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Medigap: Prevalence, Premiums, and Opportunities for Reform

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OVERVIEW — *This issue brief provides an overview of Medicare's coverage gaps and the primary sources of supplemental coverage for Medicare beneficiaries. It focuses particularly on the Medigap market: the effects of standardization, recent premium trends and rating practices, and options for reform. It considers Medigap within the context of Medicare prescription drug proposals and efforts to reform the entire Medicare program.*

Medigap: Prevalence, Premiums, and Opportunities for Reform

Medicare has played a critical role in providing access to health care services for millions of beneficiaries since its inception in 1965. Recent attention, however, has focused on its significant gaps in coverage. Legislative proposals to provide a Medicare drug benefit have increased awareness of the program's inadequacies and its failure to keep pace with shifts in the private sector's benefit design. The Medicare Payment Advisory Commission's most recent report to Congress examines the limitations of Medicare's traditional benefit package, including substantial cost-sharing requirements and very limited or no coverage of important benefits like outpatient drugs. Moreover, Medicare provides no ceiling on out-of-pocket spending.

Modeled on private health insurance available in the mid-1960s, Medicare was designed to cover hospital and physician services for acute illness. Since very few working adults purchased supplemental insurance, it was generally believed that most Medicare beneficiaries would not need additional coverage. But the cost-sharing provisions that may have been appropriate for the working-age population proved to be too burdensome for many Medicare beneficiaries. By the late 1960s, more than 45 percent of Medicare beneficiaries held private health insurance to supplement their Medicare coverage.¹ Presently, the overwhelming majority of Medicare beneficiaries have some form of coverage in addition to Medicare.²

Four types of supplemental coverage prevail today: employer-sponsored retiree health insurance, Medicare+Choice (M+C) plans, Medicaid, and individually purchased Medigap insurance. The prevalence of retiree health insurance and M+C options have declined recently, forcing many seniors to look for other ways to fill Medicare's gaps. Medicaid as a supplement is available to only the poorest Medicare beneficiaries. Medigap—private health insurance designed to wrap around Medicare's benefit package—is the only supplemental insurance still broadly available to most beneficiaries.

As options have narrowed for seniors, policymakers have begun to consider how Medigap plans fit into the larger puzzle of Medicare reform. Several bills have been introduced in Congress that include provisions related to Medigap, particularly within the context of Medicare prescription drug proposals.³ The Bush administration has also put forth some Medigap proposals as part of its overall framework for Medicare reform.

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MEDICARE'S COVERAGE GAPS

Medicare's basic benefit design mirrored the private insurance system in place in the mid-1960s. Its benefit package is generally limited to acute care services that are needed for the diagnosis or treatment of illness or injury.⁴

Traditional Medicare consists of two parts. Part A, the Hospital Insurance (HI) program, helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health care services. Individuals who receive Social Security cash benefits on the basis of age or disability are automatically entitled to Part A benefits. While there is no premium for this coverage, beneficiaries are liable for required deductibles, coinsurance, and copayment amounts (see Table 1). Part B, the Supplementary Medical Insurance (SMI) program, helps pay for physician services, outpatient hospital and other outpatient facility services, home care not covered under Part A, and other services, such as diagnostic tests, durable medical equipment, ambulance services, and some preventive services. Part B is voluntary, but 95 percent of beneficiaries enroll. Beneficiaries must pay a monthly premium for Part B coverage (\$54 in 2002) and are also responsible for deductibles, copayments, and coinsurance (see Table 1).

Beneficiaries are exposed to potentially significant "front-end" and "back-end" costs.⁵ Front-end costs, such as deductibles, must be met before any program benefits are paid. In 2002, beneficiaries face a \$812 deductible for each inpatient hospitalization covered under Part A and a \$100 annual deductible for Part B covered services. On the back end, beneficiaries are vulnerable for high daily copayments associated with long-term stays in hospitals or skilled nursing facilities (SNFs). About 30 percent of beneficiaries in SNFs continue to stay in nursing facilities after they exhaust the Medicare benefit.⁶ Moreover, because Medicare has no stop-loss coverage, beneficiaries can be liable for high out-of-pocket expenses, especially those with chronic health care needs.

In addition, Medicare provides no coverage for many services and products typically needed by beneficiaries, such as long-term nursing home care, most outpatient prescription drugs, eyeglasses, and hearing aids (see Table 2). According to the U.S. General Accounting Office (GAO), "current estimates suggest that the combination of Medicare's cost-sharing requirements and limited benefits leaves about 45 percent of beneficiaries' health care costs uncovered."⁷ In 2000, elderly Medicare beneficiaries spent an average of \$3,142 out of pocket, or 21.7 percent of income, on their own health care expenses.⁸

SOURCES OF SUPPLEMENTAL COVERAGE

To limit their exposure to traditional Medicare's coverage limits, about 90 percent of Medicare beneficiaries obtain some type of supplemental

Because Medicare has no stop-loss coverage, beneficiaries can be liable for high out-of-pocket expenses.

TABLE 1
Cost-Sharing Requirements in Traditional Medicare
(Parts A and B), 2002

	REQUIREMENT	2002 AMOUNTS
PART A	Inpatient	
	Deductible	\$812 per illness spell
	Copayment for days 61–90	\$203 per day
	Copayment for lifetime reserve days 91–150	\$406 per day
	Copayment beyond day 150	100% of costs
	Skilled Nursing Facility Care	
	Copayment for days 21–100	\$101.50 per day
	Copayment beyond day 100	100% of costs
	Home Health Care	
	Coinsurance for durable medical equipment	20% of approved amount
Hospice Care		
Copayment for outpatient drugs	\$5 or less for outpatient drugs	
Coinsurance for inpatient respite care	5% of approved amount	
Blood		
First 3 pints	100% of costs	
PART B	REQUIREMENT	
	2002 AMOUNTS	
	Premium	\$54 per month
	Deductible	\$100 per year
	Physician & Other Medical Services	
	Coinsurance	20% of approved amount
	Coinsurance for mental health	50% of approved amount
	Copayment for services of physicians not accepting assignment	100% of allowable excess
	Home Health Care	
	Coinsurance for durable medical equipment	20% of approved amount
Outpatient Hospital Care	Coinsurance or copayment varies according to service (after Part B deductible)	
Blood		
First 3 pints	100% of costs	
Additional Pints	20% of approved amount	

Source: Centers for Medicare and Medicaid Services, "Medicare and You 2002" (CMS-10050), U.S. Department of Health and Human Services, Baltimore, September 2002.

coverage. While supplemental coverage has existed virtually since the creation of Medicare in 1965, sources and types of coverage have changed over time. The majority of beneficiaries obtain additional health coverage from four sources: employer-sponsored retiree health insurance, Medicare+Choice, Medicaid, and Medigap (see Figure 1).

