An Economic Assessment of Health Care Coverage for the Elderly

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THIS ARTICLE EXAMINES HEALTH CARE COVERAGE for the elderly in the United States from the perspective of economic efficiency. Economic efficiency pertains to the degree to which consumer preferences are satisfied, using as few resources as possible.

The other primary facet in a complete evaluation is equity of coverage. The distribution of medical resources is usually considered to be equitable when it is based on medical need rather than on the ability to pay. A full assessment of the equity of current coverages is beyond the scope of this article; thorough discussions can be found in Davis and Rowland (1986) and the Harvard Medicare Project (1986). Equity is addressed here only insofar as it is enhanced or diminished by policies designed to improve the efficiency of coverage.

Currently, health care services received by the elderly are financed from several sources—Medicare, private health insurance policies, Medicaid, and from the elderly's own income and savings. The particular payer providing coverage varies not only with the individual, but with the type and location of the medical services received. A central theme of this article is that the current array of coverages is so confusing that consumers have been unable to make effective choices regarding their health care coverage.

After presenting some background about the various payers for health care services, this article discusses the concept of economic

The Milbank Quarterly, Vol. 65, No. 4, 1987

efficiency and evaluates how closely the private health insurance market meets the structural norms that economists have developed to gauge efficiency. Data are presented which show that consumers are poorly informed about their health insurance coverage; it is argued that this is due to the complex array of coverages that are available from both public and private payers. Using this framework, the article concludes with a discussion of public policy interventions that might improve the efficiency of health care coverage for the elderly.

Background

Medicare

The Medicare program is the foundation of health care coverage for the elderly. Over 98 percent of the elderly have Medicare Part A coverage, and 97 percent purchase Part B at a monthly premium of $24.80 (Waldo and Lazenby 1984). Part A coverage consists primarily of hospital care. Hospital costs are covered with the following exceptions: there is an initial deductible during each "benefit period" (set at $520 in 1987), and there are daily copayments equal to one-fourth of this deductible for stays lasting between 61 and 90 days. Furthermore, each Medicare beneficiary is allotted 60 lifetime reserve days with daily copayments of one-half of the deductible. Part A also covers an unlimited number of qualifying home health visits. In theory, it also covers some nursing home care: for qualifying stays, the first 20 days are covered fully and the next 80 days are covered after a daily copayment of one-eighth the deductible (currently $65) is met. In reality, Medicare coverage for nursing home care is almost nonexistent, because, as described below, restrictions on coverage have been enacted to ensure that only acute care episodes are covered.

Part B coverage pays part of physician and some other medical services. After the patient pays a $75 annual deductible, Medicare reimburses 80 percent of the "reasonable charge" for each physician service. The patient is responsible for paying the remaining 20 percent, as well as all charges in excess of the reasonable charge whenever the physician does not accept assignment on the service. Medicare does not pay any of the costs of prescription drugs, eyeglasses, hearing aids, or physical examinations. All combined, Medicare paid for 44

percent of the elderly's personal health expenditures in 1986 (Waldo, Levit, and Lazenby 1986).

At the time of writing, the Senate and the House of Representatives have each passed legislation that will substantially modify Medicare's benefit package. The bill that eventually is enacted by Congress is likely to remove the copayments on hospital stays lasting for more than 60 days, and to cover hospital stays of any length. It is also possible that a prescription drug benefit will be added to the program, which pays for 80 percent of charges after an annual deductible of approximately $500 is met. Furthermore, total liability incurred by any beneficiary for the Part A and Part B deductibles and copayments is likely to be capped, probably at a level below $2,000 annually. Some implications of these changes are touched upon in the last part of the article.

Medicaid

For some of the poor and near-poor elderly, the Medicaid program provides coverage for many of the gaps in Medicare. Typically, states purchase Part B coverage for Medicaid eligibles. Although the precise benefit package varies by state, Medicaid benefits usually cover all Medicare deductibles and copayments, and often cover some items left uncovered by Medicare, such as prescription drugs and dental care (Davis and Rowland 1986). One of the program's most important roles is that of providing nursing home care. To become eligible, however, one has to meet the program's income and asset restrictions. In practice, this means that noneligibles wishing coverage must impoverish themselves by "spending down" their income and assets. In 1984, Medicaid paid for 14 percent of the elderly's health care costs, but almost 42 percent of their nursing home expenses. Other government programs, such as the Veterans Administration, paid for another 6 percent of total expenditures (Waldo and Lazenby 1984).

Private Health Insurance

Since the beginning of the Medicare program over twenty years ago, private health insurance companies have sold policies to the elderly that have provided coverage for some of the copayments and services left uncovered by Medicare. Because these policies to some extent

cover the gaps in the Medicare program, they have been coined "medigap" policies.

The elderly population has shown much interest in obtaining medigap coverage. In 1984, it was estimated that 72 percent of the elderly (18 million people) owned some type of private supplemental insurance, and that 80 percent had either private policies or Medicaid coverage to supplement Medicare (Gordon 1986). This includes over 30 percent of the elderly, who have policies sponsored by their employers or former employers, where the latter pay the majority of premiums (Short and Monheit 1986). The Health Care Financing Administration estimates that all private health insurance policies pay for 7.2 percent of personal health expenditures incurred by the elderly (Waldo and Lazenby 1984).

Although the so-called "gap-filling" policies receive most publicity and are subject to the most regulation, there are other types of supplemental insurance as well. The most common of these is the hospital indemnity policy, which usually provides a fixed sum per day when the policy holder is hospitalized. Another type, the specified-disease policy, pays benefits only if a particular disease (usually cancer) is contracted. The little evidence available about these policies indicates that they provide somewhat lower returns on premiums than do the gap-filling ones (McCall, Rice, and Hall 1987). Finally, some beneficiaries who still are employed have major medical policies that supplement Medicare, and others are covered by a health maintenance organization.

Although no data are available on the total amount of money spent annually on supplemental insurance premiums, one can make an approximation. The average elderly person has approximately 1.25 policies (McCall, Rice, and Hall 1983), giving a total of 22.5 million policies. About four-fifths of these policies (18 million) were the more expensive gap-filling type, while the remaining one-fifth provided indemnity benefits at about one-half the cost (McCall, Rice, and Hall 1983). In 1977 the former cost about $300 (Cafferata 1984); we can infer that the latter cost about $150. If individual policy premiums rose at the same rate as overall medical care inflation during the ensuing years, in 1984 total premium expenditures would have been $11.4 billion and in 1986, $13.0 billion.

These figures are corroborated by examining other recent data. In 1984 personal health expenditures for the elderly paid for by private

insurance amounted to $8.7 billion (Waldo and Lazenby 1984). This is consistent with the $11.4 billion figure if, on average, insurance companies keep 24 percent of premium dollars for administration and profit, that is, if their "loss ratios" were 76 percent. A recent report by the U.S. General Accounting Office (1986), discussed later, provides premium and loss ratio data for a sample of Blue-Cross/Blue Shield and commercial policies. Weighting these loss ratios by premiums, one comes up with exactly this 76 percent figure. Consequently, the $13 billion figure for 1986 is probably relatively accurate.

Not only are medigap policies prevalent, but they are controversial as well. Two of the earliest critical studies of medigap policies were published in 1978 (U.S. House of Representatives, Select Committee on Aging 1978; DeNova and Shearer 1978). They stated, among other things, that individuals were put under undue pressure by agents to purchase policies, that policies often provided few benefits, that some people had many overlapping policies, and that consumers had little idea about what they were buying. Many of these same criticisms were echoed in a recent report by the Harvard Medicare Project (Blumenthal et al. 1986). Others have been less critical. For example, *Consumer Reports* (1984) rated over 30 medigap policies and recommended that elderly individuals purchase one of the more highly rated of the policies.

