MINDING THE GAPS: THE STATE OF COVERAGE TO SUPPLEMENT MEDICARE IN MASSACHUSETTS

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EXECUTIVE SUMMARY

Medicare, the federal program that provides health coverage to eligible individuals age 65 or older and to certain younger people with disabilities, is one of the great social policy achievements in our country. It protects 49 million people in the U.S., including 1.2 million people in Massachusetts, of whom approximately 80 percent, or 915,000, are elders. Medicare is critical for helping to ensure access to care and financial protection for its members, and is especially important for low-income beneficiaries, many of whom have serious health needs.

Medicare provides broad *protection* against the cost of many health services, but it has significant gaps in coverage and leaves beneficiaries responsible for substantial deductibles, coinsurance, and copayments. As a result, most beneficiaries buy some form of private insurance coverage to protect themselves from high out-of-pocket costs. Many Medicare beneficiaries in Massachusetts are eligible for public coverage, largely through MassHealth, the state's Medicaid program, but also through federal or state assistance programs.

This policy report examines the state of coverage to supplement Medicare, with a focus on the private health insurance market for Medicare beneficiaries. A complementary poll of Massachusetts elders, conducted by researchers at the Harvard Opinion Research Program at Harvard T.H. Chan School of Public Health, examines the experience of Massachusetts elders with affordability, access, and satisfaction with health care and health coverage.

The major findings of the report are outlined below.

The vast majority of Medicare beneficiaries in Massachusetts have some form of supplemental coverage to help provide financial protection against the significant gaps and cost sharing in Medicare: Medicare beneficiaries in Massachusetts who purchase individual plans to supplement Medicare have a wide range of private coverage options, and many low- and moderate-income beneficiaries can obtain assistance from a number of public programs. About 232,000 people are covered by traditional Medicare supplemental plans, while 218,000 rely on Medicare Advantage HMO and PPO plans. Many other people have retiree health plans through former employers, although the exact number is unknown. Almost one-quarter of Medicare beneficiaries are also enrolled in the state Medicaid program, MassHealth. At least 1 million of the 1.2 million Medicare beneficiaries in the state have prescription drug coverage through private or public plans.

However, some elders in Massachusetts have no health insurance at all: In 2014, a state survey found that approximately 10,000 elders were uninsured at the time of the survey, and 6,000 had been uninsured for the entire year. Forty-six thousand elders (5 percent) had had a spell without insurance in the prior 12 months. Many, if not most, of these individuals were likely ineligible for Medicare because they did not work, or did not work long enough paying into Medicare, to become eligible.

Some other Medicare beneficiaries lack coverage to supplement Medicare: Although precise data are not available on the number of Medicare beneficiaries in Massachusetts who have no coverage to supplement Medicare, nationally 14 percent of Medicare beneficiaries have no supplemental coverage. Lack of any private or public coverage to supplement Medicare leaves beneficiaries "underinsured" and financially liable for the significant cost sharing and gaps in the Medicare program if they receive care.

Coverage to supplement Medicare is expensive, particularly when combined with Medicare Part B premiums and when compared with the average Social Security benefit: While low-premium products are available, most Medicare beneficiaries are purchasing more comprehensive, and expensive, coverage. This suggests that individuals are willing to pay higher premiums for more comprehensive financial protection and lower out-of-pocket costs. However, total annual premiums for the most popular plans combined with the Medicare Part B premium exceed $3,800 per year, which is nearly one-quarter of the average Social Security benefit in Massachusetts (the major source of income for most elders). Many beneficiaries may be suffering undue hardship or sacrificing in other areas to pay their monthly premiums, particularly those with chronic health conditions or serious medical problems.

Affordability of coverage to supplement Medicare is a growing concern: Premiums for the most popular supplemental products have risen in recent years, sometimes very rapidly (in the 50-70 percent range since 2009 for some products, an average annual increase of 9 percent). In almost every case, premiums have increased much faster than Social Security benefits have. The coverage in some popular lower-premium products has also eroded through increases in deductibles and other forms of cost sharing, which has shifted additional costs to the Medicare beneficiaries with these forms of coverage.

Medicare beneficiaries with private coverage, including those with more comprehensive products, still face significant coverage gaps and out-of-pocket expenses, particularly relative to their incomes: Many of the most popular Medicare Advantage plans have sizable cost sharing for certain services. Most prescription drug coverage has tiered copayments that can be significant for individuals who require brand-name or specialty drugs, and these drug plans generally provide no additional protection in the Medicare Part D coverage gap (often referred to as the "donut hole"). Other issues include the escalating cost of medications, which affects out-of-pocket costs for plans with coinsurance, a form of cost sharing that is becoming more common in Part D plans; the movement of more generics and brand-name drugs into higher tiers with larger cost sharing for consumers; and increasingly narrow formularies, which may limit or exclude coverage for specific medications.

Underinsurance and the lack of private insurance for some Medicare beneficiaries result in expenses for the state's Health Safety Net: The state's Health Safety Net (HSN) is a secondary payer for low-income Medicare patients and adults age 65 or older, and a primary payer for certain elders who are uninsured and not eligible for other public coverage. In HSN year 2011 (the most recent for which a report is available), elders accounted for 27 percent of inpatient discharges paid through the HSN and 14 percent of outpatient visits. Because the HSN is largely a secondary payer to Medicare, these services accounted for 8 percent of total inpatient and outpatient payments, or approximately $22 million. Some HSN expenses at community health centers are likely for medications for Medicare beneficiaries who lack full or partial coverage for prescription drugs, as well as for services that Medicare does not cover at all (e.g., dental care).

Medicare beneficiaries in some counties have limited access to lower-cost Medicare Advantage plans: There are substantial variations in premium rates and plan and product options available by county. In particular, there are significantly fewer choices available to residents in nonurban and less populated parts of the state.

The large number of plan types and products, and the lack of standardized benefits and cost sharing, make it difficult to compare plans and premiums: Even for someone with substantial health insurance knowledge, it is difficult to compare all of the options available for coverage to supplement

Medicare. The differences in plan designs are particularly complex and variable for prescription drugs plans, which have multiple copayment tiers and vastly different formularies. Key features of plans often change every year (e.g., plan name, deductibles, premiums, and copayments). Although research shows that consumers benefit greatly when they review their plan options, only 14 percent of Medicare beneficiaries change their drug plan in a given year. Adequate counseling on health coverage for people 65 and older may not occur because there is no longer a standard age at which people are qualifying for and enrolling in Medicare, as many workers are staying employed longer than workers did in the past. Employers have historically been an important source of advice and guidance for older and about-to-retire workers, but many companies have neither the resources nor expertise to help their workers navigate the increasingly complex landscape of Medicare eligibility and coverage.

Although a variety of public programs exist to help pay the out-of-pocket costs that Medicare beneficiaries may face, these programs are complicated, fragmented, and hard to navigate: Massachusetts is fortunate to have a variety of public programs, including MassHealth, Medicare Savings Plans, Prescription Advantage, and the Health Safety Net, that provide access and financial protection to lower- and moderate-income Medicare beneficiaries and elders without Medicare or coverage that supplements Medicare. However, eligibility rules for these programs are complex, and navigating the coverage landscape is difficult. In addition, the eligibility criteria can vary from program to program, causing gaps and eligibility cliffs for people in some income groups and significant changes in coverage for people who have even modest changes in income from year to year, or as individuals turn age 65.

Many Medicare beneficiaries eligible for additional coverage and assistance are not enrolled: Nationally, less than one-third of eligible Medicare beneficiaries enroll in the Medicare Savings Programs (MSPs). Although the exact number of eligible but unenrolled people in Massachusetts is unknown, the percent of eligible but unenrolled beneficiaries here is likely comparable to the national figure. A complicated enrollment process and asset tests are the major barriers to enrollment in these programs.

The state has made significant efforts to simplify the application process for these programs and to do outreach to find eligible individuals. The state's SHINE program (Serving the Health Insurance Needs of Everyone) is a vital resource that helps people through the health coverage maze by providing free assistance and counseling on health insurance to individuals and their families and caregivers. This program has become ever more important as the Medicare program has grown in complexity and as the number of private and public coverage options has increased. In addition, Medicare beneficiaries can get assistance by calling the Medicare call center.

The income cutoff for MassHealth eligibility is lower for elders than for people under age 65, and even at the same income level, elders may have less access to affordable health coverage than non-elders because of asset tests for public programs that do not apply to younger individuals: Owing to the state's health reform law and the Affordable Care Act, affordable health coverage is available to most people in the state with incomes below 300 percent of the federal poverty level (FPL), through employers, MassHealth, or ConnectorCare. Eligibility for ConnectorCare and for MassHealth for non-elders is based solely on income; no asset test applies. However, for people age 65 or older, both the MassHealth program and the MSPs have asset tests. Eligibility for public coverage (except for the HSN and Prescription Advantage) ends at 135 percent FPL for elders residing in the community, compared with 300 percent FPL for people younger than age 65, and Medicare beneficiaries are not eligible for ConnectorCare. Only 16 percent of elders

in the state are covered by MassHealth, compared with 31 percent of people under age 65 who have either MassHealth or ConnectorCare coverage.

There is little ongoing publicly available analysis and reporting that synthesizes the experience of Medicare beneficiaries in accessing and affording coverage and care: Huge changes have occurred in Medicare in the last decade, including the implementation of Medicare Part D, a proliferation of new private options for Medicare beneficiaries in Massachusetts, the implementation of important and innovative initiatives for certain groups of Medicare beneficiaries who are dually eligible for Medicaid, legislation to close the Medicare "donut hole," and, recently, new changes to premiums for certain high-income Medicare beneficiaries. While both the federal and state governments regulate and monitor private health plans that supplement Medicare, no entity has assumed responsibility for regular public reporting about the state of coverage for Medicare beneficiaries, leading to gaps in basic and important information, including total enrollment and trends in coverage and premiums. In contrast, the Center for Health Information and Analysis and the Health Policy Commission are responsible for regular monitoring and analysis of the other parts of the health insurance market, and this has generated a robust community dialogue about opportunities for improvement in these markets.

Private plans and public programs that supplement Medicare are an essential means for ensuring access to care and financial security for Medicare beneficiaries. While most Medicare beneficiaries in Massachusetts have coverage to supplement Medicare, some do not. Most people are facing rapidly rising premiums and increased cost sharing, particularly for prescription drugs. Low-income elders often have less access to affordable coverage than low-income individuals who are not elderly. Massachusetts has long been a leader in expanding health coverage, and it's time to focus additional policy attention on approaches to strengthen and secure coverage to supplement Medicare, particularly for Medicare beneficiaries with low incomes and serious health conditions.

I. INTRODUCTION

Medicare, which is celebrating its 50th anniversary this year, is one of the great social policy achievements in our country. Medicare is a federally funded health insurance program for people age 65 or older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease. It protects 49 million people in the U.S., including 1.2 million people in Massachusetts, of whom approximately 80 percent, or 915,000, are elders.[1] Medicare is critical for helping to ensure access to care and financial protection for its members, and is especially important for low-income beneficiaries, many of whom have serious health needs.

Medicare provides broad *protection* against the cost of many health services, but it has significant gaps in coverage and leaves beneficiaries responsible for substantial deductibles, coinsurance, and copayments. As a result, most beneficiaries buy some form of private insurance coverage to protect themselves from high out-of-pocket costs. Other Medicare beneficiaries have employer-sponsored health insurance, including through retiree plans sponsored by employers. Many Medicare beneficiaries in Massachusetts are eligible for public assistance, through Medicaid or one of several other state or federal programs. Approximately one-quarter of Medicare beneficiaries in Massachusetts, half of whom are elders[2], are also covered by Medicaid.

Although private coverage to supplement Medicare is an important source of financial security for elders and other Medicare beneficiaries, little detailed analysis of this part of the health insurance market in Massachusetts has been done for many years.[3] Since the enactment of Massachusetts health reform in 2006 and the federal Affordable Care Act (ACA) in 2010, much of the focus of state health policy discussion and attention has been on health coverage and costs for people who are under 65 years of age.[4] In many ways, this is understandable: according to the state's most recent survey, 99 percent of people 65 or older in Massachusetts reported being insured in 2014, the highest rate of any group in the state. However, an estimated 10,000 elders were uninsured at the time of the survey, 46,000 elders (5 percent) had a spell without insurance in the prior 12 months, and 6,000 elders were uninsured for the entire prior year.[5]

In addition to the need to address the lack of insurance among some Massachusetts elders, there is also a need to examine the state of coverage for elders with insurance, including private health insurance for Medicare beneficiaries. The structures of Medicare and the programs that supplement it are complex and fragmented, and leave many people vulnerable to inadequate and unaffordable coverage and sizable out-of-pocket costs. In Massachusetts, we do not know enough about health coverage for Medicare beneficiaries, including the adequacy and affordability of that coverage and what impact recent changes in the Medicare program itself, and in premiums for private coverage to supplement Medicare, may have had on Medicare beneficiaries. In addition, the state's 2006 coverage law, combined with the enactment of the ACA, now offers coverage and subsidies to the under-65 population that are more generous in many cases than those available to people 65 or older at the same income level.

