

National Association of Insurance Commissioners
Senior Issues Task Force
Medigap PPACA Subgroup
Medicare Supplement Insurance First Dollar Coverage and Cost Shares
Discussion Paper

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I. Executive Summary

The Patient Protection and Affordable Care Act (ACA) requires the NAIC to review the NAIC Medicare Supplement (Medigap) Insurance model act and regulation and, as appropriate, develop nominal cost shares for certain Medicare Part B services in Plans C and F. To that end, the NAIC appointed the Medigap PPACA (B) Subgroup (Subgroup) consisting of state and federal regulators, insurers and trade associations, consumer advocates and other experts in the area of Medicare and Medigap. However, after the Subgroup began its work, Congress began looking at changes to Medicare and Medigap as part of proposals for deficit reduction. The NAIC believed that it was important to comment on the discussions in Congress and was therefore given an expanded charge by the NAIC Senior Issues (B) Task Force to develop this discussion paper. The paper is intended to serve as a vehicle to provide information to policymakers.

This Executive Summary highlights areas of concern, emphasizes some of the Subgroup's conclusions and incorporates the findings of much of the literature that was reviewed. Most importantly, the paper seeks to promote the critical policy recommendation that any changes to Medigap should be considered in the broader context of changes to Medicare. The bulk of the discussion paper is devoted to providing assertions, research and findings that support that recommendation.

The appendix to the paper summarizes the various proposals being considered by Congress and the Administration that relate to Medigap insurance. Uniformly, these proposals seek to significantly increase cost sharing for Medicare beneficiaries on the premise that by insulating beneficiaries from much of Medicare's cost sharing, Medigap contributes to use of unnecessary care that drives up Medicare costs. The proposals are based on the idea that by shifting more costs onto this category of beneficiaries their care-seeking decisions will become more rational and save the program money.

The proposals focus on overutilization by beneficiaries but do not consider the potentially serious and unintended impacts for beneficiaries and the Medicare program. Namely, in response to increased costs beneficiaries may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs to the Medicare program in the long term. In addition, research indicates that once beneficiaries seek care, doctors and other medical providers, not patients, generally drive the number and types of services delivered to beneficiaries. Further, the proposals do not address the fact that Medicare determines which services are reimbursed and therefore, by law, covered by Medigap insurance policies.

The Subgroup solicited actuarial review of the Congressional Budget Office (CBO) proposals and received comment from the American Academy of Actuaries. The Subgroup cautions that the CBO estimates of cost

savings are based upon unknown assumptions. The actuarial review cautions that a reliable estimate of the impact of Medigap changes should include at least the following: (1) savings in Part A and Part B; (2) additional hospital expenses resulting from the diminution of physician services; (3) shifts between hospital and outpatient care, upcoding or unbundling; (4) identification of overused services; (5) impact of beneficiary out-of-pocket costs; (6) impact on Medicaid use and costs; and (7) impact of increased non-compliance with treatment and follow-up care for chronically ill patients that results from increased cost sharing.

The paper discusses the impact of proposed changes to all policyholders, including retroactive changes to in-force guaranteed renewable Medigap coverage. The Subgroup believes that retroactive changes to in-force contracts would raise Constitutional questions and fundamental legal issues for regulators and insurers, such as premium refund questions, concerns about contract impairment and confusion as to how to pay claims where services were received prior to the changes. There are also concerns regarding the impact of changes for new policies particularly with proposals that seek to surcharge or place an excise tax on Medicare or Medigap premiums.

In summary, the discussion paper seeks to make federal policymakers aware of the potential negative consequences of some of the changes being considered by Congress. The Subgroup is concerned that decreasing the use of some services among older populations can result in increased use of more intensive services that can offset the savings from reduction in the use of less costly services. Further, no consideration is being given to the disproportionate impact on those with low or modest incomes, those who live in rural areas who have less access to other choices such as Medicare Advantage plans, retiree health or other supplemental coverage, or those who are the sickest or have chronic conditions and need regular care. People do not necessarily distinguish between beneficial and unnecessary care and rely on the recommendations of their trained medical providers.

The focus on Medigap as the driver of the use of unnecessary medical care by Medicare beneficiaries fails to recognize that Medigap coverage is secondary and that Medicare determines the necessity and appropriateness of medical utilization. Policymakers should examine ways to ensure that the Medicare program is incentivizing and paying for appropriate care and not merely focus on discouraging the use of all care by making beneficiaries pay more of the cost.

II. Introduction

The Patient Protection and Affordable Care Act (ACA) requires the NAIC to review the NAIC Medigap model act and regulation¹ and, as appropriate, develop nominal cost shares for certain Medicare Part B expenses in Plans C and F.² It goes on to say that the NAIC is to enlist a working group of interested parties and stakeholders as was required under the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) in developing standardized Medicare supplement policies.

In 2010, the NAIC began work to fulfill its obligation under section 3210 and appointed the Medigap (B) PPACA Subgroup (Subgroup) consisting of state insurance regulators, a representative from the Centers for Medicare and Medicaid Services (CMS), Medicare supplement insurers, insurance industry trade associations, consumer advocates, and experts in the area of Medicare and Medicare supplement insurance.

¹ NAIC Model 650, *Medicare Supplement Insurance Minimum Standards Model Act* (Medigap model act) and NAIC Model 651, *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (Medigap model regulation).

² Section 3210 of the ACA.

To kick off its work, the Subgroup reviewed the relevant research on the impact of Medicare supplement insurance on the cost of Medicare, including the impact of Medicare supplement's first dollar coverage on the Medicare program's costs. The Subgroup has also begun collecting literature that analyzes the impact of cost sharing features on consumer behavior, finances and health care outcomes, focusing on articles or research that specifically examine the impact on seniors and other Medicare beneficiaries.

