

REFORMING MEDIGAP PLANS BY SHIFTING COSTS ONTO BENEFICIARIES: A FLAWED APPROACH TO ACHIEVE MEDICARE SAVINGS

Background:

In order to help pay for Medicare's significant out-of-pocket costs, most Medicare beneficiaries have some form of supplemental coverage, such as retiree plans, private Medicare Advantage plans, Medicaid or Medigap policies. Medigap policies are individual, standardized insurance policies designed to fill in some of the gaps in Traditional Medicare's coverage. Nearly one in five Medicare beneficiaries – 9.6 million – rely on Medigap policies to provide financial security and protection from high, unexpected out-of-pocket costs due to unforeseen medical care. Most beneficiaries who select Medigap policies do not have access to another form of supplemental coverage, like retiree benefits or Medicaid.ⁱ

Despite serving Medicare beneficiaries well for years, Medigap plans are being targeted by some public policymakers as a means to cut Medicare spending by shifting costs onto people who have these policies. Under the assumption that charging beneficiaries more in upfront out-of-pocket costs will deter them from using unnecessary medical care – and therefore save the Medicare program money – some proposals seek to increase Medigap deductibles and other cost-sharing. Other proposals would add a surcharge or tax on plans offering “first-dollar” or “near first-dollar” coverage – costs which insurance companies offering Medigap policies will pass on to policyholders.

Our Position:

The Leadership Council of Aging Organizations (LCAO) is opposed to adding further cost-sharing to Medigap plans or otherwise penalizing individuals who have “first-dollar coverage” through increased premiums or surcharges.

We strongly disagree with the argument that Medigap plans are a driver of unnecessary medical care. Instead, adding costs to Medigap policies will deter beneficiaries from seeking medically necessary care. Increased Medigap cost-sharing is not an effective tool for reducing Medicare spending and may harm the health and well-being of beneficiaries who forgo needed health care because they can no longer afford it. LCAO recognizes the need to bring down the nation's deficit and reduce health care spending over the long term. With respect to Medicare, we support savings mechanisms that address system wide health care inflation and build on the cost savings, innovations and efficiencies of the Affordable Care Act. Proposals that shift costs onto beneficiaries, like eliminating or discouraging “first dollar coverage,” fail to meet these standards.

Our Rationale:

- **As cost-sharing goes up, utilization of services – both necessary and unnecessary – goes down.** Increased cost-sharing in health insurance programs often result in either a barrier to or delay in accessing needed treatment, which could lead to adverse health outcomes and greater programmatic costs in the future. For example, multiple studies show that increased cost-sharing on specific services, such as ambulatory care or prescription medications, can lead to increased emergency room visits, hospitalizations, and outpatient care among older adults.ⁱⁱ
- **The Medicare program – not Medigap policies – determines what care is medically necessary.** If Medicare determines that a given service is not medically necessary, it won't pay for it. Since Medigap policies follow the lead of Medicare, a Medigap policy will not make a payment when Medicare has indicated that a service is not medically necessary. In short, penalizing policyholders for choosing to buy certain Medigap policies will not affect whether care sought by beneficiaries is appropriate.ⁱⁱⁱ

- **Eliminating first dollar coverage will not lead to beneficiaries choosing better value services.** Increased Medigap cost-sharing would inappropriately place the burden on beneficiaries to determine in advance whether a covered service is necessary or unnecessary. Instead of making such a determination, beneficiaries are more likely to avoid initiating a health care service or treatment as a result of cost-sharing, whereas once a person is engaged in the health care system, cost-sharing has little effect on whether or not a treatment is pursued. With added cost-sharing, people are more likely to forgo outpatient care and doctors visits outright, than to forgo treatments or services recommended by their provider.^{iv} In other words, it is health care providers – not patients – who order medical services.
- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries lived on incomes below \$22,000, just under 200% of the federal poverty level;^v and Medicare households already spend on average 15 percent of their income on health costs, three times as much as the non-Medicare population.^{vi} Two-thirds of people with Medigap (**66%**) have incomes below \$40,000 per year and one-third (**31%**) have incomes below \$20,000 per year. People living in rural communities are more likely to purchase a Medigap policy. Increasing cost-sharing for or adding surcharges to Medigap plans will harm those who can least afford it – those who are sick or chronically ill and those with low or moderate incomes.^{vii}
- A subgroup of the non-partisan, expert **National Association of Insurance Commissioners (NAIC)** tasked with reviewing potential Medigap changes concluded that various proposals to reform Medigap policies:
 - “[...] do not consider the potentially serious and unintended impacts for beneficiaries and the Medigap 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. [...] 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.”^{viii}
- **Interfering with Medigap contracts currently in force raises serious concerns.** There is a significant difference between applying new prohibitions or penalties to new Medigap policyholders, as opposed to altering private insurance contracts already in place – many for decades. The NAIC expressed serious concerns about this issue, stating: “An abrupt alteration of the Medigap cost-sharing benefits for in force policies will cause a major market disruption and cause serious confusion for 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.”^{ix}
- **Recent, significant changes to Medigap policies already include cost-sharing in some policies.** Several of the standardized Medigap policies already give beneficiaries the choice of purchasing products with less coverage, usually in exchange for smaller premiums. For example, Plans K and L cover a percentage of Medicare cost-sharing (e.g., 50% or 75% instead of 100%), beneficiaries with Plan M pay 50% of the Medicare Part A hospital deductible, and Plan N charges \$20 copay for physician office visits and a \$50 copay for emergency room visits.

ⁱ *Medigap Reform: Setting the Context*, Kaiser Family Foundation, September 2011.

ⁱⁱ See *Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper*, National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPCA Subgroup, October 2011. See also, e.g., Amal N. Trivedi, et. al. *Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly*, *New England Journal of Medicine*, January 2010; Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, Robert Wood Johnson Foundation Research Synthesis Report No. 20, December 2010.

ⁱⁱⁱ *Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper*, National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPCA Subgroup, October 2011.

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

^v “[Medicare at a Glance](#)” – Kaiser Family Foundation (November 2011)

^{vi} “[Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare Households](#)” – Kaiser Family Foundation (March 2012)

^{vii} *Medigap Reform: Setting the Context*, Kaiser Family Foundation, September 2011.

^{viii} *Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper*, National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPCA Subgroup, October 2011, pp. 2-3.

^{ix} NAIC letter to Senators Murray and Hensarling (Sept. 21, 2011), available at

http://www.naic.org/documents/committees_ex_grlc_110921_letter_murray_hensarling_medigap_first_dollar.pdf