



Medicare Costs and People with Supplemental Coverage

NAIC Senior Issues Task Force

Medigap PPACA (B) Subgroup

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California Health Advocates and its members have extensive experience with Medicare beneficiaries and their Medicare coverage, as well as other health benefits provided by retiree plans, the Veterans Administration, Medicaid, and Medicare Supplement insurance (Medigap). Our members and their counterparts in other states collectively counsel and assist millions of Medicare beneficiaries each year.

The Senior Issues Task Force has a charge to review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law. The NAIC, in preparation for a request from the U.S. Department of Health and Human Services (HHS) is taking on the task of developing nominal cost sharing for Medigap plans C and F effective in 2015 as outlined in federal law.¹ This directive in federal law is based on the notion that the introduction of cost sharing in these two Medigap plans will encourage Medicare beneficiaries to be more cost conscious when using Medicare services. The Senior Issues Task Force has formed a subgroup and a statutory working group to begin work on this task. We respectfully request that all parties carefully consider the impact of *any* cost sharing added to Medigap plans C and F, and the effect it may have on Medicare beneficiaries needing necessary medical care.

We cannot find any studies that examine the nature of any increased spending that appears to result from having supplemental coverage. Contrary to studies being used to promote increased cost sharing in Medigap policies, we are not convinced that the mere fact of having supplemental coverage drives unnecessary care thereby increasing Medicare's costs. Instead, we believe that increasing out-of-pocket costs for Medicare beneficiaries will more likely result in short term savings to Medigap issuers paying less supplementary costs, and in the longer term increase Medicare expenditures if beneficiaries delay or skip getting necessary care to avoid paying out of pocket costs.²

¹ H.R. 3590, the Patient Protection and Affordable Care Act, Sec. 3210, Development of New Standards for Certain Medigap Plans.

² Chandra, Amitabh, Gruber, and McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review* 2010, 100:1, 193–213, available at <http://www.aeaweb.org/articles.php?doi=10.1257/aer.100.1.193>

Studies that have been used to promote greater cost sharing in Medigap policies include supplemental coverage from sources in addition to Medicare, such as retiree plans, and Medicaid benefits that can be more difficult to use than private health insurance or Medicare. If as some studies suggest, Medicare beneficiaries with any kind of supplemental coverage are receiving “unnecessary” medical care services that determination should have been made, and the claim denied, by the contractors paying Medicare Part A or Part B claims.

Medigap policies, and other forms of supplemental coverage, only pay benefits *after* payment has been made by Medicare, therefore any determination about the medical necessity of care has already been made by the Medicare program. Medigap carriers cannot under federal law make a separate determination of medical necessity, unlike other forms of supplemental coverage. If Medicare pays a claim then by law the Medigap plan must pay its covered benefits, and it must do so based on Medicare payment data transmitted to it.

As medical care costs have grown, Medicare along with other health benefits programs has experienced increased demand for services and increased spending. While studies may show higher use of medical benefits for people with supplementary coverage there hasn't been much research into why that may be the case. Nor have any studies been done to determine if the greater use of Medicare covered services produces better long term outcomes, or whether the services were worth the extra cost or not. Without that data it's hard to argue that supplementary coverage in general, and Medigap policies in particular, drive demand for unnecessary medical services.

One reason Medicare costs may be higher for this group is that people with supplementary benefits may feel protected enough to get care early and therefore have better health outcomes as a result. Another is that people who buy a Medigap may anticipate future health conditions based on their knowledge of their family histories or their own physical problems and investigate symptoms earlier than they might do otherwise, or take greater advantage of preventive care services. However, just because beneficiaries with supplemental coverage use more services should not inevitably lead to a conclusion that their care was unnecessary.

All Medigap plans pay Medicare's 20% coinsurance costs for Part B, and the vast majority of Part B claims are assigned. Therefore the only patient payment responsibility for Part B services in most Medigap plans is the Part B deductible. Medigap plans C and F however include benefits for the Part B deductible along with benefits for the Part A deductible and the nursing home copayment, as do many of the 10 plans. Plan F adds a benefit for Part B excess charges, which most providers do not charge since the majority of Part B claims are assigned.³ Premiums for plans C and F differ slightly but are very similar in cost.

The majority of Medigap purchasers are clustered in plans C and F. This has been true since Medigap policies were first standardized in 1992 and continues to be true today.

³ MedPAC's March 2010 "Report to the Congress: Medicare Payment Policy," Section 2B

Congress has taken a number of steps to introduce greater cost sharing in Medigap plans. Yet beneficiaries have consistently resisted those efforts and continue to buy and remain in these 2 plans, despite other choices that have been added during the last 15 years.

History of Cost Sharing In Medigap

Cost sharing in Medigap policies was first introduced as part of the Balanced Budget Act of 1997.⁴

High Deductible Riders in Medigap Plans F and J (1997)

These high deductible riders require the insured person to pay the full cost of the plan's covered benefits until an annual deductible has been met. Once the deductible has been met (\$2,000 in 2011) the plan begins paying its share of those costs. The deductible amount is indexed for inflation and goes up each year.