As the Subgroup began its work, Medicare supplement insurance became a topic of discussion in Congress as it sought to address the effect of increasing costs of the Medicare program to the nation's deficit. Several proposals aimed at reducing the cost of the Medicare program included significant structural changes to Medicare supplement insurance, including the prohibition of first dollar coverage in any Medicare supplement insurance plan. As a result of these discussions, the Subgroup felt that it should examine, for potential comment, the discussions being held in Congress and within the Administration concerning Medicare supplement insurance. The Subgroup's charge was expanded to include, in addition to the statutory requirement contained in the ACA, a discussion of the structural or policy changes directed at Medicare supplement insurance that are being brought forward in Congress.

This discussion paper is the result of the Subgroup's deliberations. The conclusions contained in this paper are the consensus of the members of the Subgroup. The CMS member of the Subgroup did not provide a position regarding the Subgroup's conclusions due to CMS's role in the Department of Health and Human Services, a department of the Administration.

Medicare supplement insurance, also known as Medigap, is a product that has served our country's Medicare eligible consumers well for many years, offering them security and financial predictability concerning their out-of-pocket medical expenses. Medigap's protections are now being wrongly pointed to as a major contributor to the increasing costs of the Medicare program, and some want to make significant changes, both on a retrospective and prospective basis, relating to Medigap coverage in order to potentially generate reductions in Medicare spending and, hence, budget savings.

Based on the Subgroup's observations, the seniors who will be hurt the most by the actions currently under consideration for Medicare supplement insurance are those who can least afford it – the sick, chronically ill, and those with modest incomes who need predictability in their out-of-pocket Medicare costs through Medigap. Medigap policyholders affected by the proposed changes have already expended substantial premium for benefits that would be significantly reduced or eliminated. Most Medicare beneficiaries have some form of supplemental coverage to help manage Medicare's substantial out-of-pocket costs. Proposals under discussion to restrict Medigap first-dollar coverage would apply to Medigap policyholders only, leaving low cost sharing benefits for beneficiaries with other types of private supplemental coverage untouched.

In addition, this approach would impact rural beneficiaries disproportionately. Thirty-one percent of Medigap policyholders live in rural areas, while just 24 percent of all beneficiaries are rural.³ While more than half of all Medigap policyholders have annual income below \$30,000, in rural areas nearly two-thirds of Medigap policyholders receive less than \$30,000 a year in income.⁴

³ *Low-Income & Rural Beneficiaries with Medigap Coverage*, AHIP Center for Policy and Research, 2009. This report can be accessed at www.ahipresearch.org/pdfs/MedigapLowIncomeRuralReport2011.pdf.

⁴ Ibid.

Solutions to the increasing costs of the Medicare program cannot rest on severely limiting Medicare supplement coverage. Medigap changes should be considered in the broader context of changes to Medicare. The Medigap proposals aim to discourage use of Medicare services by asking beneficiaries to pay more at the point of service or by making those buying Medigap plans covering all cost sharing pay more. As discussed in greater detail later in this paper, we are especially concerned with the estimates of savings that, in order to be realized, require the Medicare supplement coverage limitations to be applied both prospectively to new coverage and retroactively to all existing Medicare supplement business already in force.

We recommend that the NAIC use this paper as a resource for discussions with Congress, the Administration and others. We further recommend that the NAIC oppose any changes to Medicare supplement policies that will adversely affect policyholders.

III. Medicare Supplement Insurance, Medicare Cost Control and Deficit Reduction

a. Current Proposals Concerning Medicare Supplement Insurance

Medigap coverage has been a topic of discussion in Congress and within the Administration over the last several months as various proposals consider the effect of Medigap first-dollar coverage in the broader context of projected Medicare deficits and the national budget. From the 2010 recommendations from the National Commission on Fiscal Responsibility and Reform and President Barack Obama's Deficit Reduction Task Force to proposals from Senators Tom Coburn (R-OK) and Joe Lieberman (I-CT), policymakers have called for the elimination of Medigap first-dollar coverage to reduce Medicare program costs. The Medicare Payment Advisory Commission (MedPAC) has also continued its dialogue on Medigap first-dollar benefits and the potential savings to Medicare by eliminating or reducing this type of coverage.

In addition, the Congressional Budget Office (CBO) routinely publishes a range of policy options for reducing the federal budget deficit and its March 2011 Report included three options for reforming Medicare and Medigap's cost sharing structure.⁵ Most recently, the President included several provisions focused on Medicare supplement insurance in his deficit reduction plan. A table that summarizes these, among other proposals, is included as Appendix A.

Some observers anticipate that the new joint congressional committee, created as part of the compromise on raising the federal debt limit, the Joint Select Committee on Deficit Reduction, will examine Medicare and Medigap reforms as part of their deliberations. This new congressional committee is charged with the responsibility for developing recommendations by November 23, 2011 to reduce the federal budget deficit by at least \$1.5 trillion over ten years.⁶ Key issues that policymakers will continue to wrestle with are: (1) whether Medigap coverage raises Medicare costs by spurring possible overutilization of certain health services (mostly physician office visits and certain diagnostic tests); and (2) whether proposed restrictions on Medigap coverage could have unintended consequences, including additional hospitalizations and higher health costs, especially among enrollees with chronic health care conditions and/or with low incomes.

⁵ *Reducing the Deficit: Spending and Revenue Options*. Congressional Budget Office (CBO), March 2011.

⁶ If the joint committee fails to recommend at least \$1.2 trillion in deficit reduction or if Congress fails to adopt the Committee's recommendations, across-the-board spending cuts would be applied to ensure that the second increase in the debt limit is accompanied by spending cuts that exceed the increase in the debt limit. Medicare would be included in any across-the-board cuts that are triggered.

Proponents of a prohibition on first-dollar coverage argue that Medigap coverage increases Medicare's costs by covering much of beneficiaries' cost sharing; thereby negating or reducing incentives for individuals to control utilization. CBO has noted that Medicare enrollees with no supplemental coverage have Medicare costs that are about 25 percent less than those with Medigap coverage. The MedPAC June 2009 report found that virtually all of the differences in Medicare spending among Medigap purchasers and beneficiaries with no supplemental coverage were attributable to Part B (physician and outpatient) services. However, it is not known what portion of the higher use among Medigap enrollees with first-dollar benefits represents unnecessary care. And, it is also not known whether service use among those without supplemental coverage reflects the right amount of care or optimal use of care.

