HealthAffairs | Robert Wood Johnson Foundation

Health Policy Brief

SEPTEMBER 13, 2011

Putting Limits on 'Medigap.' Medicare enrollees who buy supplemental private coverage also use more health services. Should the coverage be limited?

WHAT'S THE ISSUE?

Many people enrolled in Medicare—the federal health program for the aged and the disabled—also purchase separate supplemental private insurance coverage known as "Medigap." This coverage offers them financial protection for much of what Medicare doesn't pay for—for example, by paying the Medicare deductibles and copayments that individuals would otherwise pay out of pocket.

The most popular Medigap plans protect beneficiaries from having to pay almost anything out of pocket, starting with the first services they obtain under Medicare. This is called "first-dollar coverage." Studies have demonstrated a link between having first-dollar coverage and making greater use of health care services. The result is higher federal Medicare spending than would be the case if the supplemental coverage didn't exist, or if it were less generous in paying for what Medicare doesn't.

One proposal that has been advanced to slow the rate of growth of Medicare spending is to put limits on Medigap coverage so that it would cover less than it typically does now. Proponents say such a change would lead to less use of health care services and lower overall Medicare spending, thereby helping to reduce federal budget deficits.

Critics contend such a change would hurt Medicare beneficiaries by making them pay more out of pocket. They say that would especially hurt people in poor health who genuinely need the services and those with modest incomes who would have trouble absorbing the extra expense.

This policy brief explains how Medigap works and explores the arguments for and against changing its coverage options.

WHAT'S THE BACKGROUND?

People enrolled in the traditional fee-for-service Medicare program face substantial out-of-pocket expenses. Under what is known as Part A of Medicare, they are required to pay deductibles for inpatient services, such as hospital stays. In 2011, for example, the inpatient hospital deductible is $1,132 per episode or "spell of illness." For hospital stays that exceed 60 days, beneficiaries also have to pay a portion of per day costs, known as "coinsurance."

Under Part B of Medicare, which covers physician and outpatient services, such as visits to a doctor or care in an emergency department, beneficiaries also must pay a deductible; in 2011, that amount is $162 per year. Beneficiaries are also responsible for paying 20 percent out of pocket for most outpatient services, such as a visit to the doctor (Exhibit 1). There is no limit on the amount of money that they

10.1377/hpb2011.14

10 million

Medigap enrollment
About 10 million Medicare beneficiaries also purchase Medigap insurance policies.

may have to pay in case of serious illness or prolonged hospitalization.

REDUCING FINANCIAL RISK: Medicare enrollees are subject to substantial financial risk because of the deductible and coinsurance requirements and because there is no cap on how much they may have to pay. To reduce this risk and make their health care costs more predictable, about 90 percent of Medicare beneficiaries either receive or actively purchase protection against these unlimited out-of-pocket costs (Exhibit 2).

Some people have coverage provided through former employers or the military that "wraps around" Medicare and pays Medicare's deductibles and coinsurance. Low-income or disabled beneficiaries may qualify for Medicaid coverage in addition to Medicare. Among other benefits, Medicaid may pay for these beneficiaries' monthly Medicare premiums for Part B coverage.

Approximately half of Medicare beneficiaries do not have employer coverage or qualify for Medicaid. Many of them enroll in Medicare Advantage plans, which typically have lower cost sharing and provide additional benefits not covered by traditional Medicare. About 10 million beneficiaries—more than 15 percent of the Medicare population—purchase Medigap insurance policies (Exhibit 3). This number has remained fairly constant in recent years.

Medigap plans are sold by private insurance companies and are currently offered in 10 standard packages of benefits. These packages, identified by the letters A through D, F, G, and K through N, were developed by the National Association of Insurance Commissioners, an organization of elected and appointed officials who oversee the private insurance industries in their respective states.

Four previously available plans—E, H, I, and J—are no longer sold; however, they may still be held by beneficiaries who purchased them before June 2010, when Medigap plans were updated to reflect the change in Medicare prescription drug benefits. Three states, Massachusetts, Minnesota, and Wisconsin, also allow carriers to offer nonstandardized plans in addition to the standardized ones labeled with letters.

BENEFITS AND COVERAGE: All Medigap plans must cover certain basic benefits, including coinsurance for extended hospital stays and total costs for 365 hospital days once enrollees have used up all their Medicare hospital benefits. Plans also must pay for all cost-sharing amounts after enrollees meet their annual Part B deductible, and the first three pints of any blood that enrollees may need in the course of their care.

Depending on the Medigap plan, other benefits may also be covered. These may include payment of deductibles for hospital stays under Part A; Medicare's required cost sharing for hospice care; coinsurance for stays in certain types of nursing homes known as skilled nursing facilities; and coverage for emergency medical care needed during foreign travel.

