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Medicare Supplemental Insurance: Today's Crisis

Health Care for All

Gerontology Institute, University of Massachusetts Boston

MEDICARE SUPPLEMENTAL INSURANCE:

Today's Crisis

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EXECUTIVE SUMMARY

The purpose of health insurance is to spread health care risk over a broad population in order to reduce the financial burden an individual faces in the case of illness accident. When grouped together for this purpose, however, seniors represent a high-risk population. Elders are more likely than others to need health care services yet less likely to have adequate financial resources.

The Medicare Program began in 1965 as a partial response to the income and health factors that limit the success of traditional health insurance for the elderly population. This federal program, however, does not cover all the health care costs or health care services needed by seniors. Medicare Supplemental Insurance, or Medigap, developed to fill the "gaps" in federal coverage.

In Massachusetts, Medigap insurers are regulated by the Massachusetts Division of Insurance. There are four benefit packages that govern the structure of all nongroup products available in the state, and consumer protections guard seniors from some marketing abuses. Medigap policies cover a range of Medicare deductibles and co-payments as well as additional benefits, for some packages, such as prescription drugs. Medicare and Medigap together, however, still do not cover all necessary health care expenses, most notably long-term care.

As the only insurer in Massachusetts required to offer Medigap insurance, Blue Cross and Blue Shield (BC/BS) has historically been the major provider of Medigap coverage in the state. The products offered through BC/BS under the brand name of Medex are subject to more regulation than those of either commercial insurers or Health Maintenance Organizations (HMOs), which offer contracts for Medicare beneficiaries. BC/BS must provide all seniors with the opportunity to buy Medicare Supplemental Insurance.

However, rising health care costs combined with the declining competitiveness of BC/BS are producing Medex premiums so costly that they block access to health care for growing numbers of low- and middle-income seniors. The national medical care inflation rate from 1980 to 1990 was 115%, about twice as high as regular inflation. Prescription drug costs are rising at even faster rates, accounting for about 40% of Medex premium increases in recent years. Additionally, from 1985 to 1989, the administrative costs of BC/BS rose significantly faster than claims. Certain changes in the health insurance industry have reduced the ability of BC/BS to generate reserves which in the past have offset their losses in Medex products.

From 1980 to 1990, premium rates for three Medigap plans offered through BC/BS -- Medex 2, Medex 3, and Standard -- rose 210%, 298%, and 409% respectively. During that same period, Social Security Cost of Living Adjustments increased only 52%. Twenty-five years after the Medicare Program first began to offer elders some relief from their medical bills, Massachusetts seniors today are spending more of their income on health care costs.

Growing numbers of seniors are unable to afford Medex premiums and, regardless of whether they need health care services, are dropping or downgrading their coverage. While there was a rapid initial growth in HMO coverage for Medicare beneficiaries, enrollment has slowed in recent years. And, rather than assuming coverage responsibility for a share of high-risk seniors, HMOs on average have been insuring younger, healthier seniors, leaving the "Blues" to cover seniors with more expensive health care needs. While HMOs were once thought to provide at least a partial solution to the crisis in Medigap insurance, rising health care costs and inadequate federal reimbursement levels are beginning to raise doubts.

In 1990 alone, close to 40,000 seniors either dropped or downgraded their nongroup BC/BS supplemental coverage. The rising rates are causing some seniors to assume the health and financial risk of being underinsured. Less healthy seniors with inadequate coverage are choosing between foregoing necessary medical care or shouldering huge out-of-pocket costs.

Rising premiums and declining enrollment have given rise to a number of initiatives on the federal and state levels designed to address both the immediate need for Medigap relief and also the long-term questions of Medigap reform. These bills struggle to incorporate premium reduction and premium subsidization strategies into the current health care system. Each of the proposed solutions, however, brings with it political or practical barriers for full and effective implementation.

In this report, we investigate in detail the cost and enrollment trends in Medigap insurance, particularly in the products of BC/BS, which give evidence of the crisis situation facing elders today. We critique some of the proposed solutions currently being debated on the national and state levels and analyze the impact they may have on the immediate crisis and long-term problems of Medigap insurance in Massachusetts.

INTRODUCTION

The purpose of health insurance is to spread risk. The system works under the assumption that, at any given point in time, only a percentage of the people in a given group will be sick. Regardless of health status, all members of the group will be paying premiums in order to cover the cost of care for those who need it.

As a group, however, seniors represent a high-risk population. They are more likely than younger people to need health care services and tend to require longer hospital stays. Yet, while their expenses are greater, their financial resources are generally more limited. Seniors are falling victim to their double vulnerability in the areas of health and income.

As the only insurer in Massachusetts required to offer Medicare Supplemental Insurance (Medigap), Blue Cross and Blue Shield (BC/BS) has historically been the major provider of such coverage. Today, however, rising health care costs combined with the declining competitiveness of BC/BS are producing expensive Medigap premiums that many people cannot afford. Growing numbers of Massachusetts' elders are without adequate health care coverage.

In 1990 alone, close to 40,000 Massachusetts seniors either dropped or downgraded their nongroup BC/BS supplemental coverage. The rising premium rates are causing some seniors to assume the health and financial risk of being underinsured. Other seniors with inadequate coverage are being forced to choose between foregoing necessary medical care or shouldering huge out-of-pocket costs.

In this report, we investigate the cost and enrollment trends in Medigap insurance over the past ten years, particularly those in BC/BS, and identify some of the systemic problems of Medigap in the context of the Massachusetts insurance market. Finally, we look at some possible directions for Medigap insurance reform.

THE BASICS

In order to create a foundation on which to build a better understanding of the systemic problems in Medicare supplemental insurance, we begin this report by examining the basics. In this section, we answer the following four questions:

- **What is Medigap insurance?**
- **What does Medigap insurance cover?**
- **Who provides Medigap insurance?**
- **How is Medigap insurance regulated?**

After answering these questions, we look at evidence of a crisis situation and move forward to suggest directions for reform.

What is Medigap insurance?

Medigap insurance is health insurance, offered by various private insurers, which supplements the federal **Medicare Program.**

The **Medicare Program** is a health insurance program that pays for a portion of specified medical services for people over 65 as well as certain disabled individuals. It is a program of the United States Department of Health and Human Services and is administered by the Health Care Financing Administration. The Medicare Program began in 1965 under President Johnson, at a time when elders were spending an average of 15% of their income on health-related costs.

The **Medicare Program** is divided in two parts: Part A and Part B.

- **Part A** generally covers inpatient hospital costs. It is funded through a portion of the 7.65% Social Security payroll tax on both employers and employees. For most people there is no individual **premium** for Part A.

- **Part B** covers 80% of physicians' and other outpatient bills. Twenty-five percent of the funding for Part B comes from premiums paid by Medicare recipients. In 1991, Part B premiums were $29.90 per month. The remaining funds for Part B come from federal general revenue.

This federal program, however, does not cover all the services or all the costs associated with the health care needs of Medicare recipients. Routine services including physicals and tests for vision and hearing are not covered by the Medicare Program. Outpatient prescription drugs are not covered. Long-term care costs such as nursing home charges and extended home care are not covered, except under very limited circumstances.

Additionally, both Medicare Part A and Part B have **deductibles**, or minimum out-of-pocket costs, which must be incurred by the enrollee before the benefits of the program begin. Currently, the first-day hospital deductible under Part A is $628 and the Part B deductible is $100. Hospital **co-payments** (which range from $148 per day after the 60th day to full payment after the 150th day) and 20% Part B coinsurance are also the responsibility of the Medicare beneficiary.

In order to address the many expensive "gaps" in Medicare coverage, supplemental insurance products designed for individuals enrolled in both parts of the Medicare Program have been developed. Collectively, the various Medicare supplemental products are referred to as **"Medigap"** insurance.

What does Medigap insurance cover?

Medigap insurance generally covers some combination of Medicare deductibles, hospital co-payments, and Part B coinsurance. Certain policies may also include coverage for prescription drugs, home health care, preventive care, and excess doctors' charges.

Excess doctors' charges occur when physicians bill Medicare for more than the amount approved by Medicare for given procedures. Medicare pays only 80% of its approved amount, leaving the beneficiary with the 20% Part B coinsurance plus all of the cost above the approved amount. **In Massachusetts, physicians are prohibited from charging and collecting more than the Medicare approved amount.** This prohibition is referred to as the **"ban on balance billing."** In other words, the patient is not liable for the balance of the bill, or the amount beyond the approved charge.

Because there are hundreds of different Medigap policies offered across the country, there is no simple answer to the question of what Medigap covers. To address this confusion, Congress in 1990 ordered the standardization of Medigap policies. In response, the National

Association of Insurance Commissioners (NAIC) tentatively approved 10 standardized benefit packages. According to the NAIC, all of these policies include a set of "basic benefits" which consist of payment of the 20% Part B coinsurance and the hospital co-payments for the 61st to 90th days.

Unlike most state regulators, however, the Massachusetts Division of Insurance already controls the benefit content of the nongroup Medigap policies sold in the state. Only four nongroup (see p. 5) benefit packages can be sold in Massachusetts. The basic benefits of each of these plans are shown in the table below:

Massachusetts Medigap Packages

BENEFIT	PLAN 1 * Standard	PLAN 2 * Medex 2	PLAN 3 * Medex 3	PLAN 4 * Basic
Hospital Deductible	No	Yes	Yes	No
Hospital Co-payments	Yes	Yes	Yes	Yes
Part B Deductible	No	Yes	Yes	No
Part B Coinsurance	Yes	Yes	Yes	Yes
Excess Doctors' Charges	NONE IN MASS	NONE IN MASS	NONE IN MASS	NONE IN MASS
Home Health Care	No	No	No	No
Prescription Drugs	100% generic, 80% brand; $35/quarter deductible	No	100% generic, 80% brand; $35/quarter deductible	100% generic, 80% brand; $250/year deductible
Mail-Order Prescription Drugs	$2.00 generic; $10.00 brand	No	$2.00 generic; $10.00 brand	$2.00 generic; $10.00 brand
Preventive Care	No	No	No	No

* Corresponding Blue Cross/Blue Shield Plans
Source: Massachusetts Division of Insurance

It is important to remember that no Medigap policy covers all of the gaps in the Medicare Program (for example, almost none cover long-term care expenses) and that Medigap will not pay anything for medical services denied by Medicare.

The Commonwealth of Massachusetts
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June 1992

Dear Colleague,

The enclosed report, Medicare Supplemental Insurance: Today's Crisis, provides important data that explains the crisis situation in which elders are struggling to pay for necessary health insurance. For those attempting to provide solutions to this problem, it also discusses reforms.

