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findings brief

New Research Highlights Effects of Medigap Reform

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OBRA-90 Helped Beneficiaries and Market, but Left Room to Improve the Benefit Structure

Research funded by the Changes in Health Care Financing and Organization program has resulted in important findings on the effects of reforms to the Medigap program. Although Medigap coverage receives little public attention, it is a critical source of health insurance for about one-quarter of Medicare beneficiaries, for whom Medigap reimburses for cost sharing and selected services that Medicare does not cover. It is particularly important for researchers and policymakers to understand the role of Medigap coverage as Congress considers reforming the Medicare program. The findings highlighted in this brief can inform the current debate.

In 1990, Congress passed the Omnibus Budget Reconciliation Act (OBRA-90), which reformed Medigap by stipulating that all Medigap policies must conform to one of 10 standard sets of benefits (plans A–J).[1] Peter Fox of PDF, LLC, along with co-principal investigator Thomas Rice of the UCLA School of Public Health and Rani Snyder of the Donald W. Reynolds Foundation in Las Vegas, are completing a project in which they reviewed OBRA-90 and its impacts on the Medigap market and beneficiaries over the 10 years since its enactment. They found that the 1990 legislation reduced consumers' confusion about the program, led to a decrease in the staffing levels needed to regulate the Medigap market, and has been viewed positively by the public and state legislators.

"Overall, the Medigap reform legislation has had a favorable impact," says Fox. Contrary to their expectations, however, the researchers found that plan standardization did not succeed in enhancing price competition. They hypothesized that enhanced price competition would have caused premiums to be lower, resulting in a higher proportion of premium dollars being devoted to benefit payments rather than administration and profit. However, this did not occur. In addition, the researchers found that the three standardized benefits plans that provide prescription drug coverage—plans H, I, and J—are expensive and provide limited coverage. Finally, the investigators discovered that some Medigap benefits, such as in-home services, are rarely used and therefore may not be necessary.

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Background and Methods

The Medigap market changed dramatically with the passage of OBRA-90. Its provisions included, in addition to standardization of benefit packages:

- Higher requirements for "loss ratios" (i.e., the percentage of the premium dollar that is paid for benefits rather than for administration and profit). Minimum loss ratios were set at 65 percent for individual policies and 75 percent for group policies. Failure to meet these standards generated requirements for premium refunds.
- Severe penalties on agents or insurers who knowingly sold duplicate policies.
- Limitations on agent commissions during the initial year of coverage to no more than twice the commissions for renewal policies. This provision was intended to discourage agents from "churning," or inducing beneficiaries to switch policies in order to generate commission income.
- A requirement that insurers hold a six-month open enrollment period when beneficiaries aged 65 and over first enroll in Part B of Medicare. During that period, a person can purchase any policy offered regardless of health status and receive the carrier's most favorable rate.
- A limitation on pre-existing condition exclusions to no more than six months' duration.

States are generally allowed to have regulations that are more restrictive than those in OBRA-90.[2]

These reforms motivated the research, conducted in 2001 and 2002, which included making site visits to six states (Florida, Missouri, New York, South Carolina, Texas, and Washington); gathering data from these six states; and conducting interviews with carrier representatives, federal officials, and representatives of various interest groups.

Did Standardization Go Far Enough?

The main aspect of Medigap that has not been standardized is the manner in which carriers reflect age in setting premiums—which can be done in one of three ways. Premiums can be:

- community rated, meaning that all policyholders in a geographic area are charged the same amount;
- issue-age rated, whereby premiums are based on the beneficiary's age at initial purchase; or
- attained-age rated, whereby premiums rise as beneficiaries age.

Most carrier representatives believe that beneficiaries should be able to choose among insurance policies based on the age-rating practices they use to calculate premiums. However, the researchers found that few beneficiaries understand how the three methods differ. Moreover, choice may be limited or non-existent depending on where beneficiaries live. Some states have precluded attained-age rating and others require community rating. Thus, because most consumers either are not exercising choice or cannot exercise it, Fox believes the federal government should standardize age-rating practices.

Prescription Drug Benefits

While Medigap standardized plans H, I, and J include some coverage for prescription drugs, Medigap carriers are not required to offer any of these plans and many do not.[3] The researchers did find that consumers in most states can choose among a reasonable number of carriers with drug coverage. Nonetheless, prescription drug coverage has been problematic for reasons unrelated to standardization. Specifically, these plans have three important problems.