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1 Massachusetts Division of Insurance and http://kff.org/medicare/state-indicator/distribution-of-medicare-beneficiaries-by-eligibility-category-2.

2 Unless otherwise noted, the term "elders" in this report will refer to people who are age 65 or older.

3 The Division of Insurance produces annual reports on enrollment in medigap plans and holds an annual public hearing concerning the overall condition of the market for Medicare Supplement insurance in Massachusetts, as required by M.G.L. c. 176K, §7(j).

4 The state has focused considerable attention on improving access and quality of care for people who are dually eligible for Medicare and Medicaid, through both its Senior Care Options (SCO) and One Care programs.

5 Skopec, L., Long, S., et al., "2014 Massachusetts Health Insurance Survey." The Center on Health Information and Analysis. May 2015.

This policy report aims to help fill these gaps by examining recent trends and issues in private health coverage and public programs to support payment of out-of-pocket costs for Medicare beneficiaries in the state, using publicly available data from state and federal sources. With respect to private health coverage, it focuses on products that individuals purchase directly, rather than employer-sponsored retiree health coverage, about which very little public information is available. A complementary poll of Massachusetts elders, conducted by researchers at the Harvard Opinion Research Program at Harvard T.H. Chan School of Public Health, examines the experience of Massachusetts elders with affordability, access, and satisfaction with health care and health coverage. The shared goal of these two efforts is to be a catalyst for discussion and debate about the state of health coverage for elders and other Medicare beneficiaries in Massachusetts, rather than to propose or advocate any particular policy solutions.

II. OVERVIEW OF MEDICARE AND COVERAGE TO SUPPLEMENT MEDICARE IN MASSACHUSETTS

> **Note:** *The term "coverage to supplement Medicare" will be used in this report to mean several types of private health insurance plans: traditional Medicare supplements, Medicare Advantage plans, and stand-alone prescription drug plans (PDPs).*

The structures of Medicare and the programs that supplement it are fragmented, complicated, and hard to navigate. Medicare has several parts, there are several types of private health insurance coverage, and both the federal and state governments have programs to help certain Medicare beneficiaries pay for coverage and care. Many beneficiaries have multiple plans, which makes coordination of coverage and care difficult and creates an administratively complex and costly structure. The structure of this system is summarized briefly below.

MEDICARE

Medicare is a federal program that provides health coverage to eligible individuals age 65 or older and to certain younger people with disabilities.[6]

The Medicare program has four parts:

- **Part A** *(Hospital Insurance)* covers care associated with stays in hospitals and skilled nursing facilities, and home health/hospice. Almost all Medicare beneficiaries have Part A, and most do not pay a Medicare Part A premium. Medicare Part A has significant cost sharing, including a deductible and copayments.
- **Part B** *(Medical Insurance)* covers physician services, medical laboratory procedures/tests, devices, and other outpatient medical services. Medicare Part B is optional, although virtually all beneficiaries select Part B, for which they pay a monthly premium. People who do not enroll in Medicare Part B when they are

6 To be eligible for Medicare, you must be a U.S. citizen or a permanent legal resident. If you are 65 or older, you (or your spouse) must have worked long enough to be eligible for Social Security or railroad retirement benefits or be a government employee or retiree who has not paid into Social Security but has paid Medicare payroll taxes while working. If you are under 65 years old, you must have been entitled to Social Security disability benefits for at least 24 months; or receive a disability pension from the Railroad Retirement Board and meet certain conditions; or have Lou Gehrig's disease (amyotrophic lateral sclerosis); or have permanent kidney failure requiring regular dialysis or a kidney transplant.

first eligible, and have not had equivalent coverage, pay a late enrollment penalty. This permanent penalty is equivalent to a 10 percent premium surcharge for each full 12-month period for which a Medicare member could have been enrolled in Medicare Part B but was not enrolled. Medicare Part B premiums also vary based on yearly income for Medicare beneficiaries with incomes above $85,000 (or $170,000 for couples). Approximately 6 percent of beneficiaries pay income-related premiums.[7] Medicare Part B has significant cost sharing, including a deductible, coinsurance, and copayments.

- **Part C** *(Medicare Advantage)* is an alternative that allows Medicare beneficiaries to receive covered services by enrolling in a private health plan, primarily health maintenance organization (HMO) and preferred provider organization (PPO) plans. Beneficiaries must have Medicare Parts A and B to enroll in a Part C/ Medicare Advantage plan. They continue to pay the Medicare Part B premium and may be required to pay an additional plan premium, depending on the private health plan and product in which they enroll. Medicare Part C plans provide all Medicare-covered services and may provide additional benefits as well. Coverage is generally more comprehensive than it is in the traditional Medicare program, and cost sharing (e.g., deductibles and copayments) is usually lower. Some Medicare Advantage plans provide prescription drug coverage and some do not. However, Medicare Advantage members who enroll in an HMO or PPO Part C plan that does not cover prescription drugs may *not* choose to enroll in a stand-alone Medicare Part D drug plan (but it is permissible to enroll in a private fee-for-service Medicare Advantage plan and a stand-alone Part D plan). Plans without drug coverage can be particularly useful for people who have other drug coverage (e.g., from the Veteran's Administration or a union or employer plan).
- **Part D** *(Prescription Drug Coverage)* provides benefits for prescription drugs. Part D is optional, although most beneficiaries are enrolled. Part D coverage is provided exclusively through private health insurers, in the form of both stand-alone plans (Prescription Drug Plans, or PDPs) and Medicare Advantage plans that include drug benefits (MA-PD plans). Most beneficiaries pay an additional plan premium for Part D coverage, depending on the specific prescription drug coverage plan they select. Beneficiaries who do not enroll in Part D when they are first eligible pay a permanent penalty equal to 1 percent of the national average premium for PDP plans for each month that they delay enrollment (unless they had drug coverage from another source that was at least as good as standard Part D coverage.) As with Medicare Part B, Medicare Part D premiums vary based on yearly income for Medicare beneficiaries with incomes above $85,000 (or $170,000 for couples). Medicare Part D has significant cost sharing, including a deductible, coinsurance, copayments, and a coverage gap (often referred to as the "donut hole"), at which coverage is no longer provided until spending exceeds a certain amount.

The ACA improved the federal Medicare Part D benefit by closing the donut hole/coverage gap over time, although beneficiaries can still face substantial costs for specialty drugs or if they take many medications. Recently enacted changes to Medicare, which were part of the Medicare Access and CHIP Reauthorization Act of 2015, will also further increase Part B and Part D premiums for some higher-income beneficiaries who already pay higher premiums.[8]

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7 Cubanski, J., and Neuman, T., "Medicare's Income-Related Premiums: A Data Note." Kaiser Family Foundation, June 2015.

8 These additional income-related premiums will apply to Medicare beneficiaries with incomes above $133,500 ($267,000 for married couples).

Table 1 provides a summary of the 2015 cost sharing and premiums for Medicare Parts A, B, and D.

TABLE 1. MEDICARE BENEFITS AND COST-SHARING REQUIREMENTS, 2015

PART A	Premium	None for most beneficiaries (up to $407 per month for some)
	Deductible	$1,260 per benefit period*
	Inpatient hospital	Days 1-60: no copayment; days 61-90: $315 /day; days 91-150: $630/days; days after 150: no coverage
	Skilled nursing facility	Days 1-20: no copayment; days 21-100: $157.50 per day; days after 100: no coverage
	Home health	No cost sharing
	Hospice	No cost sharing
	Inpatient psychiatric hospital	Same as inpatient hospital (up to 190 days in a lifetime)
	Out-of-pocket spending limit	None
PART B	Premium	$104.90 per month** (higher for those with higher incomes: sliding scale up to $335.70 for individuals with annual income above $214,000 and joint filers above $428,000)
	Deductible	$147 per year
	Physician and other medical services	20% coinsurance
	Clinical laboratory services	No coinsurance
	Home health	No coinsurance
	Outpatient mental health services	20% coinsurance
	One-time "Welcome to Medicare" physical exam and annual "Wellness" visit	No coinsurance
	Preventive services	No coinsurance for most services (although 20% for some); some limitations based on frequency, type of service, and patient's age and medical history
	Out-of-pocket spending limit	None
PART D	Premium	Varies based on income: up to $70.80 per month for higher-income beneficiaries (plus plan premium)
	Deductible	$320
	Initial coverage (up to $2,960 in total drug costs)	25% coinsurance
	Coverage gap (between $2,960 and $6,680 in total drug costs)	45% coinsurance for brand-name drugs; 65% coinsurance for generic drugs (phasing down to 25% for both brand-name and generic drugs by 2020)
	Catastrophic coverage (above $4,700 in out-of-pocket spending)	Maximum of $2.65/generic, $6.60/brand-name; or 5% coinsurance

* A Medicare "benefit period" begins when a beneficiary is admitted as an inpatient to a hospital or skilled nursing facility (SNF) and ends when the beneficiary has received no inpatient care or skilled care in a SNF for 60 days in a row. A beneficiary can have more than one benefit period in a calendar year and, as a result, incur more than one deductible.
** The Part B premium for *new* beneficiaries could be as much as $159 per month, starting in 2016, although the amount has not yet been set. Most Medicare beneficiaries will see little, if any increase, in their Part B premium because those increases are linked to the Cost of Living increases for Social Security benefits, which are not expected to rise significantly.

PRIVATE COVERAGE TO SUPPLEMENT MEDICARE

Although Medicare covers a large share of medical expenses, Medicare beneficiaries are still exposed to substantial out-of-pocket costs, in the form of premiums, copayments, coinsurance, and deductibles. In addition, Medicare does not cover many necessary services (e.g., dental care). Private health insurance

policies protect individuals with Medicare coverage against some or most of these expenses and in some cases provide additional benefits that are not covered by Medicare.

Private coverage to supplement Medicare is sold on an individual (nongroup) and group basis. Group coverage is available to many Medicare beneficiaries, usually as a retiree benefit from a former employer. Medicare beneficiaries purchase individual coverage directly from insurers.

There are three basic types of private coverage to supplement Medicare: Medicare supplement/medigap plans, Medicare Advantage plans, and Prescription Drug Plans (PDP). Medicare beneficiaries who have coverage to supplement Medicare may have one form of private coverage, several forms of private plans, or some combination of private and public coverage.

Medigap/Medicare supplement plans: These plans are sold by commercial carriers. Under state law, carriers in Massachusetts may sell only two types of Medicare supplement plans in the nongroup/individual market[9]: "*Medicare Supplement Core*" and "*Medicare Supplement 1.*" Appendix 1 provides a brief summary of the benefits required in each of the two standardized Medicare supplemental plans. Carriers are also permitted to offer "Medicare Select" plans, which are medigap plans that require the use of a specific provider network. In general, benefits in Medicare Select plans are the same as in the Core and Supplement 1 plans if care is received in the provider network, but cost sharing may be greater if care is given by a non-network provider.

Ten insurers offer individual/nongroup Medicare supplement plans in Massachusetts, although three companies sell only to members of certain groups (e.g., members of AARP). (See Appendix 2.)

Medicare Advantage plans: As noted above, Medicare beneficiaries also have the option to receive their Medicare benefits through private health plans offered under Medicare Part C, called Medicare Advantage plans, as an alternative to the traditional Medicare program. There are many different types of Medicare Advantage plans, including HMOs and PPOs, which serve the majority of Medicare Advantage beneficiaries nationally and in Massachusetts; and Special Needs Plans (SNPs), which provide coverage to beneficiaries who are dually eligible for Medicare and Medicaid, including the Massachusetts Senior Care Options (SCO) program. Medicare Advantage plans may provide drug benefits but are not required to do so. Medicare Advantage plans in Massachusetts must meet requirements of state and federal law.

Seven carriers offer Medicare Advantage HMO or PPO plans in Massachusetts. These carriers offer a total of 35 different products, the majority of which include some coverage for prescription drugs, although the coverage varies widely from plan to plan. (See Appendix 3.) Almost all Medicare beneficiaries in a Medicare Advantage plan in Massachusetts have chosen a plan with prescription drugs (98 percent).