From 1980 to 1990, the cost of Medex 3, the most popular supplemental policy in Massachusetts, has increased almost 300 percent. During the same period, Social Security cost-of-living increases have amounted to only 52 percent. Not surprisingly, during this same period, there has been an increase in seniors reducing or dropping their supplemental coverage.

It is our hope that this report will provide useful information concerning the extent of the problem, and encourage lawmakers, advocates, and policymakers to seek appropriate solutions.

We welcome any comments that you may have regarding this publication. Additional copies are available upon request from the Gerontology Institute.

Very truly yours,

Scott A. Bass, Ph.D.
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Enclosure
EAB/lo

Who provides Medigap insurance?

There are two basic types of private Medigap coverage: traditional fee-for-service plans and Health Maintenance Organization (HMO) plans.

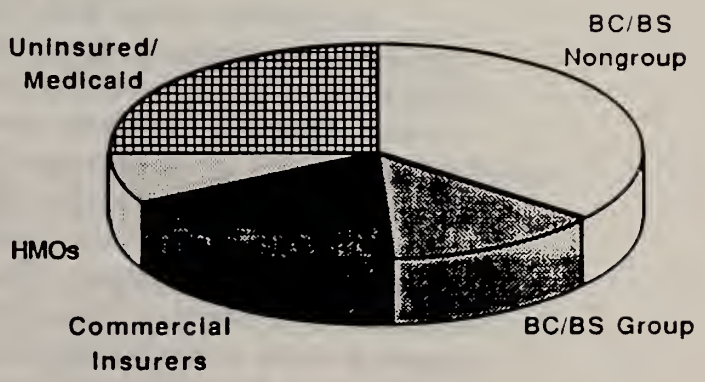
Fee-for-service plans, also known as indemnity plans, include the majority of plans offered by BC/BS and commercial insurers. Under these plans, insurers pay hospitals and physicians each time an enrollee receives medical care. In contrast, an HMO is a provider/insurer system which agrees to manage the care of an enrollee. For a fixed premium, an HMO provides medical services through a specified set of doctors and hospitals that cover a defined geographic area. The network of providers is known as the delivery system.

Elders may be insured either under group plans or nongroup plans. Group plans are available to seniors through a past or current employer or union or through a member-based organization, such as the American Association for Retired Persons (AARP). Nongroup or individual plans are directly established between seniors and insurers.

In 1990, BC/BS and the Massachusetts Division of Insurance undertook a joint project to look at the decline in BC/BS's ability to compete in the insurance market. The resulting Cresap-Tillinghast report indicated that 75% of the Medicare-eligible population in the state in 1988 had Medigap coverage.

Medigap Coverage in Massachusetts

- o 36% were covered by BC/BS non-group coverage;
- o 18% were covered by commercial insurers;
- o 13% were covered by BC/BS group plans; and
- o 8% were covered by HMOs.



Source: Cresap-Tillinghast Analysis, 1990

Most of the remaining 25% either had no Medigap coverage or received their Medigap coverage through Medicaid, the federal/state health care program for the poor.

Blue Cross and Blue Shield. The most popular Medigap policies are offered through BC/BS under the brand name of **Medex**. Both nongroup and group plans are available. These Medigap policies offer relatively comprehensive benefits, and all Medicare-eligible residents of the Commonwealth who are enrolled in Medicare Part A and Part B are guaranteed the opportunity to buy coverage. Because BC/BS insures many people who have expensive needs, the growing cost of this coverage is forcing many people to drop or downgrade their Medex policy.

Commercial Insurers. Banker's Life and Mutual of Omaha are examples of commercial insurers that provide nongroup policies. AARP is an example of a member organization that offers group health insurance policies. Because commercial insurers are able to **age-rate**, a practice of charging higher premiums to older enrollees, and to reject coverage on the basis of health status, they serve a smaller, and probably healthier, segment of Medicare beneficiaries than does BC/BS. According to a General Accounting Office (GAO) report (see Congressional Quarterly, February 17, 1990), on average premium rates for commercial insurers are rising more slowly than those for BC/BS.

Health Maintenance Organizations. There are three types of HMO coverage for Medicare beneficiaries: **Risk Contracts, Wrap-Around Contracts**, and **Cost Contracts**. All HMO plans have some restrictions on which health care providers a beneficiary may choose.

An HMO Medicare Risk Contract is a substitute for rather than a supplement to Medicare. Under a Risk Contract, an HMO agrees to a certain level of federal reimbursement for providing elders with health care services. (The reimbursement level is computed using a formula that begins with 95% of the estimated Part A and Part B costs for a senior on a fee-for-service plan and adjusts this figure based on demographic factors.) A beneficiary receives all the benefits of Medicare Parts A and B without deductibles and co-payments. There are usually additional preventive care benefits. All medical services must be received within the HMO delivery system in order to be reimbursed. Neither Medicare benefits nor supplemental benefits extend beyond the delivery system. In 1991, 6 out of 23 licensed HMOs in Massachusetts had Medicare Risk Contracts.

HMOs may also choose to offer Wrap-Around Contracts or Cost Contracts, plans that function more like traditional Medigap products. While these types of contracts look almost identical to a Risk Contract for the Medicare beneficiary receiving care from within the delivery system, they are supplements to, not substitutes for, Medicare. HMOs, which may have switched to these models because they found the Medicare

reimbursement inadequate, are federally reimbursed on a fee-for-service basis. Central Massachusetts Health Care and Tufts Associated Health Plan are two examples of HMOs that have dropped their Risk Contracts and replaced them with Wrap-Around Contracts.

Under Wrap-Around Contracts, enrollees receive all supplemental Medicare benefits when utilizing services within the delivery system. This means that enrollees do not pay Medicare deductibles or co-payments. In contrast to the Risk Contracts, however, the Wrap-Around Contracts allow enrollees to maintain Medicare Part A and Part B benefits outside the delivery system provided they pay all deductibles and co-payments.

Cost Contracts are a combination of the Risk Contracts and Wrap-Around Contracts. Under Cost Contracts, there are again full supplemental benefits within the HMO delivery system. Outside the system, however, enrollees maintain only Medicare Part A benefits and must themselves pay the hospital deductible and coinsurance. Medicare Part B services are only reimbursable within the delivery system.

How is Medigap insurance regulated?

Until 1978, Medigap policies were regulated as other insurance products were -- by state government. As the Medigap insurance industry grew, however, abuses in the market quickly developed. By the mid-1970s, abuses such as the following began to surface:

- the sale of multiple, overlapping Medigap policies to the same individual;
- the sale of policies that duplicated the Medicare or Medicaid coverage the individual was already receiving; and
- the sale of worthless policies through clever marketing devices, including scare tactics and the use of misleading names, single "dread disease" plans.

These practices were serious enough to command federal attention.

FEDERAL REGULATIONS

Baucus Amendment. The most notable early effort to reduce abuses related to the sale of Medigap policies was the 1980 Baucus Amendment, named for its chief sponsor Senator Max Baucus. Included in the Amendment was the prohibition of the sale of duplicate policies to the same individual and the setting of "federal standards." These standards defined basic coverage and required that 60% of the monies collected as premiums for nongroup policies and 75% for group policies be returned to the enrollees in the form of benefits. These percentages are known as loss ratios.

The Amendment was, however, a voluntary program. Insurers who agreed to the guidelines were declared "federally approved," but other insurers were not prohibited from offering policies. The Baucus Amendment proved to be but one in a series of federal reforms aimed at eliminating the abuses in the Medigap market.

Omnibus Budget Reconciliation Act. The most recent federal initiative regulating the sale of Medigap policies is contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). Included in OBRA '90 are provisions that:

- require that every policy offer a core group of "basic benefits" which address certain costs of Medicare Part A and Part B;
- standardize the language of policies in order to make comparisons among the many policies easier;
- require that each policy inform the Medicare recipient that only one Medigap policy is needed or, if on Medicaid, no Medigap policy is needed;
- increase the protection against the sale of duplicate coverage to the same individual;
- mandate enrollment eligibility for all seniors for the first six months after they turn 65;
- guarantee renewability;
- mandate the approval of each Medigap policy by the state insurance commission or comparable body; and

- require that 65% (rather than the previous 60%) of the premium collected for nongroup policies be returned to the enrollees in benefits (effective November 1991).

These federal regulations apply to all nongroup Medigap policies in all states.

STATE REGULATIONS

In comparison with other states, Massachusetts has many more regulations relating to Medigap policies. As noted above, there are only four approved nongroup benefit packages. This means that all nongroup Medigap policies offered in the Commonwealth must fit the coverage requirements of one of the four packages. Premium rates for all these policies are subject to disapproval by the Massachusetts Division of Insurance. Additionally, no Medigap policy approved for sale may exclude coverage for any particular health condition. The practice of refusing coverage for health services related to a particular illness or health problem is known as a **pre-existing condition exclusion.**

Blue Cross and Blue Shield Regulations. BC/BS was chartered under Massachusetts law as a "nonprofit hospital service corporation" and a "medical service corporation." (See Chapters 176A and 176B of the Massachusetts General Laws.) BC/BS has the unique social responsibility of providing access to health care for all residents of the Commonwealth, regardless of health status.

As products of the "insurer of last resort," the Medigap packages of BC/BS, sold under the brand name of Medex, are subject to more regulation than any other policies. BC/BS must:

- accept all applicants;
- hold an open enrollment period from February 1 - March 31;
- NOT age-rate, a practice of charging higher premiums for older seniors;
- set premium rates by pooling everyone in the state, a process known as **community rating;**
- keep premium rates in effect for an entire year;

- subject nongroup premiums to approval by the Massachusetts Division of Insurance;

- subject nongroup premiums to a public hearing; and

- demonstrate cost containment measures each year which result in savings for Medex customers. An example is the recently approved mail-order drug option. The requirement that BC/BS demonstrate annual cost containment measures is known as Chapter 199 and has been in effect since 1984. (See p. 28.)

Commercial Insurer Regulations. Commercial insurers are subject only to the above mentioned federal and state regulations which apply to all Medigap policies. They are free to reject applicants because of health status and can charge higher premiums to older enrollees. Unlike BC/BS, they can raise their premiums at any point throughout the year.

Health Maintenance Organization Regulations. There are specific consumer protections for enrollees in HMOs. All HMOs offering the federal Medicare substitute plans known as Risk Contracts must have internal Quality Assurance Programs. Peer Review Organizations evaluate the access and quality of care provided by HMOs.

While HMOs are not required to offer supplemental coverage to Medicare beneficiaries, if they choose to do so, they must have a two-month open enrollment period for individuals and must coordinate their group enrollment with other group health plans. There are no state regulations governing age-rating and pre-existing condition exclusions for these HMO plans, but "federally approved" HMOs cannot base their premiums on age and are limited in the exclusions they can make based on health status. Unlike BC/BS, HMOs can raise their premiums at any point throughout the year for their supplemental-type contracts.