Retiree Health Insurance

Employer-sponsored retiree health insurance is the largest source of supplemental coverage for Medicare beneficiaries, with about 33 percent of all beneficiaries obtaining coverage from their or their spouse's former or current employer.⁹ This coverage tends to be the most comprehensive and least expensive to beneficiaries. According to a survey conducted in 2001 by the Henry J. Kaiser Foundation, the Hospital Research and Educational Trust (HRET), and the Commonwealth Fund, nearly all (99 percent) Medicare-age retirees (65 and older) with employer-sponsored health benefits had prescription drug coverage in the firm's largest retiree health plan.¹⁰ Retirees in employer-sponsored plans typically receive more in drug benefits and pay less in out-of-pocket expenses than beneficiaries in other supplemental plans. However, beneficiaries with employer-sponsored retiree health insurance typically still pay some portion of Medicare deductibles and face greater point-of-service cost sharing than those with individually purchased Medigap policies.¹¹ Medicare-age retirees contribute \$50 per month on average for single coverage.

Large firms are substantially more likely than small firms to offer retiree health benefits. Nearly two-thirds (64 percent) of firms with 5,000 or more workers offered retiree health benefits in 2001, while only 3 percent of firms with 3 to 199 workers did.¹² Benefits are more likely to be available to retirees in some employment sectors, such as finance and manufacturing, than in others, such as service industries.

The prevalence of employer-sponsored health coverage for Medicare-eligible retirees has declined in recent years, with some employers dropping coverage and few newer employers adding retiree health coverage. Since 1997, the percentage of all firms offering health benefits to Medicare-age retirees has declined, from 31 percent of all firms with 200 or

TABLE 2
Products and Services Not Covered
by Traditional Medicare, 2002

Outpatient prescription drugs <i>(with limited exceptions)</i>
Routine or annual physical exams
Hearing exams and hearing aids
Routine eye care and most eyeglasses
Dental care and dentures <i>(in most cases)</i>
Screening tests <i>(except for those specifically identified by Medicare)</i>
Routine foot care <i>(with limited exceptions)</i>
Orthopedic shoes
Vaccinations <i>(except for those specifically identified by Medicare)</i>
Long-term custodial care at home or in a nursing home <i>(help with bathing, dressing, using the bathroom, and eating)</i>
Acupuncture
Cosmetic surgery
Health care received while traveling outside of the United States <i>(except in limited cases)</i>
Private-duty nursing

Note: Medicare covers drugs not usually self-administered, oral anticancer drugs, drugs used following an organ transplant, erythropoietin for beneficiaries on dialysis, and injectable drugs used for treatment of postmenopausal osteoporosis. Screening tests covered by Medicare include bone mass measurement for some at-risk beneficiaries; colorectal cancer screening; glucose monitors, test strips, and lancets for all diabetics; diabetes self-management training for at-risk diabetics; glaucoma screening for at-risk enrollees; mammograms; pap tests and pelvic exams (including clinical breast exams) for all women; and prostate cancer screening for all men age 50 and over. Vaccinations covered by Medicare include those for flu, pneumococcal pneumonia, and hepatitis B (for those at medium to high risk).

Source: Centers for Medicare and Medicaid Services, 2002.

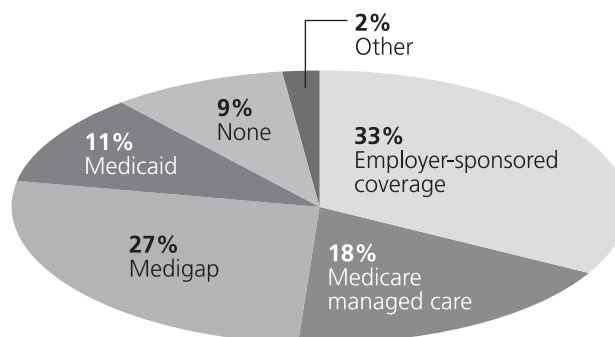
more workers to 23 percent in 2001. However, in the vast majority of cases where large employers have terminated retiree health coverage, the change was made on a prospective basis, for future retirees only.¹³ And, while fewer employers sponsor retiree health benefits today, the percentage of retirees obtaining health benefits through an employer remained relatively stable between 1994 and 1999, covering about 57 percent of retirees aged 55 to 64 and providing Medicare supplemental coverage to about 32 percent of retirees 65 or older.¹⁴

Nonetheless, firms offering retiree health benefits have reported that they have made substantial changes in their benefit design and/or cost-sharing requirements since 1999. According to the Kaiser/HRET/Commonwealth survey, more than half (53 percent) of employers offering retiree health benefits reported increasing the retirees' share of premiums in the past two years.¹⁵ One of every three firms (32 percent) increased cost-sharing for prescription drug coverage in the past two years. Many firms predict that they will increase retiree cost-sharing over the next two years. In testimony before Congress, William J. Scanlon, director of health care issues for the GAO, stated that "increasing cost pressures on employers, such as rising premiums and a weakening economy, suggest that erosion in retiree health benefits may continue."¹⁶

Medicare+Choice

Nationally, about 15 percent of older and disabled Americans get their Medicare-covered services through private M+C plans. This figure has declined from about 18 percent in 1999.¹⁷ While they place some restrictions on choice of doctors and hospitals, M+C plans have attracted beneficiaries generally because they offer additional benefits to Medicare, such as prescription drugs and vision care, at low premiums. While M+C is not synonymous with supplemental insurance, its enrollees typically have benefits beyond the traditional Medicare package. Since the early 1990s, many beneficiaries turned to M+C plans to obtain the sort of benefits available in costly Medigap policies at lower or no costs, particularly prescription drug benefits.

