

# Current Trends in Medicare Supplement

Southeastern Actuaries Club

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- *History*
- *Regulations*
- *PPACA Impact*
- *Current Discussions on Cost Sharing Modifications*
- *NAIC Recommendations*
- *Future Viability*

## History

- Medicare – created in 1965
  - Contains significant cost sharing
    - IP deductible - \$1,156
    - Part B (OP & Professional) deductible - \$140
    - 20% cost sharing on most non-IP/SNF services
    - Limited number of IP days covered
    - **No OOP (Out-of-Pocket) Limit**
  - Medicare supplement (aka, Medigap) covers cost sharing
    - Varies by benefit plan
    - Minimum MLR requirements
      - 65% Individual
      - 75% Group

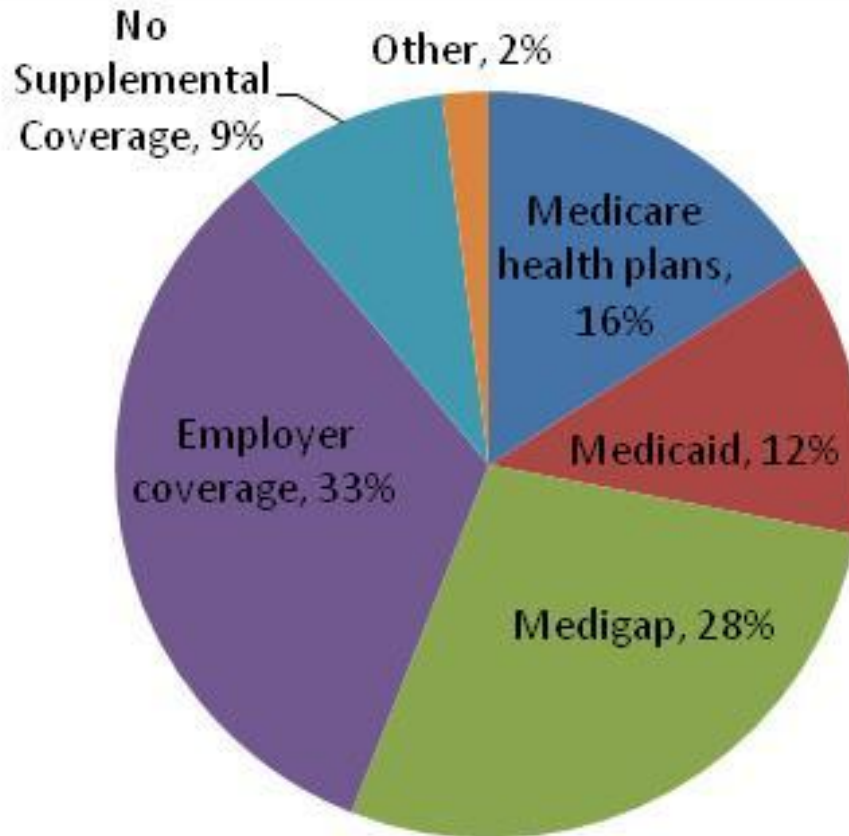
## OBRA'90 Legislation

- Standardized plans developed by NAIC
- 10 benefit plans developed – A – J (see Appendix A)
- Variations Part B (OP & Professional) cost sharing
  - 3 plans included Rx benefits (until PDP introduced in 2006)
- All carriers must offer Basic plan (A)

## Underwriting/Guaranteed Issue

- **Guaranteed Issue**
  - 6 month open enrollment at age 65 AND enrollment in Part B
    - No Pre-Ex exclusions
    - No premium loads
  - Same open enrollment after losing creditable coverage
- **Underwriting**
  - Available to those applying for coverage outside of above open enrollment periods
- **Renewable**