COST TRENDS

In this chapter we will investigate the increases in the premium rates for the four Medigap products offered by BC/BS: Standard, Medex 2, Medex 3, and Basic. We will examine the impact of the changing health insurance industry and the decreasing competitiveness of BC/BS on the 300% increase in Medex 3 premiums over the past ten years.

In 1991, almost 73% of seniors enrolled in BC/BS Medex plans were enrolled in Medex 3, the most comprehensive Medex product. Listed below, side-by-side, are the monthly premiums for Medex 3, and the Social Security Cost-of-Living Adjustments (SSCOLAs) for the same time period. SSCOLAs are used to determine elders' monthly Social Security checks. The total percentage increase of seniors' Social Security income was 52% while the corresponding aggregate rise in premiums was 298%.

Social Security v. Medex 3

Year	SSCOLA % Increase	Medex 3 % Increase	Medex 3 Monthly Premiums
1980	14.3%	15.8%	$21.58
1983	11.2%	7.6%	$40.04
1982	8.2%	10.5%	$47.89
1983	delayed til 1/84	22.9%	$40.04
1984	3.5%	16.4%	$40.04
1985	0.0%	8.2%	$40.04
1986	3.1%	0.0%	$40.04
1987	1.3%	10.5%	$47.89
1985	3.1%	9.3%	$52.32
1989	4.0%	0.0%	$52.32
1990	4.7%	64.1%	$85.87
TOTAL	52 %	298 %	
1991	5.4%	7.0%	$91.97

These are nongroup premium rates. Group rates are not subject to the approval of the Division of Insurance and may therefore be significantly higher.
Source: Massachusetts Division of Insurance

In 1980, seniors on Medex 3 were paying $258.96 per year for their Medicare supplemental insurance. In 1990, they were paying $1030.44 per year. If the premium rates had risen at the same rate as the SSCOLAs, which determine seniors' Social Security income, seniors enrolled in Medex 3 would only be paying $392.58 per year.

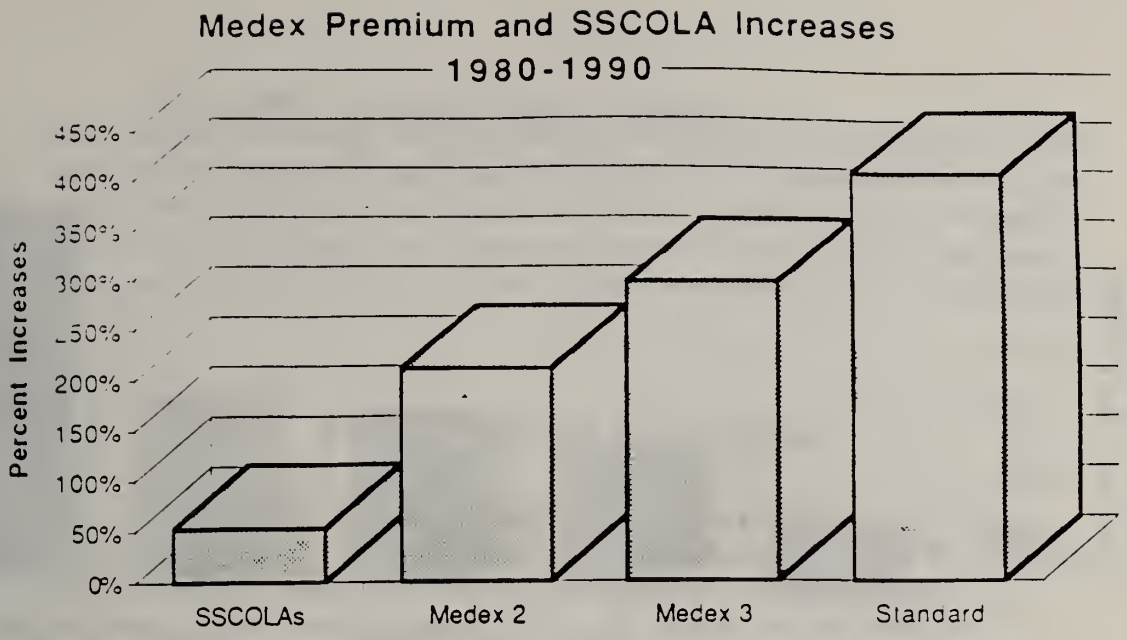
Although increases in Medex 2 and Standard policies affect fewer seniors, they have also been substantial. According to figures at the Massachusetts Division of Insurance, the ten-year period which brought seniors a 52% increase in their Social Security checks also brought them a 210% increase in Medex 2 and a 409% increase in Standard. Basic, a new product first sold by BC/BS in 1990 rose 3.6% in 1991.

Monthly Premium Rates
1980 to 1990

Year	Standard	%Incr.	Medex 2	%Incr.	Basic	%Incr.
1980	$14.02		$18.40			
1981	$15.36	9.6%	$19.86	7.9%		
1982	$18.14	18.1%	$24.59	23.8%		
1983	$22.92	26.4%	$28.87	17.4%		
1984	$26.89	17.3%	$32.26	11.7%		
1985	$29.07	8.1%	$32.73	1.5%		
1986	$29.07	0.0%	$32.73	0.0%		
1987	$32.12	10.5%	$36.17	10.5%		
1988	$38.83	20.9%	$31.73	-12.3%		
1989	$38.83	0.0%	$31.73	0.0%		
1990	$71.29	83.6%	$57.12	80.0%	$64.69	
TOTAL		409 %		210 %		
1991	$75.05	5.3%	$57.58	.8%	$67.00	3.6%

Source: Massachusetts Division of Insurance

The following bar graph compares the rate increases of the three Medex products -- Standard, Medex 2, and Medex 3 -- and the SSCOLA over the period 1980 to 1990.



Source: Massachusetts Division of Insurance

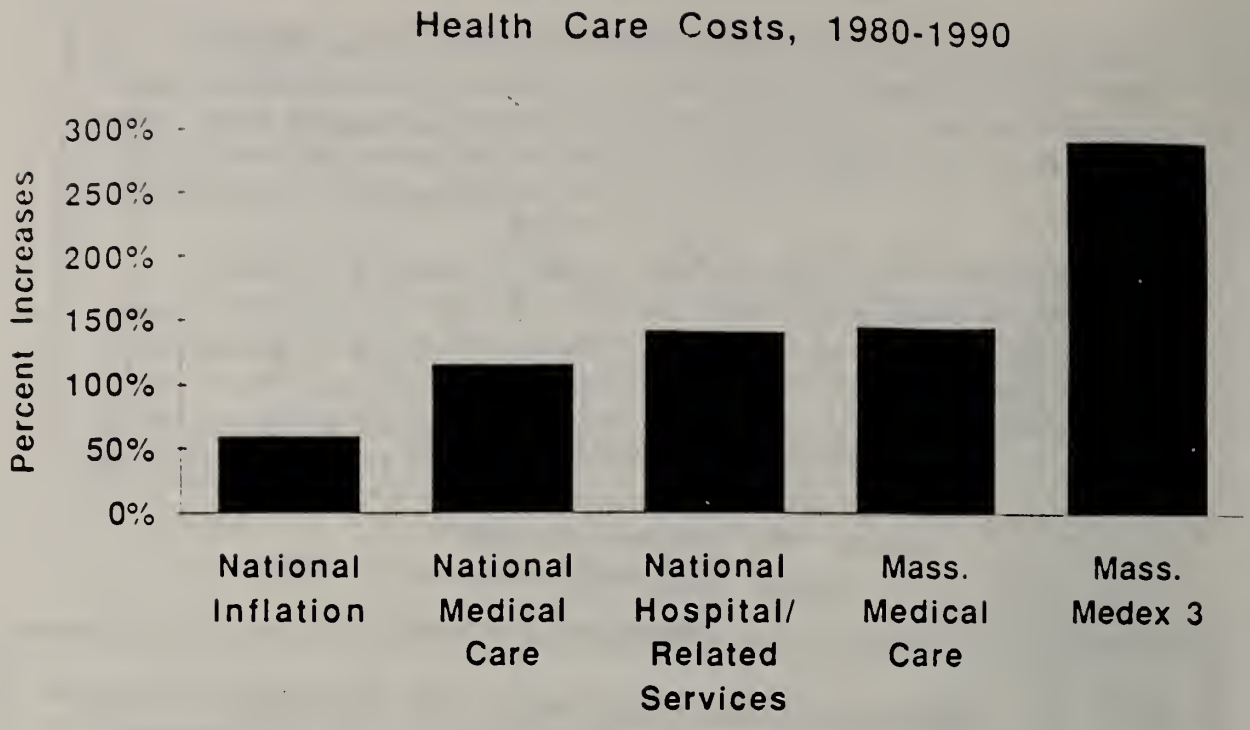
FEDERAL FACTORS

Health Care Costs. Rising medical costs are playing a role in the increasing unaffordablity of Medigap insurance. The Massachusetts medical care inflation rates have been running at 9% since 1985, with a total increase of 147% from 1980 to 1990. Below are the national inflation rates alongside the Medex 3 premium increases.

Health Care Costs

Year	National Inflation	National Medical	National Hospital	Medex 3
1989	10.4%	10.8%	14.2%	7.6%
1982	6.1%	11.6%	14.2%	20.6%
1983	3.2%	8.7%	11.4%	22.9%
1986	6.1%	6.2%	8.6%	16.4%
1986	1.9%	6.2%	6.4%	8.2%
1986	1.9%	7.5%	6.0%	9.3%
1987	3.2%	8.7%	6.9%	10.5%
1989	4.1%	6.5%	7.4%	9.3%
1989	4.8%	7.7%	7.1%	0.0%
1986	5.4%	9.0%	10.9%	64.1%
TOTAL	60 %	115 %	142 %	298 %

Source: Bureau of Labor Statistics



While hospital and medical inflation rates are high, drug costs are higher still. According to the Division of Insurance (see Nancy Turnbull, "Trends in Medex Use in Massachusetts" in Elders at Risk, 1989), while the total amount paid out in claims by BC/BS for Medex 3 members increased 143% from 1980 to 1986, the largest item increase in claims was for prescription drugs. Prescription drug claims quintupled. From 1980-1987, the average annual number of prescriptions per enrollee rose from 6.2 to 13. Accompanying this increased utilization was a jump in the average cost of a prescription from $9.49 to $17.50.