One result of the controversy that has surrounded medigap policies is that the federal government has become involved in regulating them, something heretofore left to the states in insurance matters. In 1980 Congress enacted Public Law 96-265. Section 507 of this statute is commonly known as the Baucus amendments; it established voluntary certification requirements for medigap policies. To be certified under the legislation as "Medicare supplements," policies must cover all Medicare hospital copayments from days 61 to 90 of a stay ($130 per day in 1987), the copayments for the 60 lifetime-reserve days for hospital stays over 90 days ($260 per day), 90 percent of costs for stays lasting up to one more year, and the 20 percent coinsurance on physician services, subject to a maximum deductible of $200 and a minimum of at least $5,000 in Part B coverage annually (Cafferata 1985). Policies sold by certain groups must have expected loss ratios of at least 75 percent; those sold to individuals as well as mass-marketed group policies are required to have minimum expected loss ratios of 60 percent. (Interestingly, the Department of Health and

Human Services has not interpreted this as requiring that actual loss ratios meet these levels, only that the companies' anticipated revenues and claims expenses be above the minimum [U.S. General Accounting Office 1986].) Furthermore, the legislation has a variety of other requirements, such as restrictions on the use of clauses limiting policy payment for preexisting medical conditions, and mandating that companies distribute consumer guides and outlines of policy benefits to prospective buyers. All but four states have adopted the Baucus requirements, and most of the few which have not (Massachusetts, New York, Rhode Island, and Wyoming) have established equally stringent requirements.

Partly as a result of the Baucus legislation, there is now a standard benefit package included in medigap policies, although many policies provide additional coverage. (It should further be noted that certain policies—notably those providing indemnity and specified disease benefits, and those which were converted from group to individual policies when a person retired—are not subject to the legislation.) In a 1982 survey conducted in six states (Rice and McCall 1985), it was found that practically all gap-filling policies now cover the initial hospital deductible, which is *not* required under the federal legislation; all hospital copayments for stays up to 150 days; 90 percent of costs for stays lasting another year; and the 20 percent copayment on physician services up to at least $5,000 of coverage annually. About one-half of policies cover the $75 Part B deductible, but fewer than one-half cover any prescription drugs or any physician charges in excess of Medicare's customary, prevailing, and reasonable level (Rice and McCall 1985). Almost no policies cover 100 percent of physician charges for nonassigned services. Furthermore, practically none provide benefits for nursing home stays that are not covered by Medicare, or coverage for appliances such as eyeglasses and hearing aids.

It is unclear exactly how medigap policy benefits will be altered as a result of the legislation now before Congress, which was discussed earlier. A likely possibility is that the policies will cover all or a large percentage of the out-of-pocket liability up to the annual cap. For example, if a $500 Part A and $1,000 Part B cap are enacted, medigap policies may cover the Part A liability in full, and all or a large part of the Part B liability. This might include coverage for some of the deductibles and copayments if a prescription drug benefit is added to the Medicare program. It is unlikely that medigap policies will extend

their coverage to include nursing home stays not covered by Medicare, or provide any extra coverage for nonassigned physician services in excess of the Medicare reasonable charge.

The Nature of the Medigap Market

Before embarking on an economic evaluation, it is necessary to clarify just what is being evaluated. In the next section, I will examine what I will refer to as the "medigap market," that is, the market that has developed in which private supplemental health insurance policies are sold to Medicare beneficiaries. Although this market bears little resemblance to standard economic ones, such as those for particular agricultural commodities, it is a market nonetheless.

The standard concept of a market is as follows: Suppose there are several firms, A through F, selling goods or services. Furthermore, let there be a high degree of substitutability between the product sold by firms A, B, and C, but little between these firms' product and that sold by D, E, and F. (In economic terms, there is a high cross-price elasticity of demand among the first three firms' products, but a low elasticity between the two groupings of firms.) We might then loosely characterize the first three firms as constituting a market.

In the most general sense, the product we are dealing with in this article is protection against high out-of-pocket costs. Consumers have a few choices in this regard, and one would suspect that they are somewhat substitutable (i.e., part of the same market). These would include the typical medigap policies, hospital indemnity policies, cancer policies, and probably health maintenance organizations (HMOs). HMOs are an interesting case in point: they usually provide more extensive coverage for the elderly than do traditional medigap policies. For example, prescription drugs are commonly covered after a small copayment is paid. HMO policies are designed to cover the same contingencies, however, as medigap policies (acute care illnesses), usually do not cost much more, and can be purchased by anyone who has access to an HMO.

Are there types of financial protection that are not part of the medigap market? One obvious example is nursing home insurance. These policies typically cover nursing home stays lasting up to several years in length, and allow the policy holder to receive benefits in homes other than Medicare-approved skilled nursing facilities. Their

benefits are not at all substitutable with those of medigap policies. Another, perhaps more interesting example would be life care communities, which provide all medical services to elderly residents who pay a very large initiation fee in addition to monthly payments. These communities are now selected by only a tiny minority of wealthy elderly, and cannot be thought of as highly substitutable with medigap policies.

Perhaps the most peculiar aspect of the medigap market is its dependence on the federal government. Although all markets are affected by government regulations, tax policies, and so on, the relationship is usually an indirect one. But the very existence of the medigap industry depends on the Medicare policy established by Congress. If Congress extends Medicare to cover unlimited hospital stays, for example, medigap policies will have to alter their coverage to account for this. More extreme than this would be comprehensive, government-financed health insurance for the elderly, which would probably wipe out medigap policies as we know them.

Economic Efficiency in the Supplemental Health Insurance Market

There is no simple formula one can use to assess whether a market is competitive and, therefore, operating efficiently. Although we do expect certain outcomes from a perfectly competitive market, such as price being equal to the marginal cost of production, comparing an actual market to such a norm as this is not appropriate. In most markets like the one for insurance, we cannot expect there to be perfect competition; in fact, these markets are regulated partly for just this reason. A more appropriate way to assess efficiency is not to use the standards of perfect competition but to look at the effects on efficiency of changes in the market: if changes could increase the degree of efficiency of the market, then obviously there is room for improvement. If there exists no change that could improve the performance of the market, then it is operating at peak efficiency. This is the approach taken later in this article.

Nonetheless, it is still very useful to examine the structure of a market using the norms of competition. By doing this, we can pinpoint

areas in which there appear to be major competitive problems and, thus, we can focus on them when examining measures of market outcomes. Furthermore, examining how well a market meets these norms will help us assess the anticipated effectiveness of policy changes aimed at enhancing the competitiveness of market structure.

With this in mind, there are five structural conditions which, if fulfilled, ensure that a market operates efficiently (Henderson and Quandt 1971): (1) The goods being produced are homogeneous; (2) there are numerous producers and consumers in the market; (3) consumers possess good information concerning prices of goods and their characteristics, as well as those of substitute goods; (4) there is free entry into and exit from the market; and (5) there are no external effects in consumption or production. (An externality occurs when someone other than the consumer or producer incurs benefits or costs from an economic activity.) In a so-called monopolistically competitive market that exists for many consumer goods, the assumption of product homogeneity is relaxed in recognition that firms will wish to differentiate their product from those of competitors.

At first glance it appears that the supplemental insurance market possesses most of the structural characteristics ensuring efficiency, although, in part, this may be due to the imposition of the Baucus regulations. First, there appears to be a basic homogeneous product in the market (a policy that fulfills the minimum Baucus standards), and which pays for part or all of the initial hospital deductible. Some policies provide a higher degree of protection for a higher price by covering some prescription expenses and physician charges up to the insurance company's usual, customary, and reasonable (UCR) charge level. Most analysts would agree that the opportunity to choose among several policies, all of which meet certain minimum coverages, enhances the degree of economic efficiency.

