Health Economics Program

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A Brief Overview of Medicare Supplemental Coverage in Minnesota and the United States

Medicare provides health care coverage for almost all of the elderly, some disabled people under age 65, and people with permanent kidney failure. However, Medicare has relatively high deductibles and coinsurance and does not cover health care goods and services such as prescription drugs or dental care. Many Medicare beneficiaries have additional health insurance to pay for the cost sharing and services that Medicare does not cover. This issue brief describes the demographic characteristics of the non-institutional Medicare population and provides information on supplemental coverage for beneficiaries in Minnesota and the United States.

Characteristics of Medicare Beneficiaries

Demographically, Medicare beneficiaries in Minnesota differ in a number of ways from the national average. Table 1 shows that beneficiaries in Minnesota are similar to the national average in terms of age, gender, and health status. However, for all other demographic characteristics, Minnesota beneficiaries are different from the national average:

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

Table 1

Characteristics of Non-Institutional Medicare Beneficiaries

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

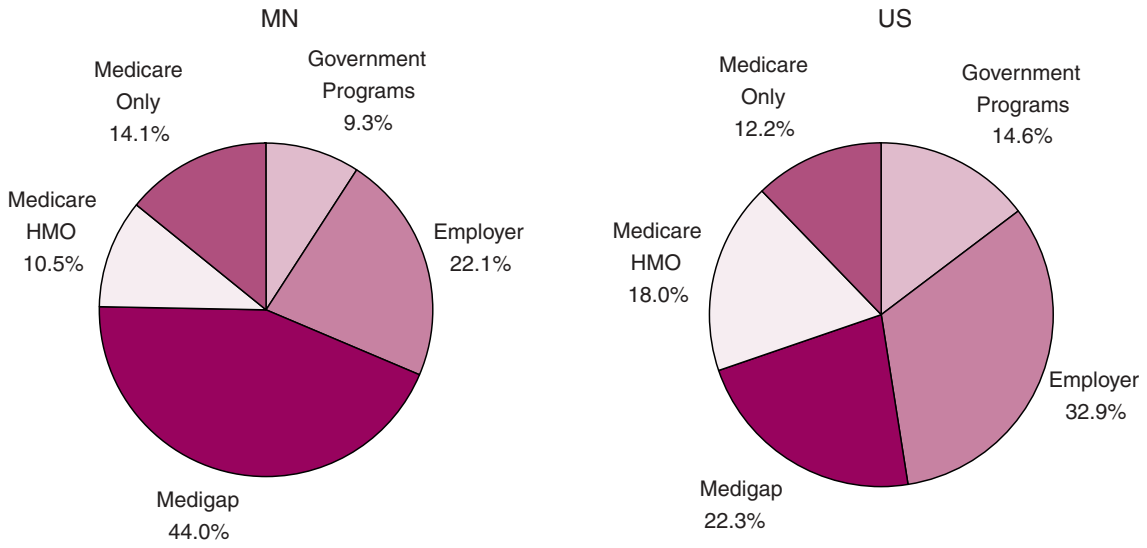
Minnesota results are from the 2001 Minnesota Health Access Survey
United States results are from the 2000 Medicare Current Beneficiary Survey (MCBS), Westat Inc., "Characteristics and Perceptions."

Supplemental Coverage

Most Medicare beneficiaries obtain additional coverage through the private market or government programs to pay for the services and costs that Medicare does not cover. Figure 1 shows that the proportion of Medicare beneficiaries without supplemental coverage (i.e. those with Medicare only) is relatively the same in Minnesota and the United States (14.1% in Minnesota vs. 12.2% in the United States). However, Minnesota beneficiaries are less likely to have coverage through a government program, employer, or Medicare HMO and more likely to have an individually purchased Medigap policy to supplement Medicare than the national average.

Figure 1

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



Minnesota results are from the 2001 Minnesota Health Access Survey

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

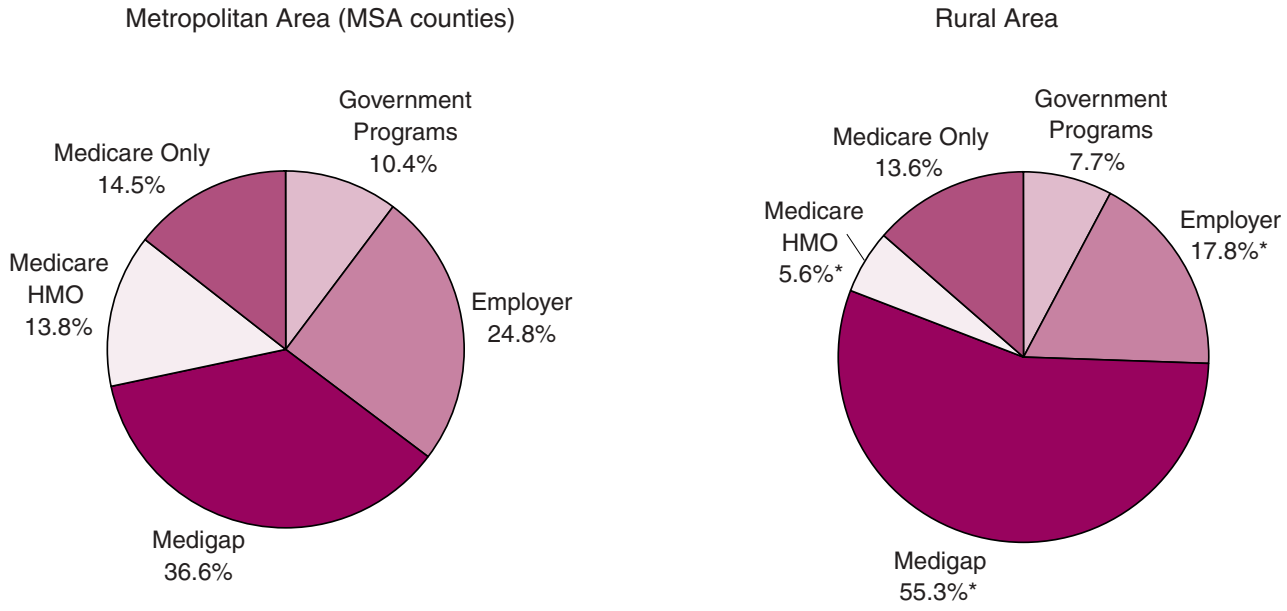
Note: Government programs may not be directly comparable between Minnesota and the United States as the Minnesota survey did not specifically ask about enrollment in Medical Assistance programs such as QMB, SLMB, QI-1 or QI-2. These people may be classified in Government Programs or as Medicare Only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