In addition, the effect of adding cost sharing requirements on Medicare beneficiaries by restricting Medigap first-dollar benefits is unclear. MedPAC noted, in its June 2009 report that "(r)esearchers agree that beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage. However, they disagree about what proportion of this difference is due to the pure effect of insurance (called moral hazard or insurance effect) compared with the tendency of sicker individuals to seek insurance coverage (adverse selection)."⁷

Multiple studies have called into question the impact of increased cost sharing on the health outcomes associated with vulnerable populations (i.e., the elderly, chronically ill and low-income). Some suggest that increasing cost sharing for elderly patients may have adverse health consequences and may also increase total spending on health care. For example, a study published in the *New England Journal of Medicine* in January 2010 noted that increased cost sharing for ambulatory care for elderly patients led to both reduced outpatient visits and higher rates of hospital admission and inpatient days, as well as a higher percentage of enrollees who were hospitalized.⁸ The offsetting increase in hospitalization occurred particularly for those with lower incomes and those with chronic conditions. A *Robert Wood Johnson Foundation* report released in December 2010 similarly found that cost sharing increases were associated with adverse outcomes for vulnerable populations.⁹ It found that elderly, chronically ill and low-income patients had increased expenditures for emergency room visits and hospitalizations when cost sharing for prescription drugs was increased.¹⁰

b. Discussion of Medicare Supplement First Dollar Coverage

First dollar coverage in Medicare supplement insurance has been an issue, especially as the cost of the Medicare program has continued to increase. Over the years, Congress has introduced Medicare supplement plans with cost sharing to address the issue of perceived inappropriate use of Medicare services by those Medicare beneficiaries who have first dollar Medicare supplement coverage.

In the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), the conference report explanation specifically asked the NAIC to "modernize" the standardized plans and highlighted the goal of "reforming first dollar coverage". In addition to new statutory Plans K and L, the report urged the

⁷ Christopher Hogan, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly*, Direct Research for the Medicare Payment Advisory Commission (MedPAC), June 2009.

⁸ Amal N. Trivedi, et. al. *Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly*, *New England Journal of Medicine*, January 2010.

⁹ Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, Robert Wood Johnson Foundation Research Synthesis Report No. 20, December 2010.

¹⁰ *Ibid.*

NAIC "to consider broader changes to effectuate reduced premiums and more rational coverage policies that create incentives for appropriate utilization of services."¹¹

As a result of the conference report language, Plans M and N were developed as part of the NAIC Model Regulation revisions in 2007. Plan N includes required copayments of \$20 for physician office visits and \$50 for emergency room services. These amounts were not specified in the statute, but were developed through the NAIC Subgroup process. These new Plans M and N were only recently made available for sale beginning in June of 2010.¹² Early enrollment information suggests that Medicare beneficiaries are more receptive to plan designs with copayments than they have been to cost sharing designs that cover a share of Medicare coinsurance and deductibles, have high deductibles, or an out of pocket cap. Congress created plans with these benefit designs when it created Plans K and L and high deductible versions of Plans F and J.

In the ACA, Congress again sought to introduce more cost sharing into Medigap plans by asking the NAIC to recommend possible revisions to Plans C and F through the work of this Subgroup. Section 3210 of the ACA appears to be the result of research and recommendations of MedPAC, the group that provides policy suggestions to Congress and the Administration on Medicare issues.

Prior to the enactment of the ACA, MedPAC held many hearings and submitted published reports to Congress that included discussion on the effect of first dollar coverage on the costs to the Medicare program. The MedPAC Reports detailed and discussed the specific types of physicians' services that might result in increased costs to the Medicare program. Following, is discussion on various MedPAC reports on first dollar Medicare supplement coverage:

PPRC Report in 1997--Initial First Dollar Coverage Scrutiny

MedPAC, in its predecessor form as the Physician Payment Review Commission (PPRC) first began a formal review of Medigap and the "first dollar coverage" effect in the 1997 Annual Report to the Congress. Chapter 16 of the report, entitled "Secondary Insurance for Medicare Beneficiaries" examined the types of secondary insurance (Medigap and employer-provided), and discussed the "first dollar coverage" effect on Medicare service use.

The PPRC included a range of approaches to address the "first dollar coverage" effect. First, incremental changes to Medigap that included reformulating the then-10 standardized Medigap plans to incorporate some beneficiary cost sharing. Other options included expansion of Medicare SELECT¹³, establishing partial risk-sharing arrangements, and requiring insurers to assume full financial risk for Medicare and supplemental benefits (now called Medicare Advantage).

MedPAC Report in 2009--Linking Medigap to Higher Service Use

Section 3210 of ACA is a direct descendent of MedPAC's June 2009 Report to the Congress that began with the Commission's hearings initiated in 2007. The June 2009 report included Chapter 6 entitled "Improving Traditional Medicare's Benefit Design". The report declared that by filling in Medicare's cost

¹¹ H. Rept. No. 391, 108th Cong., 1st Sess. at 511 (November 21, 2003).

¹² 74 Fed. Reg. 18807 (April 24, 2009).

¹³ Medicare Select plans are standardized Medigap plans that contain restricted network provisions.

sharing requirements, supplemental coverage can lead beneficiaries to use more or higher priced Medicare covered services.

The June 2009 Report stated as a broad assumption that "researchers agree" that beneficiaries with supplemental coverage tend to have a higher use of services and spending than those with no supplemental coverage. The Commission contracted with Dr. Christopher Hogan of Direct Research, LLC, to look at the effects of secondary insurance on the use of and spending for Medicare services. That study concluded that the presence of secondary insurance was "causative" with higher Medicare spending.

The study analyzed different components of beneficiary Medicare spending in detail to see what patterns emerged. The study found that office-based care was higher than hospital-based care, and that spending for elective inpatient hospital services, specialist care, and preventive care was higher with secondary coverage. The study also observed significant differences in demographics, income and health status between the compared groups of beneficiaries.

The study observed that the largest differences in spending were in areas where the treating physician invoked more discretion. However, the report could not conclude that the additional care was a waste or of marginal value. The study noted that, although secondary insurance increased service use, the result from the increased services was not all negative or all positive.

