

The Structure of Supplemental Insurance for Medicare Beneficiaries

by Marsha Gold and Jessica Mittler

Although Medicare is a uniform, nationwide program, there are multiple and sometimes overlapping markets for supplemental coverage. As a result, beneficiaries face a range of choices for supplemental insurance from employers, Medicaid, and the individual private Medigap and Medicare HMO market. In local communities, information about these options comes from numerous organizations, further com-

Employer-Based Coverage

The relatively fortunate Medicare beneficiaries—more than one in three—have some form of group coverage through their own or their spouse's former employer or union (34 percent) and/or through their service in the military (6 percent) (see Table 1). Of those with employer-based coverage, 24 percent have it as a result of their own employment and 15 percent through a spouse, with some

having both. Most beneficiaries with group coverage have it as their only source of supplemental insurance. Some also have other coverage (see Table 2).

Individuals with employer-based coverage are fortunate on several accounts.

- First, they have access to a fairly comprehensive set of benefits to supplement Medicare. For example, in 1998, 90 percent of those with employer-based supplemental insurance had prescription drug coverage, compared to 73 percent of all Medicare beneficiaries (Poisal and Murray, 2001).
- Second, they typically pay less for the coverage because their former employer subsidizes all or part of the premium. Of those covered by an employer group in the MPR survey, 33 percent said their employers covered the entire premium, 42 percent

part of it, and 18 percent none of it (6 percent did not know).

- Third, supplemental coverage is associated with socioeconomic and health status characteristics (Pourat et al., 2000); beneficiaries with group-based coverage have substantially higher incomes and socioeconomic status and are less likely to be in fair/poor health than others (see Table 3).

Medicare HMOs for Groups. Employers often do not include Medicare health maintenance organizations (HMOs) in their retiree benefits package. This market, however, is more relevant to Medicare managed care than many assume. While only 13 percent of those with group coverage are enrolled in Medicare HMOs, these enrollees accounted for more than a quarter of Medicare HMO enrollees in 2000.

Employers may not offer Medicare HMOs for several reasons (Fox, 2000). For example, if an HMO is not offered to active workers, it is unlikely to be offered to retirees. Medicare HMOs are also not available in certain communities, making it more difficult for national firms with highly dispersed workforces to offer such plans. Also, plans switch in and out of Medicare, requiring employers to restructure their Medicare retiree benefit options if the choices they offer are no longer available. In the past, some managed care organizations had a Medicare HMO product

The Medicare supplemental market is highly complex, creating challenges for beneficiary education and choice and also for Medicare reform.

plicating choice for Medicare beneficiaries. This Operational Insights, based on research conducted by Mathematica Policy Research, Inc. (MPR), describes the different kinds of supplemental coverage, whom they attract, and what this means for beneficiary education and design of Medicare reform. The structure of the Medicare supplemental market has important policy implications.

Table 1

Sources of Supplemental Coverage by Type, 2000

	All Beneficiaries	All Beneficiaries in Counties with Medicare+Choice
Any group coverage	38%	40%
Employer	34	37
Self	24	27
Spouse	15	16
Military	6	6
Any Medicaid	14	13
Any Medigap	21	22
Any Medicare HMO	16	24
Any other	14	13
None	17	13

SOURCE: MPR Survey of Medicare Beneficiaries, 2000

NOTE: Individuals may have multiple forms of coverage, so totals are more than 100 percent. Data are self-reported except for Medicare HMO status, which comes from Health Care Financing Administration records.

to service employee accounts with both active workers and retirees. However, this may be less true today, with some major national firms, such as CIGNA and Aetna, exiting many Medicare markets.

When employers offer HMOs to Medicare-eligible retirees, they often have their retirees join the Medicare HMO's basic plan, and then they may add and pay for a rider to cover additional benefits the employer plan covers that are outside the basic Medicare HMO package, such as additional prescription drug coverage. This allows employers to take advantage of the supplemental benefits Medicare HMOs offer at no additional expense. Without this, employers could be liable for these costs.