Medicare Advantage plans are paid a different amount by Medicare depending on county, and as a result the availability of Medicare Advantage programs, and choice of products, vary significantly by county. Two counties, Dukes and Nantucket, have only one carrier and one product available (and it is offered to AARP members only),[10] while other regions of the state have as many as five carriers and more than 20 product

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9 State law and regulation (M.G.L. c. 176 K and 211 CMR 71.00) prescribe the standardized benefit packages that may be offered in the individual/nongroup Medicare supplement market. These requirements do not apply to employer group Medicare supplement policies. In certain respects, the regulatory scheme in Massachusetts is substantially different from that in most other states. For example, Massachusetts has long had standardized benefit packages and permits only two types of Medicare supplemental insurance, rather than the larger number of plans permitted in most other states. Massachusetts is one of a handful of states that require community rating and guaranteed issue rights for Medicare beneficiaries with disabilities.

10 It currently costs $16 per year to be an AARP member; an additional membership for a spouse or partner is free.

choices. People in different counties may also pay significantly different premiums for the same product.[11] For example, residents of Barnstable County pay $65 per month for a product that has no premium in Hampden and Hampshire counties. As of December, 2013, the percent of Medicare beneficiaries enrolled in Medicare Advantage plans ranged from less than 2 percent in Dukes and Nantucket counties to 35 percent in Worcester. (See Appendix 4.)

In general, the benefits provided in Medicare Advantage plans are more comprehensive than the benefits required in the state's standardized Medicare supplement plans. However, cost sharing varies widely from product to product, particularly for prescription drug benefits, which are typically structured with tiered copayments or coinsurance levels that vary significantly from the lowest to highest tier.

Appendix 5 gives a comparison of the cost sharing in the three Medicare Advantage plans with the largest membership as of February 2015. Approximately one-third of direct-pay Medicare Advantage members were enrolled in one of these three products. As the appendix shows, although the plans help with the cost sharing in the Medicare program, members still face significant out-of-pocket costs.

Prescription Drug Plans: As noted earlier, Medicare beneficiaries also have the option to obtain prescription drug coverage by participating in Medicare Part D and selecting a Prescription Drug Plan (PDP). PDPs can be purchased by Medicare beneficiaries with no other form of coverage to supplement Medicare, by individuals who have Medicare supplemental products, or by those who have other forms of group coverage.

Medicare D specifies two types of PDPs, Basic and Enhanced, and these categories apply to stand-alone Prescription Drug Plans and Medicare Advantage plans with drug coverage. Basic plans are required to cover the Medicare Part D defined standard benefit (i.e., they generally do not cover the Part D deductible or provide benefits in the coverage gap). Enhanced plans exceed the Medicare Part D defined standard benefit by providing additional benefits, such as reduced cost sharing, broader formularies, and coverage in the coverage gap, although they usually do so at a significantly higher premium.

Most PDPs have a coverage gap for the Medicare donut hole. This causes a change in the amount beneficiaries must pay for their medications if their spending on medications exceeds certain limits. When beneficiaries are in this gap, they must pay out of pocket for all medications up to a certain limit.

In 2015 the Part D coverage gap/donut hole begins after an individual's total yearly drug costs (i.e., expenses paid by the Part D plan and the individual, including any deductible but not including any Part D premiums) reach $2,960. Once in this coverage gap, a beneficiary with basic Part D coverage must pay 45 percent of the plan's cost for covered brand-name drugs and 65 percent of the plan's cost for covered generic drugs until the individual's total expenses are $4,700, which is the end of the coverage gap. (In calculating out-of-pocket payments toward the coverage gap, all amounts paid by the individual and most of the price the plan pays for brand-name drugs are included.[12])

From this point on, the beneficiary has "catastrophic coverage" under Medicare Part D and pays $2.65 per month for generics, $6.60 per month for brand-name medications, or 5 percent of the medication's retail cost, whichever cost is higher.

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11 Premiums for some other types of nongroup health insurance sold in Massachusetts also vary by region because insurers are permitted to use geography as a rating factor.

12 For more detail on this somewhat complicated calculation, see https://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html.

As noted above, the ACA is mitigating the impact of this coverage gap by providing discounts on covered brand-name and generic drugs purchased at a pharmacy or through the mail. This means that drug companies, health plans, and Medicare are all helping to pay to close the coverage gap. Each year until 2020, Medicare will increase the size of this discount. However, even when fully implemented in 2020, beneficiaries will have to pay 25 percent for brand-name drugs and 25 percent for generics after they meet any deductible until they reach the annual out-of-pocket limit (i.e., the equivalent in 2020 of the $4,700 in 2015).

Twelve insurance companies sell a total of 26 PDPs in Massachusetts, all of which are available statewide. (See Appendix 6.) The cost sharing in these products varies widely, and the majority (15) have a deductible (usually $320, which is the Part D deductible in 2015).

Appendix 7 shows detailed information for the PDPs that had at least 5,000 members as of February 2015; these plans account for nearly all PDP members in Massachusetts. As shown, most PDPs have tiered copayments that increase significantly from the lowest to highest tier, and some have coinsurance rather than copayments for some tiers, including the highest tier for the most expensive specialty drugs. In some cases, medications in certain tiers are not subject to the deductible. The plans offer little or no coverage in the donut hole/coverage gap. In addition, many products have restricted or preferred pharmacy networks, which require or encourage beneficiaries to fill prescriptions at certain pharmacies, including mail-order pharmacies.

Retiree health coverage: In addition to these forms of private coverage, some Medicare beneficiaries in Massachusetts are eligible for retiree health benefits through their former employers. Although it is hard to estimate the number of Medicare beneficiaries in Massachusetts with retiree coverage, one-quarter of Medicare beneficiaries in the U.S. have employer-sponsored coverage.[13] The largest group in the state with retiree health coverage—consisting of about 68,000 individuals—is retired state and municipal workers who obtain coverage through the Group Insurance Commission (GIC): either HMO coverage or coverage under the state's retirement health insurance plan administered by UniCare. Many other retired municipal workers obtain health coverage through the city or town where they worked. Federal government retirees are likely to be another large group; approximately 43,000 federal retirees live in Massachusetts, and are most likely to have coverage through their former employer.[14] People may have other forms of coverage to supplement Medicare, including through the Veteran's Administration or the Medicare Tri-Care Health for Life supplemental program of the U.S. Department of Defense.

13 Jacobson, G., et al., "Medigap Reform: Setting the Context for Understanding Recent Proposals." Kaiser Family Foundation, January 2014.

14 http://eyeonwashington.com/few_map_2010/htm/Massachusetts.html.

PUBLIC COVERAGE PROGRAMS TO SUPPLEMENT MEDICARE

A variety of public programs are important sources of additional coverage and financial protection for Medicare beneficiaries in Massachusetts.

Medicaid/MassHealth: Approximately 292,000 Medicare beneficiaries in Massachusetts are also covered by the state's Medicaid program, MassHealth,[15] approximately half of whom are elders. In contrast to Medicaid coverage for most non-elders, low-income elders must meet both income *and* asset tests to qualify for coverage, and the income threshold is lower for elders than for people who are under 65 years old. Medicare beneficiaries are not eligible for ConnectorCare. As a result, only 16 percent of elders in the state are covered by MassHealth, compared with 31 percent of people under age 65 who are covered by MassHealth or ConnectorCare.[16]

Medicaid generally covers Medicare cost sharing and provides subsidies to cover the full amount of the Part B premium. In Massachusetts, the majority of these dually eligible individuals are enrolled in traditional MassHealth programs, but some are enrolled in CommonHealth, Program for All-inclusive Care for the Elderly (PACE), Senior Care Options (SCO), and One Care programs. In the PACE, SCO, and One Care programs, members join one of several private health plans, which contract with Medicaid and Medicare to provide all Medicaid and Medicare benefits to covered members. To be eligible for CommonHealth, an elder must be working as well as have a qualifying disability.

Medicare Savings Programs: The Medicare Savings Programs (MSPs), which are part of Medicaid, help low-income Medicare beneficiaries to pay Medicare premiums and provide assistance with Medicare deductibles and copayments. There are three MSPs, and an individual may be eligible for one of these depending on his/her income:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI) programs.

In Massachusetts, QMB is called MassHealth Senior Buy-In and the SLMB and QI programs are called MassHealth Buy-In.

Medicare beneficiaries must meet both income *and* asset tests, as well as MassHealth immigration criteria, to qualify for these programs, which are administered by MassHealth. The QI program is funded by a block grant, and benefits are granted on a first-come, first-served basis each year. Once the funding runs out, applications to the program are not accepted.

In recent years Massachusetts has not used its entire federal funding allotment and so has not had to stop enrollment in the QI program.

The eligibility criteria and benefits for the MSPs and Part D Extra Help program are shown in Appendix 8.

As shown in Appendix 8, the QMB program offers most of the benefits of a Medicare supplement plan if care is received from providers who accept both Medicare and Medicaid or who participate as QMB-only providers.

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15 MassHealth *Snapshot* report, March 2015.

16 Calculated from MassHealth Snapshot report, March 2015; Massachusetts Health Connector Board Report Metrics (September 10, 2015); and U. S. Census Bureau at http://quickfacts.census.gov/qfd/states/25000.html.

The SLMB and QI programs do not provide coverage that is as significant and therefore do not substitute for another plan that covers the gaps in Medicare. People covered by any of the MSPs are automatically enrolled in the Medicare Part D Low-Income Subsidy, known as "Extra Help."

Medicare Part D Low-Income Subsidy ("Extra Help"): This program, which is administered by the federal Social Security Administration, provides assistance to low-income Medicare beneficiaries by paying Medicare Part D premiums and deductibles, paying for coverage during the donut hole/coverage gap period, and limiting Part D copayments to the same amounts as are applied during the catastrophic coverage period (i.e., a maximum of $2.65 for generics and $6.60 for brand-name drugs). Extra Help is available to individuals with incomes up to 135 percent of the federal poverty level (FPL), and Partial Extra Help, which has lower benefits, is available to individuals with incomes up to 150 percent FPL. Applications for a Part D subsidy are automatically sent to be determined for eligibility for a MSP unless the individual opts out. (See Appendix 8.)

Prescription Advantage: This is the state's pharmaceutical assistance program (SPAP), which helps elders and people with disabilities who meet certain income eligibility guidelines to lower their out-of-pocket costs for prescription drugs. For people with Medicare, Prescription Advantage is structured as secondary coverage that complements Medicare Part D and the federal Extra Help program. The program provides financial assistance once individuals meet the "donut hole" coverage gap (i.e., when the cost of covered drugs reaches $2,960). Medicare members with annual incomes up to 500 percent FPL may qualify for Prescription Advantage. Although Prescription Advantage has no asset limits, individuals who apply to Prescription Advantage are required to apply for Extra Help, which does have asset limits. Individuals with incomes above 300 percent FPL pay an annual enrollment fee of $200 for Prescription Advantage. Approximately 46,000 people are enrolled in Prescription Advantage. Appendix 9 provides more information on the structure of the program, showing how the program works in combination with Extra Help and Partial Extra Help for low- and moderate-income individuals.

III. ENROLLMENT BY TYPE OF COVERAGE

From publicly available data, it is not possible to know accurately how many Medicare beneficiaries in Massachusetts have coverage to supplement Medicare. Table 2 provides the data on membership that is available, as of the end of calendar year 2013.

TABLE 2. MASSACHUSETTS MEDICARE BENEFICIARIES WITH SUPPLEMENTAL COVERAGE BY TYPE: 2013 (INCLUDES INDIVIDUALS <65 AND 65 AND OLDER)

		2013	% OF MEDICARE ELIGIBLES
MEDICARE ELIGIBLES		1,167,100*	100%
PRIVATE COVERAGE	Medicare supplemental	231,600	20%
	• Individual	225,700	
	• Group	5,900	
	Medicare Advantage (excluding SCO)	218,300	19%
	• Individual	149,200	
	• Group	69,100	
	GIC Unicare plan	68,200	6%
	Federal retirees	43,000	4%
	TOTAL PRIVATE	561,100	48%
PUBLIC COVERAGE	MassHealth (including SCO)	279,100	24%
	• MassHealth Standard	262,700	
	• CommonHealth	16,400	

*Rounded to nearest 100.
Sources: Massachusetts Division of Insurance; MassHealth; Group Insurance Commission (GIC).