With respect to the second and fourth competitive conditions, the medigap market again appears largely to meet the competitive norms. Although national data are generally lacking because insurance is regulated through the states, it appears that there are a large number of firms engaged in selling medigap policies. A recent study by the U.S. General Accounting Office (1986) examined a dozen states that contain about 30 percent of the country's Medicare beneficiaries, and found 111 companies that had sold 398 different medigap policies

during 1984. With respect to entry, although insurance is regulated in all states, the above figures indicate that lack of free entry into the market does not constitute an important problem.

Meeting the fifth condition (the absence of externalities) may be a problem, but we cannot know this for sure. The primary externality we are concerned with is what economists might refer to as a "positive consumption" externality. If members of society receive some satisfaction in knowing that the elderly are protected against the risk of catastrophic illness expenses, then it might be in society's best interest to have the government provide such coverage. Relying on the market could be inefficient because some people would not purchase coverage, either because they could not afford it or did not want it, which, in turn, would imply that persons possessing the aforementioned altruism would be unsatisfied.

The problem with gauging the extent, if any, of this potential market failure relates to the information problem, discussed in detail below. I will argue later that consumers do not know much about what Medicare covers or what additional protection is received from medigap policies. Consumers are also unaware of any remaining gaps. If most people do not know what is best for them (or their parents), it is difficult for them to know whether they will want to help finance additional coverage for other elderly persons as well. Consequently, until the problem of consumer information is cleared up, it is hard to assess whether society wishes to provide additional coverage for those who currently are unprotected. Given that most elderly have shown an interest in protecting themselves by purchasing policies, however, and that those who do not have coverage tend to be less well off financially, it is not difficult to envision that society does wish to provide more coverage. Thus, there may be some degree of market failure in this regard.

What remains is the third competitive condition—consumer information. Unlike the others, it appears that there is an enormous problem with fulfillment of this condition, which I will argue has resulted in a serious failure of the medigap market. The next two subsections examine the degree to which consumers lack information about the medigap market, and the problems that have arisen as a result.

The Problem of Consumer Ignorance

One of the many unresolved issues in health economic theory concerns what constitutes adequate information about a market. In one oft-cited debate about this issue, Pauly (1978) and Sloan and Feldman (1978) point out that a market can operate efficiently without everyone being well informed. They argue that so long as there are some number of purchasers possessing the knowledge, prices may be kept at competitive levels. Reinhardt (1978), on the other hand, argues that the previous authors look at competition in too limited a context. Whereas everyone need not be well informed for price to reach equilibrium at a competitive level, everyone does need information if he is to choose the product that maximizes his own utility. In other words, the purpose of good information in a market is not just to keep the price down, but also to ensure that consumers choose the particular products that are right for them.

From this viewpoint, which I believe to be the more appropriate one, one of the things that matters in the efficient operation of a market is that consumers understand a market well enough to make rational choices. Unfortunately, consumers do not appear to be nearly knowledgeable enough in the areas of Medicare and medigap benefits. A recent study of consumer knowledge of Medicare and medigap policies (McCall, Rice, and Sangl 1986) provides a review of research findings in this area. Briefly, studies of consumer information about Medicare program benefits (Lambert 1980; LaTour, Friedman, and Hughes 1983) show that beneficiaries have, at best, a very uneven understanding of these benefits. Whereas they appear to have a general knowledge that Medicare will not pay for all physician services, nor for products such as prescription drugs and eyeglasses, most beneficiaries understand little more. In particular, they almost totally lack any meaningful understanding of their liabilities for infrequent medical events that may have grave financial consequences—long hospital stays and nursing home care. For example, only about 35 percent of beneficiaries know that Medicare provides coverage for hospital stays over 30 days, and a similarly small proportion understand that Medicare will not cover a six-month nursing home stay (McCall, Rice, and Sangl 1986).

Another study of beneficiary knowledge, not reported in the above literature review, provides perhaps the most disturbing indication of

beneficiary ignorance. The American Association of Retired Persons (1984) (AARP) conducted a survey of its members and found that almost 80 percent think that Medicare will help pay for a nursing home stay lasting a month, and most of these people believe that Medicare will pay for the majority of costs. Similarly, 50 percent say that their private health insurance policy will contribute. Although we don't know exactly how often Medicare and medigap pay something toward a nursing home stay, we can say that the beliefs of the elderly with regard to overall generosity of coverage are seriously in error. Medicare and private insurance combined pay for only about 2 percent of the elderly's nursing home expenses (Waldo and Lazenby 1984).

Exactly how and why it is that Medicare and, thus, medigap policies cover so little nursing home care is beyond the scope of this article; good explanations appear in Feder and Scanlon (1982) and Smits, Feder, and Scanlon (1982). In broad terms, Medicare provides only acute care benefits; program policies have developed in a way to ensure that chronic nursing home care is excluded from coverage. For example, not only must a nursing home stay meet certain restrictions designed to cover only acute care—it must take place in a Medicare-approved skilled nursing facility, and follow a hospital stay of at least three days, with admission to the nursing home coming within 30 days of the hospital discharge—but even if these conditions are met, it is difficult for a chronically ill patient's stay to qualify for Medicare reimbursement. Because Medicare has traditionally focused on acute care, it usually requires that the patient have rehabilitation potential, something most long-staying patients have difficulty meeting.

Adequate knowledge of the medigap market should also include understanding of the expected costs of illness, which, in turn, means that beneficiaries should have some idea of the probability of incurring out-of-pocket costs, as well as the number of dollars involved. Perhaps it is not surprising that Medicare beneficiaries do not have much information about these things. In the study by Lambert (1980), respondents were asked several questions, including the percentage of medical expenses paid by Medicare, the cost of a day in the hospital, hospital length of stay, and the likelihood of staying in a hospital for 60 days. In general, few beneficiaries knew much about any of these.

Unfortunately, beneficiary knowledge of medigap policies is equally poor. The review cited above also discusses this literature; other note-

worthy studies include Lambert (1980), A.D. Little (1982), Cafferata (1984), and McCall, Rice, and Sangl (1986). The latter two studies are particularly interesting because beneficiary responses were compared with actual copies of their medigap policies. Among other things, the first of these two studies reports that only 40 percent of beneficiaries know whether their policies cover skilled nursing home care. The latter study reaches a similar conclusion. In addition, it finds that fewer than 40 percent know if their policies cover hospital stays of over 150 days, or cover custodial care. The only area in which beneficiaries show a high degree of knowledge (over 80 percent correctly answering) concerns coverage for prescription drugs.

The fact that beneficiaries know so little about events that occur infrequently may not be surprising, but it provides strong a priori evidence that the medigap market will not function properly. The overriding purpose of insurance is to provide financial protection against uncertain, costly events. It is precisely these events—hospitalization and nursing home institutionalization—that beneficiaries do not understand. Consequently, we might expect that they will be unable to choose policies that provide the most cost-effective financial protection. As noted earlier, however, the question of primary importance is not simply whether there is a problem in the market, but whether there are changes we could enact that would improve market functioning. This issue will be addressed below.

The Consequences of Consumer Ignorance

In the previous section, it was argued that one structural irregularity in the medigap market—poor consumer information—could seriously impair the efficiency of the market. Whether in fact this is the case should be examined directly, by examining market outcomes.

The previous discussion of the issues raised by Pauly (1978), Sloan and Feldman (1978), and Reinhardt (1978) indicates that we should be looking at two outcomes: whether consumers are buying the coverage that best suits their needs (which are defined below), and whether the coverage that they do purchase is priced competitively. If either of these outcomes is not evident, then we need to think about whether there are policy measures available to bring it about.

Are Consumers Buying Policies that Suit Their Needs? Not surprisingly, there is no direct method of assessing whether consumers are acting

in a "rational" manner—that is, behaving in a way that is most nearly in their best interests. An indirect method used by economists is to construct a theory of "optimal" consumer behavior, based on certain assumptions of consumer rationality, and to examine whether consumers are behaving in this manner.

