessment of needs for care and service provision to physically and mentally disabled people, health care financing and access for vulnerable population, and the development and application of data sources for health policy analysis and health services research. She has published in numerous journals in the fields of health policy, health services research, and aging, including *Health Services Research*, the *Milbank Quarterly*, and the *Journal of Gerontology*.

Dr. Kasper has been Principal or Co-Principal Investigator on several studies of vulnerable elderly people. These include the Women's Health and Aging Study (WHAS), a longitudinal study of 1,000 functionally limited older women that addresses trajectories in disability and the influence of personal and social characteristics, disease, and health care; a study of caregiving to the WHAS population; a study of access to care and unmet needs among low income elderly people with Medicare and Medicaid coverage; and a longitudinal study of health services use and outcomes for community-dwelling elderly persons with Alzheimer's disease and other dementia. She has extensive experience in the design, conduct, and analysis of national population-based surveys that address significant health policy and health services research issues, and was a member of the research teams that developed and implemented the 1977 National Medical Care Expenditure Survey (now the MEPS conducted by the Agency for Healthcare Research and Quality [AHRQ]), and the Medicare Current Beneficiary Survey (conducted by CMS).

Dr. Kasper joined the Department in 1987, having previously served as Senior Analyst in the Office on Research of the Health Care Financing Administration (now the Center for Medicare & Medicaid Services, or CMS) from 1983 to 1987, and as Senior Researcher at the National Center for Health Services Research (now AHRQ) from 1977 to 1983.

**Bruce Stuart, Ph.D.**, is Professor and Executive Director of the Peter Lamy Center on Drug Therapy and Aging at the University of Maryland. Dr. Stuart is an economist and health services researcher. He received his economics training at Whitman College and Washington State University.

Dr. Stuart is an experienced research investigator, having directed numerous grants and contracts with the National Institute on Aging (NIA), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the Assistant Secretary for Planning and Evaluation in DHHS, private foundations, State governments, and private corporations. Among his current projects are a study of disease management, formulary design, and other managed care policies on Medicaid recipients with asthma funded by AHRQ; an analysis of cost differences between demented and nondemented nursing home residents for NIA, an analysis of quality indicators for prescription coverage of the elderly for The Commonwealth Fund; and a study of the impact of prescription coverage on Medicare Part A and B spending for CMS. Dr. Stuart co-authored the book *Medicare's Disabled Beneficiaries: The Forgotten Population in the Debate Over Drug Benefits* and a report on "Graying of Medicare's Disabled Population: Implication for a Medicare Drug Benefit."

He began his career in health services research as an economic analyst and later Director of the Health Research Division in the Michigan Medicaid program in the early 1970s. Leaving State government for academe, Dr. Stuart taught health economics, finance, and research methods at the University of Massachusetts and The Pennsylvania State University. In 1997, he joined the faculty of the University of Maryland School of Pharmacy as the Parke-Davis endowed Chair in Geriatric Pharmacotherapy and was selected as a Maryland Eminent Scholar for his work in geriatric drug use.

**Marc A. Cohen, Ph.D.**, is President of LifePlans, Inc., a long-term care insurance services, risk management and research company in Waltham, MA. The company works with insurers, HMOs, foundations, and trade associations on issues related to private and public initiatives in long-term care financing for the elderly and disabled. Dr. Cohen received his Ph.D. from the Heller School at Brandeis University and his Master's Degree from the Kennedy School of Government at Harvard University.

Dr. Cohen has conducted extensive research and analysis on a variety of public policy issues affecting the development and growth of the long-term care insurance market. He also has developed a number of insurance

products and programs for the elderly, conducted research and analysis on issues affecting long-term care financing and delivery, and has conducted the only national studies of individual purchasers and nonpurchasers of long-term care insurance. He recently completed the first industrywide study of long-term care insurance claimants, which was sponsored by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation, and is currently working on a new study of claimants.

Dr. Cohen has published widely on topics related to long-term care insurance, services utilization, and the interactions between the public and private market as well as on public policies affecting the elderly. He has been asked to testify before Congress, provide testimony to congressional committees and government agencies, and consult to insurers, HMOs, and retirement communities.

**John L. Czajka, Ph.D.**, senior fellow at Mathematica Policy Research, Inc. This title is reserved for individuals who have nationally recognized expertise in a policy or research field, have established Mathematica as a leader in a technical or methodological area, and have an outstanding record of achievement in directing large and complex projects.

Czajka, who has a Ph.D. in sociology from the University of Michigan, joined Mathematica in 1978 as a research sociologist and has built a strong reputation for his substantial technical contributions to the statistical field. His work has focused on development of administrative data files, small area estimation, census taking, policy analysis, and the evaluation of estimates obtained from survey data. He has also directed many studies of health insurance coverage, including analyses of the dynamics of coverage over time and the impact of the State Children's Health Insurance Program on trends in children's coverage.

Czajka's work for the Internal Revenue Service has improved the practice of statistics at the Statistics of Income Division, one of the federal government's major statistical agencies. His research for clients such as the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, and the Social Security Administration has been widely cited. Czajka is the immediate past president of the Washington Statistical Society and a fellow of the American Statistical Association.

**Deborah J. Chollet, Ph.D.**, is a Senior Fellow at Mathematica Policy Research in Washington, DC. Dr. Chollet conducts and manages research on private health insurance coverage, markets, and regulation, including employer-sponsored health plans for workers and retirees, individual health insurance, and Medicare supplement plans. She holds M.A. and Ph.D. degrees in economics from the Maxwell School of Citizenship and Public Affairs at Syracuse.