Information Needs. Beneficiaries need to understand fully the supplemental coverage choices available to them through their employer's retirement plan. For example, an employer may not offer all (or any) of the Medicare+Choice options in the area, so if beneficiaries enroll in such a plan, they may not qualify for employer-based benefits.

The MPR study shows a lack of good

communication about supplemental insurance to beneficiaries in the group market. Only 23 percent of those with employer-based coverage said they received information this past fall from their employer or union about how being in a supplemental plan affected their choice of Medicare plans; 65 percent received no information, and another 12 percent did not know. Yet 80 percent of those with group coverage reported seeing or hearing about new choices available to Medicare beneficiaries. Fortunately, most who heard about these choices were not confused, but one-quarter of them found the publicity about Medicare options confusing.

Medicaid: The Safety Net

Although Medicare is always the first payer, Medicaid provides a safety net for some low-income Medicare beneficiaries. The extent of additional benefits that a Medicare beneficiary can receive through Medicaid depends on the individual's financial circumstances and the state's Medicaid eligibility criteria. Many low-income Medicare beneficiaries qualify for the full range of Medicaid benefits, including prescription drug coverage and long-term care. For others, Medicaid covers only Medicare Part B premiums and, in some instances, cost-sharing expenses (see box: Options for Limited Medicaid Coverage for Medicare Beneficiaries).

Fourteen percent of Medicare beneficiaries surveyed reported having some form of

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Medicaid coverage. As expected, they are substantially more likely to have incomes of \$10,000 a year or less, to be under age 65, to be in fair/poor health, and to be ethnically diverse. National data show that the vast majority of dual eligibles receive full Medicare-Medicaid benefits (O'Brien, Rowland, and Keenan, 1999). To some extent, this may be because some beneficiaries are eligible but do not apply for less extensive Medicaid coverage options, either because they don't know about them or they are discouraged by the burden of applying for such benefits.

Only 6 percent of those with Medicaid coverage are in a Medicare HMO, which is far less than the proportionate size of this subgroup in the market (14 percent). Those who receive full Medicare-Medicaid benefits have little incentive to enroll in a Medicare HMO because enrollment is voluntary and Medicaid covers the benefits that an HMO otherwise might provide as an enticement to enroll. As states move toward mandatory Medicaid managed care, there may be more

Table 2

Patterns of Multiple Coverage among Medicare Beneficiaries, 2000

	SOURCE OF COVERAGE						
	GROUP			ANY			
	All	Employer	Military	All Others ¹	Medicaid	Medigap	Medicare HMO
Percent with other coverage ²							
Employer	90%	—	35%	—	15%	10%	27%
Military	15	6%	—	—	6	4	5
Medicaid	6	6	14	25%	—	5	6
Medigap	7	6	14	36	8	—	5
Medicare HMO	13	13	13	28	6	4	—

SOURCE: MPR Survey of Medicare Beneficiaries, 2000

¹Medicaid, Medigap, and Medicare HMO coverage as well as those with other coverage (20%) and those with no coverage (17%).

²Excludes those reporting other sources of coverage. Fourteen percent of the sample had such coverage. It was the only source of coverage for 5 percent.

Table 3

Characteristics of Medicare Beneficiaries by Source of Supplemental Coverage, 2000

	SOURCE OF COVERAGE ¹						
	All Beneficiaries	Any Group ²	All Others	Any Medicaid	Any Medigap	Any Medicare HMO	None
Under 65 years	12%	6%	16%	31%	5%	8%	22%
65-84 years	77	85	72	59	79	80	66
85 and over	11	8	12	11	16	12	12
\$10,000 or less	27%	10%	37%	69%	16%	16%	45%
\$10,001-\$20,000	33	32	35	23	32	38	44
Over \$20,001	40	59	28	8	52	46	11
Less than high school	26%	18%	31%	51%	26%	21%	35%
High school graduate or more	74	82	69	49	74	79	65
White	87%	90%	85%	77%	95%	83%	77%
African American	9	5	11	16	3	8	19
Other	5	5	4	7	2	9	4
Hispanic	4%	4%	5%	8%	0%	10%	6%
Health Status							
Excellent	13%	11%	14%	2%	20%	15%	11%
Very good/good	51	59	46	42	56	53	42
Fair/poor	36	30	40	56	24	32	47
Number (millions)	(34.2)	(12.8)	(21.3)	(4.9)	(7.0)	(5.5)	(5.9)

SOURCE: MPR Survey of Medicare Beneficiaries, 2000

¹Data on other coverage (not presented) also were useful in defining those with no supplemental coverage. Among all beneficiaries, 14 percent have other coverage, but only 5 percent have it as their only source of supplemental coverage.