## Types of Supplemental Coverage, 2001

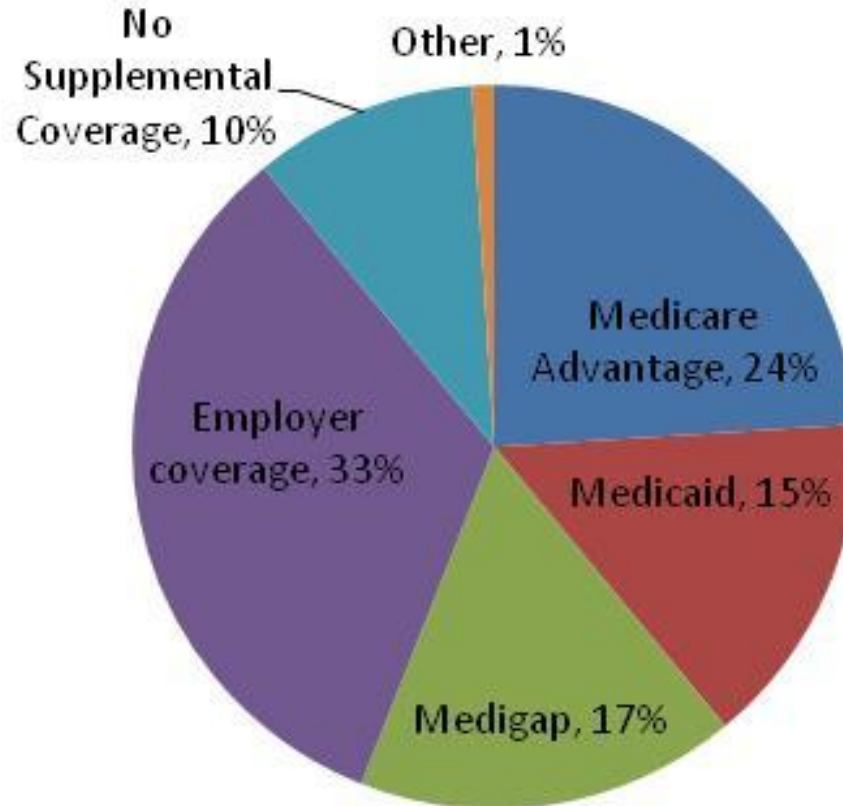


Source: MedPac "Report to Congress: Medicare Payment Policy", March 2004

Excerpted from Brian Webb, NAIC, Medicare Supplement (Medigap) Coverage for Medicare Beneficiaries, 2/6/09

- MMA (Medicare Modernization Act) 2003
  - Eliminated duplicative plans
  - Created 2 new plans with cost sharing
  - Added 2 high deductible options
  - Created Hospice benefit
  - Eliminated “At-Home Recovery” and “Preventive Care” benefit
  - *“Game-changer” => creation of Medicare Advantage and PDP options*
- MIPPA (Medicare Improvements for Patients and Providers Act)
  - Added 2 new Plans – M and N
    - OV and ER Copays included (Plan N)
    - Cost sharing 50% and 75%
    - Part B deductible not covered
  - Carriers must offer Plan A and Plan C or Plan F
- **ESRD/Disabled Beneficiaries**

## Types of Supplemental Coverage, 2008



Source: Mark Merlis, Kaiser Family Foundation Program on Medicare Policy, July 2011  
Excerpted in National Health Policy Forum, 12/9/11;



## Current Proposals to Limit First Dollar Coverage in Med Supp plans

Source	Proposal	Savings (over 10 Years)
The President's Plan for Economic Growth and Deficit Reduction	30% Part B premium surcharge on new enrollees with Med Supp first dollar coverage	\$2.5 B
National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)	No coverage for first \$500 Maximum 50% coverage of next \$5,000	\$38 B
CBO Option 1	Replace current Medicare structure with \$550 single deductible; 20% coinsurance and OOP \$5,500	\$32 B
CBO Option 2	Bar Med Supp policies from paying first \$550; limit coverage to 50% of next \$4,950	\$53 B
CBO Option 3	Bar Med Supp policies from paying first \$550; require 10% coinsurance up to \$5,500 OOP	\$93 B

Sources:

*National Health Policy Forum; Medicare Supplemental Coverage Background, 12/9/11*

*NAIC Senior Issues Task Force, Medigap PPACA Subgroup*

*Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper, 10/31/11*

## PPACA Directives

- Section 3210
  - NAIC requested to review and revise benefit packages **C** and **F**
    - Update to include **nominal cost sharing** for physician services
    - Consult **published evidence** from peer-reviewed journals
    - Consult **current examples** used by integrated delivery systems
    - Revised benefit plans implemented by **January 1, 2015**
      - “to extent practicable”

