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Medicare Policy

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE BRIEF

MEDIGAP REFORM: SETTING THE CONTEXT

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Introduction

Policymakers and stakeholders have been focusing on a wide range of options to inform the national debt reduction debate, including proposals that would slow the growth in Medicare spending by reforming the current Medicare supplemental insurance (Medigap) market. Because of Medicare's relatively high cost-sharing requirements, 90 percent of all beneficiaries have some source of supplemental coverage, including 9 million Medicare beneficiaries who purchase Medigap. Beneficiaries with Medigap tend to include those without access to a relatively comprehensive employer-sponsored retiree health plan, those not poor enough to qualify for Medicaid to supplement Medicare, and those who choose fee-for-service Medicare rather than a Medicare Advantage plan.[1] Medigap policies help shield beneficiaries from sudden, relatively high out-of-pocket costs due to an unpredictable high-cost medical event, and also allow beneficiaries to more accurately budget their health care expenses, which is important to a population living on fixed incomes.

On September 19, 2011, as part of his deficit reduction proposal, President Obama recommended charging a 30 percent surcharge on Part B premiums to new beneficiaries that purchase Medigap policies with "near first-dollar" coverage, beginning in 2017.[2] The Office of Management and Budget (OMB) estimates this proposal would save approximately $2.5 billion over 10 years. Current beneficiaries, and individuals who become eligible for Medicare prior to 2017, would not be subject to the premium surcharge. In addition, other Medigap reform proposals have also received some attention in the context of the debt debate. One such proposal, described by the Congressional Budget Office (CBO) in its 2011 report *Reducing the Deficit: Spending and Revenue Options*, and a similar policy included in the recommendations of the National Commission on Fiscal Responsibility and Reform (also known as the Bowles-Simpson Commission),[3] would bar Medigap policies from paying the first $550 in cost-sharing liability and limit coverage to 50 percent of the next $4,950 before the plan could cover 100 percent of beneficiaries' out-of-pocket costs.[4] CBO estimates this policy would achieve $53.4 billion in savings over 10 years, if implemented in 2013. An alternate approach, described by CBO in its 2008 report *Budget Options, Volume 1: Health Care*, and would impose a 5 percent excise tax on all Medigap insurers, with estimated savings of $12.1 billion over ten years.[5]

Policy proposals that discourage first dollar coverage are motivated by several studies that find most (but not all) Medicare beneficiaries with Medigap use more Medicare-covered services and incur higher Medicare costs than beneficiaries without supplemental coverage.[6] For example, a 2009 study from the Medicare Payment Advisory Commission (MedPAC) showed that spending for Medicare beneficiaries with Medigap policies was 33 percent higher than for beneficiaries without supplemental coverage.[7] Prohibiting first dollar Medigap coverage is therefore expected to reduce Medicare spending and beneficiary spending, because exposure to higher cost-sharing requirements would lead enrollees to use fewer health care services.[8] These studies are consistent with numerous studies that show individuals use fewer services – both necessary and unnecessary – when confronted with new cost-sharing requirements.[9]

This policy brief provides new data to inform current policy discussions pertaining to Medigap, including national and state-level data on enrollment and average premiums by plan type, with particular attention to plans C and F that provide "first dollar" coverage, with full payment of both Part A and Part B deductibles, and the 20 percent coinsurance for physician and other services (and excess charges in the case of plan F), along with other benefits.[10] However, we recognize that first dollar coverage could be defined to include other plans (e.g., those

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plans that pay 20 percent of Part B coinsurance). The analysis of beneficiary characteristics with Medigap is based on the Medicare Current Beneficiary Survey Cost and Use File (2007). The analysis of enrollment and premiums nationally and by state is based on 2010 data from the National Association of Insurance Commissioners (NAIC) for all states except California, because the majority of health insurers in California do not report their data to the NAIC.[11] All premiums were weighted by plan enrollment in 2010.

