



Recent Proposals to Limit Medigap Coverage and Modify Medicare Cost Sharing

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OVERVIEW — As policymakers look for savings from the Medicare program, some have proposed eliminating or discouraging “first-dollar coverage” available through privately purchased Medigap policies. Medigap coverage, which beneficiaries obtain to protect themselves from Medicare’s cost-sharing requirements and its lack of a cap on out-of-pocket spending, may discourage the judicious use of medical services by reducing or eliminating beneficiary cost sharing. It is estimated that eliminating such coverage, which has been shown to be associated with higher Medicare spending, and requiring some cost sharing would encourage beneficiaries to reduce their service use and thus reduce program spending. However, eliminating first-dollar coverage could cause some beneficiaries to incur higher spending or forego necessary services. Some policy proposals to eliminate first-dollar coverage would also modify Medicare’s cost sharing and add an out-of-pocket spending cap for fee-for-service Medicare. This paper discusses Medicare’s current cost-sharing requirements, Medigap insurance, and proposals to modify Medicare’s cost sharing and eliminate first-dollar coverage in Medigap plans. It reviews the evidence on the effects of first-dollar coverage on spending, some objections to eliminating first-dollar coverage, and results of research that has modeled the impact of eliminating first-dollar coverage, modifying Medicare’s cost-sharing requirements, and adding an out-of-pocket limit on beneficiaries’ spending.

Beneficiaries in fee-for-service Medicare are liable for cost sharing for services covered under Parts A and B (Table 1, next page).¹ The amount of the cost sharing varies by service and, in some cases, by the number of days the service is used. Medicare Part A has a relatively high deductible (\$1,156 in 2012) for inpatient stays for each spell of illness and varying daily copayments for extended hospital stays. Part B has a relatively low annual deductible (\$140 in 2012), but has 20 percent copayment on physician visits and most other Part B services.

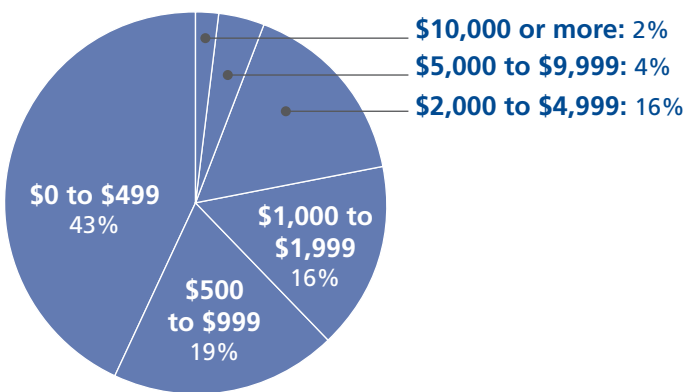
There is no upper limit on beneficiaries' out-of-pocket spending in fee-for-service Medicare, which leaves beneficiaries at risk for significant expenditures if they use a lot of health care services or very expensive services. In any given year, cost-sharing liability varies

across beneficiaries. In 2009, 43 percent of beneficiaries had cost-sharing liability of less than \$500, while 6 percent had more than \$5,000 in cost-sharing liability. See Figure 1 for the distribution of fee-for-service (FFS) beneficiaries' Medicare cost-sharing liabilities in 2009.

To protect against some or all of their liability for cost sharing and the absence of a cap on out-of-pocket expenditures, over 90 percent of beneficiaries had some kind of supplemental coverage in 2010.² About one-third of beneficiaries had supplemental coverage through an employer-sponsored retiree plan, which may cover all or some of Medicare's cost sharing, but is an option only for those whose employers offer such coverage.³ Over one-

quarter of beneficiaries are enrolled in Medicare Advantage plans, which have an annual mandatory maximum out-of-pocket limit on total enrollee cost-sharing liability for Parts A and B services, and may have lower cost sharing and offer more benefits than traditional FFS Medicare. Another one-fifth of Medicare beneficiaries are dually eligible for Medicaid, which covers some or all of their cost sharing. One in five Medicare beneficiaries had a Medigap policy in 2010.⁴

FIGURE 1
Cost-Sharing Liability for Medicare Fee-for-Service Beneficiaries, 2009



Note: The amounts reflect Medicare beneficiaries' liability but do not reflect what Medicare beneficiaries actually paid out of pocket because most beneficiaries have supplemental coverage that covers all or some of their Medicare cost sharing.

Source: Medicare Payment Advisory Commission, "Reforming Medicare's Benefit Design," presentation to the Commission, October 7, 2011, p. 8, available at www.medpac.gov/transcripts/benefit%20design.pdf.