As a final point, the study's author observed that policy actions in this area would "require judgment" as to whether the benefit of the additional health care use induced by insurance coverage is or is not worth the additional cost.

MedPAC included an illustration in the June 2009 Report to the Congress of using copayments in Medigap and employer-sponsored retiree coverage to "steer" beneficiaries toward certain types of care. These were: \$10 copayments for primary care office visits; \$25 copayments for specialty care (including chiropractors and physical therapists); and \$50 copayments for visits to emergency rooms. These co-pays are very similar to those developed by the NAIC in 2007 in response to the MMA and are now contained in Medigap Plan N.

The MedPAC report is unclear as to whether these nominal copayments would result in the "appropriate use" of physician's services. The primary result appeared to be an estimated "savings" to Medicare by discouraging the use of the identified services and that those "savings" could offset the cost of a MedPAC proposal to establish an out-of-pocket limit on Medicare cost sharing requirements for some Medicare beneficiaries.

On this point, the CMS Chief Actuary estimated the "savings" to only Medicare Part B from PPACA Section 3210 as \$380 million over the five year period of 2015-2019. It is unclear from the estimate which specific covered physician services are affected by the nominal cost sharing additions to Plans C and F, or how those savings are actually achieved.¹⁴

MedPAC Report in 2010--Linking to PPACA Directive

Immediately after enactment of the ACA, at its April 1, 2010 meeting, MedPAC staff discussed the provisions of section 3210, noting that the legislation does not specify the amount of the nominal

¹⁴ Richard S. Foster, *Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended*, April 22, 2010.

copayments and that the decision is left to the NAIC. The staff also noted that the nominal copayments do not apply to employer-sponsored coverage, but demonstrates "that the approach we've been talking about for redesigning supplemental coverage is being taken seriously."¹⁵

The June 2010 Report to Congress continued the MedPAC discussion for "Improving Traditional Medicare's Benefit Design". The report noted that beneficiaries' use of care is strongly affected by the recommendations of medical providers. However, the report observed that the amount patients pay at the point of service can affect whether they seek care, the type of provider they see, and which treatment they select.

The report again makes a broad statement that unidentified "researchers agree" that beneficiaries with Medigap and retiree health benefits have higher use of services and spending than those without such coverage. The report also notes that researchers disagree on the impact, and that some studies find small or statistically insignificant induced demand for care resulting from supplement coverage after controlling for "selection bias" in that those with higher health care needs purchase insurance.

MedPAC Report in 2011---Reiterating Prior Reports

The most recent MedPAC report entitled "Medicare and the Health Care Delivery System" (June 2011) reiterates the commission's previous work to reform the traditional Medicare benefit package. The report restates the undocumented proposition that "researchers agree" that beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage and that supplemental coverage "dampens financial incentives to control utilization".

The 2011 report again proposes to cap beneficiaries' out-of-pocket costs in the Original Medicare benefit to reduce financial risks for beneficiaries with the highest levels of cost sharing. The report cites the Hogan study results and then suggests that supplemental policies be required to have fixed-dollar copayments for services such as office visits and emergency room use to lead to reductions in the use of Medicare services sufficient to help finance the proposed out-of-pocket cap.

The 2011 report also incorporates into its discussion a proposal that goes beyond the provisions of PPACA section 3210, and reviews an "option" included in a report by the CBO to more strictly limit Medigap coverage of Medicare cost sharing. This option has been included in various "deficit reduction" proposals and would alter the cost sharing benefits of existing "in force" Medigap policies despite the "guaranteed renewability" of the terms and benefits of these contracts under federal and state law.

First Dollar Coverage Effect--Reconsidered by RAND

The "first dollar coverage" theory that has prompted the PPRC and subsequent MedPAC discussions is attributed to the RAND Health Insurance Experiment that was conducted in 1982. In 2006, RAND researchers, reflecting on the 1982 study, cautioned that increased cost sharing reduced the use of both needed and unneeded health care services and that the 1982 study did not review the impact of increased cost sharing on Medicare beneficiaries.¹⁶

¹⁵ See Transcript of April 1, 2010 MedPAC meeting, page 254.

¹⁶ *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, RAND Health Research Highlights, January 2006.

In addition, the authors also found that increased cost sharing only reduced the use of services where the patient decided not to initiate treatment or services because of the higher cost sharing. However, once patients entered the health care system, cost sharing only modestly affected the intensity or cost of an episode of care and has little effect on costs once care is sought. This strongly suggests that physicians affect the "overuse" of Medicare services after patients seek treatment, more so than the presence of secondary coverage.

c. Actuarial Assumptions

In the context of deficit and budget debates, the CBO estimates get particular attention. The soundness of the estimates rest on the underlying assumptions. Since CBO's assumptions are not public, the actuarial assumptions are not known. These estimates raise concerns about how the CBO interprets and applies the policy options. In its March 2011 Budget Options paper, the CBO included three options specifically related to Medigap policies. One proposal requires Medicare beneficiaries with Medigap policies to pay the first \$550 of required Medicare cost sharing liability and 50% of the next \$4,950 of required Medicare cost sharing liabilities. Medigap policies would be prohibited from covering these cost sharing liabilities for **existing** and future Medicare beneficiaries with Medigap insurance coverage.

CBO estimates that this proposal would "save" Medicare \$53.4 billion over a ten year period. The proposed savings result from both shifting costs to Medicare beneficiaries and from Medicare services forgone and also not used by Medigap beneficiaries. CBO states that both factors would result in savings to Medicare. The Medicare program would cost less therefore, monthly premiums would decrease and premiums for Medigap policies would also be reduced.

CBO concludes that Medicare costs for this group of Medicare beneficiaries with Medigap would be reduced "about 5%". It is difficult at best to determine the appropriateness and efficacy of the estimate of 5% savings to Medicare. It appears to be a simple calculation taking the proposed \$550 cost sharing liability multiplied by all Medigap policyholders. CBO does not provide an actuarial justification for this 5% estimate.