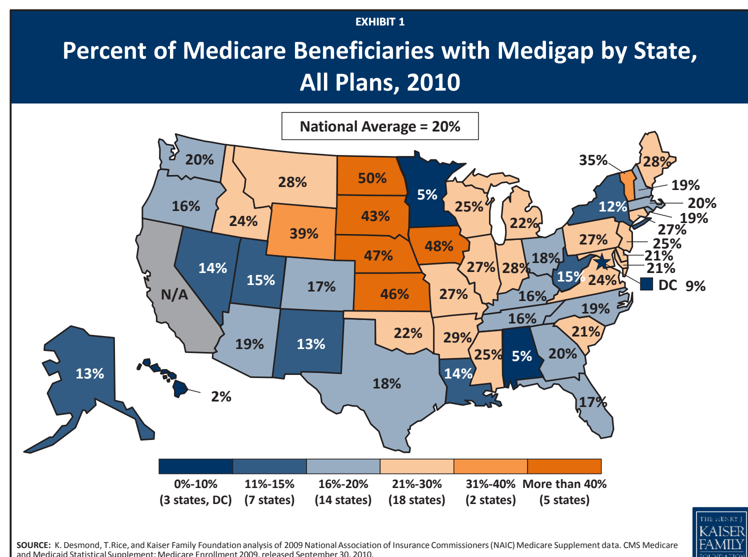
Background

Medicare provides broad protection against the costs of many health care services, but has relatively high cost-sharing requirements and significant gaps in coverage. The Medicare fee-for-service program has deductibles for Parts A (inpatient) and B (physician and outpatient) services, 20 percent coinsurance on most Part B services, coinsurance for inpatient hospital and skilled nursing facility stays exceeding 20 days, and no maximum on the amount beneficiaries could incur in out-of-pocket costs each year. As a result, most beneficiaries have some form of supplemental coverage. Many beneficiaries without access to relatively generous employer-sponsored retiree health plans or Medicaid purchase a Medigap policy to help make their health care costs more predictable, and vary less with the quantity or cost of health care services they actually receive; with Medigap plans, nearly all costs are absorbed by the premium, which is both known and typically paid in advance. Also, first dollar coverage allows beneficiaries to avoid nearly all Medicare-related paperwork. In most cases, there are no claims to check or bills to pay. This is especially important in a population that has a disproportionate number of people who suffer from cognitive impairments. However, even with Medigap, beneficiaries often incur significant out-of-pocket expenses for services that are not covered by Medicare (such as dental and long-term care) and for cost sharing associated with prescription drug coverage offered separately by Part D plans.

The Omnibus Budget Reconciliation Act (OBRA) of 1990 standardized benefits for Medigap plans in most states, such that all plans of the same letter are required to offer the same benefit package, in order to make plan benefits more transparent and allow beneficiaries to make more of an "apples to apples" comparison when comparing plans.[12,13] As of June 2010, Medicare beneficiaries can enroll in one of 10 plan types (**Table A1**). Other plan types, including plans E, H, I, and J, are not available for purchase by new policyholders, but existing policyholders can remain in these plans. Two Medigap plans – C and F – cover both the Part A and the Part B deductible, thus providing "first dollar" coverage for all Medicare-covered services.[14]

How Many Beneficiaries Have a Medigap Policy?

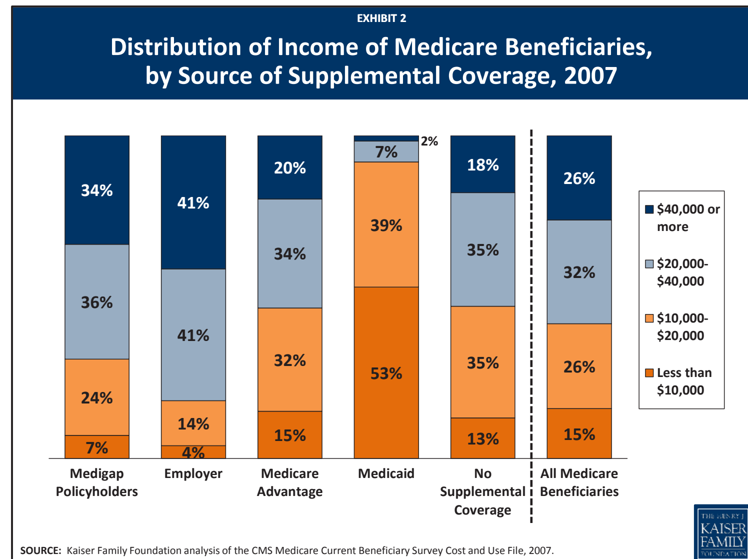
- One in five (20%) Medicare beneficiaries nationwide had a Medigap policy in 2010 (**Exhibit 1**). The share of all Medicare beneficiaries with a Medigap policy varies across states, ranging from 2 percent of beneficiaries in Hawaii to half of all beneficiaries in North Dakota (**Table A2**).