TABLE 1
Medicare Cost Sharing, 2012

SERVICES	BENEFICIARY LIABILITY
Part A	
Hospital Inpatient Stay	<ul style="list-style-type: none"> • \$1,156 deductible per benefit period • \$0 for the first 60 days of each benefit period • \$289 per day for days 61–90 of each benefit period • \$578 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over a lifetime) • All charges for each day after the exhaustion of covered benefit period and lifetime reserve days
Skilled Nursing Facility	<ul style="list-style-type: none"> • \$0 for the first 20 days per benefit period • \$144.50 per day for days 21–100 of each benefit period • All charges for each day after day 100 in a benefit period
Home Health Care	<ul style="list-style-type: none"> • \$0 for Medicare-approved services
Hospice Care	<ul style="list-style-type: none"> • \$0 for hospice care • A copayment of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management • 5 percent of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest)
Blood	If the hospital has to buy blood, beneficiaries must either pay the hospital costs for the first three units of blood in a calendar year or have the blood donated.
Part B	
Part B Deductible	\$140 per year
Medical and Other Services (including physician services)	20 percent of the Medicare-approved amount for most doctor services, outpatient therapy, durable medical equipment, and drugs covered under Part B
Outpatient Hospital Services	Coinsurance (for doctor services) or a copayment amount for most outpatient hospital services that varies by service (amounts are being phased down over time to 20 percent of Medicare allowed amount). The copayment for a single service cannot be more than the amount of the inpatient hospital deductible.
Mental Health Services	40 percent of the Medicare-approved amount for most outpatient mental health care
Home Health Services	\$0 for Medicare-approved services
Clinical Laboratory Services	\$0 for Medicare-approved services
Blood	<p>Beneficiaries pay a copayment for the blood processing and handling services for every unit of blood and the Part B deductible applies.</p> <p>If the provider has to buy blood, the beneficiary must either pay the provider costs for the first 3 units of blood in a calendar year or have the blood donated.</p> <p>Beneficiaries pay a copayment for additional units of blood received as an outpatient (after the first 3), and the Part B deductible applies.</p>

Source: Medicare.gov, "2012 Medicare Costs," U.S. Department of Health and Human Services, available at www.medicare.gov/cost/.

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Beneficiaries may have more than one type of supplemental coverage; for example, dual eligibles may be enrolled in Medicare Advantage plans or have a Medigap policy, and these counts reflect those overlapping sources of coverage.⁵

MEDIGAP INSURANCE

Medigap is a private individual or group health insurance product designed to pay for costs that Medicare does not cover. Medigap policies were standardized as part of the Omnibus Budget Reconciliation Act of 1990. The law mandated that all companies selling Medigap plans must offer the standard set of benefits to facilitate consumers' comparisons across products. The National Association of Insurance Commissioners (NAIC) developed ten standardized policies, designated by letters A through J, that were the only plans that could be sold after July 31, 1992 (although policies already in effect could be renewed).⁶ Individual states were permitted to restrict the number of standardized plans sold to fewer than ten. In addition, a grandfathering provision allowed states that had previously standardized their state's plan offerings to apply for an exemption from the federal rules. Massachusetts, Minnesota, and Wisconsin were eligible for this exemption and continue to permit different standardized policies to be sold in their states.⁷

Over time, standardized plans have been tweaked or eliminated and new plans have been added. The currently offered Medigap plans are designated by the letters A through N. Plans E, H, I, and J are no longer sold, except to those who had them before they were eliminated and elect to keep them. Not all letter-designated plans are available in all states. Insurers that sell Medigap plans in a state must sell plan A and must also offer plan C or F if they offer additional plans.

Medigap Benefits

All of the standardized plan types cover the Part A hospital coinsurance, 365 additional hospital days, and all or some of Part B coinsurance. (See Table 2, next page, for a list of standard policies and their benefits.) All but plan A cover some or all of the hospital deductible. Plan F, which offers the most comprehensive coverage of all the plans, is the most popular by far, with 44 percent of policyholders choosing it in 2010. Plan C, which offers identical benefits to plan

TABLE 2
Available Medigap Plan Benefits

BENEFITS	A	B	C	D	F*	G	K	L	M	N
Part A Hospital Coinsurance and Hospital Costs (up to an additional 365 days after Medicare benefits are used)	•	•	•	•	•	•	•	•	•	•
Medicare Part B Coinsurance or Copayment	•	•	•	•	•	•	50%	75%	•	•**
Blood (first 3 pints)	•	•	•	•	•	•	50%	75%	•	•
Part A Hospice Care Coinsurance or Copayment	•	•	•	•	•	•	50%	75%	•	•
Skilled Nursing Facility Care Coinsurance			•	•	•	•	50%	75%	•	•
Medicare Part A Deductible		•	•	•	•	•	50%	75%	50%	•
Medicare Part B Deductible			•		•					
Medicare Part B Excess Charges					•	•				
Foreign Travel Emergency (up to plan limits)			•	•	•	•			•	•
							Out-of-Pocket Limit			
							\$4,640	\$2,320		

• Indicates coverage of described benefit at 100 percent.

* Plan F also offers a high-deductible plan. If a beneficiary chooses this option, she must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of \$2,000 in 2011 before the Medigap policy pays anything.

** Plan N pays 100 percent of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

Source: Center for Medicare & Medicaid Services, *Medicare & You 2012*, p. 67, available at www.medicare.gov/publications/pubs/pdf/10050.pdf.

F except for coverage for Part B excess charges,⁸ is the second most popular plan with 15 percent of policyholders in 2010.⁹ Plans K and L, which cover some but not all of Medicare's cost-sharing requirements and have out-of-pocket limits on beneficiary spending, are newer products that were established in the Medicare Prescription Drug, Modernization, and Improvement Act of 2003. Premiums for these two plans are generally lower than other plans but, as of 2008, they had not proven to be very popular options, chosen by less than 0.5 percent of Medigap policyholders.¹⁰ Plans M and N are even newer—first offered in June 2010—and they too cover some but not all of

Medicare's cost sharing. Plan N is novel in that it will cover Medicare's Part B coinsurance, except for a beneficiary copayment of up to \$20 for office visits and \$50 for emergency department visits.

