October 3, 2011

The Coalition to Promote Choice for Seniors represents the vast majority of the Medigap market, which provides approximately 20 percent of all Medicare beneficiaries with affordable, popular Medigap coverage options. We appreciate that the Joint Select Committee is working to achieve a critically important set of recommendations and we are committed to assisting in the development of thoughtful solutions.

Medigap is a form of private supplemental insurance available to all Medicare beneficiaries, protecting them from significant out-of-pocket costs resulting from Medicare's necessary cost-sharing obligations and benefit limitations. Medigap insurance is a vitally important product for beneficiaries who choose Medicare's original fee-for-service (FFS) program (Parts A and B). Working in tandem with Medicare, it allows seniors and younger Medicare enrollees with disabilities – many of whom are on fixed incomes – to budget for medical costs and to avoid the confusion and inconvenience of handling complex medical bills from providers.

We oppose proposals that either prohibit coverage for Medicare beneficiaries choosing to budget for their out-of-pocket health care costs through the purchase of Medicare Supplement (Medigap) insurance or impose a new tax on seniors who purchase certain Medigap plans. We are deeply concerned that these proposals are based on assumptions that are inaccurate, and we offer the following information in response to common myths about Medigap:

- Medigap carriers do NOT make medical necessity determinations and therefore cannot impact utilization. Medigap simply pays the claims that Medicare has reviewed and found medically necessary and payable. A major misperception is that Medigap coverage leads to higher utilization and spending. The National Institute for Health Care Management (NIHCM) identified a number of different factors that impact utilization and spending in the United States (e.g., advances in medical technology, the prevalence of chronic conditions). In fact, the report notes that the top 5 percent of the population accounted for almost half of all spending and the top 1 percent was responsible for over 20 percent of all spending[1].

- The studies cited by MedPAC and CBO supporting these proposals simply speculate that it is possible that Medicare beneficiaries with private insurance use too many or unnecessary services because of the presence of an insurance policy. However, there is no hard, peer-reviewed data that support this speculation. The studies also openly admit that reduced utilization from increased cost-sharing does not distinguish between necessary and unnecessary medical treatments. The proposals, therefore, could prevent seniors from accessing "medically necessary" care. Without an appropriate

[1] "Understanding U.S. Health Care Spending," NIHCM Foundation Data Brief (July 2011).

level of coverage, there is an increased chance that many, especially the most vulnerable of beneficiaries, will forego necessary services early, requiring more costly care in the long term[2].

- The majority of today's Medigap plans do not provide first dollar benefits and already include beneficiary cost-sharing obligations. In addition, the Patient Protection and Affordable Care Act (ACA) requires the National Association of Insurance Commissioners (NAIC) to review the two most popular Medigap plans (Plans C and F) for potential revision to include nominal cost-sharing. It is important to note that Plans C and F are the two remaining benefit designs that currently have little or no cost-sharing.

We also believe Medigap proposals being considered in the budget debate would have unintended consequences for both current and future beneficiaries:

- Recognizing that Medigap is particularly important to those on fixed incomes and rural beneficiaries,[3] we are deeply concerned that restricting Medigap options would result in financial hardship for millions of seniors, who on average already spend 15 percent of their income on health care[4]. A recent study found that 31 percent of Medigap policyholders resided in rural areas in 2009; by comparison, 24 percent of all Medicare beneficiaries resided in rural areas.[5] It further noted that 52 percent of all Medigap policyholders and 61 percent of rural Medigap policyholders had incomes below $30,000. Overall, 45 percent of Medigap policyholders had incomes ranging from $10,000 to $30,000 in 2009. This income bracket accounted for the highest proportion of Medigap purchasers. In rural areas, 53 percent of Medigap policyholders had incomes in the $10,000 to $30,000 range.

- Seniors are bound to see this as a cost-shift. Several of the proposals under consideration would impose cost sharing obligations of several thousand dollars for a senior buying Medigap, which will be seen as a punishment for a beneficiary who was simply trying to finance and budget for his/her health care needs.

We echo the concerns raised by the NAIC in its September 21, 2011, letter regarding the unprecedented application of such an idea to current enrollees. Current policyholders have expectations from the insurance contracts they signed: they expect the benefit structure of their plans to remain unchanged, that they can keep the coverage they have as long as the premiums are paid, and that we will pay benefits as promised. The current CBO options assume that these policies will be modified to reflect reduced benefits and cost-shifting to Medigap beneficiaries. This will be exceptionally disruptive to seniors, many of whom have owned their policies for years.

---

[2] Chandra, Amitabh, Gruber, and McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," American Economic Review, Vol. 100, No. 1 (March 2010), pp 193–213, available at *http://www.aeaweb.org/articles.php?doi=10.1257/aer.100.1.193*. Also see Trivedi, Amal N., Moloo, Husein, M.P.H., et. al., "Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly," The New England Journal of Medicine, Vol. 362, No. 4 (January 2010), pp 320 – 328, available at *http://www.nejm.org/doi/full/10.1056/NEJMsa0904533*

[3] America's Health Insurance Plans (AHIP), Low-Income & Rural Beneficiaries with Medigap Coverage, 2009 (September 2011), citing data from the Medicare Current Beneficiary Survey Access to Care files 2009 (CMS), available at http://www.ahipresearch.org/pdfs/MedigapLowIncomeRuralReport2011.pdf.

[4] Medicare Rights Center Press Release (June 16, 2011).

[5] America's Health Insurance Plans (AHIP), Low-Income & Rural Beneficiaries with Medigap Coverage, 2009 (September 2011), citing data from the Medicare Current Beneficiary Survey Access to Care files 2009 (CMS), available at http://www.ahipresearch.org/pdfs/MedigapLowIncomeRuralReport2011.pdf.

We also concur with the NAIC concern about potential legal issues: the impairment of contracts, due process, and the taking of valuable benefits under in-force policies. These issues will encourage litigation by policyholders and further disrupt the market.

Medigap is a vitally important product for millions of seniors. As Medigap carriers and distributors, with millions of policyholders and thousands of agents and employees, we want to be helpful during this budgetary crisis. We just do not believe that introducing a drastic measure that shifts costs to seniors with Medigap coverage is the appropriate path to deficit reduction. We stand ready to advise and expand on these and other Medigap-related issues, and we urge you to make use of our data and expertise in formulating legislative policy. Particularly in the current situation, where time may prevent a thorough review of certain budget options, we believe this input is vitally important.

We appreciate your consideration of our position and that of our policyholders. As you continue to consider proposals related to Medigap we would appreciate the opportunity to meet with you to discuss the implications and share our expertise.

Respectfully,

AEGON USA
Aetna
America's Health Insurance Plans
Blue Cross Blue Shield Association
CNO Financial
Combined Insurance Company
Equitable Life & Casualty
Great American Supplemental Benefits Group
Highmark
Liberty National Life
Medico Insurance Company
Mutual of Omaha
National Association of Health Underwriters
National Association of Insurance & Financial Advisors
Old Surety Life Insurance
Physicians Mutual Insurance Company
State Mutual Insurance Company
Sterling Insurance
United American Insurance Company