The economic theory of insurance predicts that utility maximizing, risk-averse individuals will want to purchase insurance for a potentially high-cost illness whose occurrence is subject to a great deal of uncertainty. That is, they will want to insure against low-likelihood, high-cost illness. Conversely, such persons will find it less worth their while to purchase coverage for events that have a high likelihood, because it will be cheaper to self-insure (Feldstein 1983). The reason that self-insurance is cheaper for high-likelihood events is that the person will have to pay the expected costs of the illness in higher premiums even if insurance is purchased. Furthermore, premiums will reflect the administrative costs of processing these claims; with self-insurance, the latter costs are avoided.

A strong case can be made that the purchases of medigap policies are inconsistent with what would be predicted by the theory of insurance. First, it appears that consumers are purchasing too much first-dollar coverage, items for which they could be self-insuring (that is, paying out-of-pocket when the service is incurred rather than paying out-of-pocket in the form of higher annual premiums). Over 90 percent of medigap policy owners purchase coverage that pays the entire Part A hospital deductible, and about one-half purchase policies covering the Part B deductible (Rice and McCall 1985; Cafferata 1984). Two possible explanations for this phenomenon, discussed in an early work by Keeler, Morrow, and Newhouse (1977), are that consumer purchases of medigap policies are often subsidized by employers (making any coverage, including deductibles, worth their while), and that there may be tax advantages for individual purchasers that would make it desirable for most to purchase deductible coverage. Substantial tax advantages could make it more desirable to purchase medigap policies that cover deductibles, because the government shares in the cost of the policy through the tax deductions. The first reason does not appear to be consistent with the evidence: purchase of the deductibles is almost as high among individuals as it is for those whose policies are subsidized by employers (Cafferata 1984). Neither does the second reason provide an adequate explanation. In 1977, the year that the

National Medical Care Expenditures Survey (NMCES) was conducted, fewer than 20 percent of the elderly itemized medical expenses (U.S. Internal Revenue Service 1978); consequently, relatively few individuals received tax breaks when they purchased medigap policies. The low proportion of elderly who itemize medical expenses, therefore, is not enough to explain the high purchase rates of deductibles.

Nevertheless, it is not hard to come up with reasons as to why the elderly may want to purchase insurance for deductibles. The most plausible one is that since they do not understand what gaps exist in Medicare, they desire coverage for all gaps. They may also balk at the size of the initial hospital deductible, although it should be noted that this sum is comparable to the annual premium of the typical medigap policy. Finally, they may prefer to have a fixed annual expenditure in the form of a medigap premium than risk the uncertain expenditure on one or more hospital deductibles. More important than the over-purchase of first-dollar coverage, however, is the under-purchase of catastrophic coverage.

Although there is no generally agreed-upon definition of "catastrophic" medical occurrences, I will use it to connote medical events that can have the potential of seriously depleting a family's resources (see Wyszewianski [1986] for a fuller discussion). One of the problems one faces in analyzing this issue is that almost all recent studies are based on only one group of elderly—the so called "noninstitutionalized," in effect, those not in nursing homes. This focus is due to the large amount of out-of-pocket cost data collected on the noninstitutionalized by NMCES (conducted in 1977) and the National Medical Care Utilization and Expenditure Survey (NMCUES) conducted in 1980. Conversely, there is a dearth of data on out-of-pocket payments by those in nursing homes, although, as noted below, two studies have tried to construct such a data base synthetically.

Two studies concerning the out-of-pocket costs of the noninstitutionalized are noteworthy. In a recent study, Kovar (1986) uses data from NMCUES to examine noninstitutionalized out-of-pocket payments. One finding was that whether a person is hospitalized has a large effect on out-of-pocket costs. In 1980 the mean out-of-pocket expenditures (excluding insurance premiums) for persons who were hospitalized were about $650 (7.8 percent of family income) whereas they were only $202 (3.2 percent of income) for those not in the hospital. Another study using NMCUES, conducted by the U.S.

Congressional Budget Office (Gordon 1986), also looked at acute care expenditures. Not surprisingly, it found that among the nonhospitalized, those without medigap policies had lower out-of-pocket payments (including premiums), presumably because they did not have to pay these insurance premiums. Those with a hospitalization, however, paid much less out-of-pocket if they had a medigap policy. For example, it is estimated that 0.8 percent of medigap owners had a hospital stay that reached the coinsurance stage (over 60 days), and their out-of-pocket costs that year were $1,900. Among the 0.3 percent of nonowners with a stay of that length, average out-of-pocket costs were over $10,000. Clearly, if one has a long hospital stay, it is advantageous to have a medigap policy.

Although studies like this provide useful data, reliance on them gives a distorted picture of the extent to which medigap policies protect the elderly. (It should be noted that the authors make it quite clear that their findings refer only to the noninstitutionalized.) When one looks at the entire elderly population, including those who are in nursing homes, a much bleaker picture emerges.

Before going into these studies, it should be pointed out that it is easy to underestimate the significance of nursing home expenditures because of the way national data are collected. NMCUES, for example, represents 95 percent of the elderly population during 1980—that is, those not in a nursing home during that year. It is tempting to believe, therefore, that the results reflect the out-of-pocket experiences of the vast majority, but this is simply not true. Whereas it may be true that 95 percent live in the community in any one year, it is also true that at some point in their lifetime over 40 percent of the elderly enter a nursing home (Cohen, Tell, and Wallack 1986). Focusing on one year, therefore, understates the magnitude of the risk of nursing home care. From a policy standpoint, our goal is to reduce the possibility that elderly persons will incur catastrophic out-of-pocket costs at any point in their lifetime. Viewed in such a way, protection against the costs of nursing home stays becomes a critical component of complete catastrophic protection.

Two recent studies (Rice and Gabel 1986; ICF 1985) attempt to examine the entire elderly population by creating a data base that includes both the institutionalized and noninstitutionalized. Because no such data base exists, it is necessary to create one by merging

together selective data on the noninstitutionalized (NMCUES) and those in nursing homes (the National Nursing Home Survey [NNHS], conducted in 1976 and 1977). Synthetic estimation techniques are fraught with problems. In this case, one has to eliminate the overlap between the data bases, compensate for the fact that they were conducted in different years, and, most important, find a method to estimate out-of-pocket costs and costs covered by medigap policies for nursing home patients because such data are not directly available from the NNHS.

Rice and Gabel (1986) examined the extent to which medigap policies pay for high health care costs. They concluded that medigap policies provide increasingly thorough coverage as total health care costs rise when health care costs are less than $7,500 annually (in 1980 dollars), but, after that, the share paid by medigap declines. Medigap policies pay 7.3 percent of costs for persons with annual expenditures below $500, and this percentage rises to 19.1 percent for those with expenses between $5,000 and $7,500. These policies, however, pay only 8.7 percent for persons with expenses above $7,500 annually. Conversely, out-of-pocket costs decline to a low of 17.1 percent of total expenditures up to the $7,500 level, but rise to 24.0 percent when expenses exceed $7,500. This pattern occurs largely because if a person's health care costs reach the $7,500 level it is very likely that he or she has been in a nursing home. The study also looked at what services are responsible for high levels of out-of-pocket expenditures. For persons with less than $2,000 in out-of-pocket costs, acute care services were almost entirely the cause, comprising over 90 percent of these costs. For those with over $2,000 in annual out-of-pocket costs, however, over 80 percent of these costs were due to nursing home stays.

The ICF study also broke costs down by institutional status, and found that although the elderly pay for 25 percent of health costs out-of-pocket, the proportion paid by the institutionalized (37 percent) is twice that of the noninstitutionalized (19 percent). The study further examined family health expenditures as a percentage of income. It reported that whereas 8.6 percent of the average household's total income is spent out of pocket (either directly or in premium payments), this varies dramatically by age. The figure is 4.2 percent for those with the head of household aged 65 to 69, but rises to 37.5 percent

when the head is over 85 years of age. Although this is due partly to different income levels by age, the primary reason is the risk of entering a nursing home.