Guaranteed Issue and Medical Loss Ratio Requirements

All Medicare beneficiaries are eligible to purchase a Medigap policy when they turn 65.¹¹ Specifically, for six months after the first day of the month in which they are 65 and enrolled in Medicare Parts A and B, Medicare beneficiaries have an open enrollment period during which they are guaranteed to be issued a Medigap policy, provided they can pay the premiums. During this open enrollment period, insurance companies cannot apply medical underwriting (that is, charge more for a policy based on health status or pre-existing conditions), refuse to sell a Medigap policy, or make a beneficiary wait for coverage to start.¹² Beneficiaries may still be able to buy Medigap after the open enrollment period, but an insurance company does not have to sell the policy if an applicant does not meet medical underwriting requirements.¹³

In addition to requirements for standardized benefits and guaranteed issue, Medigap plans are required to meet medical loss ratio requirements. By federal law, Medigap plans must spend at least 65 cents of every premium dollar that enrollees pay on medical care (this is known as the medical loss ratio), as opposed to administrative costs, for policies sold in the individual market, and 75 cents of every premium dollar for policies sold in the group market. If plans do not meet this requirement, policyholders must be paid a refund so that the required loss ratio is met. These medical loss ratio requirements are lower than those imposed by the Patient Protection and Affordable Care Act (PPACA) on individual and small group plans; legislation was introduced in the 112th Congress to require higher medical loss ratios for Medigap plans.¹⁴ According to the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), the average enrollment-weighted medical loss ratio for individual policies was 80 percent for the period between 2001 and 2010. For that same period, the average for group policies was 83 percent.¹⁵

Medigap Market

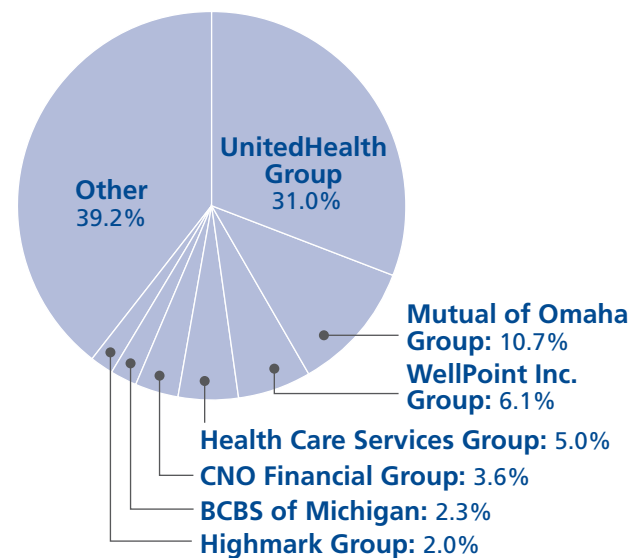
The market for Medigap plans is concentrated. (See Figure 2 for national Medigap market shares.) Two companies, active in nearly all insurance markets, have 40 percent of the national market.¹⁶ UnitedHealth Group has the largest national market share with about 31 percent. UnitedHealth Group's purchase of the AARP brand allows it to use that brand to market and sell using a recognized name.¹⁷ The Mutual of Omaha Group has nearly 11 percent of the market. Five other firms each had between 2 and 6 percent of the market. Many other firms share the remaining 39 percent of the market, but none had a market share greater than 1.8 percent. According to ASPE research, "the top 2 insurers account for more than half of the Medigap market in 45 states and more than 80 percent of the market in 12 states" in 2010.¹⁸

Medigap Premiums

Beneficiaries pay a monthly premium, set by the insurance companies selling the plans, to maintain their Medigap policies. Medigap plans are priced one of three ways, depending on the insurers' policies and the laws of the state in which the plans are sold. The difference among the three pricing methods for Medigap plans is the extent to which premiums vary with the age of the policyholder. Premiums for "community rated" policies are the same for everyone regardless of age. Premiums for "issue-age rated" policies are based on the age of the policyholder at the time the policy is purchased; people who initially purchase the policy when they are younger will have lower premiums over the life of the policy than those who initially purchase the policy at an older age. Premiums for "attained-age rated" policies are based on the current age of the policyholder, so the cost goes up as the policyholder ages.

In 2010, the average national premium for the most popular plan F was about \$172 per month (Figure 3, next page). Premiums vary across states; for example, the average monthly premium for plan F ranged from a low of \$79 per month in Vermont to \$220 per month

