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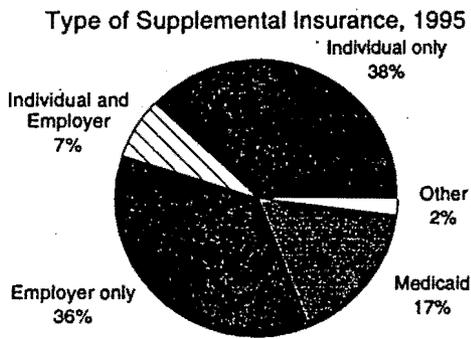
*C. Jensen*

SPECIAL ANALYSIS

**Should Medigap Coverage Have More Gaps?**

Although Medicare provides important health insurance protection to the elderly and disabled, it covers only about 45 percent of their health care costs. As a result, most Medicare beneficiaries have additional insurance to fill in some of the "gaps." The problem is that, by providing "first-dollar" coverage, many of these policies encourage the overuse of some services and thereby raise Medicare expenditures.

**Prevalence of secondary insurance.** In 1995, 87 percent of those enrolled in the traditional Medicare program were covered by some kind of secondary insurance. Almost 40 percent of this group had purchased their own supplemental policies, a

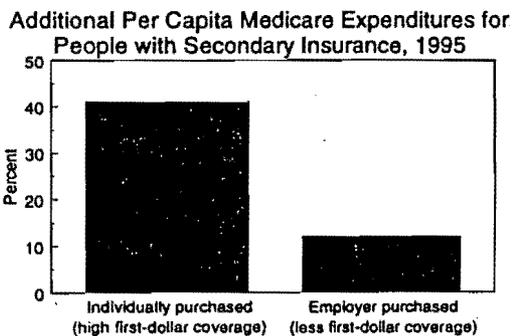


similar fraction were insured through an employer, 7 percent received coverage from both individual and employer policies, and 17 percent obtained secondary insurance through Medicaid (see upper chart).

cover the Part A (hospital) deductible, and almost 60 percent cover the Part B (physician and other outpatient services) deductible. Thus, Medigap provides first dollar coverage for many medical services.

In 1990, the Congress passed legislation to standardize individually purchased "Medigap" policies. New policies now cover most Medicare copayments. In addition, over 90 percent of these policies

**Impact on Medicare outlays.** Secondary policies that reduce or eliminate copayments and deductibles raise Medicare expenditures. In 1995, for example, per



capita expenditures for beneficiaries with individually purchased policies, which provide substantial first-dollar coverage, were 41 percent higher than those for persons without supplemental insurance (see lower chart). Spending for those with employer-purchased plans, which frequently include some copayments or deductibles, were 12 percent higher.

Note: Chart shows increase in expenditures compared with those without supplemental coverage.

Greater costs for those with Medigap policies probably cannot be explained by "adverse selection." It is not sicker people who purchase the insurance. Indeed, Medigap policyholders rate their health higher than those without secondary coverage. And most studies find higher spending

## Talking Points on the President's 1998 Medigap Proposals

The President's 1998 Budget plan includes specific proposals to expand and enhance beneficiaries' options in choosing between Medicare managed care plans and Medigap plans.

### Annual Open Enrollment

- ▶ Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice.
- ▶ If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap.
- ▶ The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances -- such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area.

### Comparative Information

- ▶ The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options -- both managed care and Medigap. Similar to information provided under FEHBP, this proposal would enable beneficiaries to examine and compare all of the information about their coverage options.
- ▶ The provision of this information and the support needed to answer beneficiaries questions through programs such as the ICA program would be funded by a tap on managed care and Medigap plans.

### Reexamine Standard Packages

- ▶ This proposal creates a process, with the NAIC, to standardize some of the additional benefits provided by managed care plans and revises standard Medigap packages so that Medicare beneficiaries can make an "apples to apples" comparison when evaluating their coverage options.

### Elimination of Pre-existing Condition Exclusions

- ▶ The President's bill proposes to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently

enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Senators Chafee and Rockefeller and Representatives Johnson and Dingell this year.

### **Community Rating for Medigap Plans**

- ▶ Our final Medigap reform addresses rating. There are currently no Federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice younger beneficiaries to enroll, but as the enrollee ages, the premiums may become unaffordable. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Attained age premium structures would potentially force lower income, aged beneficiaries to stay in managed care options. If we are serious about choice, financial considerations should not change as a beneficiary ages.

U.S. Department of Labor

Pension and Welfare Benefits Administration  
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COMMENTS:

Per request of Sarah.  
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## Retiree Health Coverage

### Coverage Trends

- The proportion of private sector retirees covered by health insurance from a former employer dropped from 37 percent in 1988 to 27 percent in 1994 resulting in only 4.7 million of the 17.4 million of these retirees being covered.
- Nine out of ten retirees with coverage reported that they expected it to be available for life, rather than for a stipulated period of time.
- Considering only early retirees (age 55-64 years i.e. non-medicare eligible), a slightly higher proportion, 30 percent (1.2 million) have health insurance from a former employer.
- The decline in coverage among active workers, which lowers the likelihood of retiree health benefits being available, is a significant factor in the decline of this coverage. The proportion of workers with coverage from their employer on reaching retirement declined from 65% in 1988 to 60% in 1994.
- The cost to retirees is also an important factor. One quarter of the retirees who elected not to carry insurance into retirement reported their decision was made because insurance was too expensive. Of those who carried insurance into retirement and then dropped it, 20 percent reported that the insurance was too expensive.

### The retiree population is increasing.

- The number of private sector retirees increased between 1988 and 1994 from 13.1 million to 17.4 million, putting cost pressure on retiree health plans.
- Almost 24 percent of retirees (4.1 million) in 1994 were between the ages of 55 and 64.
- The reduction in employer contributions to retiree health insurance premiums increased the amount that retirees paid towards insurance, from an annual average premium of \$778 in 1988 to \$840 in 1994 in constant dollars. The increase in premiums is attributed to increases in the amount that retirees paid for family coverage from \$791 to \$960, while individual premiums dropped from \$753 to \$740.

### As their costs increase, employers are engaging in cost shifting.

- The percentage of retirees covered by employer-provided health benefits for which the employer paid a portion of the premiums, remained steady between 1988 and 1994 at

78 percent. However, the percent of retirees who were covered by employer provided health benefits and whose employer paid the entire premium dropped from 50 percent to 42 percent.

**Change in accounting rules may have affected the employers' propensity to offer these benefits.**

- A 1990 Accounting Standards Board (FASB) rule change (FASB 106) required companies to account for the future costs of retiree health benefits. This requirement effectively lowered the reported earnings of companies in proportion to an estimate of their future costs, leading many firms to reduce or eliminate these benefits altogether. A 1993 survey of employers by the Foster Higgins Company found that 35% of the employers responding intended to change their retiree health plans over the next two years.