Another example of the financial consequences of nursing home stays is illustrated in a study conducted in Massachusetts (U.S. House of Representatives, Select Committee on Aging 1985). Using survey data from 900 Massachusetts elderly who were living at home, the study examined how long it would take elderly persons in a nursing home to spend-down their income and assets, and thus become eligible for Medicaid. The authors found that one-half of 75-year-olds would spend-down in only 13 weeks, and that over 60 percent of those living alone would do so in that time. Three-fourths of 75-year-olds would spend-down within a year. The study concludes that "the likelihood of impoverishment is extremely high if an elderly person is placed in a nursing home or needs extensive home care on a prolonged basis" (U.S. House of Representatives, Select Committee on Aging 1985, 54).

I believe that to a large extent the elderly's lack of coverage for catastrophic events is due to lack of knowledge about their vulnerability, or to denial—an unwillingness to confront the fact that they might enter a nursing home at some point in their lives. Currently, there are dozens of policies available that cover the costs of long-term nursing home care, but less than 1 percent of the elderly have purchased them. There are reasons other than ignorance or denial to explain the lack of success of nursing home insurance policies, however. Although there are many policies on the market that cover long-term care services, they are not well publicized, and many tend to have high premiums because the population served is at high risk of institutionalization. Annual premiums vary from $75 to $1,800 for a 65 to 69-year-old, to $150 to $2600 for a 70 to 74-year-old, and can be much higher for someone who is aged 80 (Schaeffer 1987). The primary cause of this variation is probably the extent of coverage for nursing home and home care services, which varies considerably according to the particular policy. Furthermore, some of the elderly may correctly perceive that if they incur catastrophic long-term care costs, the government will pay for them. For this to occur, however, they must first become poor by spending-down their assets to be eligible for Medicaid coverage, something which few seem to understand.

There are other reasons to believe that consumer ignorance is partly

responsible for the low popularity of products that can provide protection against catastrophic out-of-pocket costs. Besides nursing home care, the two primary gaps in Medicare and medigap policies are unassigned physician services liability and prescription drugs. Both of these are commonly covered almost in full by HMOs. In June 1986, however, only 3 percent of Medicare beneficiaries received their coverage through HMOs, compared to about 10 percent of the population under the age of 65 (McMillan, Lubitz, and Russell 1987). Although this number is growing with liberalized federal regulations toward Medicare-certified HMOs, it would still appear that ignorance about Medicare and medigap policies is partly responsible for the relative unpopularity of HMOs among this population. It is true that the elderly population is largely unused to HMOs and has already established physician relationships. Nevertheless, if they were to understand the cost advantages of many HMOs, more would consider joining.

I have argued that one manifestation of poor consumer information is that the elderly have not purchased insurance coverage that protects them against potentially catastrophic costs. Whether the policies they do purchase are priced appropriately is considered next.

Are Medigap Policies Priced Competitively? Earlier, it was noted that another way to evaluate whether a market is performing well is to see whether the product being sold is priced competitively. Private insurance policies do not return all premium dollars as benefits for several reasons: they need to make a profit; they may spend considerable amounts on advertising; claims processing and administration are costly; and they may need to keep some of the premiums to insure against unanticipated disbursements, a so-called "risk premium."

Although all of the above expenses may be perfectly legitimate, in assessing whether a policy change should be implemented it is important to consider the alternatives, and one alternative—which will be discussed in detail later—is having the Medicare program supply the coverage now being provided by medigap policies. Traditionally, the Medicare program spends about 3 percent of its disbursements on administration: 2 percent for Part A and 5 percent for Part B (U.S. Health Care Financing Administration 1983).

Given the size of the medigap market, it is surprising how little information exists on policy return rates. Only during the last year has any systematic information been compiled, from a study conducted by the U.S. General Accounting Office (1986) for the U.S. House

of Representatives Ways and Means health subcommittee. It examined earned premiums and incurred claims for 398 medigap policies sold by 111 companies in 12 states in 1984. A policy's loss ratio is derived by dividing claims dollars by premium dollars.

The study found that policies sold by Blue-Cross/Blue Shield plans have average loss ratios of 81.1 percent, but those sold by commercial insurers averaged loss ratios of only 60.2 percent. Furthermore, the latter figure was raised substantially by the fact that the largest commercial insurer, Prudential, had a loss ratio of 77.9 percent. Ratios for the remaining 97 commercial insurers averaged substantially less than 60 percent.

One must be careful in drawing too many conclusions from one set of loss ratios. New policies tend to have low loss ratios initially because they typically have fewer incurred claims during the first few years due both to a relatively healthy cohort of policy holders and to preexisting-condition clauses in policies. Once this cohort matures and the preexisting-condition clauses expire, the loss ratio will typically adjust to its long-run level.

Furthermore, the 1984 data used in the study may reflect the substantial decrease in hospital admissions and length of stay which occurred at the onset of DRGs. It could be argued that this large, unanticipated decline in policy liabilities resulted in lower loss ratios than was the case in previous years. The U.S. General Accounting Office study also examined the loss ratios from 1982 and 1983. For commercial insurers, the loss ratios went from 59.2 percent in 1982 to 65.3 percent in 1983 to 60.2 percent in 1984. For Blue-Cross/Blue-Shield plans, the figures were 93.7 percent, 91.3 percent, and 81.1 percent, respectively. For Blue-Cross/Blue-Shield, then, the 1984 figures do appear to be lower than the historical trend. This does not appear to be the case, however, for the commercial insurers.

How "low" are these figures? This depends on what they are compared to. Two comparisons of interest are how they rate with all group insurance sold in the United States, and how they compare with all individual policies. According to industry reports (A.M. Best Company 1986), the average loss ratio for all commercial group accident and health policies sold between 1980 and 1984 was 100 percent, whereas the average for other (individual) accident and health policies was 64 percent. The 100 percent figure for group policies indicates that the industry was unprofitable over this period, since companies must still

cover administrative costs. But it is noteworthy that the figures for the medigap market are no lower than for the market for other individual policies—that is, policies sold to the nonelderly.

Nevertheless, if a person desires health insurance coverage, it is clear that they will get much more for their money if they are part of a group; note the high loss ratios for group insurance policies and Medicare's relatively low administrative costs. It is not surprising that group coverage will provide much better returns on premiums; not only do the companies avoid the bulk of agent commissions and experience economies of scale in claims processing, but the nature of group insurance helps avoid adverse selection—that is, sicker people purchasing the coverage. One can, therefore, conclude that elderly consumers desiring medigap coverage would do better if they were part of a group. Since the elderly largely are not part of the labor force, however, there is no convenient way to organize such a group privately that will avoid adverse selection. An alternative would be for the government to provide coverage to all Medicare beneficiaries through an expansion of program benefits. There are several points that need to be considered before making such a large policy change, and they are discussed next.

Improving the Efficiency of Health Care Coverage for the Elderly

In the previous sections it was argued that the market for medigap policies is not functioning very well due in large part to consumer ignorance: the elderly are not buying coverage that best suits their needs (as demonstrated by the low enrollment in HMOs and small demand for nursing home coverage), and many of the policies they do buy provide low returns on their investments. The issue addressed here is why this situation has arisen, and what can be done to improve consumer understanding and, thus, health insurance choices.

One thing to be kept in mind when considering alternatives to the present types of coverage is the distinction between cost control and social efficiency. It is sometimes tempting to think that increased public spending is somehow inefficient, even if it results in a more equitable distribution of services. In fact, one need not have to raise the issues of equity to justify higher government expenditures, although

they certainly can justify it. The issue, rather, is whether consumers are better off in total after a government expenditure is made. Suppose Medicare is expanded in a way that reduces the need for medigap policies. If consumers are then receiving more benefits at the same total cost due to lower administrative and advertising costs, then a strong argument can be made that increased governmental expenditures are socially efficient. (One cannot say for certain that it is more efficient in the Pareto sense since the distribution of benefits and costs among the population has changed, with the switch from private to public financing.)