FIGURE 1
Sources of Additional Health Coverage
for Medicare Beneficiaries, 1999



Note: Sample of 11,859 consists of community-dwelling Medicare beneficiaries in 1999. Medigap also includes those with both Medigap and employer-sponsored coverage, as well as those with only Medigap coverage.

Source: Medicare Current Beneficiary Survey, Cost and Use file, 1999. Medicare Payment Advisory Commission, Report to the Congress: Assessing Medicare Benefits, June 2002, 17.

Access to M+C coverage is hardly universal among Medicare beneficiaries. In 2002, only 61 percent of beneficiaries had access to at least one M+C plan in their county, down from 72 percent in 1999.¹⁸ Differences in access between urban and rural beneficiaries are striking. According to an analysis by Mathematica Policy Research, 95 percent of Medicare beneficiaries in central urban areas had access to at least one M+C plan in 2002, while only 19 percent of those who resided in a “rural-urban fringe” area did and only 5 percent of those in other rural locales did.

Considerable variation exists in the design and expansiveness of M+C benefits, as well as in the structure of the copayments for hospitalization and physician visits. Widespread withdrawals by health plans from the M+C marketplace since 1999 have resulted in fewer M+C plans available to beneficiaries and in higher premiums and less generous benefit packages for those who do participate.¹⁹ According to the Mathematica analysis, for those who had to pay a premium, the average monthly cost has risen from \$32.11 in 1999 to \$54.05 in 2002.²⁰ Prescription drug coverage has declined from 84 percent in 1999 to 72 percent in 2002. Generic-only drug coverage has increased from 12 percent in 2001 to 40 percent in 2002. Annual prescription drug limits of \$500 or less have also become more common. Eighty percent of M+C enrollees have inpatient hospital cost sharing in 2002, and more enrollees have been required to pay increased copayments for outpatient services.

Advocates and counselors have expressed concern that M+C plans have become more like traditional Medicare in terms of the cost-sharing burden on vulnerable beneficiaries, such as the low-income and chronically ill. Yet those beneficiaries who still have an M+C option usually take it because it still provides comparatively good coverage for the price.²¹

Medicaid

State Medicaid programs provide help with some or all of the health care costs that Medicare does not cover for certain low-income, sick, and disabled Medicare beneficiaries. About 11 percent of community-dwelling beneficiaries received supplemental coverage through Medicaid in 1999.²²

By federal law, state Medicaid programs must pay Part B premiums and Medicare cost-sharing expenses for low-income Medicare beneficiaries who qualify for Supplemental Security Income, or who are deemed to be medically needy.²³ These beneficiaries are also eligible for all benefits provided by their state Medicaid program, such as coverage for preventive services, prescription drugs, and long-term nursing home care.

Other low-income beneficiaries who do not qualify for full Medicaid benefits may be eligible for additional programs that help pay for Medicare premiums and/or cost sharing, such as the Qualified Medicare Beneficiary and the Specified Low-Income Medicare Beneficiary programs.²⁴

Because Medicaid eligibility is dependent on income, Medicare beneficiaries may go on and off Medicaid as a result of income fluctuations, making it a somewhat unstable means of supplementing Medicare coverage. More commonly, at least among elderly beneficiaries, studies have shown that fewer than half of those eligible for Medicaid assistance actually enroll. Analysts have attributed this low participation rate to lack of awareness of the program, the stigma associated with Medicaid, and barriers to enrollment (for example, complex enrollment processes).²⁵

Medigap

Since many employers do not offer retiree health insurance, M+C plans are not available in many parts of the country, and Medicaid eligibility is dependent on income, private Medigap insurance is the only supplemental insurance option widely available to seniors. According to one estimate, 24.3 percent of Medicare beneficiaries had Medigap policies in fall 1999 (see Table 3).²⁶

A review of studies on supplemental coverage, conducted by the Medicare Payment Advisory Commission (MedPAC), found those beneficiaries who were most likely to purchase individual Medigap policies tended to be “older, female, white, more educated, and wealthier than beneficiaries who did not purchase Medigap policies.”²⁷ Rural beneficiaries were much more likely to have a Medigap policy than beneficiaries in urban areas, who often had more options.

Because of the complexities of the private supplemental insurance market and the relative inattention to it in policy circles of late, the remainder of this paper focuses on the Medigap market and how it relates to current options for reform.

MEDIGAP STANDARDIZATION

The individual Medigap market has been subject to a number of problems, which has resulted in a great deal of federal regulation since the 1980s. Congress enacted the “Baucus amendments” of 1980 (P.L. 96-265) in response to marketing abuses, duplication of coverage, and consumer confusion within the Medigap market. This legislation established criteria for a voluntary certification program of qualified Medigap plans that was widely implemented by most states. Under the Baucus amendment criteria, Medigap policies had to meet minimum benefit package standards and minimum loss ratios²⁸ and comply with various disclosure requirements to prospective policyholders.

The Baucus amendments reduced marketing abuses and ensured that policies provided minimum coverage, yet consumers still faced hundreds of different configurations of benefits available.²⁹ Many were subject to abusive sales practices and purchased multiple policies, which often duplicated existing coverage. To address these problems, Congress enacted

Rural beneficiaries were much more likely to have a Medigap policy than beneficiaries in urban areas, who often had more options.