According to the publicly available data, approximately 232,000 people, or 20 percent of Medicare beneficiaries, had Medicare supplement policies at year end 2013, most as individual policyholders, and 218,000 people, 19 percent of beneficiaries, were enrolled in Medicare Advantage plans (excluding dually eligible people, who are counted in the MassHealth total).[17] Medicaid provided supplemental coverage to another 24 percent of beneficiaries (the dually eligible beneficiaries and those with CommonHealth). Approximately 68,000 retirees were covered by the state GIC's UniCare plan (in addition to state retirees who have other forms of coverage that are included elsewhere in the table), and an estimated 43,000 federal retirees also had coverage.

The figures in Table 2 do not give a complete picture of the number of Medicare beneficiaries who have coverage supplemental to Medicare because no public data are available on most employer-sponsored retiree plans. Nationally, 26 percent of Medicare beneficiaries have employer-sponsored coverage to supplement Medicare, including group medigap and group Medicare Advantage plans. If this percentage is applied to Massachusetts, approximately 303,000 people would have some sort of employer-sponsored coverage.

17 Nationally, 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans. ("Report to the Congress: Medicare Payment Policy." March 2015. Medicare Payment Advisory Commission, Chapter 13, p. 321.)

Table 2 shows 186,000 people with group coverage of some type (either Medicare Advantage, Medicare supplemental, or government retiree plans through the GIC or the federal government), meaning approximately 117,000 additional people in the state could have some type of retiree coverage to supplement Medicare.

Prescription drug coverage: The available public data show that approximately 1 million Massachusetts Medicare beneficiaries, or 91 percent, were enrolled in some type of supplemental coverage for prescription drugs as of year end 2013, through a Medicare Advantage plan, a Medicare supplemental plan,[18] a stand-alone Part D plan, retiree health insurance, or MassHealth. (See Table 3.) Almost all Medicare Advantage plan members (98 percent) have some drug coverage.

TABLE 3. PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES BY TYPE: 2013

		2013	% OF MEDICARE ELIGIBLES
MEDICARE ELIGIBLES		1,167,100*	100%
PRIVATE COVERAGE	Stand-alone Part D drug plans	448,900	38%
	Medicare supplemental with Rx	6,900	1%
	• Individual	6,500	
	• Group	400	
	Medicare Advantage with Rx	213,100	18%
	• Individual	173,500	
	• Group	59,900	
	GIC Unicare retiree plan	68,200	6%
	Federal retirees	43,000	4%
	TOTAL PRIVATE	780,100	67%
PUBLIC COVERAGE	MassHealth (including SCO)	279,100	24%
	• MassHealth Standard	262,700	
	• CommonHealth	16,400	

*Rounded to nearest 100.
Sources: Division of Insurance; Group Insurance Commission (GIC); federal estimates; MassHealth.

In one respect, these figures understate the actual numbers because they do not include some number of Medicare beneficiaries who have retiree health insurance through other plans that include prescription drug coverage. However, the figures also overstate the numbers because some people may have more than one type of drug coverage. So the actual number of Medicare beneficiaries who have *some* type of supplemental coverage is impossible to estimate accurately with available data.

18 Carriers have not been permitted to sell medigap plans that include prescription drug coverage to new members since 2006.

IV. ENROLLMENT BY CARRIER

Medicare Supplement: Blue Cross Blue Shield of Massachusetts is the dominant carrier in the Medicare supplement market, with 162,000 members at year end 2013, or approximately 70 percent of Medicare beneficiaries who have this type of coverage. (See Appendix 10.)

Medicare Advantage: Tufts HMO is the dominant carrier in the Medicare Advantage market, with 101,000 members at year end 2013, or approximately 46 percent of Medicare beneficiaries who have this type of coverage (excluding SCO). (See Appendix 11.) The Medicare Advantage market is quite concentrated; five carriers have 90 percent of total enrollment.

Table 4 shows combined membership by carrier in Medicare supplemental and Medicare Advantage plans (excluding the MassHealth SCO program). The combined market is extremely concentrated, with four companies—Blue Cross Blue Shield of Massachusetts, Tufts, United Healthcare, and Harvard Pilgrim—having a combined market share of 92 percent.

Stand-Alone Prescription Drug Plans: Table 5 shows membership by carrier in stand-alone prescription drug plans in 2013. The combined market is concentrated, with four carriers—SilverScript, United Healthcare, Blue Cross Blue Shield of Massachusetts, and Humana—having a combined market share of 85 percent.

TABLE 4. MEMBERSHIP IN MEDICARE SUPPLEMENTAL PLANS AND MEDICARE ADVANTAGE PLANS: 2013*

CARRIER	# OF MEMBERS
Blue Cross Blue Shield of Massachusetts and HMO Blue	198,747
Tufts HMO and Tufts Insurance Co.	112,630
United Healthcare Insurance Co.	65,906
HPHC and HPHC Insurance Co.	34,829
• Membership: Top 4 carriers	412,112
• Market share: Top 4 carriers	92%
All other carriers	37,747
TOTAL ENROLLMENT	**449,859**

*Excludes MassHealth SCO Program.
Sources: Division of Insurance; MassHealth.

TABLE 5. STAND-ALONE PDP ENROLLMENT BY CARRIER

CARRIER	# OF MEMBERS
SilverScript (CVS/Caremark)	128,863
United Healthcare Insurance Co.	100,004
Blue Cross Blue Shield of Massachusetts	79,460
Humana Insurance Co.	72,690
• Membership: Top 4 carriers	381,017
• Market share: Top 4 carriers	85%
First Health Part D	33,342
Aetna	10,445
Other carriers (n=13)	24,098
TOTAL ENROLLMENT	**448,902**

Source: Division of Insurance.

V. PREMIUMS AND AFFORDABILITY OF COVERAGE

Massachusetts Medicare beneficiaries looking for private health coverage have a wide array of coverage options to supplement Medicare. Premiums vary widely, depending on type of coverage, product, and, for Medicare Advantage plans, region of the state.[19] In many cases premiums have risen rapidly in recent years, and annual premiums, which as a percent of income are significant for many products, have increased much faster than have Social Security benefits or average incomes in the state.

Appendices 12 through 14 provide the monthly premium rates for the Medicare supplements, Medicare Advantage plans with drug coverage, and PDPs available on an individual/nongroup basis in the Commonwealth. In the case of Medicare Advantage and PDPs, only the plans with the largest membership are shown. No premiums are shown for Medicare Advantage plans without prescription drugs because so few Medicare beneficiaries in the state have this type of coverage.

Comparing premiums is complicated because Medicare Advantage and PDPs do not have standardized benefits or cost sharing. In addition, plans have different provider networks and formularies, which make comparing plans even more complicated. There may also have been benefit changes over this time period in some plans. However, even in the case of Medicare supplemental policies, which have standardized benefits, the premium differences among plans are significant.

The appendices also show premium increases from 2009 to 2015 for the most popular products that were offered in both years. It was not possible to compare premium changes for every product because of changes in plan names and the consolidation/merger of some carriers. In addition, many of the most popular plans in 2015 were not marketed in 2009.

Although premium increases have been modest for some plans, many products have had significant increases, often exceeding 20 percent and some in the 50-70 percent range, particularly among Medicare Advantage plans. To put these increases in perspective in terms of affordability for Medicare beneficiaries, over the 2009–2015 time period, the cost-of-living adjustment (COLA) in Social Security benefits, the major source of income for most elders and many people with disabilities, was 8.7 percent (an average annual increase of 1.4 percent).[20] The majority of the plans for which premium information was available for 2009 and 2015 had premium increases that were far above this COLA amount.

19 Under Massachusetts law, direct-pay Medicare supplemental plans must be community-rated (i.e., carriers must charge the same premium to each policyholder, regardless of the age, sex, health status, or any other characteristic of the policyholder). Federal law requires Medicare Advantage and PDP premium rates to be community-rated.

20 http://www.ssa.gov/news/cola/automatic-cola.htm.

DISTRIBUTION OF MEDICARE BENEFICIARIES BY MONTHLY PREMIUM

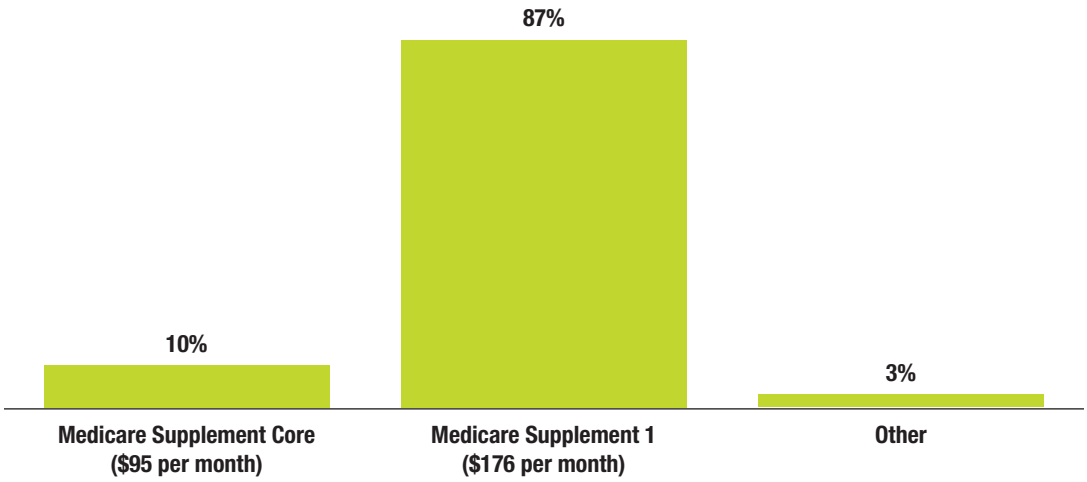
It is impossible to estimate the "average" premium paid by a Medicare beneficiary in Massachusetts (or any other state) for coverage to supplement Medicare because of the number of plans and all of the possible combinations of coverage and financial support, including government assistance plans like Prescription Advantage, MSPs, and Extra Help. However, there are various ways to assess affordability of premiums.

The first way is to examine the public data that are available on nongroup enrollment in Medicare supplement and Medicare Advantage with prescription drug plans by monthly premium, which provide some indication of the amounts that many Medicare beneficiaries in Massachusetts are paying for coverage. It is important to note that how much Medicare beneficiaries are paying for coverage is not necessarily an indication that coverage is "affordable" for all of them. Many beneficiaries may be suffering undue hardship or sacrificing in other areas to pay their monthly premiums for coverage to supplement Medicare. Assessing these premium data in the context of the poll of elders that has been commissioned by the Foundation will give a more complete picture of affordability.

These data show that Medicare beneficiaries who have individual/nongroup medigap plans are generally selecting the more comprehensive and more expensive types of coverage.

Medicare Supplemental Coverage: Figure 1 shows the distribution of Blue Cross Blue Shield of Massachusetts' direct-pay/nongroup Medicare supplement (i.e., Medex) members by premium. (As noted earlier, BCBSMA has a 70 percent share of the medigap market.) Nearly 90 percent of Medex members have the more comprehensive Medicare Supplement 1 coverage, which costs $176 per month.

FIGURE 1. DISTRIBUTION OF DIRECT-PAY MEDEX MEMBERS BY PRODUCT: FEBRUARY 2015

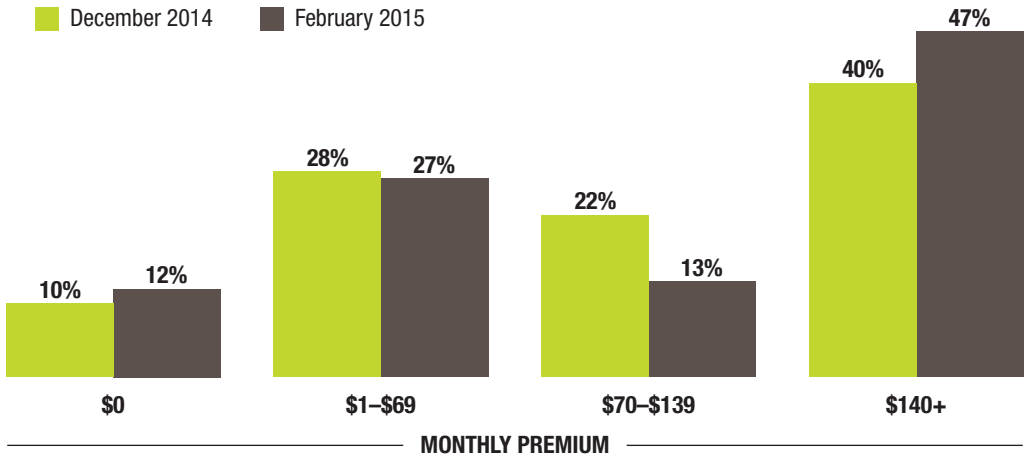


Source: Blue Cross Blue Shield of Massachusetts. Total membership is ~181,000.