First, the benefits are limited because of high cost sharing. In plans H and I, the benefit has a $250 annual deductible, 50 percent coinsurance, and an annual maximum on benefit payments of $1,250. In a typical

Variants of the Standardized Plans

Federal law allows carriers to sell two variants of the standardized plans: Medicare SELECT and high-deductible plans. Neither has garnered significant market share; their availability expands coverage options but increases complexity for consumers having to make choices.

Medicare SELECT plans have the same benefits design as the standardized plans but with the added restriction that the enrollee must receive services through the carrier's contracted network in order to receive full Medigap benefits. (Medicare benefits are payable regardless.) Medicare SELECT was authorized in 1990 as a 15-state demonstration and became a national program in 1995. The objective was to allow carriers to contract with a limited network of providers. The presumption was that these providers would waive Medicare cost sharing in return for greater patient volume, with the resulting savings being passed along to the consumer in the form of premium reductions.

"Few Medicare SELECT policies have been sold, largely because the savings have not been sufficient to generate significant consumer demand," says Fox. "Beneficiaries who are willing to accept a limited network can generally obtain greater savings by enrolling in a Medicare+Choice plan."

High-deductible Medigap policies were authorized by the Balanced Budget Act (BBA) of 1997. They incorporated annual deductibles of $1,500 in 1998 and 1999, increasing with the Consumer Price Index thereafter. The reductions in premiums from high-deductible plans are substantial. The researchers compared the premiums with the corresponding standard plan using the buyers guides obtained from the six states they visited and found premiums to be reduced by 56 percent on average (from $1,522 to $670 a year). Like SELECT plans, consumers and carriers have shown scant interest in high-deductible plans.

Medicare population (i.e., one not subject to biased selection), the two plans pay an estimated 35.5 percent of prescription drug expenses. Plan J differs from plans H and I only in that the annual maximum is increased to $3,000; it reimburses 39 percent on average.

Second, premiums are high—well over $2,000 per person in 2000—in large measure due to adverse selection, those with known need for prescription drugs are more likely to enroll in plans H, I, and J.[4] The researchers found that adverse selection results in premiums for the three plans that offer drug coverage being between 25 and 60 percent higher than what one would expect for an average population of Medicare beneficiaries. Not surprisingly, says Fox, one result of the higher premiums is that these three plans account for only 9 percent of all Medigap policies.[5]

Third, current law precludes these plans from using the myriad cost-management techniques that are common in employee benefit programs in the private sector. First and foremost is the absence of financial incentives to encourage the use of drugs that are on a formulary because they are cheaper and roughly equivalent in terms of effectiveness. Employment-based plans commonly create incentives and take other measures to encourage the use of less expensive drugs. Medigap carriers are also precluded from requiring prior authorization for selected high-cost drugs—something that many employment-based plans do, provided that safe, less expensive drugs are available that might be tried first.

If Congress enacts legislation to provide prescription drug coverage to Medicare beneficiaries, however, these may become moot points. "Clearly, if a prescription drug benefit passes Congress, the standardized packages will need to be changed," says Fox. "Plans H, I, and J only make sense in the absence of a Medicare drug benefit."

Coverage of Medicare Disabled Beneficiaries

Although disabled beneficiaries under the age of 65 represent 13 percent of all Medicare beneficiaries, they account for only 1 percent of Medigap policyholders, according to the National Association of Insurance Commissioners. Under the federal open-enrollment provision, carriers must offer coverage without health screening for the first six months after beneficiaries turn 65 and enroll in Part B of Medicare. However, this provision does not apply to beneficiaries under age 65 who become eligible for Medicare by virtue of being disabled.

"For those who do obtain Medigap policies, claims cost and resulting premiums are an estimated 78 higher, reflecting that the sicker individuals in the disabled population are disproportionately enrolling in Medigap plans," says Fox.

Some states have sought to expand access—for example, by mandating open enrollment for disabled beneficiaries when they become Medicare-eligible or by allowing them to obtain coverage through a state high-risk pool. A small number of states preclude carriers from charging higher premiums to disabled and aged beneficiaries, creating a cross-subsidy that benefits the disabled population.