TABLE 3
Percentage of Medicare Beneficiaries with Various Types of Supplemental Insurance Coverage, by Selected Beneficiary Characteristics, Fall 1999

	Medicare Beneficiaries	Medicaid	Medicare HMO	Employer-Sponsored	Medigap	Other Public	FFS Medicare Only
All Beneficiaries							
By percent	100.0%	10.9%	17.3%	33.1%	24.3%	1.9%	12.5%
By number (<i>millions</i>)	34.6	3.8	6.0	11.5	8.4	0.7	4.3
Age							
Under 65	4.4%	32.5%	8.5%	21.3%	6.0%	3.7%	28.0%
65 – 74	15.7	7.3	19.9	36.1	23.6	1.9	11.3
75 – 84	11.4	7.3	17.8	34.8	30.3	1.1	8.8
85 and older	3.2	11.7	15.3	28.7	32.0	2.2	10.3
Metro Status							
Rural	8.3	12.1	3.2	30.4	35.4	2.3	16.6
Urban	26.3	10.5	21.8	34.0	20.8	1.8	11.2
Gender							
Male	15.3	8.9	17.3	33.7	22.4	2.0	15.7
Female	19.3	12.5	17.4	32.5	25.8	1.8	9.9
Race / Ethnicity							
White (<i>non-Hispanic</i>)	27.7	6.6	17.1	36.5	27.8	1.5	10.6
Black (<i>non-Hispanic</i>)	3.1	27.3	17.2	20.6	7.4	2.4	25.2
Hispanic (<i>any race</i>)	2.5	30.7	20.8	17.1	11.3	5.1	15.1
Other race/ethnicity	0.9	31.7	21.3	15.4	13.5	3.1	15.1
Income							
\$10,000 or less	7.9	37.4	12.8	10.9	17.2	3.6	18.1
\$10,001 – \$20,000	9.2	6.3	20.8	28.3	26.4	2.2	16.0
\$20,001 – \$30,000	5.7	1.1	19.7	43.2	27.2	1.0	7.9
More than \$30,000	9.2	0.4	15.4	50.7	25.9	0.8	6.9
Self-Reported Health Status							
Excellent/Very Good	14.2	5.2	20.3	36.9	26.0	1.3	10.4
Good	10.9	10.1	17.0	33.8	26.0	1.8	11.4
Fair/Poor	9.5	20.4	13.4	26.5	19.9	2.9	16.9
Chronic Conditions							
None	4.3	9.9	18.9	30.5	21.2	1.4	18.2
1 – 2	16.3	8.8	18.2	33.8	24.8	2.0	12.4
3 – 4	11.3	12.1	16.5	33.3	25.3	1.8	11.0
5 or more	2.6	20.5	13.1	31.7	22.1	2.8	9.8

Estimates are based on beneficiaries' insurance coverage status in the fall of 1999 and apply to noninstitutionalized beneficiaries enrolled in Medicare for the entire year. Chi-square tests of independence between each beneficiary characteristic and sources of supplemental insurance coverage were statistically significant at the 99 percent confidence level. Chronic conditions include heart disease, hypertension, diabetes, arthritis, osteoporosis, broken hip, pulmonary disease, stroke, Parkinson's disease, and urinary incontinence that occurs at least once a week. Employer-sponsored current and employer-sponsored retiree coverage are combined under "employer-sponsored." FFS is fee-for-service.

Source: Medicare Current Beneficiary Survey Access to Care data, Health Affairs, Web Exclusive, February 27, 2002, W133.

significant reforms in the Medigap market as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).

OBRA 1990 replaced voluntary state certification with national requirements that all Medigap policies sold after July 1992 conform to one of 10 uniform benefit packages (except in three exempted states).³⁰ The process undertaken to establish the benefit packages was unique in that Congress gave a private entity, the National Association of Insurance Commissioners (NAIC), the authority to formulate the specifications. The ten benefit packages were developed by a working group, composed of both insurers and consumers, under the auspices of NAIC.³¹

The ten standardized Medigap options (labeled A, B, C, . . . J) are shown in Table 4. All plans cover a core set of services, and the benefits generally increase in comprehensiveness from A through J. Standardization was designed to facilitate comparison shopping for consumers. In addition, standardization eliminated some benefits (such as private-duty nursing) that, while purchased by some consumers, may not have provided much value in relation to their costs.³²

OBRA 1990 also contained several other provisions related to Medigap, including the following:³³

TABLE 4
Medigap Plans A through J

Covered Benefits	A	B	C	D	E	F*	G	H	I	J*
Core Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
SNF Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Part B Deductible			✓			✓				✓
Part B Excess Charges						✓	a		✓	✓
Prescription Drugs								b	b	c
Preventive Medical Care					✓					

* Plans F and J also have a high-deductible option under which covered individuals must pay a deductible (\$1,620 in 2002) before the plan pays anything.

a Plan G pays 80 percent of the difference between the physician's charge and the Medicare allowable rate; Plans F, I, and J pay 100 percent.

b After \$250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of \$1,250.

c After \$250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of \$3,000.

Source: Centers for Medicare and Medicaid Services.

Notes: SNF = Skilled Nursing Facility
Plan types A–J represent the 10 uniform benefit packages mandated by OBRA 1990. Plan A represents the least comprehensive package. Plan J represents the most comprehensive. This chart does not apply for individuals living in Massachusetts, Minnesota, or Wisconsin.

- Requiring insurers to hold a six-month open-enrollment period when beneficiaries 65 years or older first enroll in Part B. During this six-month window, beneficiaries cannot be denied coverage or be charged more based on their health status.
- Increasing the minimum loss ratio requirements for individual policies.
- Instituting severe penalties for agents and insurers who knowingly sell duplicate coverage.
- Limiting agents' commissions during the initial year of coverage under a new policy to reduce the incentive to "churn" or switch coverage to earn additional commissions.
- Requiring that pre-existing condition exclusions not exceed six months in duration.

Policy standardization appears to have had a major impact on the Medigap market. The range of premiums narrowed significantly between 1991 and 1994, indicating that premiums had become more competitive and consumers were better able to assess policy value.³⁴ Yet concerns remained about the adequacy and desirability of the benefits available and the risk for adverse selection.