As discussed earlier, the CMS Office of the Actuary has estimated that the imposition of "nominal cost sharing" on Medicare covered physician services as prescribed by the ACA would result in "savings" to Medicare of about \$380 million over a 5-year period. There is no explanation of the basis of this estimate in the analysis.¹⁷ CBO also believes that Medicare beneficiaries with Medigap coverage "overuse" services and cites "some studies" that have found that Medigap policyholders use at least 25% more services than Medicare enrollees who have no Medigap coverage.¹⁸

Some "studies" upon which the CBO's assumption of 25% "overuse" is based, such as the 1982 RAND health insurance experiment, are not applicable to the Medicare population because the study focused on the non-Medicare population. Medicare beneficiaries as a group are less healthy than the population at large, with nearly half of all Medicare beneficiaries having three or more chronic conditions. More than one-quarter of people with Medicare report their health status as "fair" or "poor."¹⁹

¹⁷ Foster.

¹⁸ CBO, March 2011, page 49; *Budget Options-Volume I*, Congressional Budget Office (CBO), December 2008, page 155.

¹⁹ *Medicare Chartbook*, Kaiser Family Foundation, 2010, page 102.

No studies, including the 1982 RAND study, have made any determination regarding the appropriateness (or so-called "overuse") of services by Medicare beneficiaries with Medigap coverage. Some studies have simply noted a difference in spending between those Medicare beneficiaries with Medigap, with employer coverage, with Medicaid and those with only Medicare. Studies observing differences in spending among these groups do not reach the question of whether or not the group without supplemental coverage reflects optimal use of care in terms of health and health outcomes.

Medigap is the secondary payer on covered claims, and it pays its covered share of Medicare approved claims. No studies have shown that Medicare's determination of "medical necessity" is influenced by a person's secondary coverage, whether it be Medigap, retiree, or other secondary coverage. Medicare pays claims based on its own coverage standards and rules. Medigap carriers play no role in determining the medical necessity of services received and, in fact, are required by law to pay benefits after Medicare has determined that the services are medically necessary.

More studies, including RAND, have shown that utilization is determined by physicians and that cost sharing has little influence once treatment is sought. In 2006, RAND researchers, reflecting on the 1982 study, cautioned that increased cost sharing reduced the use of both needed and unneeded health care services and that the 1982 study did not review the impact of increased cost sharing on Medicare beneficiaries.²⁰ As the 2006 RAND research pointed out, there is significant potential for the reduction of **necessary** outpatient and primary care services as a result of proposals like that offered by CBO. It is not clear that the possibility of a commensurate increase in costly inpatient hospitalization services, for those who forego early care, is factored into CBO's fiscal estimates.²¹

It is unlikely that the level of "unnecessary" care sought by a non-Medicare population would be equal to that sought by an older, sicker population for whom many more necessary services would be expected.

In considering whether it is fair to characterize additional use of services by the Medigap population as inappropriate utilization, it may be helpful to look at actual use of services by the Medicare population. Of the 13 Part B services that cost Medicare more than a billion dollars in 2009,²² many are provided in settings where beneficiaries exercise little or no control, such as hospitals or pathology laboratories.

A reliable estimate of the impact of the proposed Medigap changes should include at least the following: (1) savings in Part A and Part B; (2) additional hospital expenses resulting from physician services delayed or foregone; (3) shifts between hospital and outpatient care, upcoding, or unbundling; (4) identification of specific types of care and services that are overused; (5) the impact on beneficiary out-of-pocket costs; (6) the impact on Medicaid use; (7) any shift between Original Medicare and Medicare Advantage; and (8) the impact of increased non-compliance with treatment and follow up recommendations for chronically ill patients due to changes in Medigap coverage.

It is unclear how many of these factors were considered in the CBO estimates. Nevertheless, the actuarial assumptions used for these revenues estimates should be thoroughly examined and reviewed in order for policymakers to have confidence in their decisions using these estimates.

²⁰ See Rand study.

²¹ See Swartz study and Trivedi study which question the long term financial impact of these types of cost sharing measures.

²² CMS website, Part B Physician/Supplier National Data, Calendar Year 2009.

d. Application of Medicare Supplement Coverage Reductions to In Force Business

The magnitude of the CBO scores suggests that the policy options affecting Medigap would apply to all Medigap beneficiaries. This raises questions about the consequences of retroactive changes to in-force guaranteed renewable Medigap coverage.

Federal and state law mandates that Medigap insurance is "guaranteed renewable." This ensures that seniors can keep their existing benefits, the benefits they chose and have paid for, in force by simply continuing to pay their premiums on time. Because guaranteed renewability is a fundamental aspect of the law and the information seniors have received during the last twenty years, there is an understanding, expectation, and contractual security among seniors (and caretaker children of Medigap beneficiaries) that their Medigap benefits will not change. Further, the first dollar coverage contained in Medigap policies today has been factored into the premium payments charged to and paid by current enrollees. These are just some of the reasons why any changes to Medigap benefits have always been made prospectively and have never been applied to in-force policies. The abrupt altering of Medigap cost sharing for in-force policies would cause a major market disruption and create serious confusion for and harm to seniors, particularly the very elderly.

As Medigap insurance product changes were mandated by federal law over the past several years, Medicare eligible beneficiary education was created to provide important information to Medicare eligible consumers, including counselors at both the state and federal levels to help seniors understand the new provisions. Federal and state resources would have to be dedicated to communicate these unprecedented changes to people who have consistently been told their benefits will not change. Even if communicated clearly, significant increases in out-of-pocket health care costs for an economically vulnerable population could be expected to provoke high levels of anxiety and anger by and on behalf of seniors. Medigap policyholders will look to their state insurance regulators for assistance and to their congressional representatives for answers when they find out that the guaranteed renewability provisions of their Medigap policies have not been honored.

This would not be the only message that is counter to what seniors have consistently received in the past. For many years, state and federal sources of health information have emphasized the value of controlling chronic conditions and patient compliance with medical instructions. Medigap helps seniors afford treatment for chronic conditions, avoiding unpredictable, potentially great costs for acute care.