²Includes employer-based and military coverage.

Options for Limited Medicaid Coverage for Medicare Beneficiaries

By federal law, state Medicaid programs cover Medicare Part B premiums and Medicare cost-sharing expenses for Medicare beneficiaries with incomes of less than 100 percent of the poverty level (\$716 for an individual and \$958 for a couple per month) and resources less than twice the Social Security Income limit. Those with incomes up to 175 percent of poverty may qualify for coverage of all or part of the Medicare Part B premium.

In states with spend-down programs or special coverage provisions for long-term care, Medicare beneficiaries with higher incomes may qualify for full Medicaid coverage if their medical expenses are high enough.

reason for Medicare-Medicaid beneficiaries to enroll in a Medicare HMO. However, unless the same HMO participates in both Medicare and Medicaid, coordination of care will be difficult or impossible, so barriers to HMO enrollment will remain.

Medicare beneficiaries who are not eligible

for full Medicaid benefits may have more reason to enroll in a Medicare HMO, because they may still need coverage for prescription drugs and Medicare's cost sharing. Most Medicare HMOs cover these expenses, but drug coverage typically is restricted to an annual limited amount, and, in recent years,

residual cost-sharing requirements have expanded (Gold and Achman, 2001).

Individual Private Market for Coverage

Individuals who do not qualify for employment-based supplemental insurance or full Medicaid benefits have historically had two options: a Medigap policy or a Medicare HMO. In 1998, Congress encouraged a broader variety of options, including private insurance plans (see box: New Health Plan Options). However, few of these options exist, and those that do have limited enrollment.

Medigap. In 1989, Congress enacted legislation (effective July 1992) to simplify the Medigap market and help eliminate redundant coverage. The act authorizes 10 standardized Medigap plans (A-J) (HCFA, 2001). Plan A is the basic Medigap benefit, and the others add different combinations of benefits. Plans F and J have an optional high deductible. Insurers also may offer any of the 10 packages as a Medicare Select product, which means that certain benefits will only be provided if enrollees use a contracted network of hospitals and, in some cases, physicians.

However, not all Medicare beneficiaries with Medigap policies have standardized options. Under the legislation, insurers were permitted to renew indefinitely all policies issued before July 1992 without converting them to the standardized designs. Nearly one-third of Medigap policyholders still have prestandardized policies (Chollet, 2001). In addition, the Medigap standardization legislation allowed exceptions in Massachusetts, Minnesota, and Wisconsin.

Among standardized Medigap plans, the average annual standard prices for a man age 65 for the most popular plans were \$1,239 (C) and \$1,301 (F) in 2000, with substantial variation within and across markets (Weiss Ratings, 2001).

Plans H, I, and J are the only ones that provide some prescription drug coverage.

These packages are not offered by all insurers, and they may not all be available in all markets. Individuals seeking such coverage must enroll in them when they first become eligible for Medicare or they may be subject later to health screening. (Health screening for under age 65 disabled Medicare beneficiaries is always allowed unless states impose stricter regulation; however, when strict regulation is in force, insurers may decide to stop offering a specific package.)

Medigap plans with drug coverage can be quite expensive because of costs associated with the benefit and because they may attract those disproportionately likely to use it. In 1998, only 43 percent of beneficiaries with Medigap or other individually purchased Medicare supplemental policies had any form of drug coverage (Poisal and Murray, 2001). This share may be even lower now since premiums for Medigap options that

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include drug benefits increased an average of 37 percent between 1998 and 2000, 2.4 times as much as the other Medigap options (Weiss Ratings, 2001). In 2000, the average annual standard price for a man age 65 nationally was about \$2,400 for plans H and I and \$3,000 for Plan J. Research indicates that most Medicare beneficiaries with Medigap policies that cover drugs had purchased the policies before the legislated standardization (Chollet, 2001).