Returning to the issue at hand, surveys of consumer knowledge have been successful at recording how fully Medicare beneficiaries understand their coverage, but they have not attempted to determine exactly how these levels of understanding have been reached. Consequently, we can only speculate. I believe that the main reason for low knowledge levels is the fragmented, very complicated system that has developed to pay for health care services for the elderly.

There are four primary payers for health care services: Medicare, medigap policies, Medicaid, and out-of-pocket payments (and this excludes the other types of insurance sometimes purchased, such as hospital indemnity coverage). Although it might be possible for people to understand how four payers share the costs, it becomes extremely difficult for even the most alert of the elderly because these four payers interact differently depending on the type of service. A few examples will illustrate the point in the case of persons who, before onset of illness, do not have Medicaid coverage.

For hospital care, coverage is relatively straightforward for the inpatient bill itself: Medicare and medigap policies combine to cover almost all expenses. For physician care either inside or outside of the hospital, it is much more complicated. Medigap policies sometimes cover the $75 annual deductible, and practically all cover the 20 percent coinsurance on the physician's reasonable charge (Rice and McCall 1985). After that the situation is very confusing, however. Some policies pay nothing above the reasonable charge for nonassigned services, some pay a percentage of the difference between the reasonable charge and the insurance company's usual and customary rate (UCR) level, some pay all of the difference, and a very few policies pay some amount above the UCR level if the physician's billed charge is even higher. For patients (or physicians, for that matter) to understand their liability, they need to know the reasonable charge for a particular

service, the billed charge, the assignment status, and perhaps the insurance company's UCR level. Furthermore, in making an informed insurance decision, they must predict these things in advance. It is no wonder that patients are perplexed when they discover that Medicare does not pay for 80 percent of physician costs.

The situation for nursing home care is the most complex of all. A cursory look at the Medicare literature shows that Medicare pays for the first 20 days of care in a skilled nursing facility, and part of the next 80 days. As noted earlier, however, coverage is usually cut off after less than a month because the stay no longer meets Medicare standards for eligibility. What is even less well known is that medigap policies tend to tie their coverage to Medicare, so that when Medicare is cut off, medigap stops payment, too. Not surprisingly, the medigap policy literature does not dwell on this point. Typical policies point out that they will pay up to tens of thousands of dollars in nursing home costs, without explaining how unlikely it is that such coverage will be allowed. Policies that cover nursing home care do so only as long as a stay is Medicare-approved, and only 6 percent of all Medicare-covered stays remain eligible for as long as 90 to 100 days (U.S. Health Care Financing Administration 1985). None of this even alludes to the complexity of Medicaid coverage, which comes into play in most (but not all) states when patients spend-down their assets to a certain level, which varies by state.

The above gives only a flavor of the complexity of the health insurance system for the elderly. Many more examples could have been cited. It is this fragmented, unnecessarily complicated system that is largely responsible for the confusion that exists, and, ultimately, for the poor choices many of the elderly make in the health insurance market.

The remainder of this article provides a framework for improving the efficiency of health care coverage for the elderly, using the discussion on consumer information developed earlier. It also touches on how such changes affect the equity of coverage. The material is divided into two sections: acute care and long-term care.

Acute Care

There are a number of possible ways to improve consumer information concerning the financial risk of acute care costs. Two related methods would be either to increase government regulations that require companies

to disclose information to consumers, or to have the government itself provide the information directly. On the surface, these would appear to be the most logical methods because they deal directly with consumers' lack of information, which I argue is largely responsible for market inefficiencies. These options, however, are unlikely to result in much improvement.

Already, as a result of the Baucus legislation, prospective buyers of medigap policies receive substantial amounts of information about both Medicare and medigap coverage. Under the legislation, which has been enacted in all but four states, consumers must receive a state-approved guide explaining Medicare and medigap coverage, as well as an outline of benefits which shows in tabular form what services are covered by Medicare and by the medigap policy. Thus, there is much information already being distributed. But the complexities of Medicare coverage (into which medigap policies tie their benefits) make these information sources insufficient in helping consumers make informed decisions. The problem is not just the lack of information being distributed, but the extremely confusing nature of covered and uncovered services.

The best means of solving the information problem is to simplify Medicare coverage. This would not only clarify to consumers what benefits they would receive from the program, but it would simplify the benefits provided by medigap policies too, since they tie into Medicare's benefits structure. The theory of insurance tells us that the ideal situation would be one where all of the catastrophic costs of hospital and physician services are covered, but where people self-insure for the more manageable costs through deductibles or some other form of self-insurance.

If our present experience provides any evidence, however, the elderly do not want to face the uncertainty of paying large deductibles; note the fact that almost all medigap policies cover the initial hospital deductible, even though this is not required by the Baucus legislation. What is likely to happen if the above "ideal" is enacted by Medicare is that most people will purchase a redesigned medigap policy that provides first-dollar coverage for the new Medicare deductible. We would then be in a situation similar to that in effect today; because most policies are sold on an individual basis, loss ratios would be low, which means that the elderly would be receiving a low average

return on their investment in private health insurance. I would suggest that a better situation would be one where Medicare itself provides full coverage for hospital and physician services, and where physicians are not allowed to bill the patient for any extra charges.

There might be three major objections to such an expansion of Medicare. First, it would eliminate the cost-sharing requirements that are designed in part to keep utilization rates down. The answer to this objection is that, for the most part, currently there is very little cost sharing for covered services anyway. Eighty percent of Medicare beneficiaries already have complete or near-complete coverage for these services—72 percent through medigap policies and 8 percent through Medicaid (Christensen, Long, and Rodgers 1987). Making coverage universal would only reduce cost-sharing requirements for 20 percent of the elderly, who happen to be a less-well-off group financially.

A second objection is that it would require all elderly people to have this comprehensive coverage, even if they did not desire it. Once again, it appears that this is in line with the desires of the vast majority of beneficiaries who have chosen to supplement their Medicare coverage in the private market. There is another reason that the change might be desirable. In the beginning of the article, it was noted that we must look at social as well as private efficiency in our analysis of a market. There is one externality, which, if not corrected, may make a private market operate inefficiently. This relates to altruism—our desire to see that other people are not impoverished by health care expenses. If supplemental coverage is voluntary and some people do not purchase it, they put themselves at financial risk, something that we as a society may not wish to have. In fact, if medical expenses get too high, the government usually covers them through Medicaid. It could, therefore, be argued that it is better simply to provide coverage ex ante by universal supplementation, thus avoiding the spending-down of assets.

A third objection would be that the proposal expands the role of government at the expense of private medigap policies. This is undoubtedly the case. In defense of the idea, recent evidence cited above indicates that private health insurance policies appear to have substantially lower returns on premiums than Medicare, largely because the medigap market is oriented toward individuals rather than groups. Since there is no convenient way to transform it into a group market without

experiencing adverse selection, consumers will be better off, on average, if the coverage is provided directly by the government as part of an expanded Medicare benefits package.

I have argued that overall efficiency would be improved if Medicare expanded its benefits by covering all hospital and physician costs. What would be the consequences of such a change from the standpoint of equity? Clearly, there would be a big improvement. When examining equity, one must look at how many beneficiaries lack supplementation from any source: either medigap policies or through Medicaid. In 1984, 32 percent of the poor lacked any form of supplementation, compared to only 19 percent of the nonpoor. Perhaps even more telling is the consistent relation between poor health and lack of supplementation. Twenty-eight percent of beneficiaries who rate their health as "poor" lack supplementation; this is true of 24 percent in "fair" health, but only 20 percent in "good" health, 19 percent in "very good" health, and 17 percent in "excellent" health (Christensen, Long, and Rodgers 1987).