Changes in the Medicare Program. Changes in the Medicare Program have also affected Medigap insurance in Massachusetts. In 1988 the Medicare Catastrophic Coverage Act (MCCA) was signed into law. The MCCA brought changes that expanded some areas of Medicare coverage and transferred certain costs, including the hospital deductible, away from Medigap policies.

When this act was repealed in 1989, approximately $100 million in Medicare costs were shifted back to BC/BS Medigap plans. In addition to the costs of the benefits taken back by Medigap, there were also administrative costs associated with policy modification and notification. A GAO survey (see Congressional Quarterly, February 17, 1990) estimated

that half of the average Medigap premium increases in the nation in 1990 were directly related to the repeal of the MCCA. Changes on the national level only account for a portion of the crisis in Massachusetts, however. While the same GAO survey reported that the anticipated rate increases were to range from 5% to 52%, the Medex rate increase in this state was 67%.

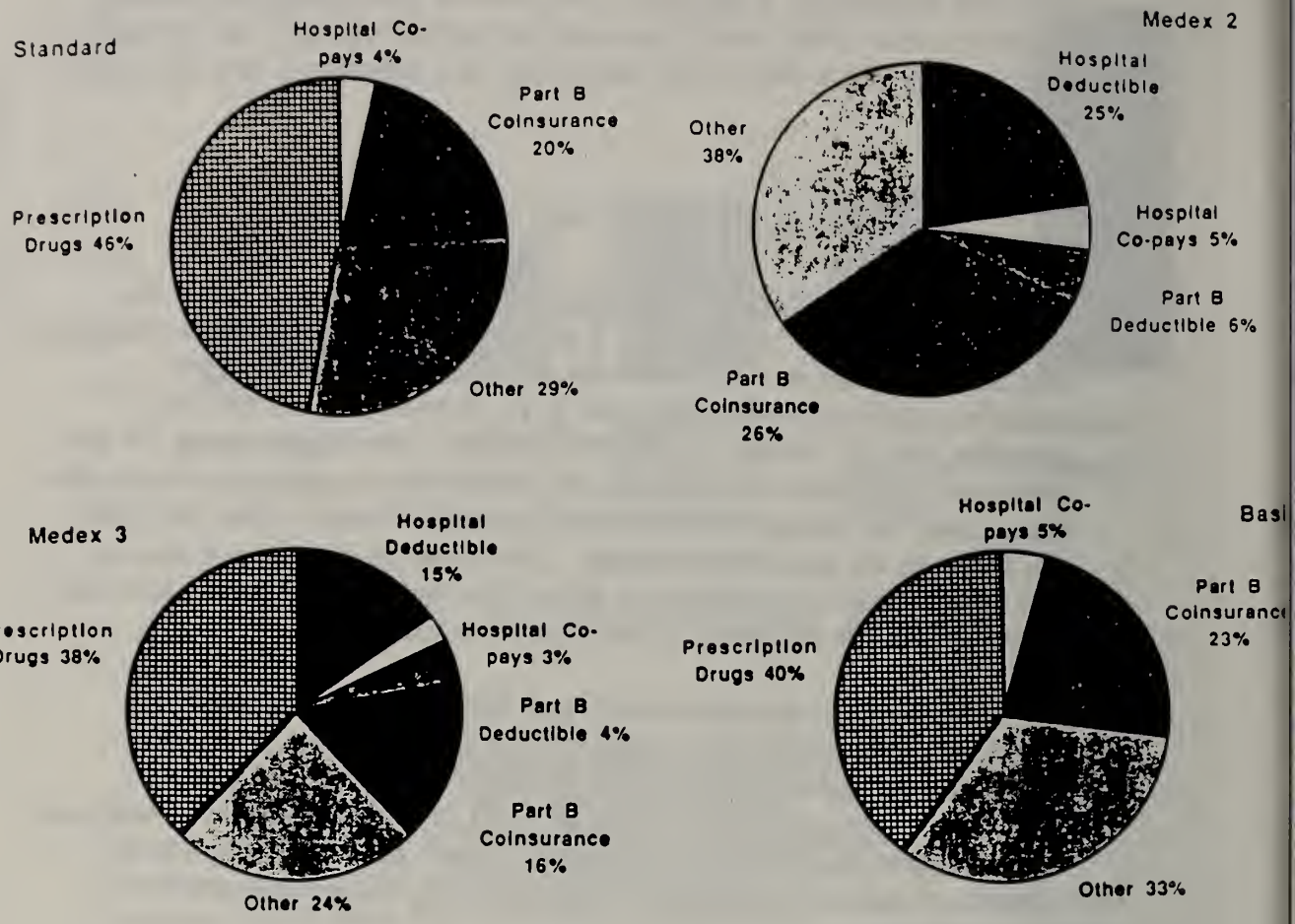
BLUE CROSS AND BLUE SHIELD

Reasons for Varying Percentage Increases in Medex. Over the period from 1980 to 1990, Medex 2 premiums increased 210% as compared with 298% for Medex 3 and 409% for Standard. The year-by-year reporting of the premium rates (see p. 12) reveals that in 1988 the premium rate for Medex 2 actually decreased. The major reason for the substantial difference in increases among the various plans lies in the fact that, unlike the Medex 3 and Standard policies, Medex 2 does not offer any coverage for prescription drugs. The dramatic increases in cost as well as utilization of prescription drugs have been passed on in the form of higher premiums for Medex 3 and Standard enrollees.

As the premiums have increased, people who do not use prescription drugs (as well as seniors who simply cannot afford the premiums) have downgraded their Standard or Medex 3 coverage to Medex 2. This trend leaves only high users of drugs in the plans covering drugs, thereby increasing the number of claims filed in relation to the number of enrollees. Increased utilization then causes increases in premium rates.

Increases in Standard over the same period exceeded those of Medex 3, a more comprehensive plan. While both products cover prescription drugs and have the same $35 quarterly deductible, Standard does not cover the hospital deductible or the Part B deductible. The difference in the premium increases of these two plans is largely a result of the percentage of the total premium rate dedicated to prescription drugs. Prescription drug costs for Standard represent a larger portion of the total premium than for Medex 3. According to the 1991 rate filing breakdown of the Massachusetts Division of Insurance, prescription drugs accounted for $34.65 of the monthly premiums for both Standard and Medex 3. This represents 46% of the Standard premium as opposed to only 38% of the Medex 3 premium.

Premium Breakdowns for BC/BS Medigap Plans
1991



Source: Massachusetts Division of Insurance
Percentages may not add up to 100% because of rounding.

Decreasing Competitiveness of BC/BS. In the past, the size of BC/BS -- covering 54% of the insured population in Massachusetts in 1988 (64% including BC/BS HMOs) -- and the benefits it enjoyed in exchange for its status as the "insurer of last resort" allowed BC/BS to sustain losses in its Medigap products without risking the stability of the company. Statutory hospital discounts as well as other "advantages" including partial tax-exempt status, the ban on balance billing, and the restrictions on reimbursement to nonparticipating physicians, allowed BC/BS to generate reserves from which it could then subsidize its expensive lines of coverage internally.

However, changes in the health insurance industry and increased costs and utilization of medical care have undermined the competitive position of BC/BS and have made internal generation of reserves and the following subsidization of Medigap policies increasingly difficult.

The key change in the insurance market in recent years has been the increasing ability of HMOs and commercial insurers to negotiate discounts on hospital charges with providers. Often these negotiated discounts are greater than the statutory discounts for BC/BS which were designed to allow BC/BS to compete with other insurers.

As HMOs and commercial insurers take away the more profitable lines of BC/BS through competitive premiums and benefits, BC/BS loses its source of internal subsidization for the regulated, high-risk lines, including Medex, which by law it must insure. Over a four-year period ending in 1990, BC/BS reported a loss of 800,000 subscribers.

Administrative Costs. At the same time that BC/BS was losing the competitive advantage of its hospital discounts and, as a result, business among younger groups, the administrative costs of BC/BS were increasing significantly faster than income from its premiums. According to five-year historical data on BC/BS which was part of its 1990 filing, from 1985 to 1989, both the income earned from premiums and the claims incurred increased 34%. The administrative expenses over the same period of time increased by 52%. Administrative costs include marketing and claims processing.

ENROLLMENT TRENDS

Along with the substantial premium increases over the past ten years, BC/BS has experienced both an overall decline in enrollment in its Medigap policies and also a shift in the distribution over its four plans. In this chapter we look at the movement within the Medigap market along with its effect on seniors. We also explore the suggested partial solution to the Medigap crisis: HMO managed care.

The table below shows the 1980 to 1990 approximate enrollment figures for both Medex nongroup and group policies and for HMO policies. The percentage figures indicate approximately what portion of Massachusetts residents over the age of 65 were covered by each Medigap option. Elders covered by Medicaid or by commercial insurers are not included in the table.

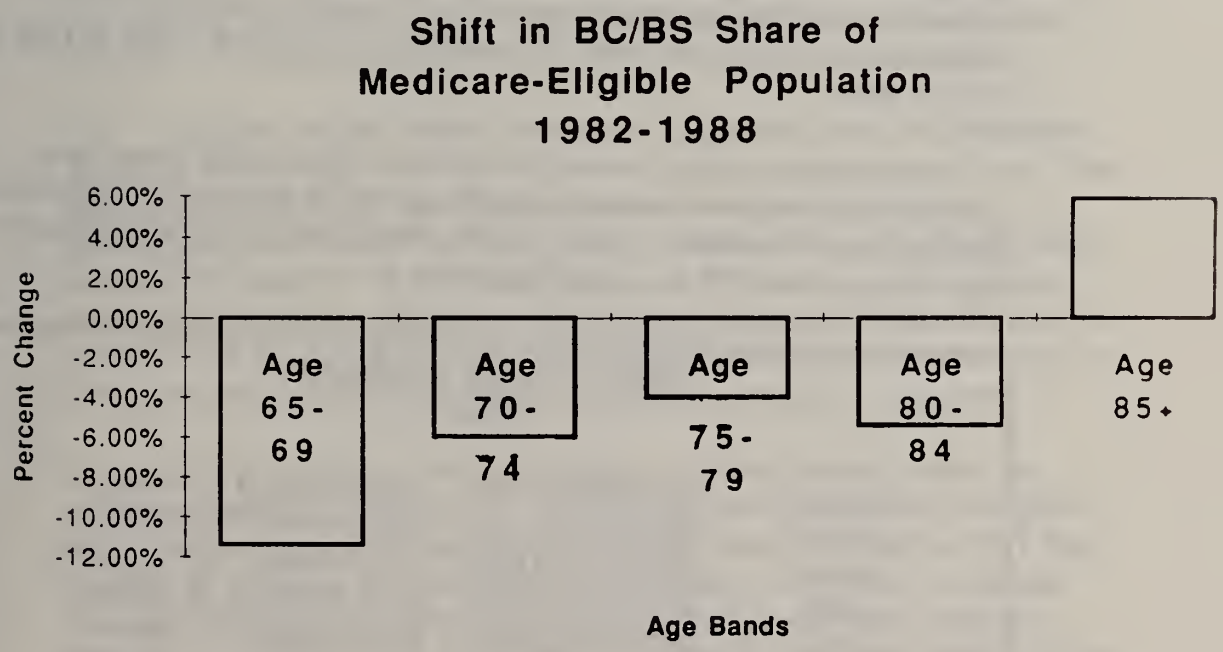
Medigap Enrollment
1980 to 1990

Year	* #Mass Elders	** # in HMOs	% in HMOs	*** #Group Medex	%Group Medex	*** #Non-Group	%Non-Group
1980	726,531	4,000	.6%	127,000	17.5%	313,000	43.1%
1984	773,000	20,000	2.6%	119,000	15.4%	325,000	42.0%
1986	791,000	53,162	6.7%	125,000	15.8%	292,000	36.9%
1987	800,000	55,728	7.0%	124,000	15.5%	292,000	36.8%
1988	806,000	54,068	6.7%	102,000	12.7%	288,000	35.7%
1989	815,000	65,200	8.0%	102,670	12.6%	293,801	36.0%
1990	819,284	60,322	7.3%	99,828	12.2%	275,392	33.6%