As noted earlier, by contract, Medigap policies are secondary coverage that pay cost sharing for items and services that Medicare itself has already determined to be allowable, covered benefits. As a result, the proposed changes to Medigap coverage will impact cost sharing for benefits Medicare allows as "medically necessary" and appropriate care. The level of changes contemplated to Medigap cost sharing in the various budget proposals would inevitably impact use of necessary services for economically vulnerable seniors.

Traditional Medicare's fee-for-service cost sharing requirements are not insignificant. Medigap is instrumental in allowing beneficiaries to continue accessing their fee-for-service Medicare benefits by budgeting for their medical expenses in a predictable manner. Millions of beneficiaries do not have access to other supplemental coverage options, such as employer-sponsored supplemental coverage and Medicaid. These beneficiaries should not face higher hurdles in accessing Medicare coverage, and they should continue to have access to affordable, comprehensive Medigap options.

Although Medicare provides many preventive services free of beneficiary cost sharing, these services are often prescribed during office or clinic visits for which there is cost sharing. Thus seniors may not know about preventive services they should be receiving for which there is no out-of-pocket cost.

Almost inevitably, these changes to existing contracts would create an atmosphere of anger, anxiety and frustration that could encourage litigation by seniors and their advocates, and possibly even insurers and regulators. This is particularly true if seniors feel the changes were unfair because they violate the previous understanding that Medigap benefits are guaranteed for life.

Retroactive changes to in-force contracts would raise fundamental legal issues for insurers and regulators, such as premium refund questions, and how to pay claims submitted to and processed by Medicare in accordance with the changes, where services were received before the changes. The potential legal issues include Constitutional questions regarding impairment of contracts and whether reducing the value of guaranteed renewable Medigap benefits would be a “taking” compensable under due process principles.

e. The Role of Medicare as Primary Payer

The essential fact that Medigap policies pay benefits only after Medicare has made payment is not often highlighted in policy research regarding Medicare utilization. If Medicare authorizes payment for a claim then, by law, Medigap policies must provide payment for those covered and allowed benefits. The determination of medical necessity and appropriateness of care for items and services rendered to Medicare beneficiaries is made solely by the Medicare program through its administrators and fiscal intermediaries.

Section 1862(a)(1)(A) of the Social Security Act states that Medicare may not provide payment for items and services unless they are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part. Medigap carriers cannot, under federal law, make a separate determination of medical necessity or reasonableness. Medigap coverage for Medicare beneficiaries is based upon Medicare’s benefit determination.

Consequently, concerns with overutilization of services by beneficiaries with Medigap coverage ties back to Medicare's determination to allow coverage for a claimed service. However, most of the reported research has focused on the "effect" of Medigap coverage on medical service utilization by Medicare beneficiaries, without appropriately acknowledging the responsibility of Medicare in making the underlying coverage decisions.

As is detailed above, the literature does not reach consensus on the impact of Medigap coverage on Medicare expenditures. In studies commissioned by MedPAC²³, findings support the theory that Medicare beneficiaries who have more generous supplemental coverage are more likely to obtain medical services than those with less generous supplemental coverage or without coverage. This finding also has been supported by studies that have, on occasion, included other supplemental coverages as well as those focused on individuals who have non-supplemental private coverage.

Other studies have reached different conclusions. The Robert Wood Johnson Foundation (RWJF) report recently found that once medical services are sought, the intensity of medical services is driven by the medical provider and not by the patient²⁴. Further, the RWJF study found that patients are not able to discern between appropriate and inappropriate care in response to increased cost sharing. Both the RWJF

²³ *Medicare and the Health Delivery System*, MedPAC Report to Congress, June 2009, pages 146-150 and June, 2011, pages 75-78.

²⁴ Swartz, pages 24-26.

report and a recent study published in the New England Journal of Medicine determined that increased cost sharing by Medicare plans may shift the types of services rather than reduce overall expenditures²⁵. Additionally, particularly with vulnerable, older populations, forgoing early care could result in increased hospitalizations and, ultimately, greater cost to the Medicare program.

As stated previously, the focus on utilization by Medicare beneficiaries must be directed to the coverage first and foremost on policies and decisions of the Medicare program, as well as provider payment incentives and fraud. This is the logical conclusion when faced with the fact that Medicare, as primary payer, determines whether a claim for care is covered. And, this conclusion is further bolstered by a recent study by the National Bureau of Economic Research which found that eligibility for the Medicare program, itself, accounts for an increase in medical utilization.²⁶

f. Summary and Conclusion of Section III

Recent policy discussions looking for ways to reduce the growth in Medicare spending have focused on Medigap, among other things. Some proposals would require increased cost sharing for Medigap policyholders or an outright prohibition of first-dollar coverage to discourage the so-called inappropriate use of Medicare benefits on the questionable theory that first-dollar coverage in Medigap encourages Medicare beneficiaries to overutilize Medicare covered services. Some proposals explicitly limit what and how much Medigap policies could cover. Others would require those holding the most generous Medigap policies to pay either a surcharge on their Medicare Part B premium or an excise tax on their Medigap premium in certain circumstances.

We all agree that the Medicare program itself is in a difficult financial position and general health care cost growth is on an unsustainable path. Medicare's general fiscal problems cannot be solved by changing Medigap. To that end, substantially changing Medigap's benefit structure at the expense of Medicare beneficiaries is not a viable or acceptable solution to addressing Medicare's fiscal problems.

This paper shows that some of the fiscal estimates used by policymakers lack documentation and are not transparent for peer review. In addition, some of the assumptions made in coming up with alternatives for Medigap failed to consider important potential outcomes such as foregoing needed services resulting in greater Medicare costs later on. The basis for overutilization failed to take into account that demand is really driven by health care providers, not the beneficiaries, once a beneficiary becomes sick or is injured and visits a medical provider. There has been little discussion on Medicare's claim adjudication role regarding overutilization and the failure of Medicare properly enforcing its prudent and reasonable standards in assessing claim submissions, especially under Part B. Finally, a major study used in targeting Medigap is a twenty-nine year old study of the impact of cost sharing on utilization by the general population, a study that did not adjust for the Medicare population in its conclusions.