Medicare Advantage with Prescription Drugs (MA-PD): Figure 2 shows the distribution of direct-pay/nongroup members in Medicare Advantage plans with prescription drug coverage, by monthly premium, as of February 2015. Nearly half of the 160,000 MA-PD members in Massachusetts are paying $140 or more per month for their coverage, and this proportion represents a significant increase since last year's open enroll-

ment period. Only 12 percent of members have selected a $0 premium plan (i.e., a plan for which they pay no monthly premium).[21]

FIGURE 2. ENROLLMENT OF MEMBERS BY MONTHLY PREMIUM: MEDICARE ADVANTAGE WITH PRESCRIPTION DRUGS (DIRECT PAY): DECEMBER 2014 VS. FEBRUARY 2015



Source: Blue Cross Blue Shield of Massachusetts, based on CMS Enrollment Data reports. Enrollment in 2015 is ~160,000 people.

PREMIUMS AND POTENTIAL OUT-OF-POCKET EXPENSES FOR BENEFICIARIES WITH DIFFERENT TYPES OF COVERAGE

A second way of assessing premiums and affordability is to compare the premiums and potential out-of-pocket expenses for a Medicare beneficiary who has various combinations of coverage. Table 6 shows the premiums and potential exposure for uncovered expenses for three coverage options: Option 1 is no coverage to supplement Medicare; Option 2 is the most popular Medicare Supplement 1 plan (Blue Cross Blue Shield of Massachusetts' Medex Bronze product) and the most popular stand-alone PDP (SilverScript Choice by CVS/Caremark); and Option 3 is the most popular Medicare Advantage plan with prescription drug coverage (Tufts Health Plan Medicare Preferred HMO Prime Rx Plus). As these options show, individuals without supplemental coverage have significant financial exposure for cost sharing in Medicare and also pay nearly $1,300 a year for Part B premiums. Medicare beneficiaries who buy coverage have less financial exposure, but premiums for the most popular and comprehensive forms of coverage are expensive. When combined with Part B premiums, annual total premiums for Options 2 and 3 exceed $3,800 per year and still leave significant potential exposure to out-of-pocket expenses, particularly for prescription drugs.

21 Zero premium plans do not require the Medicare beneficiary to pay any monthly premium for coverage (beyond any Medicare Part A and Part B premiums). All Medicare Advantage plans receive a fixed monthly payment from Medicare for each member (which varies based on member age, sex, locality, and health status), which finances Medicare benefits and a range of other covered services, usually within a specified provider network. The ability to provide benefits for no additional premium is possible because of cost savings that result from the contractual relationship with the provider network and other care management activities. In addition, there is long-standing concern among policymakers, including the federal Medicare Payment Advisory Commission (MedPAC), that the federal Medicare Advantage payment formula does not adequately adjust for the health status of members who enroll in these plans, which leads, in many cases, to an overpayment of Medicare Advantage plans relative to the health risk of members who select these plans.

TABLE 6. WHAT DOES THE MEDICARE BENEFICIARY PAY OUT OF POCKET?

	OPTION 1: NO COVERAGE TO SUPPLEMENT MEDICARE	OPTION 2: MOST POPULAR MEDIGAP AND PDP	OPTION 3: MOST POPULAR MEDICARE ADVANTAGE-PD
Plan Name(s)		Medex Bronze and SilverScript Choice	Tufts Medicare Preferred HMO Prime Rx Plus
PREMIUMS			
Part B premium: Annual	$1,259	$1,259	$1,259
Premium for supplemental coverage: Annual		$2,400 $177/month for Medex and $23/month for SilverScript	$2,546 $212.20 per month
Total annual premium	$1,259	$3,659	$3,805
Total out-of-pocket spending limit	None	None	$3,400
MEDICARE PART A SERVICES			
Inpatient hospital care	Deductible of $1,260 per benefit period and then copayments: Days 61-90: $315/day; days 91-150: $630/day. After 150 days in a benefit period: Pays full amount	Nothing (plus coverage for an extra 365 lifetime reserve days)	$200/day (up to maximum of $400 per year)
Skilled nursing facility	Days 21-100: $157.50 per day; days after 100: Pays full amount	Nothing	Days 1-20: $20 per day
Home health	Nothing (up to 35 hours)	Nothing	Nothing
Hospice	Copayment of $5 per prescription; 5% of Medicare-approved payment for respite care per day, not to exceed $1,260	Nothing	Nothing
Inpatient psychiatric hospital	Same as inpatient hospital (up to 190 days in a lifetime)	Nothing (plus 120 days per year)	$200/day (up to maximum of $400 per year)
MEDICARE PART B SERVICES			
Deductible	$147 per year	Nothing	Nothing
Physician and other medical services	20% coinsurance	Nothing	PCP: $10/visit and Specialist: $15/visit
Clinical laboratory and X-ray services	Nothing	Nothing	Nothing for most services; up to $75 for diagnostic radiology
Home health	Nothing	Nothing	Nothing
Outpatient mental health services	20% coinsurance	Nothing	$15/visit
Preventive services covered by one-time “Welcome to Medicare” physical exam and annual “Wellness” visit	Nothing	Nothing	Nothing

(continued)

TABLE 6. WHAT DOES THE MEDICARE BENEFICIARY PAY OUT OF POCKET? *(continued)*

	OPTION 1: NO COVERAGE TO SUPPLEMENT MEDICARE	OPTION 2: MOST POPULAR MEDIGAP AND PDP	OPTION 3: MOST POPULAR MEDICARE ADVANTAGE-PD
MEDICARE PART D SERVICES			
Deductible	$320	Nothing	
Initial coverage (up to $2,960 in total drug costs)	100% of costs	Retail and mail-order tier 1 (preferred generic): $8/20; tier 2 (preferred brand): $27/$67.50; tier 3 (non-preferred generic and brand): 45%/45%; tier 4 (specialty): 33%/33%	Retail and mail-order tier 1 (preferred generic): $2/5; tier 2 (non-preferred generic): $5/12; tier 3 (preferred brand): $30/90; tier 4 (non-preferred brand): $80/$240; tier 5 (specialty): 33%/33%
Coverage gap (between $2,960 and $6,680 in total drug costs)	45% coinsurance for brand-name drugs; 65% coinsurance for generic drugs	45% coinsurance for brand-name drugs; 65% coinsurance for generic drugs	
Catastrophic coverage (above $4,700 in out-of-pocket spending)	Maximum of $2.65/generic, $6.60/brand; or 5% coinsurance	Maximum of $2.65/generic, $6.60/brand; or 5% coinsurance	Maximum of $2.65/generic, $6.60/brand; or 5% coinsurance
Other benefits	None	3 pints blood	Various, including wellness, eyewear, weight loss

A third way of assessing the affordability of coverage to supplement Medicare is to examine the coverage that would be available to a "hypothetical" beneficiary.

Table 7 shows the premiums and cost sharing that would be faced by an individual who lives in Suffolk County[22] and has annual income of $11,000, or approximately the federal poverty level. Low-income individuals are most vulnerable to out-of-pocket medical expenses, and having a low income is also generally associated with poorer health and higher medical needs.[23] Approximately 8 percent of elders in Massachusetts have an income at or below the poverty level,[24] while the average Social Security benefit in Massachusetts is approximately $16,000 in 2015. Thirty percent of Social Security beneficiaries in Massachusetts derive 100 percent of their annual income from Social Security. [25]

As shown, the experience of an individual 65 or older at this income level varies significantly based on her/his assets, because eligibility for various government programs varies by assets, and different assistance programs have different asset limits.

22 It is necessary to specify the county because Medicare Advantage premiums vary by county.

23 Wilkinson, G., and Marmot, M.G. (editors), *Social Determinants of Health: The Solid Facts.* World Health Organization, 2003.

24 Cubanski, J., et al., "Poverty Among Seniors: An Updated Analysis of National and State Level Poverty Rates Under the Official and Supplemental Poverty Measures." Kaiser Family Foundation, June 2015.

25 Calculated based on an average Social Security benefit in Massachusetts of $15,189 in 2012, increased by SS COLA (2013=1.7%; 2014=1.5%; 2015=1.7%). Sources: *Social Security:* "2014 Massachusetts Quick Facts," AARP, and http://www.ssa.gov/news/cola/automatic-cola.htm.

TABLE 7. PREMIUMS AND COST SHARING FOR AN INDIVIDUAL WITH $11,000 ANNUAL INCOME

	AGE 65 OR OLDER				AGE UNDER 65
ASSETS	<$2,000	$2,000–$7,280	$7,280–$13,640	>$13,640	ANY AMOUNT
Qualifies for	MassHealth	QMB-MSP, Extra Help, and Prescription Advantage	Extra Help and Prescription Advantage	No assistance	MassHealth
Does Beneficiary Have to Pay:					
• The Part B monthly premium ($105 per month/$1,260 per year)?	No	No	$105	$105	n.a.
• The Part D premium (average of $30 per month)?	No	No	No	Yes	n.a.
• The Part A and Part B deductibles, copayments, and coinsurance?	No	No	Yes	Yes	n.a.
• The Part D deductible?	No	No	No	Yes	n.a.
• Part D cost sharing up to $2,960 in total drug expense (25% after the deductible)?	No: Copayment limited to $1 certain generics and $3.65 others	No: Copayments limited to $2.65 generics and $6.60 brand-name	No: Copayments limited to $2.65 generics and $6.60 brand-name	Yes: Amount depends on Medicare Part D plan, if any	No: Copayment limited to $1 certain generics and $3.65 others
• Coinsurance on drug expenses while in the donut hole (35% on brand Rx and 65% on generics)?	No	No	No	Yes: Amount depends on Medicare Part D plan, if any	n.a.
• Copayments during the Part D catastrophic benefit?	No	No	No	Yes: Amount depends on Medicare Part D plan, if any	n.a.
Out-of-pocket limit: Rx	$250	Varies depending on category of eligibility. Generally less than Medicare Part D catastrophic limit		Depends on Medicare Part D plan, if any	$250
Out-of-pocket limit: Other covered services	$36	None	None	Depends on Medicare Part D plan, if any	$36
Average premium for medigap plan with drug coverage ($140 per month)	n.a.		$0 $140	$140	n.a.
Total annual premiums (Part B premium and medigap plan)	$0	$0	$1,260	$1,260 plus $1,680 in medigap premiums for the average MA-PD plan	$0

While someone under age 65 with annual income of $11,000 would be eligible for MassHealth regardless of assets, an elder must have less than $2,000 in countable assets to qualify for MassHealth.[26] Individuals who qualify for MassHealth have comprehensive coverage to supplement Medicare, minimal copayments, and a low limit on out-of-pocket expenses. Elders with assets under $13,640 would be eligible for various forms of assistance, including Partial Extra Help. Elders with less than $7,280 in assets would also qualify for QMB assistance through the MSPs and could obtain a subsidy for the Medicare Part A and B premiums and cost-sharing amounts.

Someone with assets between $7,280 and $13,640 would need to buy a plan to cover the Medicare Part A and Medicare Part B cost sharing, or pay these expenses out-of-pocket. The experience of an elder above the asset limit for the MSPs and/or Extra Help would be vastly different, with significant potential out-of-pocket payments, including premiums for coverage to supplement Medicare.

VI. OVERALL FINDINGS

It appears that the vast majority of Medicare beneficiaries in Massachusetts have supplemental coverage to help provide financial protection against the significant gaps and cost sharing in Medicare. However, this analysis identified the following issues that deserve attention:

Some elders in Massachusetts have no health insurance at all: According to the most recent state survey, conducted in 2014, approximately 10,000 residents age 65 or older were uninsured at the time of the survey, 46,000 elders (5 percent) had a spell without insurance in the prior 12 months, and 6,000 elders were uninsured for the entire prior year.[27] Many of these individuals likely are ineligible for premium-free Medicare A because they did not work, or did not work long enough paying into Medicare, to become eligible. Certain groups of workers are more likely to be ineligible for Medicare, including domestic workers, seasonal workers, and migrant workers, as well as some federal, state, and local government retirees.

Some other Medicare beneficiaries lack coverage to supplement Medicare: Although precise data are not available on the number of Medicare beneficiaries in Massachusetts who have no coverage to supplement Medicare, nationally 14 percent of Medicare beneficiaries have no supplemental coverage.[28] Lack of any private or public coverage to supplement Medicare leaves beneficiaries underinsured, and financially liable for the significant cost sharing and gaps in the Medicare program if they receive care.