* 1980, 1990 United States Census
1984-1988 United States Department of Commerce, Population Estimates and Projections
** Massachusetts Association of HMOs
*** BC/BS of Massachusetts

Enrollment Shifting. Enrollment figures alone, however, do not tell the whole story. While HMOs are insuring a slowly growing segment of the Medicare- eligible population, their participation in the Medigap market does not necessarily reduce the strain on BC/BS which must insure the high-risk elderly population. Because HMOs are able to insure selected segments of the population, their participation in the Medigap market is working against BC/BS. A 1990 General Accounting Office report (GAO 1990 T-HRD-90-27) published the findings of national studies which indicated that seniors enrolled in HMOs tend to be healthier and their care less expensive than average.

The Cresap-Tillinghast analysis reported that from 1982 to 1988, BC/BS lost 11.4% of the Medicare eligible population aged 65 to 69. This represents a loss of the youngest, and probably healthiest, segment of the population. In contrast, over the same time period, BC/BS gained 5.8% of the market for seniors over age 85.



Source: Cresap-Tillinghast Analysis, 1990

Nationally, the number of "oldest old" is growing six times faster than any other segment of the population.

Additionally, the shift of seniors away from BC/BS is much slower than the shift of the younger populations which make up the more profitable insurance lines of BC/BS. As changes in the insurance industry decrease the competitiveness of BC/BS and allow HMOs to draw more of the market through relatively attractive premiums and benefits, seniors represent a growing percentage of the total business of BC/BS. The Cresap report showed that in 1988 BC/BS had 42% of the Commonwealth's insured group market in contrast to approximately 65% of the insured Medicare-eligible population.

Movement within BC/BS. The 1990 increases in Medex premium rates caused an alarming number of seniors to drop or downgrade their BC/BS coverage to less comprehensive and lower-cost plans.

Voluntary terminations in nongroup Medex plans rose from 1,635 in 1989 to 4,687 in 1990. This represents a 186.7% increase in the number of individuals dropping their Medex coverage. Nonpayment terminations, terminations which were not requested but occurred because of nonpayment of premiums, more than doubled, rising from 3,424 in 1989 to 8,220 in 1991.

Many other seniors are assuming more risk, downgrading their coverage while they are relatively healthy or simply because they have been priced out of the market. Out of 27,350 elders who individually changed their coverage in 1990, only 1,000 upgraded it.

Shifts in Medex Enrollment
1990

20,000	DOWNGRADED - from Medex 3 to Medex 2
2,600	DOWNGRADED - from Medex 3 to Basic
2,400	DOWNGRADED - from Medex 3 to Standard
1,000	DOWNGRADED - from Standard to Medex 2
300	DOWNGRADED - from Standard to Basic
1,050	UPGRADED - from Medex 2 to Basic

Source: Blue Cross and Blue Shield

Dangers of Assuming Greater Risk. Downgrading and dropping coverage creates problems both for individual seniors and for the Medigap insurance system as a whole. Some seniors assume greater risk in order to pay less in premiums while they remain relatively healthy, thereby endangering their health and their financial security. Others simply cannot afford the health coverage they truly need.

If individuals among the 21,000 who downgraded their coverage from Medex 3 or Standard to Medex 2 suddenly need drugs, they will either face the financial burden of paying for prescription drugs themselves or they will face more serious illness by going without. If seniors among the 5,000 who downgraded from Medex 3 to Standard or to Basic end up in the hospital, they will immediately find themselves with a $628 first-day hospital deductible.

Additionally, downgrading to a lower-coverage policy and dropping coverage entirely may have negative effects on the premiums of those individuals who remain in more comprehensive plans. Health insurance is designed to spread the cost of health care over as broad of a population as possible by including healthy people who will not use some benefits.

As more healthy seniors downgrade out of the most comprehensive Medex 3, the concept of health insurance as risk sharing is destroyed. The pool of individuals paying for comprehensive benefits becomes both smaller and less healthy. In 1988, 84% of seniors insured by BC/BS were covered by Medex 3. In 1990, approximately 73% were enrolled in that plan (Massachusetts Division of Insurance). Increased claims because of a sicker risk pool combined with fewer people contributing premiums force some premium components of comprehensive coverage to cost more.

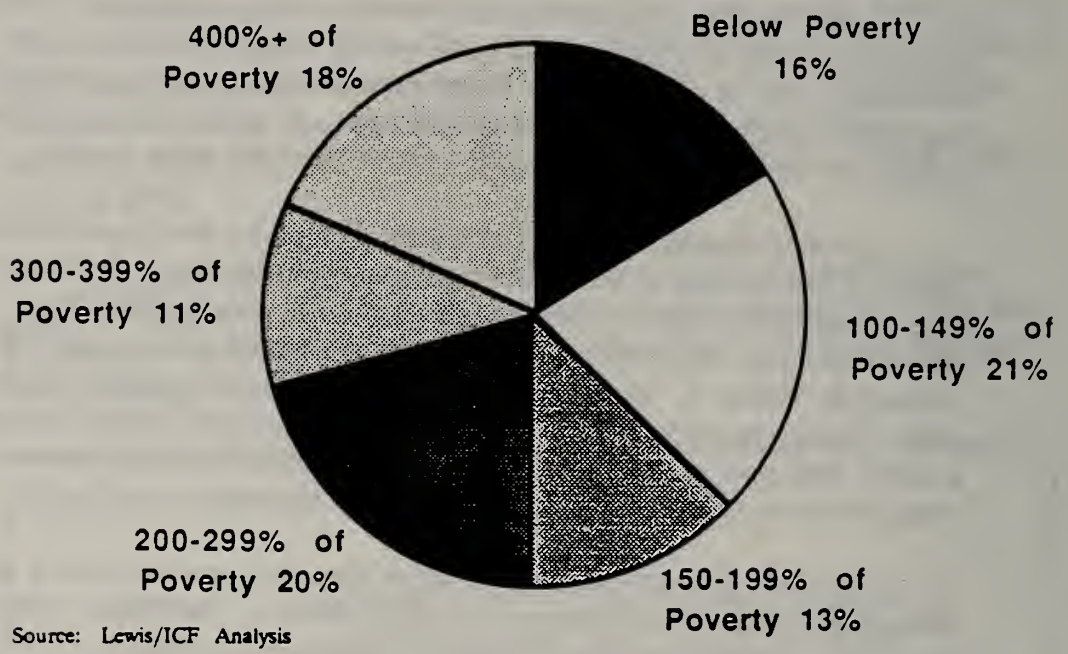
There is evidence that may suggest that this process, known as **adverse selection**, is happening. The distribution of the Medex composite rate increase across the four plans was significantly different in 1991 than in 1990. In 1991 the proposed increase in Medex 3 of 11.1% was greater than the average of the four plans while in 1990 it was lower than the average. In 1990 the cost of Medex 3 increased by 64% while Medex 2 and Standard increased by 80% and 84% respectively.

Downgrading and dropping coverage has negative effects on seniors, on BC/BS, and also on the larger health care system. When access to health care becomes more difficult, both practically and financially in terms of increased out-of-pocket costs, it becomes more likely that when an individual finally receives care it will be expensive. Preventive medicine is less expensive than emergency room costs.

Poverty Issues. There is no conclusive data available on the income ranges of Medigap enrollees. However, while it is clear that some seniors are dropping or downgrading Medigap coverage because they can no longer afford the premiums, seniors who struggle to maintain coverage are not necessarily able to manage their payments without substantial financial sacrifice.

According to a Lewis/ICF analysis of population data from 1985-1988, 16% of Massachusetts senior households live at or below the poverty line. Another 21% live between poverty and 150% of poverty. Thirty-three percent live between 150% and 300% of poverty.

Poverty Levels of Massachusetts Elders



Source: Lewis/ICF Analysis

These percentages are based on single senior households which include all non-institutionalized individuals 65 or older and households of couples in which one or both individuals are 65 or older. Because couples tend to be better off financially than individual seniors and yet only count once in the computation of the percentage, the figures above indicate a larger proportion of elderly at the poverty level than is actually true. However, on the other hand, since poverty guidelines are lower for couples than for two individual seniors, couples may be classified misleadingly in higher income level categories. Couples pay the same in health care premiums as two individual seniors.

1991 Federal Poverty Guidelines

	Individual	Couple
100%	$ 6,620	$ 8,880
150%	$ 9,930	$13,320
200%	$13,240	$17,760
300%	$19,860	$26,640
400%	$26,480	$35,520

A 1988 analysis (1988 Living Budgets for Low-Income Seniors in Massachusetts, Health Care For All) revealed that after paying monthly expenses excluding medical care, seniors up to 200% of poverty had no or insufficient income to pay their Medicare Part B and Medex 3 premiums.

In 1991, seniors paid $358.80 annually for Medicare Part B coverage. If enrolled in Medex 3, they spent $1,103.64 per year on premiums alone. These two costs together represent 15% of the income for a senior living at 150% of the poverty level and 11% for a senior living at 200% of the poverty level. The situation is even more serious for couples. Couples living at 150% of poverty spend about 22% of their income on Medicare and comprehensive Medigap premiums and couples at 200% of poverty spend an average of 17%. These percentages do not include the $35 Medex 3 quarterly drug deductible or coverage for extended hospital or nursing home care, extended home health care. routine physicals, vision, foot care, and dental care.