FIGURE 2
Medigap Market Share by Company, 2010

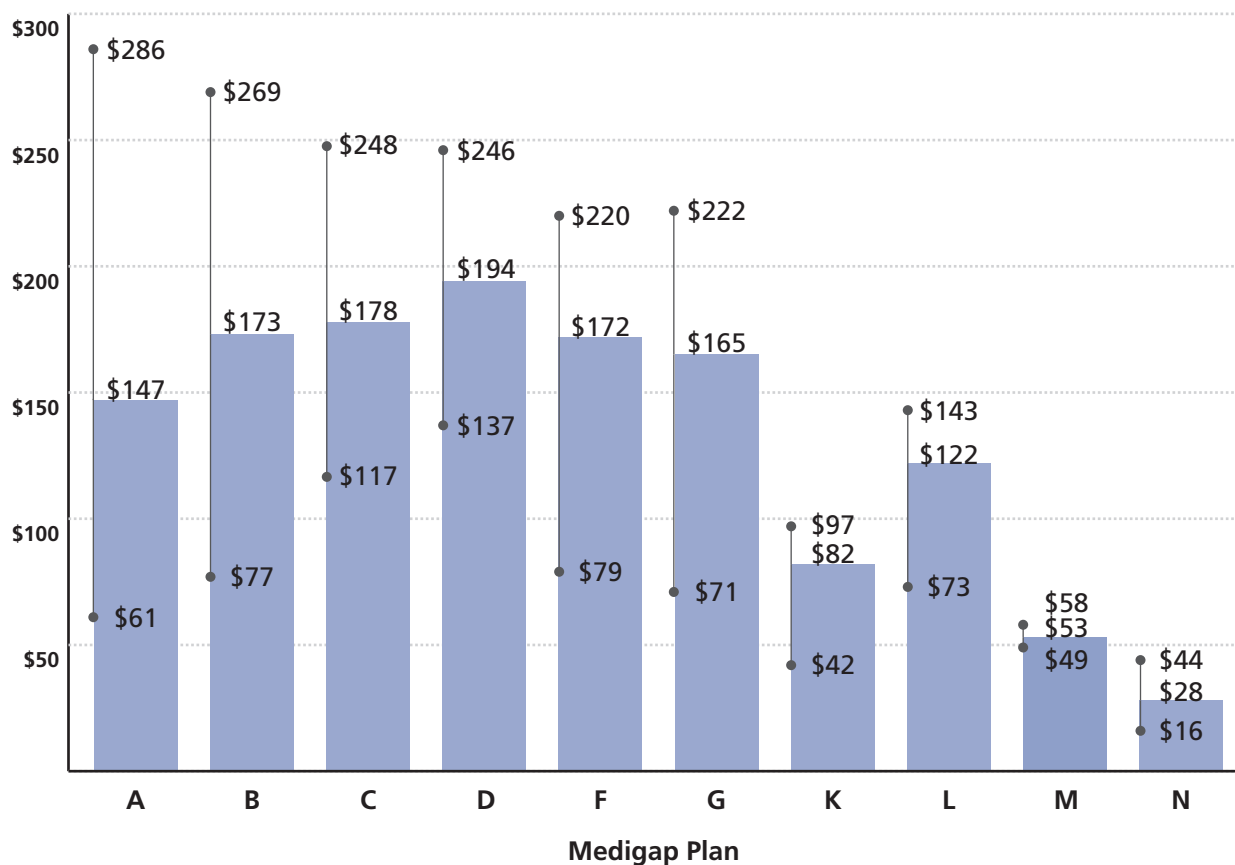


Note: Organizations are identified by insurer group codes in the NAIC Medicare Supplemental Insurance Experience Exhibit data. Market share is based on the number of covered lives.

Source: Steven Sheingold, Adele Shartzter, and Dan Ly, "Variation and Trends in Medigap Premiums," U.S. Department of Health and Human Services Assistant Secretary of Planning and Evaluation, Office of Health Policy, December 2011, p. 18, available at <http://aspe.hhs.gov/health/reports/2011/MedigapPremiums/index.pdf>.

in New York.¹⁹ Plans K and L, which do not provide first-dollar coverage for all services, but do pay a share of the cost sharing and provide coverage after beneficiaries reach out-of-pocket spending limits (Table 2), have lower national average monthly premiums than the vastly more popular and comprehensive plans C and F.²⁰ Plans M and N, the two newest standardized policies which also cover some but not all of Medicare’s cost sharing, have the lowest premiums, on average.

FIGURE 3
Monthly Medigap Premiums, National Averages with High and Low Premiums by State, 2010



Source: Kaiser Family Foundation Program on Medicare Policy, “Medigap Reform: Setting the Context,” September 2011, p. 4, available at www.kff.org/medicare/upload/8235-2.pdf.

A recent study by ASPE examined factors that are associated with the variations in the Medigap premiums at the state level.²¹ It found that:

- Higher per capita Medicare spending was associated with higher Medigap premiums: a 10 percent increase in Medicare spending per person was associated with a 6 percent higher Medigap premium.
- Market concentration was associated with premiums for plan C but not all plans' premiums: Plan C premiums were higher in markets with higher Medigap market concentration, but market concentration was not a significant predictor of premiums in general.
- State rating rules were associated with premiums: premiums in states where most policies are issue-age rated were about 7 percent lower than premiums in states where most plans were attained-age rated.
- Older policies were more expensive than newer policies.
- Individual policies were more expensive than group policies.
- Policies with a fewer number of covered lives were more expensive than those with more covered lives.

LIMITING FIRST-DOLLAR COVERAGE AND MODIFYING MEDICARE'S COST SHARING

Section 3210 of PPACA contained a provision for the Secretary of Health and Human Services to request the NAIC to review and revise the benefit packages of plans C and F, the most popular Medigap plans.²² The law states that the packages are to be updated to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under Part B, and that the NAIC, in its considerations, is to look at evidence published in peer-reviewed journals or current examples used by integrated delivery systems. To the extent practicable, the revised benefit packages are to be implemented as of January 1, 2015. As of January 2012, the NAIC Medigap PPACA Subgroup of the Senior Issues Task Force,²³ consisting of state regulators, consumer advocates, and insurance industry representatives, has not yet made its final recommendation on adding nominal cost sharing, but it has drafted modified Medigap regulations that add nominal cost sharing to plans C and F of the lesser of \$20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit. The draft language would

also add nominal cost sharing (of an unspecified amount) for specific Part B services that have yet to be decided.²⁴ The NAIC's work toward making recommendations is ongoing.