As a senior consultant to the Robert Wood Johnson Foundation's *State Coverage Initiatives* program, she regularly provides direct technical assistance to States on matters related to private health insurance coverage and markets. Dr. Chollet currently serves on the Medicare study panel of the National Academy of Social Insurance and on the editorial boards of *Benefits Quarterly*, the *Journal of Insurance Issues*, and *Health Administration Press*. She co-authored *Mapping State Health Insurance Markets: Structure and Changes in the States' Group and Individual Health Insurance Markets, 1995-1997* and has published articles in the *Journal of Health Politics, Policy, and Law*; *Medicare Brief*; and *Health Affairs (Millwood)*. Her previous positions include Vice President of Alpha Center (now AcademyHealth), Director of the Center for Risk Management and Insurance Research and Associate Professor of Risk Management and Insurance at Georgia State University, Senior Researcher at the Employee Benefit Research Institute, and Assistant Professor of Economics at Temple University.

**Pamela Farley Short, Ph.D.**, is a Professor of Health Policy and Administration at The Pennsylvania State University, where she is also Director of the Center for Health Care and Policy Research. She obtained her Ph.D. in economics from Yale University in 1984.

An economist, Dr. Short's current and recent research involves public and private health insurance programs, the uninsured, and the economic consequences of cancer survival. Her work regularly appears in *Health Affairs*, *Health Services Research*, and *Inquiry*. Dr. Short is currently the Principal Investigator on a grant from The

Commonwealth Fund to continue her studies of health insurance dynamics, for which she is well known. Before joining the faculty of Penn State in 1997, Dr. Short was a Senior Economist in the Washington office of RAND and Director of RAND's Center for the Study of Employee Health Benefits. For a number of years, Dr. Short was a Senior Manager in the intramural research program of the Agency for Healthcare Policy and Research, where she helped to direct the design and analysis of the 1987 National Medical Expenditure Survey. Dr. Short has worked in the White House for the Council of Economic Advisers as the Senior Staff Economist for health care issues. She served on President Clinton's Task Force on Health Care Reform and consulted with the first Bush Administration on the design of its reform proposals.

**Jeannette Rogowski, Ph.D.**, is a Senior Economist at RAND with more than 15 years of research experience in health economics. She is also an adjunct Senior Fellow of the Leonard Davis Institute of Health Economics at the University of Pennsylvania. Dr. Rogowski is the director of RAND's Center for Employer Sponsored Health and Pension Benefits. Her ongoing research includes studies of the effects of health insurance availability and premium cost on retirement and gender differences in access to employment-based retirement benefits. Dr. Rogowski earned her Ph.D. in economics from Massachusetts Institute of Technology and a Bachelor of Science from the University of Michigan.

Dr. Rogowski is nationally recognized for her research on health insurance for older workers. She has written many articles on the subject and has served in high-level advisory capacities to the White House, the Secretary of Labor, and other government agencies on issues related to health insurance for the near elderly. She currently serves as Chair of the Health Services Advisory Committee for the Health and Retirement Survey, a large, ongoing panel survey of the elderly and near elderly funded by the National Institute on Aging. In that role, she has oversight of the health insurance, utilization, and expenditure components of the survey. Dr. Rogowski also serves on the HRS Steering Committee. Articles by Dr. Rogowski have appeared in *Pediatrics*, *American Journal of Public Health*, *Health Affairs (Millwood)*, and *Health Care Financing Review*.

In related research, Dr. Rogowski also serves as the Co-director of RAND's Center for Health Care Markets and Vulnerable Populations. Her research in this area includes studying the effects of changing health care market structure on access to care for vulnerable populations and on the quality of care provided by safety net hospitals. In recognition of leadership in her fields of work, Dr. Rogowski was named a Fellow of the Association for Health Services Research.

**Melinda Beeuwkes Buntin, Ph.D.**, is a Health Economist at RAND in Arlington, VA. She graduated from the Ph.D. Program in Health Policy at Harvard University where she concentrated in health economics and specialized in the economics of the Medicare program. Her dissertation was entitled "Risk Selection in the Medicare Program" and included chapters on techniques for modeling health care costs, the effect of benefits packages on risk selection among Medicare+Choice Plans, and the costs of Medicare beneficiaries at the end-of-life.

Dr. Buntin is working on projects related to Medicare physician payment rates, Medicare financing of end-of-life care, Medicare+Choice plan benefits packages, and the market for individual health insurance policies in California. She is also the Principal Investigator on a project to develop a cost, quality, and access to care monitoring system for Medicare postacute care generally, with a focus on the effects of the inpatient rehabilitation prospective payment system. She has published articles in *Health Affairs*, *Inquiry*, and *The Gerontologist*.

## **Appendix 4:**

### **Glossary Resources on Health Insurance Terms**

## **Glossary Resources on Health Insurance Terms**

The reader is directed to the following resources.

Web site addresses provided in this Appendix were valid as of February 27, 2006.

### **Interagency Forum on Aging Related Statistics: Glossary**

Developed by the Interagency Forum on Aging Related Statistics this glossary is included in the Aging Forum's report *Older America's 2004: Key Indicators of Well Being*. This document is posted on the Aging Forum's web site:

URL: <http://www.agingstats.gov/chartbook2004/glossary.html>

### **Definitions of Health Insurance Terms**

In February 2002, the Interdepartmental Committee on Employment-based Health Insurance Surveys approved a set of definitions for use in federal surveys collecting employer-based health insurance data. This document is posted on the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey web site:

URL: <http://www.meps.ahrq.gov/MEPSDATA/ic/ICDefinitions.htm>

### **Glossary of Terms Found on the CMS Web Site**

This glossary explains terms found on the Centers for Medicare and Medicaid Services (CMS) web site and contains many terms specific to health insurance for older Americans.

URL: <http://www.cms.hhs.gov/glossary/>