Coverage to supplement Medicare is expensive, particularly when combined with Medicare Part B premiums, and when compared with the average Social Security benefit: While low-premium products are available, most Medicare beneficiaries are purchasing more comprehensive coverage. This suggests that individuals are willing to pay higher premiums for more comprehensive financial protection and lower out-of-pocket costs. However, total annual premiums for the most popular plans combined with the Medicare

26 Among the major assets that are not generally countable are an elder's principal place of residence, car, and $1,500 of funeral or burial arrangements. Asset limits are higher for couples.

27 Skopec, et al., op. cit.

28 Jacobson, et al., op. cit.

Part B premium exceed $3,800 per year, which is nearly one-quarter of the average Social Security benefit in Massachusetts (the major source of income for most elders).

Affordability of coverage to supplement Medicare is a growing concern: Premiums for the most popular products have been rising in recent years, sometimes very rapidly, and in almost every case much faster than Social Security benefits have been increasing. The coverage in some popular lower-premium products has also eroded through increases in deductibles and other forms of cost sharing, which has shifted additional costs to the Medicare beneficiaries with these forms of coverage.

It is not clear how much attention is being paid to increases in the premiums for private coverage to supplement Medicare—or how much, if any, regulatory authority the state has over Medicare Advantage and PDP plans, which are regulated largely at the federal level.

Medicare beneficiaries with private coverage, including those with more comprehensive products, still face significant coverage gaps and out-of-pocket expenses, particularly relative to their incomes: Many of the most popular Medicare Advantage plans have sizable cost sharing for certain services. Most prescription drug coverage has tiered copayments that can be significant for individuals who require brand-name or specialty drugs, and these drug plans generally provide no additional protection in the Medicare Part D coverage gap. (On the other hand, MA-PD plans have a limit on out-of-pocket spending, unlike most other forms of prescription drug coverage.) Other issues include the escalating cost of medications, which affects out-of-pocket costs for plans with coinsurance, a form of cost sharing that is becoming more common in Part D plans; the movement of more generics and brand-name drugs into higher tiers with higher cost sharing for consumers; and increasingly narrow formularies, which may limit or exclude coverage for specific medications. These issues are national trends in the Medicare Part D plans.[29]

Underinsurance and the lack of insurance for some Medicare beneficiaries result in expenses for the state's Health Safety Net: The state's Health Safety Net (HSN) is an important source of financial protection and support for uninsured and underinsured individuals, and for the providers who serve them. This group certainly includes elders. In fact, the eligibility criteria for the HSN are significantly more generous than the criteria for other forms of public coverage available to elders in Massachusetts. The HSN is a secondary payer for low-income Medicare patients who are adults age 65 or older, and a primary payer for certain elders who are uninsured and not eligible for other public coverage. In HSN year 2011 (the most recent for which a report is available), elders accounted for 27 percent of inpatient discharges paid through the HSN and 14 percent of outpatient visits. Because the HSN was largely a secondary payer to Medicare, these services accounted for 8 percent of total inpatient and outpatient payments, or approximately $22 million.[30] In addition, some HSN expenses at community health centers are likely for medications for Medicare beneficiaries who lack full or partial coverage for prescription drugs, as well as for services that Medicare does not cover at all (e.g., dental care).

Medicare beneficiaries in some counties have more limited access to lower-cost Medicare Advantage plans: There are substantial variations in premium rates and plan and product options available by county. In particular, there are significantly fewer choices available to residents in non-urban and less popu-

29 Hoadley, J., et al., "Medicare Part D: A First Look at Plan Offerings in 2015." Kaiser Family Foundation, October 2014. http://kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-plan-offerings-in-2015/.

30 Division of Health Care Finance and Policy, "Health Safety Net 2011 Annual Report." September 2012.

lated parts of the state. This mirrors the national pattern of there being fewer Medicare Advantage options for Medicare beneficiaries in rural areas than for those in urban areas.[31]

The large number of different plan types and products, and the lack of standardized benefits and cost sharing, make it difficult to compare plans and premiums: Even for someone with substantial health insurance knowledge, it is difficult to compare all of the options available for coverage to supplement Medicare. The differences in plan designs are particularly complex and variable for prescription drugs plans, which have multiple copayment tiers and vastly different formularies. Key features of plans often change every year (e.g., plan name, deductibles, premiums, and copayments). The Medicare Plan Finder (https://www.medicare.gov/find-a-plan/questions/home.aspx) is a useful tool but still requires a level of understanding and sophistication about health coverage that may be beyond that of many Medicare beneficiaries, particularly those with limited literacy or health insurance literacy or those whose first language is not English. Although research shows that consumers benefit greatly when they review their plan options, only 14 percent of Medicare beneficiaries change their drug plan in a given year. Prescription Advantage found similar results in its member population.[32]

One growing problem, according to several knowledgeable officials, is that adequate counseling on health coverage for people over 65 may not occur because there is no longer a standard age at which people are qualifying for and enrolling in Medicare, as many workers are staying employed longer than in the past. For example, many people do not realize that they may need to sign up for Medicare in the seven-month window around their 65th birthday or face a late enrollment surcharge. Employers have historically been an important source of advice and guidance for older and about-to-retire workers, but many companies have neither the resources nor the expertise to help their workers navigate the increasingly complex landscape of Medicare eligibility and coverage.

Although a variety of public programs exist to help pay the out-of-pocket costs Medicare beneficiaries may face, these programs are complicated and fragmented: Massachusetts is fortunate to have a variety of public programs, including MassHealth, Medicare Savings Plans, Prescription Advantage, and the Health Safety Net, that provide access and financial protection to lower- and moderate-income Medicare beneficiaries and elders without Medicare or coverage that supplements Medicare. However, eligibility rules for these programs are complex, navigating the coverage landscape is difficult, and public awareness or knowledge about these programs is often very low, which contributes to low enrollment. In addition, the eligibility criteria can vary from program to program, causing gaps and eligibility cliffs for people in some income groups, and significant changes in coverage for people who have even modest changes in income from year to year or when individuals turn 65.

Many Medicare beneficiaries eligible for additional coverage and assistance are not enrolled: Nationally, less than one-third of eligible Medicare beneficiaries enroll in the MSPs.[33] Although the exact number of eligible but unenrolled people in Massachusetts is unknown, the percent of eligible but unenrolled beneficiaries here is likely comparable to the national figure. Complicated enrollment processes and the asset test are the major barriers to enrollment in these programs.

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31 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," p. 321. March 2015.

32 Communication with staff in the Executive Office of Elder Affairs.

33 Dorn, S., and Shang, B., "Spurring Enrollment in Medicare Savings Programs through a Substitute for the Asset Test Focused on Investment Income." *Health Affairs*, February 2012.

The state has made significant efforts to simplify the application process for these programs and to do outreach to find eligible individuals. For example, the state SHINE program (Serving the Health Insurance Needs of Everyone) is a vital resource that helps people through the health coverage maze by providing free assistance and counseling on health insurance to individuals and their families and caregivers. The SHINE Program is run by the Executive Office of Elder Affairs, in partnership with a variety of local elder service, social service, and community agencies and local Councils on Aging. The program is funded by the state and the federal Administration for Community Living. The SHINE program, which has operated statewide since 1992, has become ever more important as the Medicare program has grown in complexity and as the number of types of private and public coverage options has increased. In addition to SHINE, Medicare beneficiaries can seek assistance by calling the Medicare call center.

The income cutoff for MassHealth eligibility is lower for elders than for people under age 65, and even at the same income level, elders may have less access to affordable health coverage than non-elders because of asset tests for public programs that do not apply to younger individuals: Owing to the state's health reform law and the ACA, affordable health coverage is available to most people in the state with incomes below 300 percent FPL, through employers, MassHealth, or ConnectorCare. Eligibility for ConnectorCare and for MassHealth for non-elders is based solely on income; no asset test applies. However, for people age 65 or older, both the MassHealth program and the MSPs have asset tests. Eligibility for public coverage (except for the HSN and Prescription Advantage) ends at 135 percent FPL for elders residing in the community, compared with 300 percent for people younger than age 65, and Medicare beneficiaries are not eligible for ConnectorCare. Only 16 percent of elders in the state are covered by MassHealth, compared with 31 percent of people under age 65 who have either MassHealth or ConnectorCare coverage.

There is little ongoing publicly available analysis and reporting that synthesizes the experience of Medicare beneficiaries in accessing and affording coverage and care: Over the past decade, the state and a wide range of private organizations have spent enormous amounts of time and effort examining, evaluating, and reporting on health coverage and affordability in Massachusetts. These efforts, which were spawned by Chapter 58, the state's landmark health coverage law, the federal ACA, and Chapter 224, the state's 2012 cost-control law, have been enormously successful in helping us to understand the current coverage and cost landscape, to identify areas of concern, and to begin to take action to address them.

However, the market for products to supplement Medicare has not been included in these efforts, despite its importance in helping to ensure access to care and financial protection for almost 1.2 million people in the Commonwealth. During this period of state and federal health reform, huge changes have occurred in this market, including the implementation of Medicare Part D, a proliferation of new private options for Medicare beneficiaries in Massachusetts, the implementation of important and innovative initiatives for certain groups of Medicare beneficiaries who are dually eligible for Medicaid, legislation to close the Medicare "donut hole," and recent changes to premiums for certain high-income Medicare beneficiaries.

Both the federal and state governments regulate and monitor private health plans that supplement Medicare, and the Division of Insurance produces some reports that provide data on enrollment in various types of private plans to supplement Medicare and an annual consumer guide to available products and prices. However, these reports contain very limited analysis and no policy recommendations.[34] No entity, public or private, has

34 See http://www.mass.gov/ocabr/insurance/providers-and-producers/insurance-companies/group-products-and-plans/medicare-supplement-membership/.

assumed responsibility for ongoing monitoring and analysis of and reporting about the state of the medigap market, in the same way that the Center for Health Information and Analysis and the Health Policy Commission are doing for other parts of the health insurance market. This has created gaps in basic and important information, including total enrollment, trends in coverage and premiums, and affordability of premiums. Compiling even the incomplete information in this policy report has been challenging because the data come from diverse sources, most of which are not used for ongoing analysis.

VII. CONCLUSION

Private plans and public programs that supplement Medicare are essential means for ensuring access to care and financial security for elders and other Medicare beneficiaries. Medicare beneficiaries in Massachusetts have a wide range of private coverage options, and many low- and moderate-income beneficiaries can obtain assistance from a number of public programs. However, this report has identified a number of areas that deserve attention by policymakers to ensure that all Medicare beneficiaries, particularly those with lower incomes, have access to affordable coverage to supplement Medicare, and to maintain equity between low-income elders and low-income individuals who are not elderly. Massachusetts has long been a leader in expanding health coverage, and it's time to focus additional policy attention on approaches to strengthen and secure coverage to supplement Medicare, particularly for Medicare beneficiaries with low incomes and serious health conditions.

APPENDICES

APPENDIX 1. MEDICARE SUPPLEMENT PLAN BENEFITS: 2015

	BENEFIT AMOUNT	CORE	SUPPLEMENT 1
BASIC BENEFITS IN ALL PLANS			
Hospitalization Part A copayments	Days 61-90: $315 per day Days 91-150: $630 per day	● ●	● ●
365 lifetime reserve days	Paid in full	●	●
Part B coinsurance	20% of approved amount (in most cases)	●	●
Part A and B blood	First 3 pints	●	●
ADDITIONAL BENEFITS			
Part A deductible for hospital days 1-60	$1,260 per benefit period		●
Skilled nursing facility coinsurance	Days 21-100: $157.50/day		●
Part B annual deductible	$147		●
Inpatient days in mental health hospitals	In addition to Medicare's coverage of 190 lifetime days	60 days per calendar year	120 days per calendar year

*Additional days of coverage beyond those paid for by Medicare. Medicare itself provides 60 "reserve days," which can be used over the course of the beneficiary's lifetime when an inpatient stay exceeds 90 days in a benefit period.