Additional proposals to limit first-dollar coverage and modify Medicare's cost sharing have been discussed recently as policymakers look for ways to reduce Medicare spending and rationalize cost sharing and benefit design. (Proposals are shown in Table 3, next page.) Cost savings from such policies are estimated based on evidence that first-dollar coverage is related to higher Medicare spending. However, modifying cost sharing and limiting first-dollar Medigap coverage can be controversial because these policies shift costs to beneficiaries and other payers and affect beneficiaries differently depending on their coverage and health status, service use, and income levels. As discussed below, some also contend that such policies are too blunt because beneficiaries may choose to forego necessary services as well as those of questionable value when they face a greater share of the cost of services.

Relationship Between First-Dollar Coverage and Spending

Evidence has shown that Medicare beneficiaries with Medigap use more Medicare-covered services and have higher Medicare costs than beneficiaries without supplemental coverage.²⁵ For example, a study for the Medicare Payment Advisory Commission (MedPAC) in 2009 using data from 2003 to 2005 found that "secondary insurance has a substantial impact on Medicare spending, consistent with the prior literature in this area...[I]ndividuals with Medigap coverage had Medicare costs 33 percent higher than those with no secondary insurance. Other private secondary insurance was associated with smaller increases in spending."²⁶ This same study also found that first-dollar coverage, regardless of the type of supplemental insurance, was associated with higher spending, and that types of services most affected by the presence of private supplemental insurance included elective admissions, preventive services, minor procedures, and endoscopies. The conclusion usually drawn from this and similar studies, reflected in the savings estimates of current proposals to limit first-dollar coverage, is that limiting such coverage will result in use of fewer services by beneficiaries and, thus, lower Medicare spending.

TABLE 3: Recent Proposals for Modifying Medicare Part A and B Cost Sharing and Restricting First-Dollar Coverage in Medigap Policies

PROPOSAL	COMBINED ANNUAL DEDUCTIBLE	UNIFORM COINSURANCE RATE	MEDICARE ANNUAL OUT-OF-POCKET CAP	MEDIGAP LIMITS	OTHER	ESTIMATED SAVINGS
National Commission on Fiscal Responsibility and Reform (a.k.a. Simpson-Bowles)	\$550	20% up to \$5,500 5% between \$5,500 and \$7,500	\$7,500	Cannot cover first \$500 in cost sharing Limit coverage to 50 percent of the next \$5,000 in Medicare cost sharing	Similar provisions apply to TRICARE for Life, federal retirees, and private employer covered retirees	\$148 billion from 2012-2020
Congressional Budget Office (Option 1: Modify cost sharing)	\$550	20%	\$5,500	N/A	N/A	\$32 billion from 2012-2021
Congressional Budget Office (Option 2: Limit Medigap coverage)	N/A	N/A	N/A	Cannot cover first \$550 in cost sharing Limit coverage to 50 percent of the next \$4,950 in Medicare cost sharing	N/A	\$53 billion from 2012-2021
Congressional Budget Office (Option 3: Modify cost sharing and limit Medigap coverage)	\$550	20%	\$5,500	Cannot cover first \$550 in cost sharing (new deductible) Limit coverage to 50 percent of the next \$4,950 in Medicare cost sharing	N/A	\$93 billion from 2012-2021
The President's Plan for Economic Growth and Deficit Reduction	N/A	N/A	N/A	N/A	30% Part B premium surcharge on new enrollees who purchase first dollar Medigap policies, starting in 2017	\$2.5 billion from 2017-2021

Notes: Estimated savings from National Commission on Fiscal Responsibility and Reform are \$110B from expanding Medicare cost-sharing, restricting Medicare Coverage, and creating a catastrophic cap and an additional \$38 billion from reforming TRICARE for life to align with Medigap rules.

Source: National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 2010, pp. 37-38, available at www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth2_1_2010.pdf; Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011, pp. 49-50, available at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf; Office of Management and Budget, "Living Within Our Means: The President's Plan for Economic Growth and Deficit Reduction," September 2011, p. 39, available at www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.

The policy implications of studies finding more use among those with first-dollar coverage may be less clear, as noted in the MedPAC study and echoed by critics of limiting first-dollar coverage. Many studies of greater service use among beneficiaries with Medigap coverage cannot determine whether their greater use is due to having more coverage or due to a selection effect, whereby those who need more services are more likely to buy insurance coverage.²⁷ Similarly, studies cannot clearly distinguish between differences in beneficiaries' use of necessary and unnecessary care, nor can they definitively measure the effects of the use of additional services on health. This has led some to conclude that the exacerbation of conditions due to foregone services may partially offset savings achieved by eliminating first-dollar coverage.²⁸

The NAIC Subgroup working on adding nominal cost sharing to plans C and F voiced some of these concerns in a discussion paper²⁹ and a letter to the co-chairs of the Joint Select Committee on Deficit Reduction³⁰ in the fall of 2011. In the discussion paper, the Subgroup argues that policies to restrict first-dollar coverage are based on a faulty assumption that beneficiaries drive overutilization. In addition, they say that policies to eliminate first-dollar coverage do not adequately consider the adverse impact on health that could result from avoiding necessary services, or the disproportionate effect that such policies would have on those with low or modest incomes and those who are very sick. Two recent studies discussed below modeled the effects of such policy changes and their effect on the spending of different groups of beneficiaries.