Medigap policies are the second most common form of supplemental coverage, with 21 percent of beneficiaries saying they have it. These policies disproportionately attract those with at least moderate incomes. Though only 40 percent of Medicare beneficiaries reported incomes above \$20,000, 52 percent of those with Medigap coverage did. Despite its costs, Medigap also attracts beneficiaries with more limited incomes, probably because they are risk averse and want the financial protection. Also, lower-cost Medicare HMO options may not be available or may be unattractive because of their reduced choice of providers.

Though Medigap coverage is considered an alternative to a Medicare HMO, 4 percent of beneficiaries with Medigap policies also are enrolled in an HMO. These may be individuals who are fearful of not being able to regain coverage if they drop it. (Medicare has certain protections for those whose HMOs leave the program, but prices are not guaranteed, and the protections do not extend to plans with drug coverage, nor do they apply in most cases of voluntary disenrollment.) Under current law, it is illegal in most cases to sell a Medigap policy to a beneficiary who is known to have Medicaid or to be enrolled in a Medicare HMO or other option authorized under Medicare+Choice.

Medicare HMOs. More than two-thirds of Medicare beneficiaries (68 percent) lived in a county where at least one Medicare HMO was offered in 2000. The availability of such plans declined in 2001, and when they are available, they are primarily in urban areas (Gold, 2000). Sixteen percent of all beneficiaries surveyed—and 24 percent of those living in counties with a Medicare HMO—were in a Medicare HMO in 2000.

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New Health Plan Options

The Medicare+Choice Program enacted in 1998 authorizes the following plans:

Coordinated Care Plans (Medicare HMOs): Folds existing managed care options such as the Medicare risk and cost programs—often referred to as Medicare HMOs—into a coordinated care option. Allows greater flexibility in product design to support products that include some coverage for out-of-network providers used on a self-referral basis. New options, including preferred provider organizations (PPOs) and provider-sponsored organizations (PSOs), are authorized, but there have been few such offerings.

Private Fee-for-Service Plans (Medigap): Authorizes fee-for-service insurance products that do not use a provider network. May depart from Medicare billing policies and may allow balance billing. May not restrict participation by legally authorized providers who agree to the plan's terms and conditions. A single private fee-for-service plan (Sterling Life Insurance Company) has been approved since mid-2000 to operate in all or portions of 17 states, most without coordinated care plan options.

Medical Savings Account Plans: Authorizes limited demonstration of a high-deductible plan with funding for an individual savings account for qualified medical expenses. No plans have applied, and authorization expires in 2002.

enrollees were in zero-premium plans; others were in plans whose premiums averaged \$36 per month (Gold and Achman, 2001). Seventy-eight percent were in plans with a drug benefit, though almost all had an annual limit on the amount of coverage.

Though premiums are rising and benefits shrinking, Medicare HMOs are the most affordable private option for supplemental coverage. In counties where a Medicare HMO is offered, almost as many beneficiaries are enrolled in it as in Medigap. It is also more attractive than Medigap to beneficiaries with incomes of \$20,000 or less. Because they are precluded from underwriting, Medicare HMOs also are more accessible to beneficiaries with fair or poor health.

When a Medicare HMO leaves a market, beneficiaries may find none of the other options attractive. In 2000, 27 percent of those whose Medicare HMO exited had secured no other form of supplemental coverage by the time of the MPR survey. Of the rest, 29 percent joined another HMO, 24 percent enrolled in Medigap, and 20 percent had other coverage (Gold and Justh, 2000).