SOURCE: K. Desmond, T.Rice, and Kaiser Family Foundation analysis of 2009 National Association of Insurance Commissioners (NAIC) Medicare Supplement data. CMS Medicare and Medicaid Statistical Supplement: Medicare Enrollment 2009, released September 30, 2010.

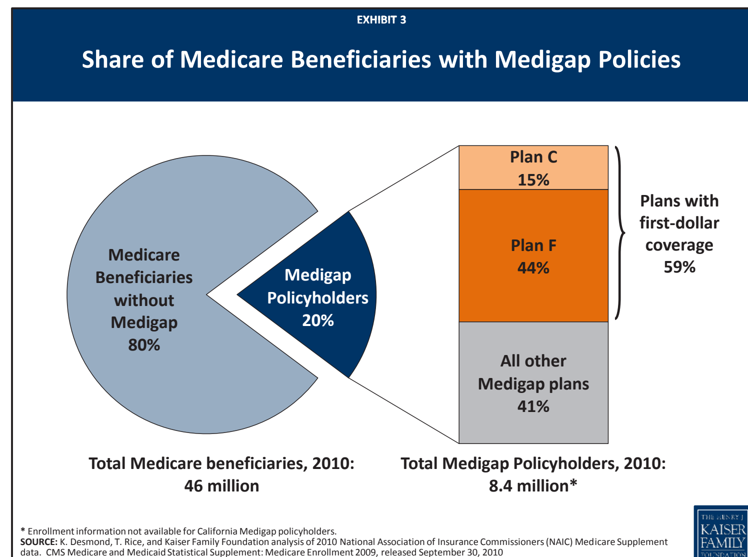
- About 3 million beneficiaries with a Medigap policy also have other forms of supplemental coverage, primarily employer-sponsored plans. Most beneficiaries who do not have a Medigap policy have other forms of supplemental coverage; about one-third have employer-sponsored insurance, about one-quarter have Medicare Advantage plans, and about one-fifth are dual eligibles and have Medicaid.

- Two-thirds (66 percent) of people with Medigap have incomes below $40,000. Nearly one-third (31%) of people with Medigap plans have incomes below $20,000 (**Exhibit 2**). Medigap policyholders have lower incomes than those with employer-sponsored supplemental coverage, but higher incomes than the total population of Medicare beneficiaries, which includes 9 million beneficiaries with low incomes who receive supplemental coverage under Medicaid (dual eligibles). Beneficiaries who purchase Medigap policies are also slightly more likely than others on Medicare to live in rural areas (28% versus 22%) and to be in relatively good health (80% versus 68%). Younger Medicare beneficiaries with disabilities are less likely than seniors to have Medigap because federal law does not require insurance companies to offer Medigap plans to disabled beneficiaries and because many of the under-65 disabled on Medicare qualify for Medicaid to supplement Medicare.