APPENDIX 2. MEDICARE SUPPLEMENT CARRIERS CURRENTLY OFFERING PRODUCTS

CARRIER	# OF PRODUCTS	TYPES	RESTRICTIONS
A. PRODUCTS AVAILABLE TO ALL			
Blue Cross Blue Shield of Massachusetts	2	Core and Supplement 1	
Blue Cross Blue Shield of Massachusetts (Medex Choice)	2	Core and Supplement 1	Uses HMO Blue Medicare Select limited network
Fallon Health and Life Assurance Company	2	Core and Supplement 1	
HNE Insurance Company	2	Core and Supplement 1	
HPHC Insurance Company	2	Core and Supplement 1	
Humana Insurance Company	4	Core and Supplement 1	
Tufts Insurance Company	2	Core and Supplement 1	
Subtotal	16		
B. PRODUCTS AVAILABLE ONLY TO MEMBERS OF CERTAIN ORGANIZATIONS			
Transamerica Life Insurance Company	2	Core and Supplement 1	Members of certain industry, trade, and other specific associations only
Transamerica Premier Life Insurance Company	2	Core and Supplement 1	American Medical Association members
United Healthcare Insurance Company	2	Core and Supplement 1	AARP members only
Subtotal	6		
TOTAL	**22**		

APPENDIX 3. MEDICARE ADVANTAGE CARRIERS CURRENTLY OFFERING INDIVIDUAL/NONGROUP PRODUCTS*

CARRIER	# OF PRODUCTS	TYPES	RESTRICTIONS
AARP Medicare Complete by Secure Horizons	4	3 HMO, 1 PPO	AARP members only
Blue Cross Blue Shield of Massachusetts	5	2 HMO, 3 PPO	
Erickson Advantage	3	3 HMO-Point of Service	
Fallon Community Health Plan	3	3 HMO	
Harvard Pilgrim Health Care	2	2 HMO	
Health New England	7	6 HMO, 1 HMO-Point of Service	
Tufts Health Plan	9	9 HMO	
TOTAL	**35**	**25 HMO, 4 PPO, 4 POS**	

*Senior Care Organizations (SCOs) and Program for All-Inclusive Care for the Elderly (PACE) plans are also options for elders with Medicare.

APPENDIX 4. MEDICARE ADVANTAGE PLANS BY COUNTY

COUNTY	# MEDICARE BENEFICIARIES (2013)	% ENROLLED IN MA PLANS	CARRIERS		# PLANS	LOWEST MONTHLY PREMIUM			
			#	NAME		PLAN WITHOUT RX	LOWEST-COST PLAN NAME	PLAN WITH RX	LOWEST-COST PLAN NAME(S)
Barnstable	67,000	11%	4	AARP, BCBS, Fallon, Tufts	16	$65	Fallon Senior Plan Saver	$0	BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Berkshire	31,000	6%	2	AARP, Health New England	8	$19	HNE Medicare Basic No Rx	$20	HNE Medicare Value
Bristol	107,000	16%	5	AARP, BCBS, Fallon, HPHC, Tufts	20	$27	Fallon Senior Plan Saver	$0	BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx, AARP Medicare Complete
Dukes	4,000	2%	1	AARP	1	n.a.	n.a.	$40	AARP Medicare Complete Choice (PPO)
Essex	137,000	19%	5	AARP, BCBS, Erickson, Fallon, Tufts	21	$19	Fallon Senior Plan Saver		BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Franklin	15,000	20%	4	AARP, BCBS, Fallon, HNE	20	$19	HNE Medicare Basic No Rx		BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Hampden	91,000	24%	5	AARP, BCBS, Fallon, HNE, Tufts	24	$0	Fallon Senior Plan Saver	$0	AARP Medicare Complete,BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx, Tufts Medicare Preferred HMO Basic Rx
Hampshire	28,000	18%	5	AARP, BCBS, Fallon, HNE, Tufts	23	$0	Fallon Senior Plan Saver	$0	BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx, Tufts Medicare Preferred HMO Basic Rx
Middlesex	242,000	25%	4	AARP, BCBS, Fallon, Tufts	19	$27	Fallon Senior Plan Saver	$0	AARP Medicare Complete 1, BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Nantucket	2,000	1%	1	AARP	1	n.a.	None	$40	AARP Medicare Complete Choice (PPO)
Norfolk	117,000	22%	5	AARP, BCBS, Fallon, HPHC, Tufts	19	$27	Fallon Senior Plan Saver	$0	BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Plymouth	93,000	16%	5	AARP, BCBS, Erickson, Fallon, Tufts	20	$27	Fallon Senior Plan Saver	$0	BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Suffolk	98,000	18%	4	AARP, BCBS, Fallon, Tufts	22	$19	Fallon Senior Plan Saver	$0	AARP Medicare Complete 1, BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx
Worcester	136,000	35%	5	AARP, BCBS, Fallon, HPHC, Tufts	21	$33	Tufts Medicare Preferred HMO Basic	$0	BCBS Medicare PPO Blue SaverRx, Fallon Senior Plan Super Save Rx

Sources: Division of Insurance; U.S. Census.

APPENDIX 5. COMPARISON OF PREMIUMS AND MEMBER COST SHARING FOR THREE MOST POPULAR MEDICARE ADVANTAGE PLANS*

	TUFTS MEDICARE PREFERRED HMO PRIME RX PLUS	TUFTS MEDICARE PREFERRED HMO PRIME RX	BLUE CROSS BLUE SHIELD OF MASSACHUSETTS MEDICARE PPO BLUE PLUSRX	
Members (as of February 2015)	23,100	19,700	14,300	
Monthly premium range	$110 to $212 depending on county	$76 to $183 depending on county	$153	
			IN-NETWORK	OUT-OF NETWORK
Annual out-of-pocket maximum for covered services	$3,400	$3,400	$3,400	$5,100
Annual out-of-pocket maximum for covered prescription drugs	$4,700	$4,700	$4,850	$4,850
COST SHARING				
Medicare preventive visits	$0	$0	$0	$45 or 20% of cost, depending on service
Primary care visits (not preventive)	$10	$10	$15	$45
Specialist visits	$15	$15	$35	$45
Inpatient hospital stays	$200 per day ($400 max per year)	$200 per day ($400 max per year)		
• Days 1-5			$150/day	20%
Skilled nursing facility				
• Days 1-20	$20 per day	$20 per day	$40 per day	20%
• Days 21-44	$0	$0	$100 per day	20%
Outpatient services/surgery	$100 per day	$100 per day	$150/visit	20%
Lab/X-ray and diagnostic procedures	$0	$0	$10 lab and x-ray	20%
Diagnostic radiology services	20% up to $75	20% up to $75	$150 hi-tech imaging	40%
Emergency room	$65	$65	$65	
Ambulance	$50	$50	$0-100 depending on services	
Other	$150 eyewear; $150 wellness; $150 weight loss	$150 eyewear; $150 wellness; $150 weight loss	$150 eyewear; $150 wellness; $150 weight loss	

(continued)

APPENDIX 5. COMPARISON OF PREMIUMS AND MEMBER COST SHARING FOR THREE MOST POPULAR MEDICARE ADVANTAGE PLANS* *(continued)*

	TUFTS MEDICARE PREFERRED HMO PRIME RX PLUS	TUFTS MEDICARE PREFERRED HMO PRIME RX	BLUE CROSS BLUE SHIELD OF MASSACHUSETTS MEDICARE PPO BLUE PLUSRX
PRESCRIPTION DRUGS			
INITIAL COVERAGE (UP TO $2,960 IN COSTS)			
Drug deductible	$0	$0	$0 Tiers 1 and 2; $200 Tiers 3, 4 and 5
Cost sharing (retail 30-day/mail 90-day)			
• Tier 1: Generic	$2/ $5	$4/ $10	$2/ $2
• Tier 2: Non-preferred generic	$5/ $12	$8/ $21	$6/ $12
• Tier 3: Preferred brand	$30/ $90	$45/ $135	$45/ $90
• Tier 4: Non-preferred brand	$80/ $240	$95/ $285	$95/ $190
• Tier 5: Specialty	33%/ 33%	33%	28%
COVERAGE GAP ($2,961 TO $4,700)			
Generic	Same copayments as above	65% of drug cost	65% of drug cost
Brand	45% of drug cost	45% of drug cost	45% of drug cost
CATASTROPHIC COVERAGE (ABOVE $4,700)			
Generic	The greater of 5% of cost or $2.65	The greater of 5% of cost or $2.65	The greater of 5% of cost or $2.65
Brand name	The greater of 5% of cost or $6.60	The greater of 5% of cost or $6.60	The greater of 5% of cost or $6.60

* Based on membership as of February 2015.
Sources: Plan documents accessed at http://www.tuftsmedicarepreferred.org/plans/hmo-plans/tufts-medicare-preferred-hmo-prime-rx-plan and https://www.bluecrossma.com/medicare-options/2015/medicare-plans/ppo-blue-plusrx/benefits.html.

APPENDIX 6. MEDICARE STAND-ALONE PRESCRIPTION DRUG PLANS SOLD IN MASSACHUSETTS

	# PDPs
Aetna	2
Blue Cross Blue Shield of Massachusetts	2
Cigna-Health Spring Rx	3
Envision Rx Plus	1
Express Scripts Medicare	2
First Health Part D	2
Humana Insurance	3
SilverScript	2
Stonebridge Life Insurance	2
United American Insurance	3
United Healthcare Insurance*	2
WellCare	2
TOTAL	**26**

*Available to AARP members only.
Source: Division of Insurance.

APPENDIX 7. STAND-ALONE PRESCRIPTION DRUG PLANS AVAILABLE IN MASSACHUSETTS WITH >5,000 MEMBERS*

CARRIER	PLAN NAME	# OF MEMBERS AS OF FEB 2015	2015 MONTHLY DRUG PREMIUM	2015 ANNUAL DRUG DEDUCTIBLE	2015 DEDUCTIBLE ACROSS ALL TIERS	PREFERRED PHARMACY NETWORK (Y/N)	2015 PLAN DESIGN: COPAYMENT BY TIER	PLAN DESIGN: NON-PREFERRED PHARMACY NETWORK	ADDITIONAL DRUG COVERAGE OFFERED IN THE GAP (2015)	$0 PREMIUM WITH FULL LOW-INCOME SUBSIDY
SilverScript	SilverScript Choice (PDP)	114,284	$23.30	$–	n.a.	N	$8/ $27/ 45%/ 33%	n.a.	No gap coverage	●
United Healthcare	AARP MedicareRx Preferred (PDP)	61,038	$48.20	$–	n.a.	Y	$3/ $5/ $40/ $75/ 33%	$5/ $9/ $45/ $95/ 33%	No gap coverage	
Blue Cross Blue Shield of Massachusetts	Blue MedicareRx Value Plus (PDP)	56,631	$40.30	$320	N	Y	$1/ $6/ $35/ 40%/ 25%	$6/ $16/ $45/ 50%/ 25%	No gap coverage	
Humana Insurance	Humana Preferred Rx Plan (PDP)	48,471	$26.70	$320	Y	Y	$1/ $2/ 20%/ 35%/ 25%	$2/ $4/ 25%/ 36%/ 25%	No gap coverage	●
WellCare	WellCare Classic (PDP)	40,665	$30.70	$320	n.a.	Y	$0/ $8/ $40/ $90/ 25%	$9/ $29/ $45/ $95/ 25%	No gap coverage	●
United Healthcare	AARP MedicareRx Saver Plus (PDP)	35,606	$27.40	$320	Y	Y	$1/ $2/ $20/ $40/ 25%	$2/ $4/ $35/ $50/ 25%	No gap coverage	●
Humana Insurance	Humana Walmart Rx Plan (PDP)	20,060	$15.60	$320	N	Y	$1/ $4/ 20%/ 35%/ 25%	$10/ $33/ 25%/ 50%/ 25%	No gap coverage	
Humana Insurance	Humana Enhanced (PDP)	18,938	$50.60	$–	n.a.	Y	$3/ $7/ $42/ 44%/ 33%	$7/ $12/ $45/ 50%/ 33%	Few brands (Tier 3 & 4)	
First Health Part D	First Health Part D Value Plus (PDP)	16,464	$37.20	$250	Y	Y	$0/ $3/ $35/ 50%/ 25%	$3/ $7/ $35/ 50%/ 25%	No gap coverage	
Aetna Medicare	Aetna Medicare Rx Saver (PDP)	15,797	$22.10	$320	Y	Y	$0/ $3/ $45/ 37%/ 25%	$2/ $5/ $35/ 37%/ 25%	No gap coverage	●
Blue Cross Blue Shield of Massachusetts	Blue MedicareRx Premier (PDP)	15,685	$110.20	$–	n.a.	N	$4/ $9/ $30/ $70/ 33%	n.a.	Many generics, some brands	
Cigna—HealthSpring Rx	Cigna—HealthSpring Rx Secure (PDP)	5,786	$46.30	$320	Y	Y	$1/ $4/ 20%/ 35%/ 25%	$4/ $11/ 24%/ 40%/ 25%	No gap coverage	
Cigna—HealthSpring Rx	Cigna—HealthSpring Rx Secure-Xtra (PDP)	5,270	$35.80	$–	n.a.	Y	$1/ $4/ 20%/ 35%/ 33%	$4/ $10/ 22%/ 40%/ 33%	No gap coverage	

*Data as of February 2015, when these plans accounted for 96% of PDP enrollment in Massachusetts.