In summary, it has been argued that simply providing consumers with more information will not improve market outcomes very much because of the complicated nature of Medicare's benefits structure: Increasing the quantity of information may not increase the quality of understanding. An "ideal" solution of providing true catastrophic coverage through Medicare, however, while allowing beneficiaries to self-insure for deductibles, is unlikely to work because beneficiaries will continue to seek supplementation through the private market, this time to cover any deductibles that remain in Medicare. This is not efficient because the insurance provided to medigap beneficiaries is largely individual coverage, which has relatively low rates of return on premiums. It has been suggested that a second-best solution to the efficiency problem would be to expand Medicare to pay for all hospital and physician expenses. This would eliminate the confusion surrounding coverage for these services, and lower consumer costs by taking advantage of Medicare's administrative efficiencies. It would also lead to a marked improvement in the equity of coverage.

Long-term Care

The problem of consumer ignorance is probably even more severe in the area of long-term care. In large measure, this complexity is the result of Medicare's tradition of covering only acute-care nursing home

and home health services that lead to a patient's recovery after discharge from a hospital. Because coverage decisions are made on a case-by-case basis, without much uniformity (Smits, Feder, and Scanlon 1982), it is very unlikely that additional consumer information would be sufficient to improve outcomes in the market.

It should be mentioned that a major difference between acute and long-term care is that the former is provided mostly by the medical profession, while the latter is largely done by unpaid or "informal" care offered by family and friends. It is estimated that only one-fifth of the elderly with chronic care needs reside in nursing homes; the rest are in the community and, of these, the majority receive care only from unpaid sources (Doty 1986). For reasons of both cost and quality, continuation of this form of care should be encouraged. One of the issues that must be confronted when considering the expansion of Medicare benefits is whether it will largely provide care for those who previously had unmet needs, or if the main effect will be a substitution of paid for unpaid sources of care.

This article's focus is on the paid sources of care, which in the case of long-term care is primarily the nursing home. For the same reasons as with acute care, simplification of the long-term care benefit structure would appear to be the most promising way to improve consumer knowledge, and thus allow them to make rational coverage decisions. One obvious way to achieve this, which avoids any consumer decision making, would be for Medicare to cover fully nursing home care, and perhaps home health care as well. There are some serious drawbacks to such an expansion of Medicare, however. First, the cost would be exceedingly high; in 1985 the elderly's out-of-pocket costs for nursing home services alone were $18.1 billion, and the state and local share was another $7.1 billion (Waldo, Levit, and Lazenby 1986). Spread across all elderly, these figures alone represent a per capita expense of almost $1,000. Of course, the per capita cost would be much less if it were spread across all age groups, but it is not clear that Congress would be willing to enact a major new tax like this on the working-age population.

Second, and in a related manner, full coverage would likely increase costs further due to the sudden increase in demand for long-term care services. This cost problem would be especially serious in the area of home health, where currently the majority of care is provided by nonpaid or informal sources. As noted above, extensive insurance coverage might result in a substitution of paid for unpaid help.

If complete long-term care coverage is not currently possible (and perhaps not desirable), what else can be done to improve consumer understanding and, ultimately, efficiency? I would suggest as a starting point that Medicare coverage be changed to eliminate the distinction between acute and long-term care coverage. That is, Medicare should broaden its definition of covered services to include those services that are received for sustaining as well as rehabilitating purposes. In particular, this would mean all skilled and intermediate nursing home services would have the potential for partial reimbursement, as would home services. Medicare would then have several options concerning how fully it would cover these services.

Before discussing some of these options, it is important to confront an objection often raised to the expansion of Medicare into the long-term care area: that such services are not really "medical" services, but rather largely room and board coupled with assistance in personal care. Even if this is true, it misses the point of what insurance is all about. If one were to grant that nursing home care is largely custodial, this does not lessen the fact that those receiving care are subject to catastrophic losses, against which risk-averse individuals will want to protect themselves. It is true that the government may wish to limit the degree to which it subsidizes these services. That can be accomplished, however, by charging long-term nursing home patients a portion of their Social Security income while they are residents. Such a system would have the obvious advantage of not requiring these people to spend-down their accumulated assets in order to receive coverage.

Moving back to the original question, what options would be available to Medicare, once it expands its definition of covered services? It is beyond the scope of this article to address this fully, as many plans have been proposed. Two of the many options being discussed in policy circles are: (1) to have Medicare cover the first part of a nursing home stay, perhaps increasing coverage to 100 days for all stays; and (2) to have Medicare provide coverage for the last part of a stay, such as all costs after one or two years of institutionalization. These two options are quite different; the first would provide complete coverage for the majority of nursing home admissions (who have short stays), but little protection for those few with tremendously expensive stays. The second would cover far fewer people, but provide some protection against truly catastrophic costs.

Both proposals would improve consumer understanding of what Medicare does and does not cover, primarily because of the broadened

definition that would include all nursing home stays as eligible for some coverage. Given the large gaps in coverage that would exist under both proposals, it would alert beneficiaries of their risks, and perhaps increase demand for private long-term care coverage to supplement Medicare. Currently, this market covers only about 1 percent of the elderly. The second proposal has some advantages, though, over the first. It provides coverage more consistent with the purpose of insurance, and, by providing a stop-loss, will make it more attractive for private insurance companies to sell policies that cover the (long) deductible period. The disadvantage, of course, is that those not purchasing this supplementation might become bankrupt before reaching the coverage stage.

This disadvantage is especially important when one evaluates the equity of such a proposal. Poorer individuals would still tend to become impoverished, as they currently do, because they cannot pay a one- or two-year deductible on nursing home stays. This means that the proposal would largely help the middle and upper classes, who can often afford such a deductible but would spend-down their assets if the stay were even longer. A modified proposal, which would not have these unfortunate equity implications, would be to index the deductible to a person's income and/or assets. Thus, poor persons would receive coverage by Medicare sooner than wealthy persons, before all of their income and assets have been depleted.

Once again, a review of alternative long-term care coverage and financing strategies is beyond the scope of this article. The point being stressed here is that any proposal for improving health care coverage for the elderly must simplify the system in order to facilitate wise choices by consumers; this applies to both acute and long-term care coverage. Furthermore, once consumers have a better understanding of their coverages, they will be in a much stronger position to make political choices concerning how they wish their legislators to reform the Medicare program.

Implications for Current Legislation

Ever since President Reagan proposed the concept in his 1986 state of the union address to Congress, there has been a great deal of attention paid to extending Medicare benefits to cover "catastrophic costs." As noted earlier, the legislation that is likely to be enacted by Congress will limit beneficiaries' annual liabilities, perhaps between

$1,500 and $2,000. The legislation may also include some benefits for prescription drugs, which until now have not been covered at all. The question pertinent to this article is whether such changes will improve the efficiency of health care coverage for the elderly.

Using the framework laid out in this article, the legislation is not likely to improve the situation. I have argued that the key to success is enacting programmatic changes that will simplify Medicare's benefits, thereby improving consumers' information and allowing them to make choices that are in their best interests. The legislation now being considered by Congress, unfortunately, makes matters even more confusing. It appears to a casual observer that out-of-pocket expenses will be limited to less than $2,000 a year. This is simply not the case, however, because beneficiaries will still be liable for almost all nursing home costs and for physician charges in excess of the Medicare reasonable charge. Beneficiaries will undoubtedly be disappointed and confused when they find out that the "catastrophic cap" does not apply to many of their catastrophic expenses. Private insurance companies will be sure to point out the program's failings. I suspect that the elderly will continue to purchase medigap policies, albeit ones that are designed to mimic the new benefit structure. There is no reason to believe that beneficiaries will make better choices about their health insurance needs, since Medicare's benefit structure will appear to be even more perplexing than it is now.