Eliminating First-Dollar Coverage and Modifying Cost Sharing: Effects on Beneficiaries

As shown above in Table 3, the Congressional Budget Office (CBO) and others have estimated the effects on federal spending of policy options to eliminate first-dollar coverage and modify Medicare's cost-sharing requirements. Two recent studies from the Kaiser Family Foundation Program on Medicare Policy estimated the potential effects on beneficiary spending.³¹

The first of these studies modeled the effects of three different Medigap reform proposals on federal and Medigap enrollees' spending, assuming no additional changes to the Medicare benefit design or cost sharing. The three options modeled are shown in Table 4, next page.

Under the three options modeled, 78 to 83 percent of *Medigap enrollees* would see a reduction in net out-of-pocket costs, inclusive of Medigap premiums, which are estimated to be reduced as a result of declining Medigap insurer claim costs.³² However, although the effects varied slightly in each of the three options tested, the analysis found that about one in five Medigap enrollees would pay more in cost sharing that would not be offset by premium reductions. The study found that “reforms would have a disproportionately negative impact on enrollees with modest incomes, in relatively poor health, and those with any inpatient hospital utilization.”³³ The report concludes that restricting first-dollar coverage could yield some savings for the Medicare programs and for some beneficiaries due to reduced use of services, but also cautions that “there is no way of ensuring that enrollees who might reduce their utilization would forego only services of questionable value” and notes that more research is needed on how such policies would affect beneficiaries’ health.³⁴

TABLE 4
Medigap Reform Options Modeled in Analysis

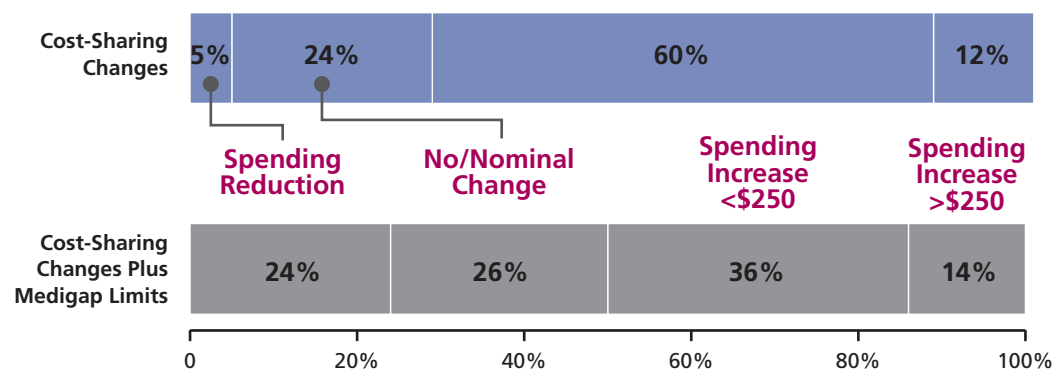
OPTION	AMOUNT ENROLLEE PAYS	AMOUNT MEDIGAP PAYS	ESTIMATED MEDICARE SAVINGS, FY 2011
1: Based on CBO and similar to Simpson Bowles	First \$550 of any required cost sharing for services covered under Parts A or B; 50% of additional required cost sharing up to \$3,025 limit on out-of-pocket spending	50% of required cost sharing after the first \$550 paid by enrollee up to \$3,025 out-of-pocket spending limit; 100% of costs for Part A/B cost sharing above out-of-pocket limit	\$4.6 billion
2: Similar to Medigap Plan L (more generous than option 1)	25% of Part A deductible (\$1,132 in 2011); 100% of Part B deductible (\$162 in 2011); 25% of required cost sharing for Part A/B services up to \$2,070 limit on out-of-pocket spending	75% of Part A deductible; 75% of A/B coinsurance up to \$2,070 out-of-pocket spending limit; 100% of costs for cost sharing above out-of-pocket spending limit	\$2.3 billion
3: Similar to Medigap Plan N	100% of Part B deductible; \$20 per office visit; \$50 per emergency room visit	100% of Part A deductible and cost sharing for all other Medicare-covered services	\$1.5 billion

Source: Mark Merlis, “Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs,” for the Henry J. Kaiser Family Foundation Program on Medicare Policy, July 2011, p. i, available at www.kff.org/medicare/upload/8208.pdf.

The second study examined the effects on *all beneficiaries'* costs of modifying Medicare's cost sharing requirements with and without changes to Medigap coverage. Specifically, it modeled (i) the impact of a \$550 combined deductible for Parts A and B, 20 percent coinsurance for all Medicare-covered services, and \$5,500 limit on out-of-pocket spending and (ii) the effects of these cost-sharing modifications *plus* prohibiting Medigap coverage for the first \$550 (new combined deductible) and limiting Medigap coverage to 50 percent of cost-sharing for Medicare covered services above the deductible, up to the new out-of-pocket limit.³⁵

Modifying cost sharing without the Medigap coverage limits would reduce spending liabilities for a small share of Medicare FFS beneficiaries, while increasing the costs for a larger share of beneficiaries. As shown in Figure 4, over 70 percent of beneficiaries would experience an increase in out-of-pocket spending (average increase of \$180 per person in 2013). Almost 24 percent would have nominal or no change to their out-of-pocket spending. Five percent would have lower out-of-pocket spending (average decrease of \$1,570 per person).³⁶ Changes in beneficiary out-of-pocket spending are a function of beneficiaries' service use and sources of supplemental coverage. On the one hand, beneficiaries "who need expensive inpatient and post-acute care or who use other high-cost outpatient services, and

FIGURE 4
Expected Change in FFS Medicare Beneficiaries' Out-of-Pocket Spending under Cost-sharing Changes and Cost-Sharing Changes Plus Medigap Coverage Limits, 2013