While surveying one zip code in California, I found 8 companies offering a high deductible plan F out of 28 companies selling Medigaps in that region.⁵ I looked at premiums for someone age 70 because typically the lowest rates are at age 65 for the first five years, and highest after age 80. Rates at age 70 are more typical of the cost of these plans. Premiums for a high deductible plan F for someone age 70 in California can be as low as \$435 annually to a high of \$903. The premium plus the first \$2,000 of expenses makes these plans fairly expensive.

Each of those 8 companies also offers a plan F *without* the high deductible rider for the lowest annual cost of \$1,811 to the highest of \$3,216. However, in the general marketplace the difference in premiums between high deductible rider plans and the plans with no high deductible rider is often not great enough to entice someone to take on the first \$2,000 in expenses. For example, a 70 year old can find a standard plan F *without* the high deductible rider for as low as \$1,536 annually from one of the companies selling it, and without the economic liability for the first \$2,000 of out of pocket costs.

Medigap Plans K and L (2003)

Because only a few companies offered the high deductible option, and very few people bought it, Congress introduced plans K and L in 2003, splitting certain covered costs between the beneficiary and the Medigap plan. Both plans K and L pay a certain percentage (50% or 75% of covered costs) and each plan has an annual out-of-pocket limit of \$4,640 for plan K, and \$2,320 for plan L (in 2011). The insured person pays their share of each covered cost until the maximum annual limit is reached. Once the annual limit has been reached, each plan pays 100% of all covered costs for the remainder of that year.

⁴ The high deductible rider to plan J disappeared in 2010 along with Plan J. Plan F can still be sold with a high deductible rider.

⁵ Data is from the California Department of Insurance website. Medigap rates are for a 70 year old in a specific zip code. Available at: <http://www.insurance.ca.gov/0100-consumers/0050-information-guides/0050-health/medicare-supplement/index.cfm>

For example, in the California zip code I surveyed only 3 companies offer plan K. Premiums for that plan range from a low of \$670 to a high of \$800 annually. Five companies offer plan L with premiums ranging from a low of \$1,138 to a high of \$1,563 annually. Neither plan has statically significant numbers of covered lives nationally.⁶

Medigap Plans M and N (2010)

Congress added plans M and N to the standardized plans effective June 1, 2010, each with another method of cost sharing. These two plans split the cost sharing for specific services between the Medigap plan and the insured person.

Plan M pays half of the Part A inpatient hospital deductible and does not cover the Part B deductible or excess charges.

Plan N introduces a new cost sharing structure by requiring the insured person to pay up to \$20 for every office visit from any health care provider authorized to bill for one, and up to a \$50 copayment for emergency room visits when the insured person is not admitted to a hospital as an inpatient under Medicare Part A. Plan N does not cover the Part B deductible or excess charges.

For example, in the California's zip code I surveyed only two companies offer plan M with annual premiums of \$1401 and \$1570 respectively, and 8 companies offer plan N with annual premiums ranging from a low of \$1,070 to a high of \$2,166. It's too early to know how many beneficiaries will decide to enroll in these two plans.⁷

It will be several years before there will credible data to show if Medicare beneficiaries are any more disposed to pay the cost sharing in plans M or N, and if there is a meaningful difference in premium cost as the experience begins to develop for each plan.

Fear of Medical Impoverishment

Medicare is the primary payer of medical care for beneficiaries and there is no annual limit on out of pocket costs for Part A or Part B in original Medicare's fee-for-service program. Medicare beneficiaries are typically living on fixed incomes with finite assets that must last them the rest of their lives, and are especially sensitive to the cost of medical care that can potentially deplete their assets and leave them penniless. Fear of impoverishment is at the root of many decisions seniors make, and once a decision has been made any attempt to change it is often viewed with suspicion. Thus, there are still sizable numbers of Medicare beneficiaries who have kept their pre-standardized Medigap policies issued prior to 1992, many of whom believe they have better benefits and are willing to pay more to keep them.

⁶ Reforming Medicare's fee-for-service benefit design, Sokolovsky, Lee and Harrison, presented to MedPac February 23, 2011

⁷ Experience data is reported by companies annually to the NAIC and/or states. Enrollment numbers for plans M and N will develop over time..

Medical insurance is a product that seniors take seriously, and they will often make adjustments in their standard of living to accommodate increased costs and assuage their fears of medical impoverishment. Medicare beneficiaries have been very clear in their preference for comprehensive coverage of their Medicare out of pocket costs for two decades.

Many want the certainty of budgeting their health care expenses on a monthly basis with a fixed premium and no copayments, some because they travel and want the flexibility of getting health care services from any Medicare provider where they may be traveling. Others have a serious medical condition and know their total out of pocket costs will be less with the combination of Medicare and a Medigap policy or retiree plan.

Some have tried other types of coverage and found that the combination of a lower premium and required copayments during a plan year totaled more than the premium for a Medigap policy without cost sharing. And most Medicare beneficiaries are averse to any financial uncertainty that might be caused by unexpected medical expenses.

Conclusion

There are several variations of cost sharing Medigap plans available to Medicare beneficiaries to choose from today. Four of the 10 plans offer cost sharing in several different ways, and a high deductible rider can be purchased and added to another plan. Only one of the ten plans eliminates all cost sharing. As the subgroup moves forward to consider recommendations to change the cost sharing in the two most popular plans we hope those changes will be very nominal, allowing Medicare beneficiaries to continue to choose the most comprehensive plan for their needs.

Respectively submitted,

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