The impact of the Medigap proposals on reducing Medicare spending is not well known, and may vary with design. Research suggests that decreasing use of some services among older populations, generally less costly services, can result in increased use of other services later on. Research does indicate the changes will most affect those with low or modest incomes, those who are sickest, those who live in rural areas of the country, and those with chronic conditions who need regular care. Additional cost sharing may

²⁵ Trivedi.

²⁶ *Does Health Insurance Affect Health Care Utilization and Health*, National Bureau of Economic Research extract, August 2011.

lead such beneficiaries to avoid needed care because they are unable to afford it, exacerbating their health problems and increasing Medicare spending. We believe that Medicare beneficiaries do not necessarily distinguish well between care that is beneficial and care that is not. Once they seek care, they rely on the recommendations of their providers.

The focus on Medigap as driving unnecessary use of Medicare benefits fails to fully recognize that Medigap coverage is secondary. This suggests that the response to the concern that people with Medigap are overusing Medicare benefits should examine ways to ensure that Medicare is incenting and paying for appropriate care, and not simply rely on discouraging use of care by making beneficiaries pay more of the cost. In a very real sense, they have already paid for these costs through their Medicare Part A and Part B premiums along with their Medigap premiums.

Past changes to Medigap policy standards have been made prospectively, because the existing contracts are guaranteed renewable. The application of changes to all Medigap policies raises contractual issues in light of current law.

IV. Recommendations

Medicare supplement insurance (Medigap) has been a valuable and meaningful product to millions of Medicare beneficiaries who tend to be low-income and unhealthy. It provides financial protection and predictability to a vulnerable population in case of serious illness or injury by filling the substantial gaps in coverage of the traditional Medicare program. Those Medicare beneficiaries who purchase Medigap coverage pay a substantial premium for this peace of mind.

For the reasons outlined in this paper, the Subgroup recommends:

1. The underlying data and assumptions used by the Administration, Congress and the Congressional Budget Office in formulating their Medigap alternatives be made public so that they can be reviewed by other actuarial and subject-matter experts to ensure a transparent and thorough debate about the proposals.
2. If there are any changes in Medigap benefits they should be carefully tailored and should only be applied prospectively.
3. In considering benefit changes, consideration should be given to the potential adverse impact on vulnerable Medicare beneficiaries, especially those in rural areas and other parts of the country where provider access is limited and incomes are relatively low, so that the value of the product is not drastically reduced for this population.
4. That the improper utilization of Medicare covered services be addressed by reviewing, adjusting and implementing the Medicare program's policies and procedures that determine whether a covered service is to be paid by Medicare and therefore covered by Medigap.
5. If Medigap restructuring is determined to be necessary, that the existing process for developing and implementing changes to Medigap benefit design where input from federal and state regulators, consumer advocates, industry, trade representatives and other

interested parties with knowledge and experience of Medicare and Medicare supplement insurance is solicited be continued.

The members of the Subgroup stand ready to assist in any policy discussions that the NAIC wishes to have on this important topic.

Appendix

Federal Medigap First-Dollar Coverage Proposals

(Updated September 26, 2011)

Proposal	Background	Recommendations
<p><i>President Barack Obama's Deficit Reduction Plan (Sept. 2011)</i></p>	<p>The President's deficit reductions plan includes an estimated \$248 billion in savings from changes to Medicare.</p>	<p>This plan includes the following proposals:</p> <ul style="list-style-type: none"> • Introduce a Part B premium surcharge for new beneficiaries that purchase Medigap policies with low cost-sharing requirements, beginning in 2017. (Estimated savings of \$2.5 billion over 10 years) • Increase premiums for Medicare Parts B and D for higher income beneficiaries, beginning in 2017. (Estimated savings of \$20 billion over 10 years) • Modify Part B deductible for new beneficiaries to apply a \$25 increase in 2017, 2019, and 2021 for new beneficiaries. (Estimated savings of \$1 billion over 10 years) • Introduce home health co-payments for new beneficiaries beginning in 2017 of \$100 per home health episode²⁷ (Estimated savings of \$400 million over 10 years) • Adopt prior authorization for the most expensive imaging services, beginning in 2013 (Estimated savings of \$900 million over 10 years)
<p><i>Senator Tom Coburn (R-OK) (July 2011)</i></p>	<p>Senator Coburn's proposal to reduce the federal deficit by \$9 trillion over 10 years includes changes to Medicare and Medigap.</p>	<p>This proposal includes the following:</p> <ul style="list-style-type: none"> • Phase in an increase for Medicare eligibility to age 67, and then index eligibility to life expectancy, reaching 69 in 2080 (Estimated savings of \$124 billion over 10 years). • Create a single combined annual deductible of \$550 for both Part A and Part B services with a 20% uniform coinsurance on spending above the deductible. Reduce coinsurance to 5% for costs in excess of \$5,500 and cap cost sharing at \$7,500 (when combined with bullet below, estimated savings of \$130 billion over 10 years). Raise cost-sharing maximum for higher-income individuals (Estimated savings of \$5 billion over 10 years). • Prohibit Medigap policies from covering any of the first \$550 of cost-sharing and limits coverage to 50% of the next \$5,000. • Phase-in increase of Part B premium paid by beneficiaries from 25% to 35% of program costs (Estimated savings of \$241 billion over 10 years). • Require beneficiaries with incomes exceeding \$150,000 (and couples above \$300,000) to pay the full premium costs under both the Part B and Part D (Estimated savings of \$21 billion over 10 years).

²⁷ Applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay.