MEDIGAP PLAN DISTRIBUTION AND PREMIUM TRENDS

Since the creation of the 10 standardized plans, most Medigap plan enrollment has been concentrated in two plans: F and C. MedPAC analysis of 2000 NAIC data found that 35 percent of Medigap policyholders enrolled in standardized plans were in Plan F, and 26 percent were in Plan C.³⁵ These plans offer identical benefits, with the exception that Plan F also provides full coverage for Part B charges in excess of the amount Medicare will allow.³⁶ Plans A and B each comprise 10 percent of policyholders in standardized plans. Altogether, the three plans with standardized prescription drug coverage (H, I, and J) comprised about 9 percent of the market in 2000.

Nationally, a few insurers dominate the Medigap market. In 1999, 64 percent of Medigap policies were sold by either United HealthCare or a Blue Cross/Blue Shield Plan.³⁷ United HealthCare offers all ten standardized plans to AARP members during the initial open enrollment period in nearly all states. All insurers marketing Medigap policies must offer Plan A. Many offer Plans B, C, and F, but few offer the other six plans, especially those that cover prescription drugs.

Medigap plans are guaranteed renewable. Therefore, once an individual purchases a policy, it cannot be cancelled (except for failure to pay the premiums). However, insurers are not prevented from increasing premiums over time. Furthermore, if someone decides to change policies, he or she could be subject to underwriting practices.

What All Medigap Plans [A-J] Must Cover (Core Benefits)

The Medicare Part A coinsurance amount for days 61–90 (\$203 per day in 2002), and days 91–150 (\$406 per day in 2002) of a hospital stay.

The cost of 365 extra days of hospital care during the insured's lifetime after Medicare coverage ends.

The Medicare Part B coinsurance or copayment amount.

The first three pints of blood each year.

What Medigap Policies Do Not Cover

Long-term care

Vision or dental care

Hearing aids

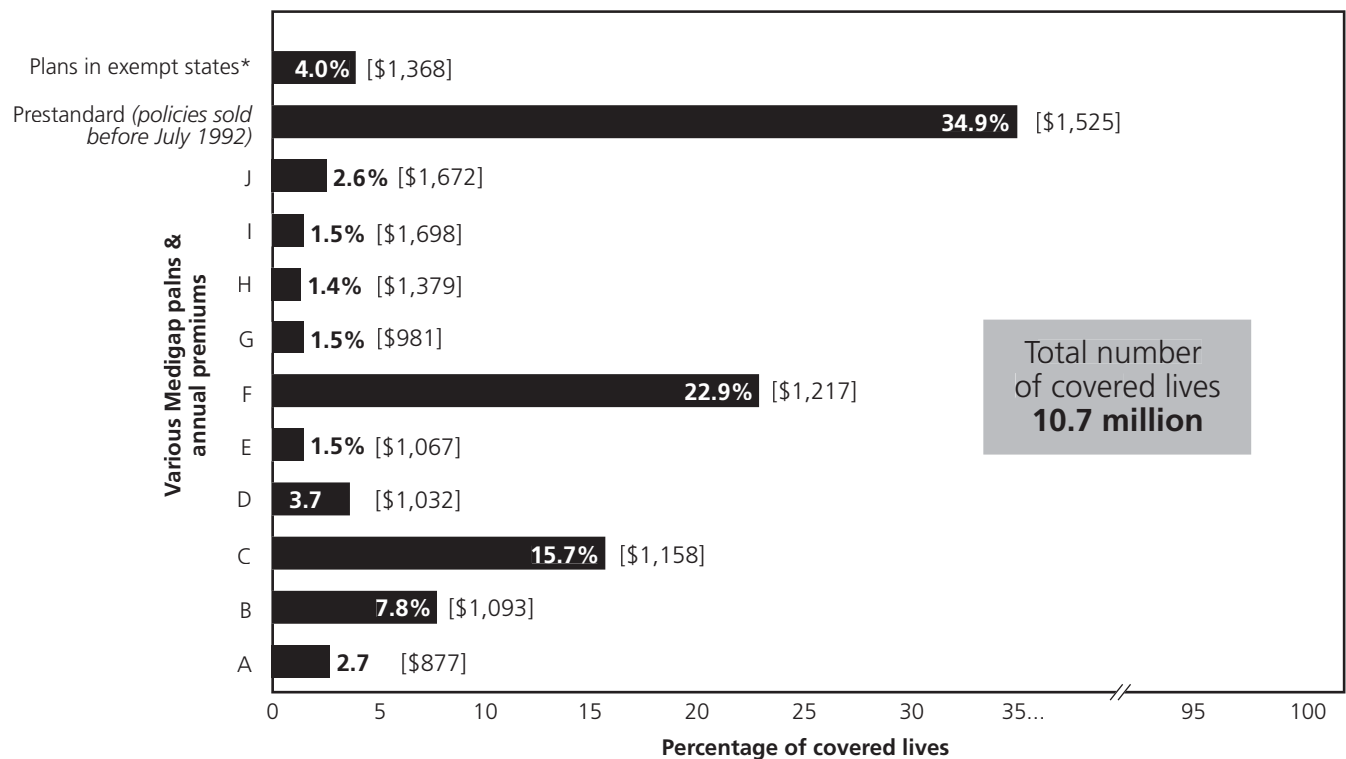
Private-duty nursing

Unlimited prescription drugs

OBRA 1990 permitted policies issued before July 1992 (OBRA 1990's effective date) to stay in place. In 2000, about 31 percent of individual Medigap policies in force were these so-called prestandard policies. The number of individuals enrolled in these plans continues to decline each year as enrollees age and die.