APPENDIX 8. MEDICARE SAVINGS PROGRAMS AND EXTRA HELP: 2015

	MEDICARE SAVINGS PROGRAMS			EXTRA HELP	PARTIAL EXTRA HELP
	QMB	SLMB	QI		
ELIGIBILITY REQUIREMENTS					
Annual Income Limit*	<=100% FPL	101-120% FPL	121-135% FPL	<135%FPL	<150% FPL
Individual	$12,012	$14,364	$16,140	$15,900	$17, 655
Couple	$16,176	$19,356	$21,744	$21,504	$23,895
ASSET LIMIT**					
Individual	$7,280 for all programs			$8,780	$13,640
Couple	$10,930 for all programs			$13,930	$27,250
Is eligibility retroactive?	Up to 3 months	Up to 3 months	No	To date of application	To date of application
BENEFITS THAT ARE PAID					
Medicare Part B premium	●	●	●		
Medicare Part A monthly premium (if the person does not qualify for free Part A)	●				
Medicare Part A hospital deductible	●				
Medicare Part A copayments if services received from a MassHealth provider	●				
Medicare Part B deductible	●				
Medicare Part B coinsurance if services received from a MassHealth provider	●				
Automatically enrolled in Medicare Part D premium "Extra Help"	●	●	●		
Part D premium	●	●	●	●	Depends on income
Part D deductible	●	●	●	●	$66 or plan's standard deductible, whichever is less
Coinsurance in coverage gap	●	●	●	●	●
Limitation on copayments	Maximum of $2.65 for generics and $6.60 for brand-name drugs. No copay after $4,700 in out-of-pocket drug costs	Maximum of $2.65 for generics and $6.60 for brand-name drugs. No copay after $4,700 in out-of-pocket drug costs	Maximum of $2.65 for generics and $6.60 for brand-name drugs. No copay after $4,700 in out-of-pocket drug costs	Maximum of $2.65 for generics and $6.60 for brand-name drugs. No copay after $4,700 in out-of-pocket drug costs	15% coinsurance or the plan copay, whichever is less. After $4,700 in out-of-pocket drug costs, $2.65/generic and $6.60/brand-name or 5% of drug cost, whichever is greater

* Income eligibility for MSPs includes a $20/month ($240/year) income disregard.
** For MSP, asset limit allows exclusion of up to $1,500/person in a burial account. For Extra Help, exclusion allows for a home, a vehicle, personal possessions, life insurance, burial plots, and burial contracts.

Source: Medicare Advocacy Project, "The 2015 QMB, SLMB and QI Programs," available at www.masslegalservices.org/system/files/.../8%20QMB-SLMB-QI-15.pdf.

APPENDIX 9. OVERVIEW OF PRESCRIPTION ADVANTAGE PROGRAM (INCLUDING ITS INTERACTION WITH EXTRA HELP AND PARTIAL EXTRA HELP)*

LEVEL OF EXTRA HELP	INCOME ELIGIBILITY	ANNUAL INCOME LIMIT: SINGLE	EXTRA HELP OR PARTIAL EXTRA HELP ASSET LIMIT: SINGLE	ANNUAL INCOME LIMIT: COUPLE	EXTRA HELP OR PARTIAL EXTRA HELP ASSET LIMIT: COUPLE	COPAYMENT (30-DAY SUPPLY)		ANNUAL OUT-OF-POCKET SPENDING LIMIT
						GENERIC	BRAND-NAME	
Full	<135% FPL	$15,890	$8,780	$21,506	$13,640	$2.65	$6.60	n.a.
Partial	<150% FPL	$17,655	$13,930	$23,895	$27,250	$7	$18	$1,575
No Extra Help	<188% FPL	$22,128	none	$29,948	none	$7***	$18***	$1,750
No Extra Help	188%–224% FPL	$22,129–$26,483	none	$29,949–$35,843	none	$12***	$30***	$2,195
No Extra Help	225%–299% FPL	$26,484–$35,310	none	$35,844–$47,790	none	$12***	$30***	$2,625
No Extra Help	300%–500% FPL**	$35,311–$58,850	none	$47,791–$79,650	none	Pays drug plan deductible and copayments until out-of-pocket drug spending is $3,500		

Note: Assets do not include home, life insurance policies, burial plots, or personal possessions.
*Prescription Advantage members are required to apply for Extra Help or Partial Extra Help.
** Beneficiaries with incomes at 300-500% FPL pay a $200 annual enrollment fee.
*** These copayments do not take effect until after the individual reaches the Part D "donut hole." The member must pay their Part D plan deductible and copayments until they reach the "donut hole."

APPENDIX 10. MEDICARE SUPPLEMENT MEMBERS BY CARRIER: 2009 AND 2013

CARRIER	2009	2013	CHANGE, 2009 TO 2013
Blue Cross Blue Shield of Massachusetts	161,152	161,568	416
United Healthcare Insurance	27,080	31,932	4,852
HPHC Insurance	4,819	15,337	10,518
Tufts Insurance	0	12,068	12,068
Humana Insurance	309	3,895	3,586
Bankers Life and Casualty	6,374	3,114	-3,260
Wellpoint Health Networks, Inc.	0	963	963
Fallon Health and Life	0	725	725
Other carriers (n=40)	2,392	1,977	-415
TOTAL	**202,126**	**231,579**	**29,453**

Source: Division of Insurance reports.

APPENDIX 11. MEDICARE ADVANTAGE MEMBERS BY CARRIER: 2009 AND 2013

CARRIER	2009	2013	CHANGE, 2009 TO 2013
Tufts Associated HMO	89,946	100,562	10,616
BCBSMA HMO Blue	40,841	37,179	-3,662
Fallon Community Health Plan	29,735	31,051	1,316
Harvard Pilgrim Health Care	23,039	19,492	-3,547
Health New England	864	8,638	7,774
Aetna Life Insurance	1,091	1,784	693
Other carriers	13,100	19,600	6,500
TOTAL	**198,600**	**218,300**	**19,700**

Note: excludes SCO program.

APPENDIX 12. MONTHLY PREMIUMS: MEDICARE SUPPLEMENT CORE AND MEDICARE SUPPLEMENT 1

CARRIER	MONTHLY PREMIUM		CHANGE IN PREMIUM, 2009 TO 2015		
	2009	2015	PERCENT	MONTHLY $ CHANGE	ANNUAL $ CHANGE
MEDICARE SUPPLEMENT CORE					
Blue Cross Blue Shield of Massachusetts	$86	$95	10%	$9	$108
Humana Insurance	$107	$157	47%	$50	$600
United Healthcare Insurance	$124	$123	-1%	($1)	($12)
Fallon Health and Life	not offered	$103			
HNE Insurance	not offered	$97			
HPHC Insurance	not offered	$101			
Humana Insurance	not offered	$156			
Monumental Life	not offered	$97			
Transamerica Life Insurance	not offered	$111			
Tufts Insurance	not offered	$105			
Difference between least and most expensive product in 2015				$61	$732
MEDICARE SUPPLEMENT 1					
Blue Cross Blue Shield of Massachusetts	$163	$177	9%	$14	$168
Humana Insurance	$167	$244	46%	$77	$924
United Healthcare Insurance	$177	$218	23%	$41	$492
Fallon Health and Life	not offered	$197			
HNE Insurance	not offered	$189			
HPHC Insurance	not offered	$199			
Humana Insurance	not offered	$243			
Monumental Life	not offered	$169			
Transamerica Life Insurance	not offered	$192			
Tufts Insurance	not offered	$194			
Difference between least and most expensive product in 2015				$75	$900

APPENDIX 13. MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION DRUGS: MONTHLY PREMIUMS FOR PLANS WITH >5,000 DIRECT-PAY MEMBERS AS OF FEBRUARY 2015 THAT WERE ALSO OFFERED IN 2009*

CARRIER AND PLAN NAME	# OF MEMBERS AS OF FEB 2015	COUNTIES AVAILABLE	MONTHLY PREMIUM		CHANGE IN PREMIUMS: 2009 vs. 2015			DRUG DEDUCTIBLE	
			2009	2015	% CHANGE	MONTHLY DIFFERENCE	ANNUAL DIFFERENCE	2009	2015
Tufts Health Plan Medicare Preferred HMO Prime Rx Plus	23,100	Hampden, Hampshire	$109	$110	1%	$1	$12	$0	$0
		Barnstable, Bristol, Middlesex, Norfolk, Plymouth	$109	$188	72%	$79	$948		
		Essex, Suffolk	$133	$212	59%	$79	$948		
		Worcester	$133	not offered					
Tufts Health Plan Medicare Preferred HMO Prime Rx	19,600	Hampden, Hampshire	$93	$76	-18%	($17)	($204)	$0	$0
		Barnstable, Bristol, Middlesex, Norfolk, Plymouth	$93	$154	66%	$61	$732		
		Essex, Suffolk	$117	$178	52%	$61	$732		
		Worcester	$117	$184	57%	$67	$804		
Tufts Health Plan Medicare Preferred HMO Basic Rx	17,000	Hampden, Hampshire	$21	$0	-100%	($21)	($252)	$0	$0 for Tiers 1 and 2 (generics); $150 for Tiers 3, 4, and 5 (brand-name and specialty drugs)
		Barnstable, Bristol, Middlesex, Norfolk, Plymouth	$21	$36	71%	$15	$180		
		Essex, Suffolk	$21	$56	167%	$35	$420		
		Worcester	$21	$66	214%	$45	$540		
BCBSMA Medicare PPO Blue PlusRx	14,300	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester	$126	$153	21%	$27	$324	$0	$0 for Tiers 1 and 2 (generics); $200 for Tiers 3, 4, and 5 (brand-name and specialty drugs)
AARP Medicare Complete Choice	10,300	Barnstable, Berkshire, Bristol, Dukes, Essex, Franklin, Hampden, Hampshire, Middlesex, Nantucket, Norfolk, Plymouth, Suffolk, Worcester	$0	$40		$40	$480	$0	$0 for Tiers 1, 2, and 5 (generics and specialty drugs); $255 for Tiers 3 and 4 (brand-name drugs)
Tufts Health Plan Medicare Preferred HMO Value Rx	7,500	Hampden, Hampshire	$63	$46	-27%	($17)	($204)	$0	$0
		Barnstable, Bristol, Middlesex, Norfolk, Plymouth	$63	$120	90%	$57	$684		
		Essex, Suffolk	$79	$141	78%	$62	$744		
		Worcester	$79	$145	84%	$66	$792		
BCBSMA Medicare HMO Blue PlusRx	6,500	Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester	$119	$193	62%	$74	$888	$0	$0 for Tiers 1 and 2 (generics); $200 for Tiers 3, 4, and 5 (brand-name and specialty)

*These plans account for ~60 percent of total direct-pay Medicare Advantage members as of February 2015.
Sources: Division of Insurance; CMS Landscape and Enrollment reports.
Note: Benefits or cost sharing may have changed over this time period.

APPENDIX 14. COMPARISON OF PREMIUMS FOR PDPs WITH LARGEST MEMBERSHIP IN 2015 THAT WERE ALSO OFFERED IN 2009

CARRIER	PRODUCT	# OF MEMBERS AS OF FEB 2015	MONTHLY PREMIUM		CHANGE IN PREMIUMS: 2009 vs. 2015			DEDUCTIBLE	
			2009	2015	% CHANGE	MONTHLY DIFFERENCE	ANNUAL DIFFERENCE	2009	2015
United Healthcare	AARP MedicareRx Preferred	61,000	$39	$48	24%	$9	$110	$0	$0
Blue Cross Blue Shield of Massachusetts	Blue MedicareRx Value Plus	57,000	$43	$40	-7%	($3)	($36)	$0	$320
WellCare Health	Classic	41,000	$32	$31	-3%	($1)	($12)	$295	$320
Humana	Enhanced	19,000	$41	$51	24%	$10	$120	$295	$0
Blue Cross Blue Shield of Massachusetts	Blue MedicareRx Premier	16,000	$81	$110	36%	$29	$348	$0	$0

Sources: CMS reports, Division of Insurance.

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