The passing of the 1988 Medicare Catastrophic Act (parts of which were repealed in 1989, see p. 14) brought a buy-in benefit for all low-income Medicare beneficiaries. This program, known as the Qualified Medicare Beneficiary Program (QMB) authorizes the Department of Public Welfare (DPW) to pay the Medicare premiums, co-payments, and deductibles of beneficiaries who meet income and asset guidelines. In 1991, a senior could have assets no greater than $4,000 for an individual and $6,000 for a couple and could have income no greater than 100% of the poverty level.

Under the QMB Program, the $29.90 monthly premium for Medicare Part B is not automatically deducted from a senior's monthly Social Security check. DPW automatically covers the premium, and seniors do not need Medigap insurance to cover their Medicare deductibles and co-payments.

Since the passage of the QMB Program, there has been an effort to enroll qualified elderly into this program and bring some relief to low-income elders. Efforts, however, have not been successful. According to a Families USA Foundation report (see The Secret Benefit: The Failure to Provide Medicare Buy-in to Poor Seniors, 1991), out of the 77,000 seniors (plus a lesser number of disabled under age 65) eligible for the QMB program in Massachusetts, 45,000 (58%) are not enrolled. Most of these people do not receive Medicaid, and many are almost certainly purchasing Medigap coverage.

According to a report released by the Harvard School of Public Health, Louis Harris and Associates, and the Department of Medical Security (see A Household Survey of the Health Insurance Status of Massachusetts Residents, 1990), an underinsured individual is one whose out-of-pocket health care costs exceed 10% of personal income.

If we use this standard conservatively and agree that 10% of annual income is a reasonable amount to dedicate to health care premium costs (as opposed to all health care costs), seniors at the poverty level need an annual subsidy of over $2,000 while those at 300% of poverty need approximately $250. An adequate subsidy based on assistance to all seniors at or below 300% of the poverty rate (and assuming increased enrollment in Medicaid and the QMB Program) would run in the neighborhood of $151 million for the state of Massachusetts.

MANAGED CARE AND THE ROLE OF HMOs

With health care costs rising and Medicare coverage being cut back with the repeal of the MCCA, the federal government has encouraged the coverage of Medicare beneficiaries through managed care options rather than through fee-for-service plans, such as those traditionally offered by BC/BS. As both insurers and providers, HMOs seemed to meet the perceived need of cost-effective care and to offer a reasonable solution to the growing unaffordability of BC/BS Medigap products.

In 1985, when HMOs first opened their doors to seniors on a large scale, there was an initial wave of enrollments of Medicare beneficiaries in these managed care programs. In recent years, however, growth has slowed significantly. (See p. 18.) While managed care plans offer positive incentives for providing efficient care, rising health care costs are driving up HMO premiums as well.

HMO Monthly Premiums

Year	Harvard Community	% Incr	Bay State	% Incr	Fallon	% Incr
1987	$45.00		$31.75		$20.00	
1988	$55.00	22.2%	$60.20	89.6%	$35.00	75.0%
1989	$67.50	22.7%	$55.00	-9.5%	$53.50	52.9%
1990	$70.00	3.7%	$55.00	0.0%	$59.72	11.6%
TOTAL		**55 %**		**73 %**		**199 %**

Source: 1987-1988 Office of Prepaid Health Care
1989-1990 Executive Office of Elder Affairs

The increases in the premiums for these HMOs have a fairly wide range. Although some have been more moderate than those for Medex, all have been greater than both the SSCOLAs and the medical inflation rate over the same time period. Unlike BC/BS, if providing health care to the Medicare population becomes too costly and federal reimbursement for Risk Contracts inadequate, HMOs can choose not to offer Medigap products at all or to offer only the more traditional Wrap-Around Contracts. **(See p. 6.)**

According to the Massachusetts Association of HMOs, in 1988, 15 out of the 22 licensed HMOs in Massachusetts (68%) offered Risk Contracts. In 1991, only 6 out of the 23 licensed HMOs (26%) offered Risk Contracts. Three offered Wrap-Around Contracts and three offered Cost Contracts. These newer products are supplements to rather than substitutes for Medicare and provide less opportunity for cost containment.

In addition to their demonstrated limitations in the area of cost containment, HMOs have specific restrictions which make them inappropriate for some elderly people. As explained above, all HMO plans have both provider and geographic constraints. Under an HMO, seniors cannot choose their own doctors and may lose the care of a long-time doctor. Also, the geographic restrictions would make an HMO plan inappropriate/inconvenient for seniors who have more than one primary residence. Much of HMO care is not reimbursable outside of the HMO delivery system. Managed care through HMOs alone is clearly not the solution to the question of affordable Medigap insurance.

DIRECTIONS FOR REFORM

The first three sections of this report describe Medigap insurance in Massachusetts and, by exploring cost and enrollment trends in BC/BS, offer some explanation of the origins of today's crisis. Below are both theoretical directions for reform as well as analyses of concrete legislative proposals.

THEORETICAL SOLUTIONS

In broadest terms, when working within the context of the insurance market in Massachusetts, there are two theoretical approaches to the problem of the growing lack of affordability of Medigap coverage:

- o Reduce Medigap premium costs; or
- o Subsidize Medigap premiums.

Reducing Medigap premium costs actually lowers the overall expense of providing care, while the subsidization approach leaves the price unaffected but provides funds to help seniors pay their premiums.

Each of these two basic approaches can be further broken down into more concrete means for attaining cost reductions or premium subsidization.

Methods of reducing the cost of Medigap premiums:

- o Reduce the benefits of Medigap coverage, cutting out expensive services and/or increasing enrollee co-payments and deductibles;
- o Reduce the amount insurers pay to providers for Medigap services/benefits; or
- o Reduce the utilization of Medigap services.

Methods of subsidizing Medigap premiums:

- o "Cross subsidize" Medigap with other lines of insurance which serve healthier, less expensive populations;
- o Find other subsidy sources within the health care system (such as the **Massachusetts Uncompensated Care Pool**); or
- o Use tax revenue to subsidize Medigap products.

These basic approaches as well as the strategies under each approach can be combined in various ways in an effort to maximize their effectiveness. The advantages and disadvantages of each approach are explained below.

REDUCTION OF MEDIGAP COSTS

Reducing actual premium costs is desirable but far from simple. Each strategy for cost reduction has drawbacks or limitations.

Reduce Benefits. One approach, proposed by BC/BS in testimony before the Joint Committee on Health Care, is to reduce benefits. By covering fewer benefits, the price of insurance will go down. Benefits can be reduced either by leaving selected services uncovered or by increasing co-payments and deductibles. BC/BS contends that Medex 3 is the "richest benefit package in the country" and that even with cuts in the benefits it would still provide reasonably comprehensive coverage. A change in the benefit packages would require a shift in the state regulations.

The major problem with the benefit reduction approach is that it is not real cost containment. Rather, it is cost shifting. Reducing benefits does not control the amount of money spent on health care. It transfers costs from the insurer to the individual through increased out-of-pocket costs for uncovered services or through higher co-payments and deductibles. This approach is therefore a regressive one in which the resulting reduction of premiums is shifted to "higher cost elders," individuals who need and use more health services.

Reduce the Price Paid for Services. Another way to reduce premiums is to reduce the price that an insurer pays providers for Medigap services. However, reducing the price paid by insurers is difficult, especially for traditional insurance plans such as those offered through BC/BS. Much of what Medigap insurance pays for is governed by the federal Medicare Program and is therefore out of the control of the Medigap insurer. When Medicare raises the first day hospital deductible, Medigap insurance premiums rise in order to cover the additional expense.

HMOs have a greater ability than BC/BS or other commercial insurers to reduce the prices they pay providers for Medigap services. Through Risk Contracts (see p. 6), they control not only the "gap" payments but also the entire flow of Medicare dollars. However, when Medicare increases costs to beneficiaries, HMOs may not be able to make up the difference solely by reducing provider payments. Instead or in addition, they may choose to raise premiums. While some HMO

premiums do remain lower than Medex premiums, there is no conclusive evidence that explains how much of this difference results from lower payments to providers, how much from reduced utilization, and how much from insuring younger, healthier enrollees.

Although traditional insurers have limited control over the amount paid for health care services, one area where they can have some impact is in payment for prescription drugs. Prescription drugs, accounting for 40% of the increases in recent years, represent one of the fastest growing portions of Medex premium rates. (See p. 16.)

In accordance with their requirement to demonstrate efforts at cost containment, BC/BS started a mail-order prescription service option for maintenance medications which will reduce costs by enabling BC/BS to obtain cheaper prices based on volume. Seniors will pay a fixed co-payment of $2 for generic drugs and $10 for brand name drugs. BC/BS has estimated that a mail-order drug option will cut drug costs by an average of 10%. While the adoption of a mail-order prescription service will certainly not drive down the current premium rates for Medex, the hope is that the program will slow the rate of increase.

Reduce Utilization. The third approach to reducing premiums is to reduce utilization of services. This approach, too, has its limitations as a cost containment strategy. The best way to reduce utilization is obviously to prevent people from getting sick. Unfortunately, the medical profession is oriented toward cure rather than prevention. The Medicare Program and most Medigap plans offer little coverage for preventive care. Also, elderly people have a lifetime of accumulated health risks. A serious prevention effort aimed at keeping older people healthy needs to start at an early age.

Another way to reduce utilization is to influence the behavior of physicians. An example of reducing drug utilization is a proposal of BC/BS known as **"counter detailing."** Counter detailing was proposed by BC/BS in 1991. This new effort is a response to a practice of drug companies called **"detailing."** Detailing takes place when drug companies send representatives to doctors' offices to encourage the use of new drugs. New drugs are often more expensive, and not always superior to drugs that have been on the market for a while. Counter detailing involves sending a representative to doctors' offices to inform physicians on the most cost-effective ways of prescribing drugs.

Efforts to reduce drug utilization by influencing the behavior of physicians through counter detailing have potential for success because Medigap insurance is the primary payer for prescription drugs. However, since Medigap insurance pays only a small portion of the hospital or physician bill, it is difficult to use Medigap reimbursement to influence other ways doctors practice. In order to influence these other areas, it would be necessary to make changes in the health care system as a whole, or at least in Medicare, that would discourage unnecessary procedures, establish standards of care, and reduce "defensive medicine" which arises with the fear of medical malpractice.

Again, for HMOs the situation is somewhat different. Since many HMOs have physicians on salary, they presumably have more control over practice patterns. However, the fact that a number of HMOs have shifted from Risk Contracts to more traditional Wrap Around Contracts combined with the steady rise in HMO premiums suggests that controlling either price or utilization may remain an unattained goal.