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

Minnesota Medicare beneficiaries are less likely to have employer coverage than the national average. Figure 1 shows that 22.1% of non-institutionalized Medicare beneficiaries in Minnesota have employer coverage, compared to 32.9% nationally. Demographic differences between Minnesota's Medicare beneficiaries and beneficiaries in the United States as a whole may explain why beneficiaries in Minnesota are less likely to have employer coverage. For example, fewer Medicare beneficiaries in Minnesota live in metropolitan areas than the national average, as shown in Table 1. Metropolitan areas generally have more large employers than rural areas and large employers are more likely to offer retiree health benefits than small employers.[1] Figure 2 provides the sources of supplemental insurance coverage for Minnesota Medicare beneficiaries in urban and rural areas of the state. As shown in Figure 2, Medicare beneficiaries living in rural Minnesota are less likely to have employer supplemental coverage than urban beneficiaries (17.8% compared to 24.8%).

Figure 2

Sources of Supplemental Insurance Coverage for
Non-Institutional Medicare Beneficiaries, MN MSA and Rural Counties



* Indicates a significant difference between Rural and Metropolitan Area at 95% level

In general, the prevalence of retiree health coverage to supplement Medicare has been declining over the past decade. For example, from 1991 to 1999 the share of employers with 5,000 or more workers that offer retiree health benefits declined from 80% to 66%.[2] Recent research suggests that retiree health benefits will continue to decline in the near future.[3]

Medicare HMO enrollment is low in Minnesota compared to the national average. In Minnesota, 10.5% of non-institutionalized Medicare beneficiaries are enrolled in self-purchased Medicare HMO plans, compared to 18.0% nationally.[4] There are various reasons for the difference in Medicare HMO enrollment. The primary reason is that most areas of Minnesota receive low capitated payments from Medicare compared to the national average. These low payment rates have made HMOs reluctant to offer Medicare products and have led some Medicare HMO plans to withdraw from the market. Another reason for the difference is that HMO enrollment is high in some states where Medicare payments are higher and beneficiaries receive extra benefits for little or no extra cost. Other reasons may include reluctance by beneficiaries to enroll in a Medicare HMO that may withdraw from the market in the next year or benefit changes, such as restrictions on prescription drug utilization.

The United States Congressional Budget Office (CBO) estimates that overall enrollment in Medicare HMOs will decline by almost 40% over the next ten years.[5] Part of the reason for the predicted decline in enrollment is the continued withdrawal of HMO plans from Medicare. In 1998, 346 HMO plans participated in Medicare; in 2002, the number of plans dropped to 153.[6] Another reason for the predicted decline in Medicare HMO enrollment is the decrease in benefits offered by the plans. In 2001, 18% of plans with prescription drug benefits only covered generic drugs; today, the percentage has increased to 51%.[7]

Figure 1 shows that almost half (44.0%) of Minnesota's non-institutionalized Medicare population is covered by an individually purchased Medigap policy, compared to 22.3% nationally. The primary reason for this difference is likely lower participation in Medicare HMOs and less availability of employer retiree coverage in Minnesota, especially in rural Minnesota.

Government programs (Medical Assistance, VA, MCHA, etc.) cover fewer non-institutionalized Medicare beneficiaries in Minnesota than the national average. Figure 1 shows that government programs cover 9.3% of Minnesota beneficiaries and 14.6% of beneficiaries at the national level. Minnesota Medicare beneficiaries are less likely to be covered by government programs than the national average for a few reasons. Table 1 shows that Minnesota Medicare beneficiaries have higher household incomes than the national average, which means that beneficiaries in Minnesota are less likely to be eligible for supplemental coverage through income-based government programs. Second, a larger percentage of the population with Medical Assistance is institutionalized in Minnesota compared to the national average. In 1999, 47.2% of low-income elderly Minnesotans received Medical Assistance and resided in a nursing home compared to 29.9% nationally.[8] Since the data presented in Figure 1 is based on non-institutionalized Medicare beneficiaries, a greater percentage of Minnesota's Medicare beneficiaries with Medical Assistance are excluded from the results compared to beneficiaries with Medical Assistance at the national level.

Conclusion

If current trends continue, the share of Medicare beneficiaries who lack supplemental coverage may rise in Minnesota and nationally over the next several years. If employers continue to scale back on retiree health benefits and if enrollment in Medicare HMOs continues to decline, beneficiaries may begin to lose access to lower cost supplemental coverage and may be forced to purchase higher cost Medigap policies or forgo supplemental insurance. In the coming years, Minnesota may be faced with more Medicare beneficiaries who have financial barriers to accessing health care. It will be important to monitor changes in supplemental coverage to determine the impact of these changes on access to health care and out-of-pocket health care spending for Medicare beneficiaries.

Endnotes

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

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

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

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

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

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

7 Ibid.

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

HEALTH ECONOMICS PROGRAM

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.

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