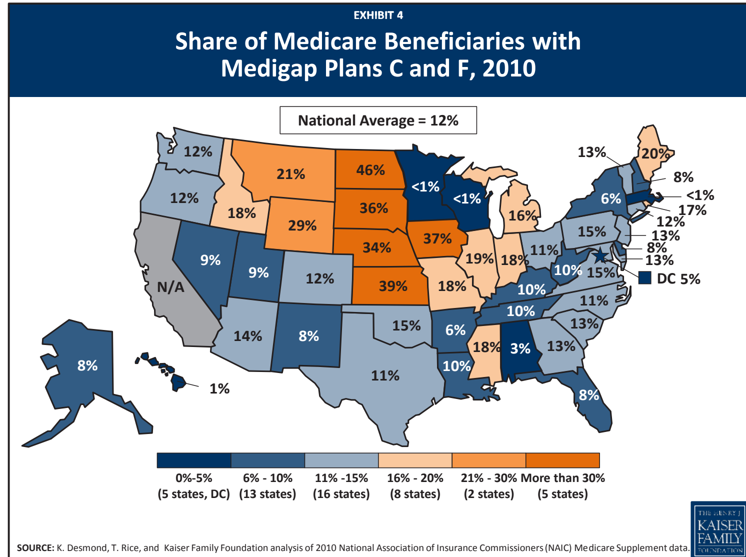


What Share of Medicare Beneficiaries Has a Medigap Plan with First Dollar Coverage?

- The majority of people with Medigap (59%) had first dollar coverage with either plan C or plan F in 2010 (15% and 44%, respectively; **Exhibit 3**). Eight percent of people with Medigap were in pre-standardized plans that were issued prior to the federal standardization of Medigap in 1992. Another 9 percent are in plan J, which is no longer available to new policyholders and included prescription drug coverage prior to the inception of the Medicare Part D prescription drug program in 2006. Plans M and N, established in June 2010, had more than 144,000 policyholders in 2010.

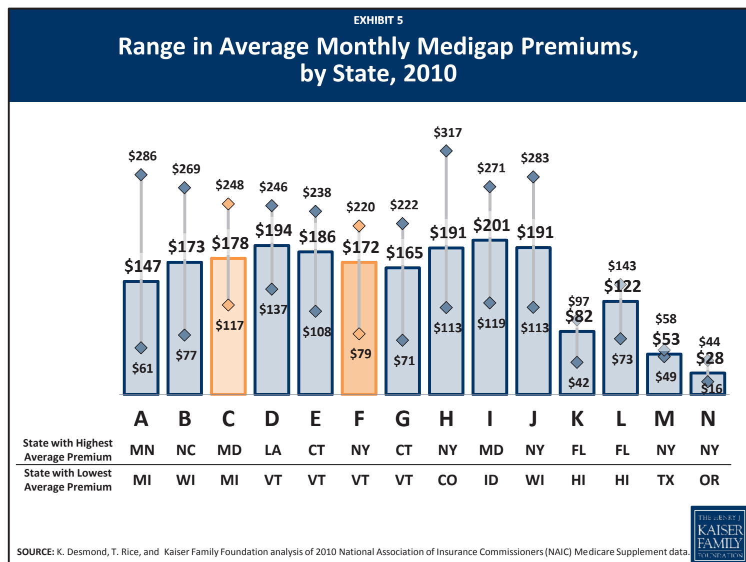


- The share of Medicare beneficiaries with Medigap plans C or F varies greatly by state (**Exhibit 4**). Nationwide, about 12 percent of Medicare beneficiaries had plans C or F in 2010. In 5 states, more than one-third of Medicare beneficiaries had Medigap plans C or F (IA, KS, ND, NE and SD), while in 4 states, less than 2 percent of beneficiaries had Medigap plans C or F (HI, MA, MN and WI).[15]
- In 29 states, more than half of the people with Medigap had plan F. In another two states, Rhode Island and Michigan, more than half of the people with Medigap had plan C.



How Much Do Beneficiaries Pay in Premiums for Medigap?

- People with Medigap paid an average of $178 per month in premiums for their policy in 2010, with wide variations across states and by plan type. Average premiums for plans C and F ($178 and $172, respectively) are very similar to the national average (**Exhibit 5**). On the whole, people with other types of Medigap plans paid slightly higher premiums ($184); however, some plans, particularly A, K and L, have much lower average premiums than C or F ($147, $82, and $122 per month, respectively, in 2010), but few Medicare beneficiaries have chosen to purchase these plans.



- Premiums for plans C and F vary greatly across states (**Table A2**). Average premiums for plan C range from $117 per month (Michigan) to $248 per month (Maryland) in 2010. For plan F, average premiums ranged from a low of $79 per month (Vermont) to more than $200 per month in New Jersey and New York ($206 and $220, respectively) in 2010. Despite having plan F premiums lower than the national average, only 3 percent of people with Medigap in Vermont chose to enroll in plan F and one-third of people with Medigap in Vermont instead chose to enroll in plan C, with average premiums of $171 per month.