*National Health Policy Forum;*

*Medicare Supplemental Coverage: Weighing the Consequences and Trade-offs for Medicare Spending and Beneficiaries, 12/9/11*

## AAA Letter to NAIC Medigap PPACA Subgroup

- Individuals Most Affected
  - Issue-age rated policies (rate equity concerns)
- Impact of Cost Sharing
  - *Delay in medical care* => may have larger impact on need and cost of medical care
  - Issue: whether a member *considers supplemental coverage* when seeking medical care
  - Repeated charge from ACA
    - Cost sharing changes must be based on *appropriate evidence* or examples from integrated delivery systems
  - Evidence should:
    - incorporate the *senior population*
    - demonstrate that *unnecessary services decline*
    - *no significant delay* of necessary care or increased future costs results
  - Encourages NAIC to reach out to other insurers with integrated delivery systems

AAA Letter to Guenther Ruch, Chair, NAIC Medigap PPACA Subgroup, 10/4/11

## AAA Letter to NAIC Medigap PPACA Subgroup

- Questions specific to CBO report assumptions
  - *Reduced utilization* of necessary and unnecessary services?
  - Applies to *all* in-force policies or *just new* policies?
  - Projected Medicare Supplement *sales* along with *shifts* to other coverage?
  - Cost shifting to *higher-intensity services*?

## NAIC Medigap PPACA Subgroup Discussion Paper Issues Raised

- Focus on *overutilization* by beneficiaries
- Medicare, itself, determines which services are reimbursed
- Potential *negative consequences*
- *Vulnerable* populations
- Impact of changes on *existing Med Supp policyholders*
- Other types of supplemental coverage is not touched
- Conclusions from multiple studies:
  - Agreement that those with supplemental coverage incur higher costs
  - *No consensus on cause* of higher costs

## NAIC Medigap PPACA Subgroup Discussion Paper Recommendations

- CBO underlying data and *assumptions be made public*
- Any changes applied *prospectively*
- Consider *potential adverse impact* on vulnerable populations
- Improper utilization of services addressed by reviewing, adjusting and implementing Medicare program's policies and procedures (*medical necessity*)
- Use *existing process* for developing and implementing changes to Medicare Supplement policies

NAIC Senior Issues Task Force, Medigap PPACA Subgroup, Medicare Supplement First Dollar Coverage and Cost Shares  
10/31/12

## NAIC Medigap PPACA Subgroup *Preliminary Determinations*

- Disagrees with premise that first-dollar coverage drives unnecessary utilization
- “Overutilized” services are candidates for new cost sharing
- Fixed copays vs. coinsurance
- Cost Sharing for physician office visits
- ER visits, therapy cost sharing appropriate
- Changes would not apply to high deductible plans
- CMS is being consulted for additional cost, utilization and coding information to assist with proposed recommendations.