Policyholders obtain their Medigap coverage by paying monthly premiums, as with other types of health insurance. In 2009, the average national premium for the most popular Plan F was equal to about $167 a month, or $2,000 a year. Some states allow Medigap premiums to vary based on the age of the beneficiary as well as based on gender and health status. Other states require "community rating," under which premiums cannot vary based on health status. Even in community rating states, premiums can still vary significantly from one carrier to another based on how much use different policyholders make of their coverage. In one market, Albany, New

EXHIBIT 1

Medicare Coverage And Beneficiary Costs, 2011

Coverage	Beneficiary costs
HOSPITAL INPATIENT EXPENSES (PART A)	
Deductible	$1,132 per episode
Days 61–90	$283 per day
Days 91–150	$566 per day
Over 150 days	All costs
PHYSICIAN, OUTPATIENT SERVICES (PART B)	
Deductible	$162 per year
Coinsurance per visit	20% of allowable charges[a]
PART B INSURANCE PREMIUMS	
Monthly premium	$96.40–$115.40[b]
SKILLED NURSING FACILITY	
Days 21–100	Up to $141.50 per day
Over 100 days	All costs
OTHER SERVICES	
Home health care	$0
Laboratory tests	$0
MAXIMUM OUT-OF-POCKET COSTS	
Limit on annual expenses	No limit

SOURCE Department of Health and Human Services. [a]Cost sharing is higher for some outpatient hospital services. [b]Premiums are substantially higher for individuals whose annual incomes exceed $85,000.

York, premiums for Plan F ranged from $1,940 to $4,130 in 2009.

The most popular plans are those labeled C and F, which accounted for 16 percent and 41 percent, respectively, of Medigap enrollment in December 2010. These two plans cover all deductibles and coinsurance under Parts A and B of Medicare—not just for hospital stays and doctor visits, but also for hospice and skilled nursing facility care. Below, this brief will expand on why this first-dollar coverage is considered by some to be so problematic.

$1,132

Inpatient hospital deductible
In 2011, the Medicare inpatient hospital deductible is $1,132 per episode or "spell of illness."

WHAT'S THE PROPOSAL?

Medicare is a significant component of US government spending. In their quest to understand and rein in Medicare spending, policy makers have zeroed in on the effect of supplemental Medicare coverage—specifically, on the effects of first-dollar coverage such as provided under Medigap plans C and F.

It's long been known that when people have health insurance that fully insulates them from the effects of health care costs they consume more services than those without such generous coverage. This phenomenon is referred to as "moral hazard." Indeed, studies have found that Medicare enrollees who have Medigap or other supplemental insurance policies that provide first-dollar coverage use more medical services than do those enrolled in traditional Medicare alone. Because of this, at various times since the 1990s, Congress has considered limiting first-dollar coverage under Medigap.

A 2009 study conducted for the Medicare Payment Advisory Commission (MedPAC) found that overall per capita Medicare spending for beneficiaries with Medigap coverage was 33 percent higher than for beneficiaries with no supplemental insurance. This effect was primarily driven by those having first-dollar Medigap coverage, but similar results were found for beneficiaries with other types of coverage that were equally generous. The additional spending was largely for office-based care, elective inpatient hospital services, specialist care, and preventive care.

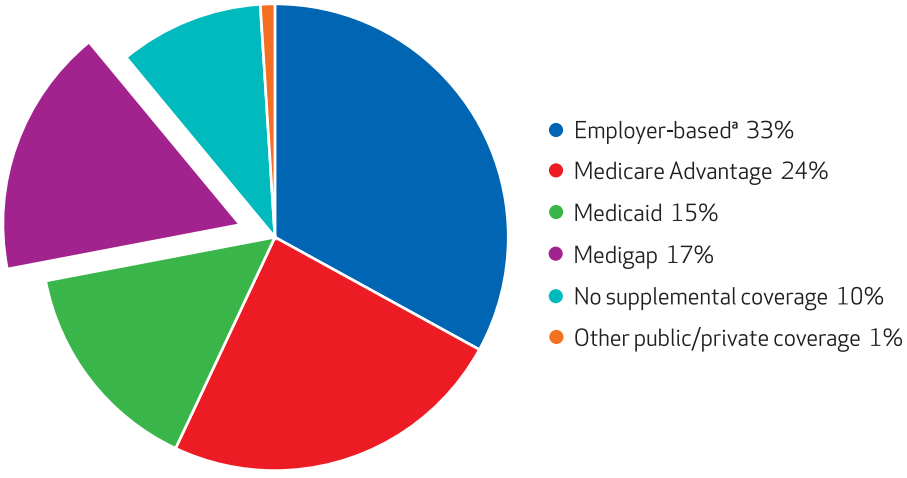
The study noted that the biggest differences were in areas where there was more discretion on the part of physicians in providing the care. However, the report could not conclude that the additional care was wasteful or of marginal value. Whether any policy changes were warranted would depend on whether the additional health care use induced by first-dollar coverage was worth the additional cost.