Medigap policies can be expensive, particularly for seniors on fixed incomes. The average annual Medigap premium was more than \$1,300 in 1999 (see Figure 2). In addition to the variations in cost based on level of coverage, premiums vary widely from state to state, city to city, and insurer to insurer. Consumers buying Medigap in California, Indiana, and Florida, for example, can be charged as much as four times more than consumers in New Hampshire, Pennsylvania, Utah, and Montana.³⁸

FIGURE 2
Percentage of Covered Lives in Various Medigap Plans
and
Average Annual Plan Premiums per Covered Life, 1999



* Massachusetts, Minnesota, and Wisconsin have alternative plans in effect and waivers that exempt them from selling the national standard Medigap plans.

Notes: Data reported by insurers to the National Association of Insurance Commissioners (NAIC) do not include plan type for policies repre-

senting less than 8 percent of Medigap policy covered lives, with an average paid premium of \$1,275. These plans are not included in the table.

Percentages do not add to 100 due to rounding.

Source: U.S. General Accounting Office (GAO-02-533T).

Annual tracking of premium quotes by Weiss Ratings Inc., an independent firm that collects premium data on behalf of the Centers for Medicare and Medicaid Services, has found that premium quotes can vary widely for the same plan type offered by different insurers for the same individual, even in the same location.³⁹ For example, in 2002 in Texas, the rate quoted for Plan F varies from a low of \$887 to a high of \$2,487 for a 65-year-old woman. In Arkansas, prices quoted for Plan J ranged from \$2,878 to \$9,376.

Medigap policyholders have also faced a pattern of erratic and often unpredictable increases in premiums. Averaged across all states, the growth in average premiums across all plan types from 1997 to 1999 was modest, ranging from less than 1 percent to about 3 percent. However, from state to state, premium changes were dramatic. According to Deborah Chollet and Adele Kirk, "median premium changes ranged from less than 1 percent (in policy form J, where enrollment typically is very low) to more than 23 percent in policy form B. The median increase in average prestandard premiums was nearly 16 percent."⁴⁰

RATING PRACTICES

Insurers' rating practices play an important role in determining the Medigap premium. While federal and some state laws provide some protections for consumers, Medigap insurers are still permitted to screen for health conditions when issuing policies beyond the initial open enrollment period.

OBRA 1990 requires an open enrollment period when an individual is age 65 or older and first enrolled in Medicare Part B. During this enrollment period, Medigap insurers are not permitted to deny coverage or discriminate in setting premiums on the basis of an applicant's health (that is, to underwrite). Beyond these provisions, OBRA 1990 did not address underwriting or rating practices. The Balanced Budget Act of 1997 (BBA) prohibited underwriting during specific additional times, such as when a beneficiary loses M+C coverage due to plan termination, or when a Medicare beneficiary loses employer-sponsored health benefits. These additional guaranteed issue rights are only extended to plan types A, B, C, or F, and do not extend to plans that include prescription drug coverage. Outside of these federal protections and some limited state restrictions, Medigap insurers are still permitted to underwrite.

The underwriting practices that prevail outside of this narrow open enrollment period has significantly limited the ability of consumers to switch policies or carriers when they wish. According to Chollet and Kirk, "most Medicare beneficiaries may have no real option ever to change their insurer or particular Medigap policy for the rest of their lives."⁴¹

The standardization of Medigap plans in 1992 encouraged market competition around price rather than product differentiation. This shift has

led to a move away from community and issue-age rating to attained-age rating as carriers try to attract younger beneficiaries. A 1997 study conducted by the Lewin Group found that fewer insurers were charging the same premiums for all policyholders (community rating) or basing premiums on the policyholder's age at the time of initial purchase (issue-age rating).⁴² Instead, the majority of insurers appeared to be basing premiums on the current age of the policyholder (attained-age rating). Outside of mandatory open enrollment periods and guaranteed issue situations, most insurers underwrite, so people may face higher rates due to health status. The study found that, in many markets, only plans sponsored by AARP offered community-rated policies. As a result, these AARP-sponsored plans often become the insurer of last resort when age-rated plans become too expensive for those with health conditions.

Some states have gone beyond federal requirements and have limited underwriting and insurance practices in the Medigap market. Eight states (Arkansas, Connecticut, Maine, Massachusetts, Minnesota, and Washington) have mandatory community rating. Ten states have banned attained age rating and six have prohibited entry-age rating.⁴³ A few other states require continuous open enrollment or annual open enrollment.

In addressing Medigap rating practices, there is an inherent tension between federal and state authorities. States traditionally regulate insurance markets, but OBRA 1990 set a new precedent in federal oversight and control. Establishing new federal requirements regarding enrollment and underwriting practices would likely be met by strong resistance from states and insurers.

Medigap coverage for younger, disabled beneficiaries is another issue that has been raised when looking at underwriting practices. Individuals under 65 who become eligible for Medicare because of a disability account for 13 percent of all beneficiaries, but only 1 percent of Medigap policyholders. This is largely because insurers are not required to extend the mandatory initial open-enrollment period to beneficiaries under 65. Extending mandatory open enrollment to these individuals could greatly increase their access to Medigap insurance; however, because they are likely to have greater claims, premiums may not be affordable and may increase for other Medigap policyholders.

OPPORTUNITIES FOR REFORM

Prescription Drug Coverage

Prescription drug coverage for Medicare beneficiaries has been the subject of intense congressional debate. As various options are being considered, it is important to understand the role of Medigap in providing prescription drug coverage and the potential impact of a Medicare drug benefit on Medigap policyholders.

Insurers use different methods in pricing Medigap policies.

Community Rating — Premiums are based on the cost of providing coverage in local areas and not on health status or age.

Issue-age Rating — Premiums are based on the policyholder's age at the time of initial purchase. Premiums will not increase as much as attained-age policies over time.

Attained-age Rating — Premiums are based on the current age of the policyholder. Premiums can increase significantly as the policyholder grows older.

As stated earlier, three standardized Medigap plans—Plans H, I, and J—provide coverage for prescription drugs. While about 10.7 million Medicare beneficiaries had a Medigap plan in 1999, only about 25 percent have purchased drug coverage through Medigap. A large number of these policyholders are in prestandard plans, and their coverage is believed to be less generous than that offered in the standard policies.⁴⁴ Since mid-1992, just 8 percent of those purchasing standardized Medigap policies bought one that covers prescription drugs.⁴⁵ These low coverage levels are generally attributed to three reasons: price, benefit design, and failure of competition.