## Future Viability

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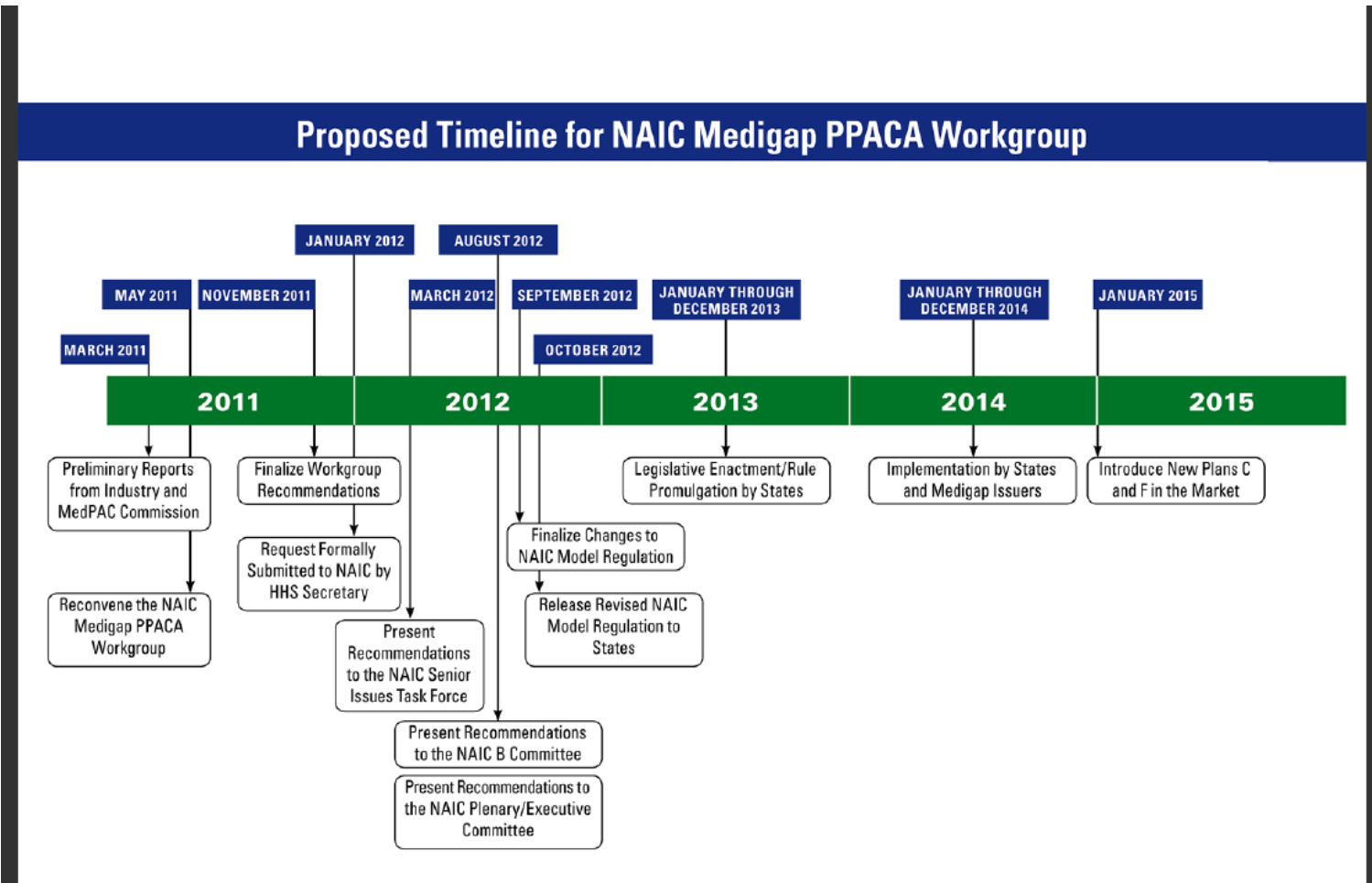
*Appendix slides*

- *Benefit summaries*
- *NAIC Subgroup Timeline*



# Benefit Summaries

BENEFIT	A	B	C	Eliminated			G	--- Eliminated ---			K	L	NEW		
				D	E	F		H	I	J			M	N	
Part A Coinsurance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance	X	X	X	X	X	X	X	X	X	X	50%	75%	X	Copays	
SNF Coinsurance			X	X	X	X	X	X	X	X	50%	75%	X	X	
Part A Deductible		X	X	X	X	X	X	X	X	X	50%	75%	50%	X	
Part B Deductible			X			X				X					
Part B Excess						X	X		X	X					
Foreign Travel ER			X	X	X	X	X	X	X	X			X	X	
At Home Recovery				X					X	X					
Rx Coverage								Limited	Limited	Limited					
Preventive Care					X					X					
2012 Out-of-Pocket (OOP)											\$ 4,660	\$ 2,330		Copays on OV and ER	
High Deductible Option Included			X			X									



[http://www.naic.org/documents/committees\\_b\\_senior\\_issues\\_medigap\\_ppaca\\_sg\\_timeline.pdf](http://www.naic.org/documents/committees_b_senior_issues_medigap_ppaca_sg_timeline.pdf)