Proposal	Background	Recommendations
<p>Senator Tom Coburn (R-OK) and Senator Joe Lieberman (I-CT) Proposal (June 2011)</p>	<p>Senators Coburn and Lieberman’s proposed changes to Medicare and Medigap to achieve an estimated \$600 billion in budget savings over ten years.</p>	<p>These proposed changes include:</p> <ul style="list-style-type: none"> • Increase the Medicare eligibility age from 65 to 67 over a 5-year period. (Estimated savings of \$124 billion over 10 years). • Create a single combined annual deductible of \$550 for both Part A and Part B services and an annual cap on out-of-pocket costs of \$7,500 (when combined with bullet below, \$130 billion over 10 years). Set the annual cap at higher levels for individuals with incomes exceeding \$85,000 and for couples with incomes exceeding \$170,000 (Estimated savings of \$10 billion over 10 years). • Prohibit Medigap policies from covering any of the first \$550 of cost-sharing and limit coverage to no more than ½ of the remaining coinsurance. • Increase the Part B premiums paid by beneficiaries from 25% to 35% of program costs. This proposal would be phased in over a 5-year period (Estimated savings of \$241 billion over 10 years). <ul style="list-style-type: none"> – Require beneficiaries with incomes exceeding \$150,000 (and couples above \$300,000) to pay the full premium costs under both the Part B and Part D (Estimated savings of \$19 billion over 10 years).
<p>Senator Joe Lieberman (I-CT) Proposal (June 2011)</p>	<p>Senator Lieberman published an Opinion Editorial in the Washington Post on changes to the Medicare program.</p>	<p>Senator Lieberman’s proposal includes:</p> <ul style="list-style-type: none"> • Raise the Medicare eligibility age by 2 months annually, starting in 2014, until it reaches 67 by 2025. • Combine the Medicare Part A and Part B deductibles. • Require a co-payment on all Medicare services. • Add a maximum out-of-pocket benefit. • Raise the premiums for all new enrollees in Part B and part D starting in 2014 to 35 percent of program costs (current level is 25 percent). • Reform the way Medigap policies work.
<p>Medicare Payment Advisory Commission (MedPAC) Report (June 2011)</p>	<p>The Medicare Payment Advisory Commission’s (MedPAC) June 2011 Report to Congress built on previous MedPAC recommendations to reform Medicare’s design payment system, while also redefining the role of supplemental coverage.</p>	<p>The MedPAC report includes the following proposals:</p> <ul style="list-style-type: none"> • Cap beneficiary out-of-pocket costs. • Combine the Medicare Part A and Part B deductibles. • Create incentives to use providers for specific services or procedures. • Prohibit Medicare supplement insurance from providing first-dollar coverage [e.g., bar payment of the first \$550 of cost-sharing, limit coverage to 50% of the next \$4950 of cost-sharing with all further cost sharing covered by the policy (\$5 billion)]. • Require beneficiaries to pay a fixed-dollar copayment for certain services (e.g., office visits and emergency room use), with exceptions provided in certain circumstances (e.g., low-income beneficiaries and/or better health outcomes). • Impose an excise tax on insurers that offer the most complete coverage – i.e., supplemental policies that fill in most of Medicare’s cost-sharing.

Proposal	Background	Recommendations
<p><i>Congressional Budget Office (CBO) Budget Options Report (March 2011)</i></p>	<p>CBO's March 10, 2011 Report outlined a range of policy options for reducing the federal budget deficit.</p>	<p>The report includes the following proposals:</p> <ul style="list-style-type: none"> • Raise the Medicare eligibility age to 67 (\$124.8 billion). • Change Medicare and Medigap's cost-sharing structure: <ul style="list-style-type: none"> – Option One: Replace the current structure, beginning in 2013, with a single combined deductible of \$550, a uniform coinsurance rate of 20% for amounts above the deductible and an annual out-of-pocket cap of \$5,500 (Estimated savings of \$32 billion over 10 years). – Option Two: Bar Medigap policies, beginning in 2013, from paying any of the first \$550 of an enrollee's cost-sharing liabilities, limit coverage to 50% of the next \$4,950, with 100% coverage thereafter (Estimated savings of \$53.4 billion over 10 years).²⁸ – Option Three: Bar Medigap policies, beginning in 2013, from covering any of the \$550 combined deductible and require beneficiaries to pay a 10% coinsurance for all services until the \$5,500 out-of-pocket cap is reached (Estimated savings of \$93 billion over 10 years).²⁹ • Impose copayments under Medicare for the first 20 days in a skilled nursing facility (Estimated savings of \$21.3 billion over 10 years) and for home health care (Estimated savings of \$40.1 billion over 10 years). • Increase the Medicare Part B premium from 25 percent to 35 percent of the program's cost (Estimated savings of \$241.2 billion over 10 years). • Increase the payroll tax for Medicare hospital insurance to 3.95% (Estimated savings of \$651 billion over 10 years).
<p><i>National Commission on Fiscal Responsibility and Reform 2010 Commission Report (December 2010)</i></p>	<p>The Commission outlined its plan for achieving deficit reduction and addressing the nation's long-term fiscal challenges.³⁰</p>	<p>The Commission report includes the following:</p> <ul style="list-style-type: none"> • Establish a single combined Part A and Part B deductible of \$550, along with 20 percent coinsurance on health spending above the deductible (Estimated savings of \$10 billion in 2015 and \$110 billion through 2020). • Provide catastrophic protection for seniors by reducing the coinsurance rate to 5 percent after costs exceed \$5,500 and cap total out-of-pocket cost-sharing at \$7,500 (savings included in above estimates). • Prohibit Medigap plans from covering the first \$500 of an enrollee's cost-sharing liabilities and limit coverage to 50 percent of the next \$5,000 in Medicare cost-sharing (Estimated savings of \$4 billion in 2015 and \$38 billion through 2020).³¹

²⁸ All further cost-sharing would be covered by the Medigap policy, so enrollees in such policies would not pay more than about \$3,025 in cost-sharing in that year.

²⁹ Under this option, the level of beneficiary spending at which the Medigap policy's cap on out-of-pocket costs was reached would be equal to the level at which the Medicare program's cap was reached. For spending between the deductible and the out-of-pocket cap, Medigap policyholders would face a uniform coinsurance rate of 10% for all service; Medicare beneficiaries without other types of supplemental coverage would face a uniform coinsurance rate of 20% on all services.

³⁰ The Commission did not officially approve the report.

³¹ The Commission also recommends similar treatment of TRICARE coverage, as well as coverage for federal retirees and for private employer-covered retirees.