Price — Medigap plans with drug coverage tend to be more expensive than those without drug coverage. In 2000, annual premiums for standardized plans that include outpatient prescription drug coverage ranged from \$1,308 for plan H (cap of \$1,250 on prescription drugs) to \$2,112 for Plan J (cap of \$3,000), with an average premium of \$1,776 across all three plan types that cover drugs. This compares to an average annual premium of \$1,150 for standardized plans without prescription drug coverage. However, premium rates can vary widely based on the age and health status of the applicant, and guaranteed issue rights do not extend to plans that include drug coverage, beyond the initial open enrollment period.

Benefit Design — Because Medigap’s standardized policies provide limited coverage for prescription drugs, beneficiaries who purchase this coverage can still be exposed to significant out-of-pocket expenses. The Medigap prescription drug benefit has a \$250 annual deductible, requires 50 percent coinsurance, and limits plan liability to \$1,250 or \$3,000, depending on which plan type is purchased. These dollar amounts have not been increased since they were established in 1992.

According to the GAO, Medigap policyholders with prescription drug coverage spent, on average in 1998, \$548 out of pocket on prescription drugs.⁴⁶ Medigap paid only 27 percent of policyholders’ drug costs. Medigap policyholders without drug coverage spent, on average \$618—about 13 percent more than beneficiaries with drug coverage. According to a recent survey, Medigap drug coverage appears to offer the least financial protection of supplemental coverage currently available.⁴⁷ The survey found that Medigap policyholders reported higher out-of-pocket prescription drug costs than groups covered by other sources (for example, Medicaid, employer, health maintenance organization [HMO], and state drug program), despite taking a similar number of medications, or fewer, than other covered groups. Thus, many beneficiaries may be acting rationally in choosing not to purchase Medigap drug coverage, since the benefit can be of limited value to them.

Lack of Competition — Another reason for the rapid growth in premiums for Medigap plans with drug coverage relates to the way the benefits are managed in the Medigap marketplace. Unlike employer-sponsored

Since mid-1992, just 8 percent of those purchasing standardized Medigap policies bought one that covers prescription drugs.

plans, which typically hire pharmacy benefit managers to control drug costs, and Medicaid, which receives rebates from pharmaceutical manufacturers, Medigap policyholders sometimes pay full retail price. Individual Medigap plans provide no real incentives for insurers to bargain with drug manufacturers or retailers for lower prices; nonetheless, most Medigap insurers do offer drug discount programs.

Between 1994 and 1999, 56 percent of the beneficiaries that left the Medigap market went to a Medicare HMO.⁴⁸ The availability of prescription drug coverage in Medicare HMOs contributed greatly to this switch. Now, in the wake of widespread withdrawals in the M+C markets and reduced drug benefits, some beneficiaries may seek to re-enter the Medigap market. Due to underwriting practices, however, plans may not be accepting new enrollees in their drug plans and the costs may be prohibitive.

The introduction of a prescription drug benefit for all Medicare beneficiaries, therefore, may have a limited impact on the Medigap market. However, if beneficiaries are forced to choose between paying a Medigap premium or a drug benefit premium, those on fixed incomes may face a dilemma.

The Bush administration has proposed the addition of two new Medigap plans to the existing ten standardized plans. One, like the current Plan J, would provide coverage for additional drug expenses, but with a higher stop-loss limit and reduced coverage of Medicare cost-sharing.⁴⁹ However, insurers have warned that more generous Medigap drug coverage might lead to severe adverse selection for those insurers who choose to offer it.⁵⁰ Adverse selection occurs because those who expect to receive the most in benefits from the policy will purchase it immediately, while those who expect to have few claims will forego purchasing it. Insurers maintain that the requirement that Medigap policies be “guaranteed renewable” already exacerbates problems with creating affordable insurance.

First-Dollar Coverage

All ten of the standardized Medigap plans cover Part A and Part B coinsurance, and three plans cover the Part B deductible, shielding beneficiaries from most Medicare cost-sharing requirements. This so-called “first-dollar coverage” has generated significant policy discussion over the past two decades. Several studies have examined the relationship between Medicare supplemental insurance and Medicare expenditures and have consistently found that supplemental insurance is associated with increased costs to the Medicare program.⁵¹ Another issue is that none of the standardized policies allow consumers to choose higher deductibles in return for lower premiums and complete stop-loss coverage—often referred to as “catastrophic” insurance.

Supplemental insurance is associated with increased costs to the Medicare program.

MedPAC states that

making beneficiaries responsible for some of the marginal costs of services would increase their price sensitivity and encourage them to be more judicious in their use of care. This, in turn, would reduce Medicare spending. Changes of this sort also would likely result in lower Medigap premiums or, at a minimum, slower premium increases, making Medigap a more affordable option.⁵²

The Bush administration's two new Medigap options would cover all of the coinsurance for extended hospital stays in the same way that current Medigap plans do, but they would not cover the Part B deductible. The administration believes these options would appeal to beneficiaries who want lower premiums but have not chosen to enroll in one of the two high-deductible options, which were created under the BBA and have not proven to be popular. These high-deductible options, available for plans F and J, require beneficiaries to pay a \$1,620 deductible before either plan covers any services. Very few of these plans have been offered by insurers.