VARIETY OF NEW APPROACHES: At this point, there is no single proposal to limit supplemental coverage, but rather a collection of ideas and approaches that target Medigap plans with first-dollar coverage. For example, in December 2010, President Barack Obama's National Commission on Fiscal Responsibility and Reform (known as the Simpson-Bowles Commission) recommended prohibiting Medigap plans from covering the first $500 of cost-sharing liability and allowing coverage of only 50 percent of the next $5,000. Because such a change would in all probability deter Medicare beneficiaries with Medigap coverage from obtaining some health care services, this proposal was estimated to save the federal government $38 billion from fiscal year 2012 through fiscal year 2020. Similar ideas were discussed in a March 2011 report from the nonpartisan Congressional Budget Office.

Other proposals surfaced in bipartisan deficit-reduction discussions during the summer of 2011. These would also have prevented Medigap plans from providing first-dollar coverage—or, alternatively, Medicare beneficiaries who wanted first-dollar coverage from a Medigap policy would also have to pay an extra $530 annual premium to Medicare. This

EXHIBIT 2

Sources Of Supplemental Coverage Among Medicare Beneficiaries, 2008



SOURCE Kaiser Family Foundation analysis of Centers for Medicare and Medicaid Services Medicare Current Beneficiary Survey Access to Care File, 2008. **NOTES** Beneficiaries with multiple sources of coverage were assigned to the category that appeared highest in this order: Medicare Advantage, Medicaid, employer, Medigap, other, none. [a]Employer-based care includes retiree drug subsidy and TRICARE, the health care program serving active-duty service members, National Guard and Reserve members, retirees, families, and survivors worldwide.

proposal was estimated to save the federal government up to $53 billion over 10 years.

Medigap changes that were never publicly specified also were discussed by President Obama and House Speaker John A. Boehner (R-OH) during negotiations over raising the federal debt ceiling during the summer of 2011. Those discussions later broke down. Congress and the president eventually did strike a deal to raise the debt ceiling and cut federal spending, although it did not include changes to Medigap. It is possible, however, that Medigap changes will be part of a package to achieve an additional $1.5 trillion in required additional federal spending cuts over 10 years. These reductions must be adopted by December 23, 2011, to avoid triggering $1.2 trillion in automatic across-the-board federal program cuts over 10 years.

33%

Higher Medicare spending
Overall per capita Medicare spending for those with Medigap was 33 percent higher, according to a 2009 study.

WHAT'S THE DEBATE?

Policy makers and economists who support limiting supplemental coverage believe that such a step may deter Medicare spending that is of limited value, even though it meets the program's standards for being considered "medically necessary." They point to the fact that, as noted above, much of the increased use of services among those with Medigap goes to nonemergency health care services, and particularly those in which decisions to provide care are discretionary on the part of the doctor and patient. In such an environment, both doctors and patients have incentives to provide or receive more care, even if such care is of only marginal additional value. The doctor or hospital, after all, will get paid, and the patient won't experience much, if any, increased costs.

In contrast, critics of limits on Medigap maintain that there are many factors that constitute far bigger drivers of increased use of medical services than any incentives provided by first-dollar coverage. These include advances in medical technology, the rising prevalence of chronic conditions, and increased medical need. What's more, some critics say, the use of health care services may be higher among Medicare beneficiaries with Medigap specifically because it may be that sicker beneficiaries are the most inclined to purchase Medigap in the first place. This tendency is known as a "self-selection" effect.

A 2008 analysis performed by America's Health Insurance Plans, an insurance industry group that includes companies that sell Medigap policies, suggested that the additional costs associated with supplemental coverage may, in fact, be mainly the result of "higher-than-average observed levels of major and chronic illnesses" among the population that buys Medigap coverage.

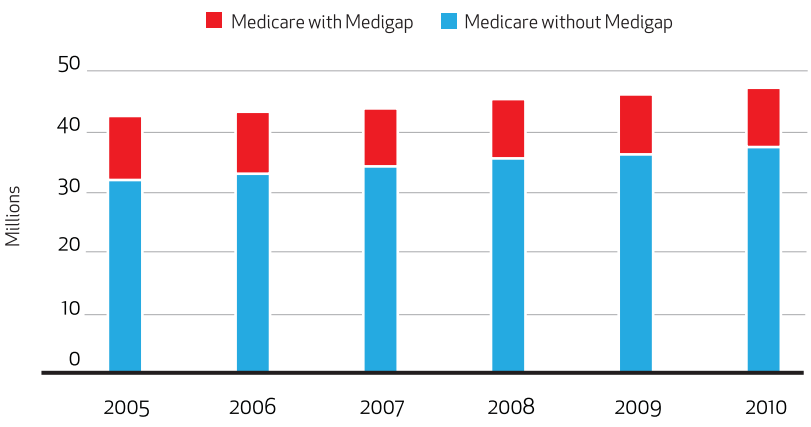
Critics also question how likely limiting Medigap coverage would be to reduce overall use of health services and, therefore, overall Medicare spending. To the extent that services are recommended by physicians, beneficiaries may be likely to seek care even if they have to bear more of the cost. In that case, the effect of limiting Medigap's first-dollar coverage would simply be to shift costs from the federal government to beneficiaries. Thus, rather than deterring Medicare beneficiaries from getting unnecessary services, the critics say, limiting Medigap would force beneficiaries who really need services to obtain them anyway, and pay more out of pocket as a result.