Source: Juliette Cubanski et al., "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," for the Henry J. Kaiser Family Foundation on Medicare Policy, November 2011, p. 14, available at www.kff.org/medicare/upload/8256.pdf.

who may be in relatively poor health—would be more likely to benefit from an alternative benefit design, because they are more likely to incur expenditures that would exceed the new cost-sharing limit.³⁷ On the other hand, beneficiaries who use only Part B services (an estimated 73 percent of beneficiaries in 2013), would experience an increase in out-of-pocket spending, as would those with no utilization, who, although they have no cost-sharing, would face expected higher supplemental premium costs.³⁸

Under the restructured cost-sharing scenario plus Medigap limits, the study estimates that a larger share (24 percent compared with 5 percent) of FFS Medicare beneficiaries (than under the cost-sharing modifications alone) would see a reduction in out-of-pocket spending relative to current policy. This is largely due to significant reductions in Medigap premiums that would be expected because “policies would cover a smaller share of Medicare covered claims and beneficiaries would use fewer services when faced with higher cost-sharing requirements.”³⁹ Fewer beneficiaries (50 percent compared with 72 percent) would experience an increase in their out-of-pocket costs (than under the cost-sharing modifications alone) because higher cost sharing would be offset by reductions in Medigap premiums. However, adding Medigap coverage restrictions would also result in higher out-of-pocket spending (than under the cost-sharing modifications alone) for those who use inpatient hospital or skilled nursing facility care, because they would be responsible for more of the coinsurance for these services, the cost of which would not be completely offset by a decrease in Medigap premiums.⁴⁰

CONCLUSION

Evidence suggests that limiting how much of a service’s cost Medigap policies may cover and modifying Medicare’s cost-sharing requirements, either separately or in combination, could yield Medicare savings. The spending effects on beneficiaries would vary by health status and amount of service use, as well as by type of supplemental coverage. However, some have urged caution about pursuing policies that spur beneficiaries to reduce service use because they may cause beneficiaries to forego services that are necessary and valuable. Nevertheless, the quest for Medicare program savings, as well as the desire to encourage prudent use of necessary health care resources, is likely to continue to make first-dollar coverage

restrictions and Medicare cost-sharing redesign viable policy options for achieving these ends.

There may also be other reasons to explore such policies, such as simplifying Medicare's long-standing cost-sharing rules that require different cost-sharing amounts depending on the provider and setting, limiting beneficiaries' out-of-pocket costs, reducing the need to purchase supplemental insurance, or encouraging beneficiaries to engage in value-based purchasing (where the value of the service is incorporated into Medicare's cost-sharing requirements). In preparation for making recommendations in its June 2012 report to Congress, MedPAC is currently reviewing ways that Medicare's benefit design could be reformed to reduce exposure to high out-of-pocket costs that result from Medicare's lack of an out-of-pocket cap on services under Parts A and B and to require some cost sharing as a way to discourage use of low-value services.⁴¹ Their work and the work summarized in this report should prove useful to policymakers seeking to understand the effects on different groups of beneficiaries and strike the balance between program savings and beneficiary spending on Medicare services and supplemental insurance premiums.

ENDNOTES

1. This issue brief does not address Parts C and D because proposals to modify cost sharing and limit Medigap coverage do not apply to these benefits.
2. Steven Sheingold, Adele Shartzter, and Dan Ly, "Variation and Trends in Medigap Premiums," U.S. Department of Health and Human Services Assistant Secretary of Planning and Evaluation, Office of Health Policy, December 2011, p. 4, available at <http://aspe.hhs.gov/health/reports/2011/MedigapPremiums/index.pdf>.
3. Gretchen Jacobson *et al.*, "Medigap Reform: Setting the Context," Kaiser Family Foundation, Issue Brief, September 28, 2011, p. 3, available at www.kff.org/medicare/8235.cfm.
4. Jacobson *et al.*, "Medigap Reform: Setting the Context," p. 3. According to that same report, about 3 million Medigap policyholders also had another form of Medicare supplemental coverage.
5. Gretchen Jacobson, PhD, e-mail communication with the author, February 8, 2012.
6. Peter D. Fox, Thomas Rice, and Lisa Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy, and Law*, vol. 20, no.1, Spring 1995, p. 34, available at <http://jhppl.dukejournals.org/content/20/1/31.full.pdf>.