In testimony before Congress, Donald Young, president of the Health Insurance Association of America, pointed out that the three plans that cover the Part B deductible are twice as popular as the other seven plans combined.⁵³ According to Young, "this popularity is likely due to the fact that Medicare beneficiaries are risk averse and derive a great deal of financial and personal security from their supplemental insurance policies." Moreover, he also pointed to reports warning that restrictions on first-dollar coverage might limit access to necessary care, noting that the health of some policyholders might be adversely affected. Supplemental insurance's effect on health is unclear, according to a comprehensive literature review by Adam Atherly.⁵⁴

As indicated, few of the new high-deductible Medigap products have actually been sold. Insurers have not actively marketed these plans because of administrative difficulties and higher costs. Also, they maintain, consumers do not want these high-deductible options. According to Young, the biggest hurdle to the sale of these products is that beneficiaries expect Medigap plans to provide first-dollar coverage. Consumer advocate Bonnie Burns, a member of the NAIC working group responsible for designing the ten benefit packages, agrees. She states that "some people would risk going without a Medigap policy if it were not for the open ended Part B coinsurance costs."⁵⁵ Prior to Medigap standardization, she maintains, consumers were confused by cost sharing on the Part B coinsurance, and heavy users faced serious repercussions since they often waited to get care because they had to pay out-of-pocket costs.

MedPAC suggests that these concerns could be mitigated "by requiring that beneficiaries make a fixed copayment (for example, \$5 or \$10) at the time of service rather than pay a percentage of the provider's charge."⁵⁶ Another possibility raised by MedPAC would combine reduced coverage

Few of the new high-deductible Medigap products have actually been sold.

of Part B coinsurance with an annual cap on cost-sharing, thereby limiting beneficiaries' liabilities but still exposing them to some costs when they use care.

Benefit Design

The ten standardized benefit plans have not been updated since they were established in 1992. Since then, the health care environment has changed considerably and many argue that the Medigap benefit design has become outdated. While the standardization of benefits has made them easier for consumers to understand, it has also stifled experimentation with different types of and levels of coverage, which could potentially reduce costs or enhance the quality of benefits. With only ten packages, standardization necessarily limits choice of benefit combinations for consumers. Yet, since the majority of Medigap policyholders choose three plan types, it appears that the remaining seven options do not meet consumer or insurer needs.

In addition, many of the benefits deemed necessary in 1992 have lost value due to changes in what Medicare covers. For example, with regard to preventive benefits, several screening tests that were identified during the development of the standardized plans are now Medicare-covered services and sometimes result in duplicate billing under Medicare and Medigap. Similarly, coverage for services from physicians who do not accept assignment (Part B excess charges) has little value to policyholders since "program assignment rates are well over 90 percent, and physicians are not permitted to charge more than 15 percent above the Medicare fee schedule."⁵⁷

The "at-home recovery" benefit has also proven confusing to beneficiaries and not particularly useful. The benefit has many coverage limitations and exclusions that require it to be carefully coordinated with Medicare-approved home health services. Some analysts have suggested that it might be appropriate to restructure the at-home recovery benefit to cover only visits that occur *after* the beneficiary has been discharged from the Medicare-approved home health plan of care.⁵⁸

Some Medigap experts have suggested offering fewer standardized plans or allowing plans to add optional riders (such as those allowed in Wisconsin and Minnesota). Some private insurers have promoted more flexibility in benefit design. Others have encouraged more expansion of the private fee-for-service or preferred provider options under M+C, which allows insurers the flexibility to depart from standardized Medigap options and offer additional benefits. On August 27, 2002, the Bush administration announced that it will expand PPO options under M+C.⁵⁹

In addition, the Department of Health and Human Services announced proposed changes to the Medicare Select program. Medicare Select plans were authorized under OBRA 1990, but only 9 percent of beneficiaries

Many of the benefits deemed necessary in 1992 have lost value due to changes in what Medicare covers.

enrolled in standardized Medigap plans had a Medicare Select plan in 1999.⁶⁰ Under these plans, beneficiaries are limited to choosing among hospitals and physicians in the plan's network except in emergencies. Medicare Select insurers will now be permitted to waive Part B cost-sharing amounts. The Bush administration believes this will encourage Medicare Select insurers to expand their provider networks to include more physicians and suppliers, as well as hospitals. Other analysts speculate that insurers are likely to innovate in their prescription drug offerings.

Flexibility in benefit design, however, moves away from the original goals of standardization. If the benefit package varies greatly, risk segmentation is more likely. Many of those who originally favored fewer plans now believe that the number should not be changed in order to avoid further confusion because the elderly have become accustomed to the ten plans. "In short, their plea is for stability over perfection," according to Lauren McCormack and colleagues.⁶¹

Another option might be to expand Medicare benefits to cover some or all of the gaps. In its latest congressional report, MedPAC put forward some illustrative examples of a comprehensive Medicare benefit package that would include modified cost sharing as well as additional benefits such as prescription drug benefits and stop-loss coverage. The commission concludes that under one proposed scenario of an expanded Medicare package "beneficiaries with Medigap policies might decide they no longer need supplemental insurance to cover their reduced health care liabilities. Medigap insurers also might determine that they could no longer profitably offer plans that spread relatively fixed administrative costs across a reduced scope of benefits."⁶²

Stop-loss protections—that is, a guaranteed amount above which the government (and not the individual) pays for any additional cost sharing—appear to be the key to benefit package reforms that meet consumer needs. However, in testimony before Congress, Marilyn Moon warns that "The problem with stop loss has always been that when it is low enough to be attractive, it becomes very expensive."⁶³

CONCLUSION

In MedPAC's assessment, Medicare's current benefit structure reflects "policymakers' decisions about how to balance financial protection on the one hand against the financial burden on taxpayers and beneficiaries on the other."⁶⁴ Medigap reforms are subject to the same trade-offs. If benefits are made more generous, enrollees will likely experience higher premiums.

Efforts to reform Medicare are complicated by the myriad of supplemental insurance products available to beneficiaries. Medicare's coverage gaps create a system that is segmented and pluralistic. Varying coverage,

rating, and enrollment practices across plan types make it difficult for consumers to compare their options. Budget constraints mean that the tension between providing catastrophic coverage to the sickest beneficiaries and first-dollar coverage for those who are risk-averse will likely worsen with time. In light of changes to retiree health insurance plans and M+C plans, the time seems ripe to reconsider whether the Medigap market is fulfilling policymakers' goals and expectations.

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