SUBSIDIZATION OF MEDIGAP PREMIUMS

Since subsidization does not inherently address cost containment, if subsidization is chosen, either the size of the subsidy must be increased annually or the real value of the subsidy will diminish. It is difficult to come up with a subsidy source which can keep pace with the rising costs of health care.

Like cost containment, there are several different approaches to subsidizing Medigap premiums.

Cross Subsidize with Other Insurance Lines. One way to subsidize Medigap is to require insurers to sell Medigap at below the cost of claims and administration. Insurers would then make up the difference by raising their prices in other insurance products. This was, in fact what happened with Medex during much of the 1980s. BC/BS regularly lost money on Medex and offset those losses by reserves it had generated from other lines of business. BC/BS was able to do this because it controlled such a large percentage of the health insurance market and had a special discount on hospital services that allowed for the creation of a surplus from their group plans. Although not an explicit subsidy mechanism, this process helped it to offset losses in its Medigap and nongroup insurance lines.

In a competitive insurance environment, however, this approach does not work. Insurance companies compete by trying to offer the lowest possible price to an employer group. If insurers have to make up for losses in one line by charging more in another, they are likely to lose business. BC/BS provides a good example of how cross subsidization does not work in a competitive environment.

Over time, BC/BS has been losing the advantages that enabled it to cross subsidize Medex. Although BC/BS still has a hospital discount, HMOs are going out and negotiating their own discounts which are sometimes larger than that of BC/BS. The "Blues" are losing their competitive advantage. Also, the Blues are competing for business with HMOs, which do not have to accept everyone and which do not have to have contracts with every doctor and hospital. As a result, BC/BS is steadily being under-priced by competitors and is losing business.

With health care costs rising and with fewer people subscribing to BC/BS, the cost per BC/BS subscriber of subsidizing Medex has been growing. In response to the increasing burden of cross subsidization in combination with a number of external factors, BC/BS was granted a huge Medigap rate increase in 1990. The increase transferred $100 million in costs onto the elderly. In the three years preceding the rate increase, BC/BS averaged approximately $48 million per year in Medex subsidies. In 1990, BC/BS reported an internal Medex subsidy of $18 million. The 1990 rate increase did not, however, solve the long-term problems facing BC/BS.

The Medex Relief Bill (see p. 33) was filed to restore the ability of BC/BS to subsidize Medigap insurance.

Use Other Subsidy Source. Another potential subsidy source is the state's "Uncompensated Care Pool" (also known as the "Hospital Free Care Pool"). The Uncompensated Care Pool is money created by adding a surcharge onto every private sector hospital bill in the state. In 1991 the surcharge was about 11%. There is no surcharge on Medicare or Medicaid bills.

This surcharge is then used to pay hospitals for giving care to the uninsured or underinsured. Low-income elders who do not have Medigap insurance sometimes use the pool to pay for their first-day hospital deductible.

Since elders are already using the pool, some have suggested that instead of paying hospital bills, money from the pool could be targeted to subsidize insurance. (See Revised Medigap Relief Bill and Senate Bill 406, p. 34.) Pool money could be used to fund vouchers for the elderly or could be paid directly to insurers to offset losses in Medigap insurance. This approach would increase the need for free care pool funds, and therefore increase the hospital surcharge needed to fund the pool.

Using the pool has two drawbacks. First, with a cap on the size of the pool, most analysts agree that it is already under funded, by perhaps $100 million or more. Diverting some of the pool to subsidize Medigap could pit underinsured elders against uninsured workers in a fight over scarce pool dollars.

Secondly, the pool is not funded very equitably. The pool is essentially a "sickness tax." While all privately insured people pay into the pool indirectly via premiums to insurance companies, sicker groups pay more than healthy groups because they use the hospital more.

Use Tax Revenue. Using either general revenue or a dedicated tax to subsidize Medigap is the third main alternative. The advantage of tax revenue is that it is likely to be more equitable than pool funding. The problem with using general revenue is that again, like the Uncompensated Care Pool, it has the potential of pitting the elderly against other needy groups (and even against other elders), particularly at a time when health care, housing, and other programs are being cut. A dedicated tax avoids this pitfall. This was the approach used in the 1989 Medigap Assistance Bill. This bill was not adopted. The main road block to this approach is political. Neither the Governor nor the Legislature is considering new tax measures in 1991.

PROPOSED SOLUTIONS

Federal Proposals

The Pepper Commission, a United States bipartisan commission on comprehensive health care, released its final report in the fall of 1990. Included in its proposals for health care reform were specific sections on reforms for the over 65 population. The Commission recommended the following:

- o Federal assistance with Medicare premiums and deductibles for all seniors below 200% of poverty;
- o Expansion of Medicare services to include selected preventive services; and
- o Medigap insurance reforms, including counseling at local levels, extension of "federal standards," and increased consumer protections.

The Pepper Commission estimated that the proposed reforms would improve health care for 30 million Americans at a total cost to the federal government of $2.8 billion. The report did not include a financing mechanism to meet the additional costs.

Some of the recommendations of the Pepper Commission have been adopted. A part of the Medicare Catastrophic Act that was not repealed includes the expansion of Medicare services to cover mammograms and the Qualified Medicare Beneficiary Program (see p. 23) which pays for Medicare premiums and deductibles for seniors at the poverty line. OBRA '90 (see p. 8) approved increased federal standards and consumer protections. Federal assistance for all seniors below 200% of poverty remains unaddressed.

State Initiatives

In addition to the federal proposals embraced by the Pepper Commission and included in other reforms, several bills designed to address the affordability of Medigap insurance have been filed in Massachusetts in 1991. Each of the proposals uses a different strategy to deal with the health insurance needs of senior citizens.

The Family Health Plan. As a solution to the health care crisis which is plaguing the entire state, young and old alike, Representative John McDonough (D - Jamaica Plain) filed a comprehensive health care reform bill (House Bill 4145). This bill, known as the Family Health Plan (FHP), would provide access to basic health care for all residents of Massachusetts, regardless of health status, employment, or age.

The FHP would provide all seniors with Medigap insurance which would cover Medicare deductibles, co-payments, and prescription drugs. If FHP had been in effect in 1990, seniors would have paid $35 per month for coverage equivalent to Medex 3. In 1990, Medex 3 cost $85.95 per month.

The FHP would reduce costs for seniors by cross-subsidizing instead of creating separate senior risk pools. The cost of health care for the elderly would be averaged into the premiums all residents would be required to pay. The FHP also would offer the prospect of systemic cost containment. For example, one statewide purchaser rather than multiple purchasers would lower costs across the board.

The FHP would require fundamental structural changes in the health care system -- most dramatically in the role of the health insurance system. To implement such a dramatic change, advocates would have to overcome both the public skepticism associated with expanding the role of government and the powerful institutional opposition from those who benefit from the current health care financing system. In addition, the shift from a premium-based to a tax-based system would, in the short run, substantially reallocate health care costs, creating many winners and losers.

Medex Relief Bill. The Medex Relief Bill (House Bill 4170) would provide assistance to all Medex subscribers without tax increases or new state funding.

BC/BS, currently the primary insurer for Medigap subscribers, would, with the help of discounts on hospital charges, continue to serve the majority of the seniors insured by Medigap products. However, in order for BC/BS to remain competitive, commercial insurers and HMOs would have to offer community rates for all Medigap, small group, and nongroup products that they offer and would not be allowed to discriminate in the sale of these policies based on age or health status. These provisions would force the commercial or HMO insurers to take their share of the sicker members of these groups should they choose to offer such products. The ability of commercial insurers and HMOs to negotiate discounts on hospital charges would be directly related to their participation in the market for Medigap, small group, and nongroup products.

In return for the restrictions placed on commercial and HMO insurers, BC/BS would have to dedicate a fixed percentage of the reserves it was allowed to generate from hospital discounts to Medex premium costs. The result would be a dollar decrease in premiums paid by all Medex subscribers. The BC/BS discount could be raised in order to adjust for the size of subsidies.

While all Medex subscribers would receive a subsidy of roughly $300, low-income subscribers would receive an additional $360, the dollar equivalent of the portion of the premium attributed to hospital claim

costs. Their hospital care would be charged to the free care pool. Because low-income seniors are entitled to free care (see p. 30), the portion of their premium dedicated to hospital costs would be covered by the pool.

Additionally, under House Bill 4170, all future Medigap rate increases would be limited to the Consumer Price Index (CPI)-Medical Care rate of inflation. Although the Medical Care rate of inflation, averaging 9% annually in Massachusetts, is significantly higher than the SSCOLAs, it is significantly lower than the Medex rate increases in recent years. Seniors would be protected from retroactive effective dates that apply regarding such increases.

While the change required for the adoption of the Medex Relief Bill would be less drastic than that required for the FHP, it does represent substantial change, and, as a result, would elicit serious political opposition.

The current practice of discounting is one in which individual insurers and hospitals negotiate their own rates. Under the bill, negotiating would be prohibited except to subsidize socially determined ends (for example, Medigap). The level of these discounts would be set by the state. Strict regulation of hospital prices moves in the opposite direction from that which Massachusetts is currently pursuing. The trend is for more insurance companies and HMOs to negotiate hospital discounts. Also, since neither the free care pool nor the BC/BS discount affect businesses who do not provide insurance, some businesses that would not be contributing to the cost of Medigap for their retirees.

Revised Medigap Relief Bill. The Joint Committee on Insurance rewrote the Medex Relief bill, changing the funding mechanism and eliminating the protection of the CPI-Medical Care rate of inflation. The new bill (House Bill 5530) calls for the transfer of $75 million annually from the free care pool to a trust to subsidize Medigap insurance beginning in January 1992. There would be full subsidization for enrollees at or below the federal poverty level and partial subsidization for individuals up to 300% of poverty.

While this is perhaps the most politically feasible option in the short run, it would increase the demand on the free care pool. As noted previously there are several drawbacks to this approach. Also, because the bill lacks any cost containment provisions, the size of the subsidy would need to be increased annually or the value of the subsidy would steadily erode.

Hospital Finance Bill. Another approach to using the free care pool relies on payments to insurance companies instead of to individual subscribers. This approach is embodied in Senate Bill 406, sponsored by Senator Edward Burke (D - Framingham) as part of a larger hospital finance bill.

Senate Bill 406 would require that free care pool funds be used to reimburse insurers for 50% of losses they incur in their Medigap line for fee-for-service (indemnity) insurance and for 75% of losses for managed care plans. (The intent is to encourage and reward managed care plans.) If adequate funds are not available from the free care pool, payments to insurers would be reduced in proportion to each insurer's market share, not in proportion to the size of their loss.