Other criticisms of limiting Medigap have suggested that the change would be penny-wise and pound-foolish. For example, an analysis by the Kaiser Family Foundation found that higher out-of-pocket spending would disproportionately impact those with more modest incomes and those in relatively poor health.

As a result, some of these beneficiaries may be discouraged from seeking outpatient medical care, driving down some costs in the short term in Part B of the Medicare program. But over the longer term, these same beneficiaries

EXHIBIT 3

Medicare Beneficiaries With Medigap Coverage, 2005–10



SOURCES Centers for Medicare and Medicaid Services, National Association of Insurance Commissioners. **NOTE** Medicare without Medigap beneficiaries include those enrolled in Medicare Advantage private plans, those enrolled in traditional Medicare, and those with employer-sponsored supplemental plans.

might grow sicker and end up requiring care in more costly settings, such as hospitals and skilled nursing facilities. Costs under Part A of the Medicare program would then be higher as a result. To date, however, no formal estimates have been made of the long-term effect on the federal budget of such a dynamic playing out.

WHAT'S NEXT?

As noted above, proposals to limit Medigap may resurface as Congress continues to look for ways to curb Medicare spending and federal budget deficits. And in fact, some changes are already ahead for Medigap first-dollar coverage. The Affordable Care Act requires the National Association of Insurance Commissioners to revise plans C and F to require beneficiaries to pay some modest amount of the cost of their care to encourage the use of "appropriate physician services" under Part B. Such changes are to be implemented by January 1, 2015.

Separately, MedPAC says it may ultimately recommend changes in the design of Medicare benefits that could reduce the need for many beneficiaries to buy some or all of the Medigap coverage they now purchase. Specifically, in its June 2011 report to Congress, MedPAC said it was interested in exploring whether or not an overall cap could be placed on beneficiaries' out-of-pocket spending so that they would be protected against the economic impact of catastrophic illness—and in a way that would not cost the federal government any more money than it is now projected to spend on Medicare.

For example, total out-of-pocket expenses for Medicare beneficiaries might be capped at $5,000 annually with beneficiaries paying a combined Part A and Part B deductible of $1,170. Policy makers would then have to decide whether or not they wanted to allow Medigap policies to cover that new combined deductible. If they did allow it, most beneficiaries would probably spend about the same or a little more out of pocket than they do now, but with far greater financial security in the event their medical expenses were very high.

In the final analysis, policy makers will have to continue to engage in a juggling act—balancing the desire to provide good benefits under Medicare with the desire to rein in federal spending on the program. Whatever they decide, it's a reasonable bet that any changes they adopt will affect Medigap coverage in some way.■

$53 billion

Savings over 10 years
Preventing Medigap first-dollar coverage would save $53 billion in federal spending.

About Health Policy Briefs

Written by
Amanda Cassidy
Principal
Meitheal Health Policy
(Cassidy previously worked for the Centers for Medicare and Medicaid Services, in the Office of Legislation and the Center for Medicare Management.)

Editorial review by
Gail Wilensky
Senior Fellow
Project HOPE

David Gross
Director of Policy
College of American Pathologists

Ted Agres
Senior Editor for Special Content
Health Affairs

Susan Dentzer
Editor-in-Chief
Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:
"Health Policy Brief: Putting Limits on 'Medigap,'" *Health Affairs*, September 13, 2011.

Sign up for free policy briefs at:
www.healthaffairs.org/healthpolicybriefs

RESOURCES

America's Health Insurance Plans, "Medicare Supplement (Medigap) Insurance: Myths and Facts," Washington, DC, July 7, 2011.

Centers for Medicare and Medicaid Services, "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," January 2011.

Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011.

Hogan, Christopher, "Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly," Study Conducted for the Medicare Payment Advisory Commission, June 2009.

Lemieux, Jeff, Teresa Chovan, and Karen Heath, "Medigap Coverage and Medicaid Spending: A Second Look," *Health Affairs* 27, no. 2 (2008): 469–77.

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

"The Moment of Truth," Report of the National Commission on Fiscal Responsibility and Reform, December 1, 2010.