Benefits Package Issues

Standardizing benefits inevitably raises controversy as policymakers seek to balance the often competing objectives of ensuring simplicity and ease of understanding, allowing a reasonable range of consumer choice, achieving public health objectives such as encouraging prevention, and restraining increases in federal spending that result from the fact that Medigap policies cover Medicare cost sharing. Some of the 10 plans include benefits whose value has been debated, including coverage of:

- the Part B deductible;
- preventive care; and
- at-home recovery.

According to the researchers, elimination of these benefits would reduce the number of standardized plans below 10—a result that some consumer advocates would favor.

Coverage of the annual $100 Part B deductible is commonly described as "dollar trading" rather than insurance. The reason is that, in any given year, roughly 90 percent of beneficiaries spend the deductible amount, and the cost of the coverage is typically priced at more than $100 after factoring in administrative expenses and profits.

The prevention benefit reimburses beneficiaries for up to $120 in charges for virtually any preventive service. It is included in two rarely purchased plans at the behest of some consumer representatives, not as a form of insurance but rather to further public health objectives. The experience of two very large Medigap carriers indicates that, for those who have the benefit, the average cost is around $1 per year. The researchers say this suggests that the benefit is hardly ever used, making its value to consumers questionable.

The at-home recovery benefit also adds little to premiums—between $2 and $3 a year for it and the preventive benefit combined—again indicating that beneficiaries who have this benefit rarely use it. The at-home recovery benefit supplements the Medicare home health benefit by covering "short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery."

According to the researchers, this benefit is poorly understood, and the coverage rules are difficult to administer. Federal regulation incorporates a series of limitations that are confusing and that are not fully described in either the consumer guides published in the states that the researchers visited or in the consumer-oriented information that the federal Medicare program provides beneficiaries.

The underlying benefit structure of the Medigap policies is also questionable, the researchers say. The 10 standardized plans are designed to cover most or all (depending on the specific plan) Medicare cost sharing, and the Medigap plans

that are the most popular are those that cover all cost sharing. "One can infer that beneficiaries want all cost sharing covered," says Fox. "However, the effect is to increase the utilization of health services and, subsequently, Medicare expenditures."

Research and Policy Recommendations

Questions about Medigap remain. For example, is the continued inclusion of certain benefits desirable? Should first-dollar coverage be avoided in order to reduce the cost-increasing impact on the Medicare budget of the 10 current plans? Should some level of prescription drug coverage be mandated in all of the plans? If so, how else might the plans change?

"Any restructuring of the standardized benefits will generate costs and cause dislocations," says Fox. Enrollees would have to become accustomed to a new set of benefits, and carriers would need to rewrite their policies, educate existing enrollees, and revise their marketing materials. Some argue that any changes in the 10 standardized plans should await broader Medicare reform, although no one knows for sure if and when that reform will happen.

The researchers suggest two changes that could be implemented without causing significant beneficiary confusion or dislocations. First, carriers selling the plans with drug coverage could be allowed to engage in broader cost-management activities, such as encouraging use of contracted pharmacies so beneficiaries do not pay full retail price or allowing carriers to require prior authorization for expensive drugs. Such measures could potentially lower premiums. Preferably, federal standards would be desirable to determine network size or the types of drugs subject to prior authorization, the researchers say. Second, some of the benefits that are hardly ever used—such as in-home services and prevention—could be eliminated.

"Whatever their theoretical merit, the fact that enrollees hardly ever use these benefits indicates a lack of consumer appeal—something that was not clear at the time the 10 standardized packages were designed," says Fox.

For more information on the effects of OBRA, see Fox, P.D., R.E. Snyder and T. Rice, "Medigap Reform Legislation of 1990: A 10-Year Review," *Health Care Financing Review*. Vol. 24, No. 3, Spring 2003, pp. 121 – 37.

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Endnotes

[1] *The standardized plans were designed by the National Association of Insurance Commissioners (NAIC).*

[2] *Three states—Massachusetts, Minnesota, and Wisconsin—are exempt from the federal standardization requirements because they had such requirements that pre-dated OBRA-90.*

[3] *Federal law requires only that carriers offering Medigap policies sell Plan A, the most basic of the 10 plans.*

[4] *In this case, adverse selection would occur when individuals who are sicker than average purchase one of the policies with drug coverage.*

[5] *Estimate of the Medicare Payment Assessment Commission (MedPAC), based on analysis of NAIC data.*