I have argued that successful changes in Medicare must begin by making program benefits easier to understand. On the acute care side, one of the keys to success is limiting beneficiary liabilities to the Medicare reasonable charge—that is, requiring assignment on all physician services. Improvement in long-term care is likely to come about only when Medicare eliminates the distinction between acute and long-term stays, and removes all of the other technicalities that prevent most stays from receiving coverage.

In conclusion, there are major problems inherent in our country's system of providing health care benefits to its elderly citizens. Many of these problems stem from the confusing nature of coverage for the various health care services that these people need. Perhaps this confusion is an inevitable consequence of the federal government's desire to control expenditures, which has been accomplished, in part, by "fine-tuning" the benefits structures of Medicare and Medicaid. There is a large social cost involved, however, in making people's coverage hard to understand: They are unable to make decisions about purchasing

medical care and health insurance that best suit their needs. It is hoped that future changes in public programs will recognize the importance of providing not only comprehensive, but comprehensible health care benefits for the elderly.

References

A.D. Little, Inc. 1982. *A Study of Consumer Health Insurance Education: Final report submitted to the Bureau of Health Education, Centers for Disease Control.* Atlanta.

A.M. Best Company. 1986. *Best's Aggregates & Averages: Property-Casualty.* Oldwick, N.J.

American Association of Retired Persons. 1984. *Long-term Care Research Study.* Washington.

Blumenthal, D., M. Schlesinger, P. Brown Drumheller, and the Harvard Medicare Project. 1986. The Future of Medicare. *New England Journal of Medicine* 314:722–28.

Cafferata, G.L. 1984. Knowledge of Their Health Insurance Coverage by the Elderly. *Medical Care* 22:835–47.

———. 1985. Private Health Insurance of the Medicare Population and the Baucus Legislation. *Medical Care* 23:1086–96.

Christensen, S., S.H. Long, and J. Rodgers. 1987. *Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options.* Washington: U.S. Congressional Budget Office.

Cohen, M.A., E.J. Tell, and S.S. Wallack. 1986. The Lifetime Risks and Costs of Nursing Home Use among the Elderly. *Medical Care* 24:1161–72.

Consumer Reports. 1984. Medicare-Supplement Insurance. 49:347–56.

Davis, K., and D. Rowland. 1986. *Medicare Policy.* Baltimore: Johns Hopkins Press.

DeNova, A., and G. Shearer. 1978. *Private Health Insurance to Supplement Medicare.* Washington: Federal Trade Commission.

Doty, P. 1986. Family Care of the Elderly: The Role of Public Policy. *Milbank Quarterly* 64:34–75.

Feder, J., and W. Scanlon. 1982. The Underused Benefit: Medicare's Coverage of Nursing Home Care. *Milbank Memorial Fund Quarterly/Health and Society* 60:604–32.

Feldstein, P. 1983. *Health Care Economics.* New York: John Wiley.

Gordon, N. M. 1986. Testimony before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, March 26, 1986.

Harvard Medicare Project. 1986. *Medicare: Coming of Age, A Proposal for Reform.* Cambridge: Division of Health Policy Research and Education, Harvard University.

Henderson, J.M., and R.E. Quandt. 1971. *Microeconomic Theory.* New York: McGraw-Hill.

ICF Inc. 1985. *The Role of Medicare in Financing the Health Care of Older Americans.* Washington.

Keeler, E.B., D.T. Morrow, and J.P. Newhouse. 1977. The Demand for Supplementary Health Insurance, or Do Deductibles Matter? *Journal of Political Economy* 85:789–801.

Kovar, M.G. 1986. Expenditures for the Medical Care of Elderly People Living in the Community in 1980. *Milbank Quarterly* 64:100–32.

LaTour, S.A., B. Friedman, and E.F.X. Hughes. 1983. *Medicare Beneficiary Decision Making about Health Insurance: Implications for a Voucher System.* Evanston: Center for Health Services and Policy Research, Northwestern University.

Lambert, Z.V. 1980. Elderly Consumers' Knowledge Related to Medigap Protection Needs. *Journal of Consumer Affairs* 14:434–51.

McCall, N., T. Rice, and A. Hall. 1983. *Medigap Study of Comparative Effectiveness of Various State Regulations: Final Report Submitted to Health Care Financing Administration.* Washington.

———. 1987. The Effect of State Regulations on the Quality and Sale of Insurance Policies to Medicare Beneficiaries. *Journal of Health Politics, Policy, and Law* 12:53–76.

McCall, N., T. Rice, and J. Sangl. 1986. Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits. *Health Services Research* 20:633–57.

McMillan, A., J. Lubitz, and D. Russell. 1987. Medicare Enrollment in Health Maintenance Organizations. *Health Care Financing Review* 8:87–93.

Pauly, M. 1978. Is Medical Care Different? In *Competition in the Health Care Sector: Past, Present, and Future,* ed. W. Greenberg, 19–48. Washington: Federal Trade Commission.

Reinhardt, U. 1978. Comment on Paper by Frank Sloan and Roger Feldman. In *Competition in the Health Care Sector: Past, Present, and Future,* ed. W. Greenberg, 156–90. Washington: Federal Trade Commission.

Rice, T., and J. Gabel. 1986. Protecting the Elderly against High Health Care Costs. *Health Affairs* 5:5–21.

Rice, T., and N. McCall. 1985. The Extent of Ownership and the Characteristics of Medicare Supplemental Policies. *Inquiry* 22:188–200.

Schaeffer, C. 1987. Insurance for Long-term Care. *Changing Times* (January):113–20.

Short, P.F., and A.C. Monheit. 1986. Private Employers, Silent Partners in Financing Health Care for the Elderly. Paper presented at conference on the Future of Medicare, Leonard Davis Institute for Health Economics, Philadelphia.

Sloan, F., and R. Feldman. 1978. Competition among Physicians. In *Competition in the Health Care Sector: Past, Present, and Future*, ed. W. Greenberg, 57–131. Washington: Federal Trade Commission.

Smits, H., J. Feder, and W. Scanlon. 1982. Medicare's Nursing Home Benefit: Variations in Interpretation. *New England Journal of Medicine* 307:855–62.

U.S. Department of Health and Human Services. 1986. *Catastrophic Illness Expenses: Report to the President.* Washington.

U.S. General Accounting Office. 1986. *Medigap Insurance.* GAO/HRD-87-8. Washington.

U.S. Health Care Financing Administration. 1983. *The Medicare and Medicaid Data Book, 1983.* Washington.

———. 1985. *Study of the Skilled Nursing Facility Benefit under Medicare: Report to Congress.* Washington.

U.S. House of Representatives, Select Committee on Aging. 1978. *Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal.* Comm. pub. no. 95-160. Washington.

———. 1985. *Twentieth Anniversary of Medicare and Medicaid: Americans Still at Risk.* Comm. pub. no. 99-538. Washington.

U.S. Internal Revenue Service. 1978. *Individual Income Tax Returns.* Washington.

Waldo, D.R., and H.C. Lazenby. 1984. Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977–1984. *Health Care Financing Review* 6:1–29.

Waldo, D.R., K.R. Levit, and H.C. Lazenby. 1986. National Health Expenditures, 1985. *Health Care Financing Review* 8:1–21.

Wyszewianski, L. 1986. Families with Catastrophic Health Care Expenditures. *Health Services Research* 21:617–34.

Acknowledgments: I would like to express my appreciation to Katherine Desmond, Deborah Freund, Marsha Gold, Judith Lave, Nelda McCall, Judith Sangl, Pamela Farley Short, Mark Schlesinger, and three reviewers for their helpful comments on a draft of this article. I also received valuable comments at presentations of this material given to the Department of Clinical Epidemiology and Biostatistics at McMaster University and the Department of Health Policy and Management at the Johns Hopkins University. All conclusions, however, are entirely my own.

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