Discussion

Almost since the Medicare program's inception, Medigap policies have been an important source of supplemental insurance for beneficiaries who do not have access to supplemental insurance through an employer, do not wish to enroll in a managed care plan, and do not qualify for Medicaid. The majority of all beneficiaries, 90 percent, have supplemental coverage of some kind, and about one in five beneficiaries rely on Medigap to supplement their Medicare coverage. The most popular Medigap plans – C and F – provide first dollar insurance by covering both the Part A and Part B deductibles, and fill in other cost-sharing requirements as well. Other plans that provide coverage of all coinsurance, or one of either deductible, could also be defined as first dollar coverage.

To help reduce Medicare spending in the context of current budget discussions, a number of policy proposals are under discussion that would discourage or prohibit beneficiaries from purchasing Medigap policies with first dollar coverage. The proposals differ with respect to their expected savings and their impact on beneficiaries, but each would be expected to decrease the use of Medicare-covered health care services by policyholders and thus reduce Medicare spending. The Administration has proposed charging an additional Part B premium to new beneficiaries with first-dollar Medigap coverage, which could discourage new beneficiaries from purchasing Medigap plans with first dollar coverage while grandfathering current beneficiaries. This would push new beneficiaries toward plans with higher cost-sharing requirements than many current Medigap policyholders face. With higher cost-sharing requirements, new beneficiaries would be expected to use fewer services, which would result in lower Medicare spending. To the extent that beneficiaries still elect to purchase Medigap plans with first dollar coverage, the higher Part B premiums they would pay would help to offset the additional Medicare spending they would be expected to incur with first dollar coverage. One proposal that would directly prohibit insurers from selling Medigap policies with first dollar coverage would almost surely result in the greatest reduction in utilization and Medicare spending by raising the effective price of Medicare-covered services to beneficiaries. Proposals that impose an excise tax per policy on all Medigap insurers would raise premiums on *all* Medigap plans, not just plans with first dollar coverage, to the extent that insurers pass along the tax to all of their Medigap policyholders. This approach would produce revenues and achieve savings for Medicare if higher premiums result in beneficiaries dropping their Medigap coverage or switching to a less expensive plan with higher cost-sharing requirements, resulting in lower use of services.

All of the proposals would have a disproportionate effect on beneficiaries living in states with the highest Medigap enrollment, which are the same states with high proportions of beneficiaries with first dollar Medigap coverage. In five Midwest or Plains states – Iowa, Kansas, Nebraska, North Dakota, and South Dakota – more than one-third of all Medicare beneficiaries own Medigap plans C or F, which provide first-dollar coverage. In addition, policies that impose a tax or a premium on insurers that offer first dollar coverage will have a disproportionately negative effect on Medigap policyholders living in states that have the highest premiums for plans C and F. Maryland, Louisiana, Texas, Illinois, and New Jersey have the highest premiums for plan C, while New York, New Jersey, Massachusetts, Florida, and Maryland have the highest premiums for plan F.

An important consideration moving forward is the way in which the new policy would be implemented and the extent to which the changes affect current policyholders. The Administration's proposal would exempt current beneficiaries and people who become eligible for Medicare before 2017. An alternative approach where Medigap policyholders were transitioned from their current plan to a new one would maximize savings but if done precipitously would give little opportunity for beneficiaries to make careful decisions about their coverage options, or for insurers to make needed changes to adapt to the new requirements. The NAIC has expressed some concern that the prohibition on first dollar coverage, if applied to current policyholders, would violate federal and state laws requiring guaranteed, renewable benefits. Striking a balance between maximizing federal savings and protecting Medicare beneficiaries will be critical and challenging as policymakers grapple with the dual issues of rising program costs and the national debt.