Beneficiaries with No Supplemental Coverage

Even with all these options, 17 percent of all Medicare beneficiaries do not have supplemental coverage. Those lacking coverage typically have low incomes (though not as low as those on Medicaid), and 47 percent have fair or poor health, a higher proportion than any other group of enrollees except those with dual Medicare-Medicaid coverage. Supplemental coverage may be getting more difficult to obtain because of the decline in group-based employer coverage (Liu et al., 2000), rising prices for Medigap (Weiss Ratings, 2001), and withdrawals of Medicare HMOs from the program starting in 1999 (Gold, 2000).

Those with no supplemental coverage are much more likely to consider their choices salient and much less likely to rate their current

Information tailored to a beneficiary's specific circumstances is needed. Providing easy access to it is challenging because information is dispersed across multiple parties.

plan highly than those with coverage (see Table 4). Of those lacking coverage, 52 percent said it was too expensive or they could not afford it. Only 15 percent suggested they did not need it because, for example, they are never sick or Medicare is enough. Because affordability is a dominant concern, better information is likely to have only a limited effect on coverage rates.

Need to Improve Beneficiary Education

A key finding of the MPR Monitoring Medicare+Choice Project (Stevens and Mittler, 2000) is that beneficiaries need help to better understand Medicare and the supplemental coverage choices available to them.

For beneficiaries in the individual market, this means getting information about specific Medigap plans and Medicare HMOs in their area as well as their state's Medicaid requirements. Beneficiaries in the group market need information about the plans offered by their employer and how employer-based offerings affect the value of enrolling in other options available in the market.

Providing individually tailored information is challenging because of the wide range of choices and the fact that many of these are geographically determined by state Medicaid policy, managed care markets, and other factors. To be most effective, information needs to reflect local circumstances. It also needs to cover the variety of options for which different agencies and organizations are responsible. For example:

- Medicare has authority over Medicare+Choice offerings, including Medicare HMOs.
- Medigap policies are regulated by state insurance commissioners. Each state has its own rules for submission and approval of plan information.
- Medicaid eligibility policies can differ by state, and even when uniformity is promoted by national legislation, each state (and sometimes each county) applies

Table 4

Salience of Choice and Satisfaction with Current Coverage by Source of Supplemental Coverage, 2000*

	All Beneficiaries	SOURCE OF COVERAGE					None
		Any Group	All Others	Any Medicaid	Any Medigap	Any Medicare HMO	
Choice was salient late 1999-early 2000							
Yes	14%	13%	15%	13%	12%	21%	25%
Actually changed plans ¹	5	4	6	2	4	14	9
Experience with current coverage							
10 (best)	32%	34%	31%	37%	33%	25%	26%
8-9	36	41	33	38	39	41	24
6-7	27	22	30	20	26	31	37
5 or less	5	3	6	5	3	3	14

SOURCE: MPR Survey of Medicare Beneficiaries, 2000

*Includes new beneficiaries; those switching to, from, or among HMOs; and other beneficiaries who say they seriously considered making a change. Consideration of choice can be either voluntarily (e.g., a beneficiary wants coverage for pharmacy or lower out-of-pocket costs) or involuntarily (e.g., a new beneficiary must choose, or a beneficiary's HMO leaves the program).

¹Includes beneficiaries newly eligible for Medicare who by definition had to make a choice and those switching into, out of, or among Medicare HMOs.

different requirements and procedures.

- Employers that offer retiree coverage tend to self-insure, so they are the only source of information about these benefits. Firms vary in their policies for classes of employees, and offerings may vary across work sites.

The fact that authority over options and information is widely dispersed creates numerous challenges for beneficiaries seeking to make informed choices and for those who want to support them in these choices. At the national level, the complexity of the Medicare supplemental market means that Medicare staff seeking to create an information infrastructure to support choice need to be knowledgeable not just about Medicare, but about private retiree benefits and Medicaid coverage for dual eligibles as well. They also must develop relationships with employers and Medicaid agencies to help coordinate information strategies. These are skills that have not previously been required, and few Medicare staff may have this kind of expertise.