7. For the basic benefits in Massachusetts, Minnesota, and Wisconsin, see Centers for Medicare & Medicaid Services (CMS), “2012 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,” pp. 41-44, available at www.medicare.gov/Publications/Pubs/pdf/02110.pdf.
8. Excess charges are the difference between the amount that a physician or other provider is legally permitted to charge for a service and the Medicare-approved amount. The majority of physicians participate in Medicare, accept the Medicare allowed amount as payment, and do not “balance bill” beneficiaries.
9. Jacobson *et al.*, “Medigap Reform: Setting the Context,” p. 3.
10. Medicare Payment Advisory Commission (MedPAC), “Improving traditional Medicare’s benefit design,” chap. 2 of *Report to the Congress: Aligning Incentives in Medicare*, June 2010, p. 58, available at www.medpac.gov/chapters/Jun10_Ch02.pdf.
11. Disabled beneficiaries do not have an open enrollment period until they turn 65.
12. CMS, “2012 Choosing a Medigap Policy,” p. 15.
13. There are some exceptions to this. See CMS, “2012 Choosing a Medigap Policy,” pp. 22–23.
14. See H.R. 2645, “Medigap Medical Loss Ratio Improvement Act,” www.govtrack.us/congress/bill.xpd?bill=h112-2645 and S. 1416: Medigap Medical Loss Ratio Improvement Act of 2011, www.govtrack.us/congress/bill.xpd?bill=s112-1416.
15. Sheingold, Shartzter, and Ly, “Variation and Trends in Medigap Premiums,” p. 20.
16. Sheingold, Shartzter, and Ly, “Variation and Trends in Medigap Premiums,” p. 18.
17. Amanda Starc, “Insurer Pricing and Consumer Welfare: Evidence from Medigap,” November 23, 2011, p. 21, available at http://hcmg.wharton.upenn.edu/documents/research/Astarc_pricing_nov.pdf.
18. Sheingold, Shartzter, and Ly, “Variation and Trends in Medigap Premiums,” p. 19.
19. Jacobson *et al.*, “Medigap Reform: Setting the Context,” p. 4.
20. Jacobson *et al.*, “Medigap Reform: Setting the Context,” p. 4.
21. Sheingold, Shartzter, and Ly, “Variation and Trends in Medigap Premiums,” p. 21.
22. Committee on Energy and Commerce, U.S. House of Representatives, “Compilation of Patient Protection and Affordable Care Act [As Amended Through May 1, 2010],” available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.
23. National Association of Insurance Commissioners (NAIC), “NAIC Medigap PPACA Subgroup–Participant List,” updated May 24, 2011, available at http://naic.org/documents/committees_b_senior_issues_medigap_ppaca_sg_membership.pdf.

24. NAIC Senior Issues Task Force, Medigap PPACA Subgroup, "Medigap Model Regulation – DRAFT with copays for specific services," January 9, 2012, available at www.naic.org/documents/committees_b_senior_issues_120110_draft_model_edits.pdf.
25. Jacobson *et al.*, "Medigap Reform: Setting the Context," p. 1.
26. Christopher Hogan, "Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly," Direct Research, LLC, for the Medicare Payment Advisory Commission, June 2009, p. 2, available at www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf.
27. For additional discussion of this issue and discussion of the literature, see MedPAC, "Improving traditional Medicare's benefit design," pp. 50–55.
28. See Cory Capps and David Dranove, "Intended and Unintended Consequences of a Prohibition on Medigap First-dollar Benefits," for America's Health Insurance Plans, October 2011, p. 2. Another recent study also observed that an increase in cost sharing for physician services and prescription drugs in an employer-based plan for retirees resulted in significant increases in hospital spending for beneficiaries with chronic conditions. See A. Chandra, J. Gruber, and R. McKnight, "Patient Cost Sharing and Hospitalization Offsets in the Elderly," *American Economic Review*, 100, no. 1, March 2010. For a brief summary of several studies, including Chandra *et al.*, on the effect of patient cost sharing on health care spending and health outcomes, see also Sarah Goodell and Katherine Swartz, "Cost-sharing: Effects on spending and outcomes," Robert Wood Johnson Foundation, Synthesis Project Policy Brief No. 20, December 2010, available at www.rwjf.org/files/research/121710.policysynthesis.costsharing.brief.pdf.
29. NAIC and The Center for Insurance Policy and Research, letter to Senator Murray and Representative Hensarling, September 21, 2011, available at www.naic.org/documents/committees_ex_grlc_110921_letter_murray_hensarling_medigap_first_dollar.pdf.
30. NAIC Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost-Shares," Discussion Paper, October 31, 2011, available at www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.
31. Mark Merlis, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," for the Henry J. Kaiser Family Foundation Program on Medicare Policy, July 2011, available at www.kff.org/medicare/upload/8208.pdf, and Juliette Cubanski *et al.*, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending," for the Henry J. Kaiser Family Foundation on Medicare Policy, November 2011, available at www.kff.org/medicare/upload/8256.pdf.
32. These results are dependent on a number of assumptions discussed in the paper. See the "Methodology" section of Merlis, "Medigap Reforms," beginning on page 5, for a complete description of the study's methods.
33. Merlis, "Medigap Reforms," p. iv.
34. Merlis, "Medigap Reforms," p. 14.

35. They also modeled variations that used a lower out-of-pocket limit of \$4,000 and a higher out-of-pocket limit of \$7,500. The lower out-of-pocket limit results in more beneficiaries experiencing a spending reduction (30 percent) or no or nominal change (32 percent) and fewer experiencing a spending increase (37 percent). The higher out-of-pocket limit results in virtually no change in the share of beneficiaries experiencing a spending increase (72 percent) and slightly fewer experiencing a spending reduction (3 percent) or no or nominal change (24 percent). The higher limit did have a significant effect on the number of beneficiaries who experience spending increases of \$250 or more in 2013 from 12 percent (under the \$5,500 scenario) to 39 percent.

36. Cubanski *et al.*, "Restructuring Medicare's Benefit Design," p. 5.

37. Cubanski *et al.*, "Restructuring Medicare's Benefit Design," p. 8.

38. Cubanski *et al.*, "Restructuring Medicare's Benefit Design," pp. 7-8.

39. Cubanski *et al.*, "Restructuring Medicare's Benefit Design," p. 15.

40. Cubanski *et al.*, "Restructuring Medicare's Benefit Design," p. 16.

41. Julie Lee, Scott Harrison, and Joan Sokolovsky, "Reforming Medicare's Benefit Design," presentation from January 13, 2012, available at www.medpac.gov/transcripts/benefit%20design%20jan_2012%20final.pdf.