TABLE A1

Standard Medigap Plan Benefits, 2011

BENEFITS	MEDIGAP POLICY									
	A	B	C	D	F	G	K	L	M	N
Medicare Part A Coinsurance and all costs after hospital benefits are exhausted	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment for other than preventive services	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓*
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance or Copayment				✓		✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)*			✓	✓	✓	✓			✓	✓
Out-of-Pocket Limit							$4,620	$2,310		

NOTES: Check marks indicate 100 percent benefit coverage. Amount in table is the plan's coinsurance amount for each covered benefit after beneficiary pays deductibles or cost-sharing amounts, where applicable. *Plan N pays 100% of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits.
SOURCE: Centers for Medicare & Medicaid Services, 2011 Guide to Health Insurance, March 2011.

TABLE A2. Share of Medicare Beneficiaries with Medigap, and Average Medigap Premiums, By State, 2010

State	Medigap Policyholders, 2010	Share of Medicare beneficiaries with Medigap policy	Share of Medigap policyholders			Average Premium, weighted by enrollment		
			First Dollar Coverage		Other Medigap Plans	First Dollar Coverage		Other Medigap Plans
			Plan C	Plan F		Plan C	Plan F	
Alabama	37,061	5%	15%	51%	34%	$ 184	$ 160	$ 152
Alaska	7,921	13%	8%	54%	38%	$ 166	$ 148	$ 163
Arizona	160,180	19%	8%	68%	24%	$ 190	$ 156	$ 169
Arkansas	152,447	29%	2%	20%	78%	$ 210	$ 157	$ 167
California								
Colorado	104,208	17%	5%	64%	31%	$ 194	$ 171	$ 182
Connecticut	154,191	27%	12%	32%	57%	$ 214	$ 182	$ 164
Delaware	30,271	21%	8%	29%	63%	$ 185	$ 167	$ 192
District of Columbia	6,883	9%	9%	42%	49%	$ 220	$ 170	$ 171
Florida	556,607	17%	17%	29%	55%	$ 208	$ 193	$ 195
Georgia	238,366	20%	12%	55%	33%	$ 189	$ 165	$ 171
Hawaii	3,913	2%	11%	46%	43%	$ 147	$ 131	$ 144
Idaho	53,489	24%	5%	73%	22%	$ 184	$ 172	$ 153
Illinois	481,940	27%	4%	68%	28%	$ 222	$ 186	$ 198
Indiana	281,482	28%	7%	58%	35%	$ 214	$ 175	$ 184
Iowa	245,189	48%	2%	75%	23%	$ 215	$ 170	$ 171
Kansas	194,837	46%	11%	75%	14%	$ 196	$ 172	$ 193
Kentucky	121,181	16%	14%	48%	38%	$ 200	$ 165	$ 183
Louisiana	90,993	14%	4%	69%	26%	$ 236	$ 183	$ 187
Maine	74,336	28%	26%	43%	31%	$ 182	$ 150	$ 177
Maryland	164,198	21%	18%	46%	36%	$ 248	$ 193	$ 198
Massachusetts	210,571	20%	1%	1%	99%	$ 147	$ 194	$ 212
Michigan	355,525	22%	52%	22%	26%	$ 117	$ 155	$ 130
Minnesota	40,747	5%	1%	2%	98%	$ 157	$ 151	$ 198
Mississippi	119,475	25%	5%	70%	25%	$ 208	$ 172	$ 168
Missouri	265,084	27%	8%	59%	33%	$ 207	$ 173	$ 170
Montana	46,839	28%	16%	58%	26%	$ 175	$ 163	$ 174
Nebraska	129,723	47%	4%	69%	27%	$ 212	$ 187	$ 182
Nevada	46,338	14%	6%	59%	36%	$ 202	$ 172	$ 186
New Hampshire	41,002	19%	9%	35%	56%	$ 214	$ 174	$ 175
New Jersey	323,922	25%	33%	21%	46%	$ 222	$ 206	$ 193
New Mexico	39,945	13%	7%	56%	36%	$ 163	$ 158	$ 152
New York	341,677	12%	12%	42%	46%	$ 219	$ 220	$ 220
North Carolina	276,017	19%	9%	48%	44%	$ 214	$ 147	$ 200
North Dakota	53,084	50%	3%	91%	7%	$ 179	$ 155	$ 158
Ohio	341,674	18%	27%	34%	39%	$ 200	$ 166	$ 180
Oklahoma	131,830	22%	5%	65%	30%	$ 190	$ 165	$ 169
Oregon	98,292	16%	6%	69%	25%	$ 182	$ 143	$ 154
Pennsylvania	606,108	27%	47%	9%	44%	$ 140	$ 129	$ 158
Rhode Island	33,954	19%	77%	14%	9%	$ 168	$ 153	$ 168
South Carolina	158,903	21%	5%	56%	38%	$ 193	$ 165	$ 164
South Dakota	57,246	43%	2%	83%	15%	$ 188	$ 176	$ 181
Tennessee	164,313	16%	11%	51%	38%	$ 207	$ 160	$ 166
Texas	542,169	18%	6%	56%	38%	$ 225	$ 180	$ 188
Utah	40,920	15%	10%	50%	40%	$ 201	$ 167	$ 170
Vermont	38,157	35%	35%	3%	62%	$ 171	$ 79	$ 144
Virginia	264,460	24%	6%	56%	38%	$ 200	$ 149	$ 210
Washington	189,972	20%	8%	53%	38%	$ 180	$ 166	$ 183
West Virginia	56,665	15%	13%	55%	33%	$ 191	$ 164	$ 191
Wisconsin	222,406	25%	<1%	<1%	100%	$ 182	$ 172	$ 191
Wyoming	29,997	39%	8%	68%	23%	$ 171	$ 156	$ 165
US Total	**8,426,708**	**20%**	**15%**	**44%**	**41%**	**$ 178**	**$ 172**	**$ 184**