Since most choices depend on local circumstances, the actual task of Medicare beneficiary education needs to reflect local circumstances, with a local base. One-on-one counseling is likely to be especially important, particularly for beneficiaries whose characteristics (such as limited education, cognitive function, or health problems) make choice more complicated and information harder to process (Gold et al., 2001b). Further, education needs to extend not just to beneficiaries, but also to the multiple organizations processing Medicare supplemental products so that they are knowledgeable about the requirements and provide beneficiaries with consistent and correct information (Stevens and Young, 2001). Substantial resources are likely to be needed to support such an infrastructure.

More fundamentally, some question whether Medicare beneficiaries in fact can handle the choices they have, even with better information (Hibbard et al., 2001). The level of

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skill needed to cognitively process the current range of choices, they argue, may be more than many Medicare beneficiaries have.

Implications for Medicare Reform

The complexity and limitations of the Medicare supplemental market and the fact that it has arisen in part because of limitations in the Medicare program itself have encouraged interest in Medicare reform. But the current structure of the Medicare supplemental market substantially complicates efforts to accomplish such reform. Beneficiaries in the traditional Medicare program paid \$3,142 out of pocket for health care in 2000, a figure estimated to rise to \$5,248 in 2025 (Maxwell, Moon, and Segal, 2001). There are two ways to protect Medicare beneficiaries more fully:

- Expand Medicare to cover prescription drugs and impose a limit on out-of-pocket expenses so that Medicare provides more financial protection. This also would lessen or eliminate the need for the complex supplemental market or would integrate it better with Medicare choice; or
- Undertake limited reform so that moderate-income Medicare beneficiaries who earn too much to qualify for Medicaid would have access to more affordable coverage choices.

Substantial new resources are likely to be required under either option.

The structure of the Medicare supplemental market is likely to make it harder to

get the resources needed for an effective reform of the Medicare program. Though support for Medicare rests in its universality, the reality is that Medicare's benefit limits create a pluralistic and segmented system of coverage for beneficiaries. Policymakers considering expanding Medicare benefits may not want to finance costs that now are paid by other parties, such as employers. But it may be difficult to convince employers to allow Medicare to use any savings the employer may accrue through Medicare reform. Alternative forms of financing probably mean that better-off Medicare beneficiaries would pay more to support benefit expansion. But they may balk at this, because many of them already receive such benefits on a subsidized basis through employer-sponsored retiree plans.

In the absence of more comprehensive reform, the most likely alternative is an expansion of income-based options through Medicaid. However, more than half the Medicare population has an income of \$20,000 or less, and states may balk at assuming substantial new cost-sharing obligations for benefits they believe should be financed entirely by the federal government through Medicare.

This means that efforts to reform Medicare face many of the same barriers as efforts to expand coverage to the uninsured (Gold et al., 2001a). If history is any guide, incremental reforms are more likely to have a chance of succeeding than are more fundamental reforms that challenge the current division of responsibilities and resources between the public and private sectors and between states and the federal government. Given this, Medicare beneficiaries who have limited supplemental coverage and look to government to provide them greater financial protection for medical expenses probably will continue to be disappointed by federal inaction. □

About the Data

The data presented are from a national survey of Medicare beneficiaries age 18 and older conducted by MPR between March and June 2000 (Gold et al., 2001b). Nationally, 6,620 responded, a 64 percent response rate. The results are weighted to provide unbiased estimates for Medicare beneficiaries nationally and in selected subgroups. Information on enrollment in Medicare HMOs comes from the Health Care Financing Administration and was updated by benefi-

ciary self-reports. Other insurance information was self-reported.

The survey asked individuals separately whether they had coverage from a current or former employer; from a union or spouse; from Medigap (and, if so, whether it was separate from a Medicare HMO); from Medicaid; from the military (e.g., CHAMPUS, CHMPVA, or TRICARE); or any other source of insurance. Plan names given for those citing other coverage were reviewed (n=769). Those plans that did not qualify as Medicare supplements were excluded. These included

cancer/dread disease, long-term care, hospital-catastrophic, accident/worker's compensation/lost wages, and single service (e.g., dental, vision, behavioral health, prescription drugs). Individuals judged to be without any form of supplemental coverage were not in a Medicare HMO, did not respond affirmatively to any of the specific types of insurance asked about, and did not list another source of coverage that appeared to be a supplemental product.

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