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Fix Medicare, Not Medigap

Most people follow the conventional wisdom: If it ain't broke, don't fix it.

Washington follows its own wisdom: If it ain't broke, break it.

One recent example is the bipartisan legislative attempt to make medigap insurance "portable."

This proposal hopes to capitalize on the popularity of the Kassebaum-Kennedy health insurance reform bill, which sought to make traditional health insurance portable so that people could retain health insurance coverage during job transition. But the new legislation targets the wrong market. If Congress really wants to help, it should reform Medicare, not medigap.

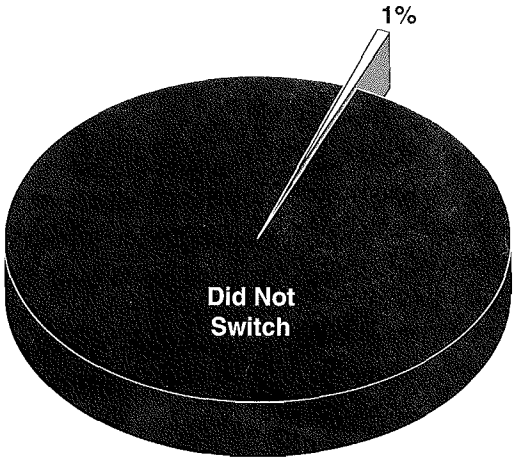
The Problem with Medicare. Medigap insurance exists because Medicare's reimbursement structure is convoluted. Under Medicare Part A, which pays for hospital stays and home health care, a person must first meet a $760 deductible, then Medicare pays all other expenses for the first 60 days. For the next 30 days the Medicare patient must make a copayment of $190 per day, and $360 each day for the next 60 days after that.

In addition, patients who have Medicare Part B, which pays for physician and outpatient services, must pay a $100 deductible and 20 percent of the doctors' bill without an out-of-pocket limit. Thus both Part A and Part B leave the senior exposed to significant expenses.

The Medigap Solution. In order to limit their financial exposure, about 75 percent of seniors acquire, either through a former employer or private purchase, supplemental health insurance known as a medigap policy, which pays many or all of the costs Medicare does not.

While the medigap market is not perfect, reforms passed by Congress in 1990 which became effective in 1992 have gone a long way toward solving any problems. That legislation stabilized the market by permitting no more than 10 standardized benefit plans and imposing other restrictions. As a result, seniors can compare policies and prices and make decisions based on their particular needs and financial conditions.

Seniors Who Switch or Drop Medigap Policies
(covered between 1991 and 1994)



☐ Dropped or switched medigap policies.

Source: Health Care Financing Administration.

Partly because of these reforms, the majority of seniors are satisfied with their policies.

- One survey found that 94 percent of medigap policy holders are satisfied with their plan.
- A survey of several states found a decline of as much as 75 percent in consumers' medigap complaints (e.g., complaints in Missouri declined from 226 in 1990 to 56 in 1994).

What Reformers Want to Do. Despite this widespread satisfaction, some members of Congress and the Clinton administration want to reform the medigap market. Reform proponents have three changes in mind:

(1) *Guaranteed issue* — When seniors become eligible for Medicare, they have six months in which to decide if they want a medigap policy. Insurers must accept them regardless of their health status (a practice known as guaranteed issue). Should the senior decide to cancel the policy, as do the 10 percent of seniors who enter a Medicare HMO, insurers are not required by law to accept seniors who reapply — as they often do if they return to traditional Medicare.

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Reform proponents want to allow anyone to obtain coverage at any time. However:

- According to the Health Care Financing Administration (HCFA), only 1 percent of the medigap policy holders covered between 1991 and 1994 either switched or dropped their policies in 1994. (See the figure.)
- A General Accounting Office (GAO) survey of the 25 largest sellers of medigap policies (representing 65 percent of the policies in effect) found that 14 of the companies accepted any applicant for some or all of their plans.
- An ongoing survey by the National Association of Insurance Commissioners (NAIC) found that out of a total of 316 complaints related to medigap underwriting in 1995, only one cited an insurer's refusal to underwrite after the open enrollment period.

Note to Congress: One complaint about refusal to cover out of 22 million policies does not justify reform.

(2) *Community rating* — Currently, older seniors pay more for a medigap policy than younger ones because they have higher health care costs. President Clinton would like to federally mandate that all seniors pay the same premium (a practice known as community rating).

Under community rating, older seniors would get lower prices, but younger ones would pay more. As a result, many younger seniors likely would drop out of the system, leaving the pool with fewer and sicker seniors and driving up premiums even more. Besides, if the policies are guaranteed issue, why would seniors not just wait until they got sick to buy a policy?

(3) *A social safety net* — Since 1973 Medicare has been the primary payer for more than 90 percent of the people with end stage renal disease (kidney failure). These patients can run up huge medical bills in a year — between $40,000 and $50,000 (1991) — and what isn't covered by Medicare is often picked up by state Medicaid programs. According to the Congressional Research Service (CRS), 41 percent of disabled Medicare recipients depend on Medicaid to pay expenses Medicare does not cover, while only 12.5 percent of elderly Medicare beneficiaries rely on Medicaid.

By permitting mostly under-65 disabled patients to purchase a medigap policy, the reformers would force medigap policy issuers to pay the additional expenses not covered by Medicare. These costs would be passed on to seniors who purchase the policies, driving premiums still higher.

Such a proposal is a misguided attempt to turn private business into a social safety net. If Congress wants to help the disabled, it should do so — directly.

Would Portability Help Medicare? No. In fact, it would make Medicare's financial problems worse. Medicare HMOs already attract the healthiest seniors, many of whom try to return to traditional Medicare if they need extensive medical treatment. Though the GAO has pointed out that these returning seniors can find some type of medigap coverage, they may be unable to purchase the specific plan they want.

But this restriction discourages some seniors from shifting out of their HMO when they get sick, which reduces the incidence of adverse selection and forces the HMO to pay for the care rather than shifting the burden back to traditional Medicare.

Who Would Medigap Portability Really Hurt? Some reformers argue that while making medigap insurance more portable by making it guaranteed issue would increase its cost, seniors should be willing to pay this price for the privilege of being able to drop their medigap policies when they move into Medicare HMOs and regain them if they return to traditional Medicare.

However, the HMO option is limited primarily to seniors living in metropolitan areas where HMOs thrive. According to testimony by the Physician Payment Review Commission (PPRC), 80 percent of rural Medicare beneficiaries have no managed care option. While these seniors would share the cost of medigap reform, they would not share its purported benefit.

Conclusion. Medigap insurance exists because Medicare is so convoluted. Medicare, not medigap, needs reform. If Congress tries to reform medigap alone, it will only make both programs worse.

This Brief Analysis was prepared by NCPA Vice President of Domestic Policy Merrill Matthews Jr.