NOTE: Excludes California, as the majority of health insurers do not report their data to the NAIC. Numbers may not sum to 100 percent due to rounding. Analysis includes standardized plans A-N, policies existing prior to federal standardization, and plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program; does not include companies and plans that identified as Medicare Select; excludes companies and plans where number of covered lives was less than 20.

SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

[1] Rice, T., R.E. Snyder, G. Kominski, N. Pourat. 2002. "Who Switches from Medigap to Medicare HMOs? *Health Services Research* 37(2): 272-290.

[2] Office of Management and Budget, "Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction," September 2011.

[3] Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," July 2011.

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

[5] Congressional Budget Office (CBO), *Budget Options Volume I: Health* Care, December 2008.

[6] Lemieux, J., T. Chovan, K. Heath. 2008. "Medigap Coverage and Medicare Spending: A Second Look." *Health Affairs* 27(2): 469-477.

[7] Hogan, C. 2009. Exploring the effects of secondary coverage on Medicare spending for the elderly. Washington, DC: Contractor report for MedPAC.

[8] Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," July 2011.

[9] For a review of the literature, see Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Aligning Incentives in Medicare*, June 2010. See also Lohr, K.N., R.H. Brook, C.J. Kamberg, et al. 1986. "Effect of Cost Sharing on Use of Medically Effective and Less Effective Care." *Medical Care* 24(9, Supplement): S31-S38.

[10] It is possible that policymakers could include additional plans in defining first dollar coverage – including all plans that pay 100 percent of coinsurance requirements under Parts A or B; however, this analysis focuses on plans C and F because these are the only policies that fully cover both deductibles.

[11] The data set also excludes Medicare Select plans (Medigap plans with provider networks) and plans with fewer than 20 covered lives. While insurers in Massachusetts, Minnesota, and Wisconsin may sell other Medigap plans with first dollar coverage, only plans C and F are included in this analysis.

[12] Plans in Massachusetts, Minnesota, and Wisconsin were not part of the federal standardization program. All existing Medigap policies in the other states were grandfathered, and could continue to not conform to the standard federal benefit packages.

[13] Rice, T., M.L. Graham, and P.D. Fox. 1997. "The Impact of Policy Standardization on the Medigap Market." *Inquiry* 34(2): 106-116.

[14] Plan F also covers extra charges incurred by beneficiaries seeing physicians who do not accept assignment.

[15] Plans in Massachusetts, Minnesota, and Wisconsin were grandfathered and were not part of the federal standardization program.

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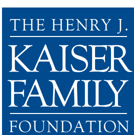

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