For example, suppose there are two insurance companies that sell Medigap insurance. Company 1 has 75% of the business and Company 2 has 25%. Each insurer loses $20 million dollars on Medigap. If there is only $10 million available to subsidize Medigap, Company 1 will get $7.5 million, in proportion to its 75% of the market, and Company 2 will get $2.5 million.

In order to be eligible to receive the subsidy, insurers must meet the following criteria. They must:

- hold an annual open enrollment period;
- charge reduced premiums to elders with incomes below 300% of the poverty line; and
- limit premium increases to not more than 10% annually.

The cost of determining eligibility for the subsidy rests with the insurer. This proposal calls for less state administration than is necessary for a voucher program.

However, this approach does not provide stability for elders. Rather than promoting an entitlement for the elder person, it entitles insurers. Nothing in the bill determines the size of the available subsidy per elder or how much total money will be available. Insurers can decide whether they would be better off with a small Medigap rate increase and write off their losses, or a large increase and no rate subsidy in any given year.

When adequate funding is available, payment from the free care pool to the insurer is connected to the size of losses rather than to the size of the subsidy being offered to seniors. Therefore, the incentive is for insurers to allocate losses to their Medigap insurance while offering the smallest subsidy possible. Despite the amount of the rate subsidy, all insurers receive payments from the free care pool equivalent to 50% of total losses for fee-for-service plans. The nominal subsidy which is encouraged by the financial incentives of this bill may do very little to make Medigap insurance more affordable for those who can least afford it.

In any case, an insurer is still worse off offering Medigap and assuming some financial loss than not offering policies at all. It is not clear that this approach will do more than improve the cash position of BC/BS, which is obligated to offer Medigap.

CONCLUSION

Coverage for the gaps in the Medicare Program was not a concern for those who drafted the federal law in 1965. When Medicare began, Medicaid served as Medigap insurance for low-income elders, and the relatively nominal out-of-pocket Medicare costs (the original hospital deductible was $40) were not beyond the financial resources of middle-income seniors. However, as health care costs have continued to outpace the growth of elders' income, many near-poor elders are unable to afford either out-of-pocket costs or Medigap premiums.

It is clear that nothing approaching universal Medigap coverage can be achieved without relying on a cross-generational subsidy. However, basic questions of who will pay the subsidy, how it will be collected, and who will receive it remain unanswered. The problem of unchecked medical inflation makes the Medigap problem especially difficult to resolve. Without control over health care costs, subsidies will continually have to be increased.

While solutions to this problem have begun to be debated both in Congress and in the Massachusetts Legislature, progress has been slow. The most comprehensive solution to the problem may be the adoption of a universal health care system such as those in Western Europe or the Commonwealth countries (Great Britain, Canada, Australia). However, such an approach, whether pursued nationally, or on a state-by-state basis, faces significant political barriers. Other less sweeping reforms may address the problem in the short run, providing temporary relief to Massachusetts elders, but any true long-term solution must both offer a subsidy and also bring stabilization to the rising cost of health care.

GLOSSARY

ADVERSE SELECTION

Adverse selection occurs when an insurance policy attracts very sick enrollees who have a greater than average number of claims. These individuals then become concentrated in particular insurance plans, driving up the price. Insurance companies use denial of coverage, waiting periods, and pre-existing condition exclusions to protect themselves from adverse selection.

AGE-RATING

Age-rating is the practice of basing premiums on the age of individuals when they apply for health coverage. Older seniors pay higher premiums.

BAN ON BALANCE BILLING

The ban on balance billing is a restriction that prohibits a provider from charging and collecting more for a medical service than an insurance plan will cover. The term is most commonly used in reference to a Massachusetts law requiring doctors to abide by Medicare rates.

COMMUNITY RATING

Community rating is the practice of setting insurance rates by averaging all enrollees' costs together. Everyone served by an insurer pays the same premium for a given benefit package, regardless of individual health status.

CO-PAYMENT

A co-payment is the share of the cost of care that the recipient must pay. For example, under the new mail-order prescription drug options, seniors on Medex 3 pay a co-payment of $10 for every brand-name prescription and $2 for every generic prescription. Medex pays the remainder.

COST CONTRACTS

These plans cover Medicare Part A outside the HMO delivery system (with the exclusion of deductibles and co-payments), but offer coverage for Part B services only within the HMO delivery system. (See **Health Maintenance Organization.**)

COUNTER DETAILING

Counter detailing is an effort on the part of BC/BS to encourage cost-effective use of drugs. It sends representatives to doctors' offices to advocate the use of the most appropriate and cost-effective drugs. Newer, more expensive options are not always superior to drugs that have been on the market longer. (See **Detailing.**)

DEDUCTIBLE

A deductible is an initial dollar amount of health care cost that an individual must incur before an insurer begins to pay the cost of the health services. For example, the Medicare first-day hospital deductible is $628. If seniors are without supplemental insurance that covers this cost, they are responsible for paying the $628 before Medicare coverage begins.

DELIVERY SYSTEM

A delivery system is a network of health care providers, covering a specified geographic area, which provides the medical services for enrollees in HMOs.

DETAILING

Detailing takes place when drug companies send representatives to doctors' offices in an effort to encourage the use of new drugs, often without regard to effectiveness or cost.

DOWNGRADING

Downgrading occurs when an individuals changes his/her health insurance policy to one that offers less comprehensive coverage.

FEE-FOR-SERVICE PLAN

A fee-for-service plan is a policy under which an insurer reimburses hospitals and physicians each time an enrollee receives care. The majority of BC/BS plans are fee-for-service plans. This type of policy is also referred to as an indemnity plan.

GROUP PLANS

Group plans are insurance policies offered to individuals by way of a past or present employer or union or a member-based organization. Group plans are subject to far less regulation than nongroup plans.

HEALTH MAINTENANCE ORGANIZATION

Health Maintenance Organizations (HMOs) are delivery systems that act both as insurers and providers of health care. The three types of HMO products available to Medicare recipients are **Cost Contracts, Risk Contracts,**

and **Wrap-Around Contracts** (see this Glossary). All three have some restrictions on the health care providers that an enrollee may use.

LOSS RATIOS

Loss ratios are the specified percentages of premiums that must be dedicated to enrollee benefits. The remaining portion of the premium may go to such things as administrative costs and company profits.

MEDEX

Medex is the brand name of the Medigap policies offered by Blue Cross and Blue Shield of Massachusetts.

MEDICAID PROGRAM

The Medicaid Program is a joint federal/state health insurance program for the poor.

MEDICARE PROGRAM

The Medicare Program is a federal health insurance program for people over 65 as well as certain disabled individuals.

MEDIGAP INSURANCE

Medigap insurance is health insurance, offered by various private insurers, that supplements the federal Medicare Program.

NONGROUP PLANS

Nongroup plans are insurance policies negotiated directly between an individual and an insurer. These policies are also referred to as individual or direct-billed policies.

PRE-EXISTING CONDITION EXCLUSIONS

Pre-existing condition exclusions are practices of insurance companies to deny payment for any services related to health problems that have been treated (or simply occurred) before the coverage began. Sometimes the policy will exclude coverage for a particular condition indefinitely while other policies will have a period of time (for example, a waiting period of three months) during which the insurance company will not provide coverage for a pre-existing condition.

PREMIUMS

Premiums are the regular payments made by enrollees to health insurance companies in exchange for their coverage.

RISK CONTRACTS

These plans are substitutes for rather than supplements to the Medicare Program. All services must be received in the HMO delivery system. (See **Health Maintenance Organization.**)

RISK POOL

A risk pool forms when people are grouped together for the purpose of setting premium rates.

UNCOMPENSATED CARE POOL

The Uncompensated Care Pool, part of the 1988 Universal Health Care law, reimburses hospitals for the free care and reduced-cost care they provide to uninsured and underinsured individuals. Funding for the pool comes from surcharges on hospital bills. Individuals and families whose incomes are below 200% of poverty are entitled to free care. Those with incomes between 200% and 400% of poverty are entitled to partial free care. The Uncompensated Free Care Pool is also known as the Hospital Free Care Pool.

UNDERWRITING

Underwriting is the process of assessing health and cost risks for individuals applying for insurance coverage and pricing the premiums accordingly.

UNIVERSAL HEALTH CARE LAW

The Universal Health Care law, passed in 1988, has brought health care coverage to thousands of uninsured residents of Massachusetts. The individual programs of the Universal Health Care law include the CommonHealth Program for working disabled adults and disabled children, the Unemployed/Uninsured Program, and the Healthy Start Program for pregnant women. The Universal Health Care law is also known as Chapter 23 and the Health Security Act.

WAITING PERIODS

Waiting periods are requirements that an insured person wait a certain number of months or years after beginning an insurance policy before services are covered by the insurance company. The practice is designed to discourage signing up for insurance only when the care is needed.

WRAP-AROUND CONTRACTS

These plans function much like traditional Medigap policies. If care is received within the HMO delivery system, all benefits apply. If services are obtained outside the system, Medicare benefits will be covered but the individual is responsible for deductibles and co-payments. (See **Health Maintenance Organization.**)

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THE GERONTOLOGY INSTITUTE

The University of Massachusetts at Boston

Established in 1984, the Gerontology Institute at the University of Massachusetts at Boston furthers the University's commitment to the study and development of social policy on aging. The Institute conducts policy research on issues affecting older people and their families. In addition, the Institute assists national, state, and local organizations analyze policy issues and formulate policy options on matters concerning the elderly. Core funding is provided by the Massachusetts Legislature. Major projects are funded through grants and contracts.

Programs of the Institute are carried out through two divisions: The Frank J. Manning Research Division and the Public Policy Division. A major research priority is productive aging, that is, opportunities for older people to play useful social roles. A second priority is long-term care for the elderly. Additional major concerns of the Public Policy Division include health care policy, income security policy, and housing, with particular attention to the special needs of racial and ethnic minority elderly.

In the fall of 1990, the University introduced a Ph.D. program in Gerontology with an emphasis in social policy. It is one of two such programs in the country. The Institute is a teaching resource for the Ph.D. program. In addition, the Institute provides doctoral students with experience in research and policy analysis.

The Institute also supports the University's Gerontology Certificate program. A one-year program of concentrated study, the Gerontology Certificate program prepares older learners for roles in aging services. Most students are over 60 years of age. Through an Advanced Certificate program, selected graduates participate in applied research projects within the Institute. The regular involvement of older people helps to assure that Institute projects reflect the concerns of older people.

Another activity of the Institute is the publication of a scholarly qua rterly with an international perspective, the Journal of Aging & Social Policy. The journal is issued by Haworth Press.

Since its formation, the Institute has been directed by Scott A. Bass, Ph.D. It has a permanent faculty and staff of approximately 16 people and is located in the heart of Boston in the University's Downtown Center.