ISSUE BRIEF

The Massachusetts Health Policy Forum

THE STATE OF THE MEDIGAP MARKET IN MASSACHUSETTS

Thursday, April 30, 1998
8:30 to 9:00 AM - Breakfast
9:00 to 11:30 AM - Presentation and Discussion
Holiday Inn Boston Government Center
5 Blossom Street, Boston (off Cambridge Street)

A DISCUSSION FEATURING:
Nancy Turnbull, Harvard School of Public Health
Michael Miller, Health Care for All

Registration: Please call Sue Thomson at 617-338-2726 as soon as possible

NO. 1

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"The State of the Medigap Market in Massachusetts"

By
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EXECUTIVE SUMMARY

Medicare, the federal health insurance program for the elderly and disabled, leaves beneficiaries responsible for substantial deductibles and co-payments. In addition, certain services, notably prescription drugs, are not covered. To protect themselves from high out-of-pocket costs, many Medicare beneficiaries purchase supplemental insurance policies known as "medigap" plans. In this paper, we examine the medigap insurance market in Massachusetts and conclude the following:

- A large number and proportion of Medicare beneficiaries (173,000 or 20%) lack medigap coverage. This exposes them to significant out-of-pocket medical costs which can be financially burdensome, particularly for low income beneficiaries.

- Traditional medigap policies are increasing rapidly in price. The premium for Medex Gold, which was until recently the most popular medigap plan in the Commonwealth, has risen by 123% since 1992. Rising costs for prescription drugs and Medicare Part B coinsurance are two of the major factors driving premium increases.

- A growing number and proportion of medigap policy holders lack coverage for prescription drugs (52% of direct pay members today as opposed to an estimated 30% in 1992).

- There is growing risk segmentation among medigap plans that do and do not cover prescription drugs and between different types of medigap coverage.

Six non-mutually exclusive options to address these problems are outlined in this paper, together with key arguments for and against each proposal. These options include:

- Increasing education and outreach efforts to improve the functioning of the market and to maximize use of existing subsidy programs such as the federal Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLIMB) programs.

- Creating premium subsidies for low income Medicare beneficiaries.

- Requiring all medigap products to provide prescription drug coverage.

- Scaling back the current drug benefit by limiting coverage or increasing the deductible.

- Reinsuring the cost of prescription drugs more broadly across the insurance market.

- Expanding or modifying the Senior Pharmacy Program or making use of existing state purchasing power to low the cost of prescription drugs.

I. INTRODUCTION

Private health insurance to supplement Medicare—so-called "medigap" insurance[1] —is an important source of financial assistance and protection for the elderly. There is, however, growing concern about the state of the medigap market in Massachusetts. This concern stems from a number of factors, including:

- the large number and proportion of Medicare beneficiaries who have no medigap coverage;
- the rising cost of medigap policies;
- the growing number of medigap policyholders who have no coverage for prescription drugs;
- growing risk segmentation among different types of medigap coverage, and among different medigap carriers; and,
- a concern that lower-cost HMO Medicare plans may not be a viable alternative to less affordable Medicare supplement coverage for some Medicare beneficiaries.

The purpose of this paper is to discuss the major trends and problems in the Massachusetts medigap market, and present a number of possible options for addressing these problems. The paper is intended to be a catalyst for discussion and debate, rather than to advocate for any particular option or solution. It is deliberately succinct: while selected data are presented to illuminate the most critical trends and issues in the market, the paper is not intended to be an exhaustive discussion of medigap insurance. Rather, it assumes a general familiarity with the Medicare program and the structure of the medigap market in Massachusetts.

II. OVERVIEW OF THE MEDIGAP MARKET IN MASSACHUSETTS

a. Medigap insurance

Medigap insurance is health insurance offered by various private carriers which supplements the federal Medicare program. Although Medicare covers a large share of medical expenses, Medicare beneficiaries are still exposed to substantial out-of-pocket costs. Medicare itself has significant premiums, copayments, coinsurance and deductibles. In addition, Medicare does not cover certain services, such as prescription drugs. Medigap policies protect individuals with Medicare coverage against some or most of these expenses.

Medigap coverage is sold on an individual (nongroup) and group basis. Group coverage is available to many Medicare beneficiaries, usually as a retiree benefit from their former employer. Individual coverage is purchased directly from carriers by Medicare beneficiaries.

There are two basic types of medigap coverage: Medicare supplement plans and HMO Medicare plans.

Medicare supplement plans: Medicare supplement plans are sold by commercial insurers and Blue Cross Blue Shield. Under state law, carriers may sell three types of Medicare supplement plans in the nongroup market[2]: Medicare Core, Medicare Supplement One, and Medicare Supplement Two. Table 1 provides a brief summary

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[1] The term "medigap" will be used throughout the paper to include both traditional Medicare supplements, such as the Blue Cross Blue Shield Medex products, and HMO Medicare plans.

[2] State law and regulation (G.L. c. 176 K and 211 CMR 71.00) prescribe the standardized benefit packages that may be offered in the individual/nongroup Medicare supplement market. These requirements do not apply to employer group Medicare supplement policies.

of the benefits covered in each of the three standardized Medicare supplemental plans. (Medex Bronze is BCBS's Supplement 1 and Medex Gold is a Supplement 2.) There are also a number of Medicare beneficiaries covered by other types of Medicare Supplement plans sold before the state's current medigap regulations became effective.

TABLE 1
Benefits in Standardized Nongroup Medicare Supplement Policies

Benefit	Core	Supplement 1	Supplement 2
Hospital Deductible	No	Yes	Yes
Hospital Coinsurance	Yes	Yes	Yes
Part B Deductible	No	Yes	Yes
Part B Coinsurance	Yes	Yes	Yes
Skilled Nursing Facility Coinsurance	No	Yes	Yes
Prescription Drugs*	No	No	Yes

* The drug benefit provides 100% payment for generic drugs and 80% coverage for brand name drugs purchased at retail pharmacies, after a $35 quarterly deductible. For prescriptions purchased through mail order, there is a $5 copayment for generic drugs and a $15 copayment for brand name drugs, for up to a 90-day supply.

HMO Medicare Plans

HMO Medicare plans are not subject to the same standardized benefit requirements as Medicare supplemental plans. Instead, HMO plans must meet the requirements of the state's HMO law and regulation, the state's medigap law, and federal standards. Under state law, any HMO that offers Medicare plans is required to offer a product that includes unlimited prescription drug coverage. In general, the benefits provided in HMO Medicare plans are more comprehensive than the benefits required in the state's standardized Medicare supplement plans. HMO copayments are quite limited, usually $5-10 for office visits, and $5-15 for prescription drugs.

b. Carriers that sell medigap coverage in Massachusetts

There are currently two insurance carriers and seven HMOs actively marketing medigap policies in Massachusetts. The types of coverage and current premium rates are listed in Table 2. (Banker's Life, which sold Medicare supplemental policies in Massachusetts for many years, stopped offering its products as of the end of January, 1998, and so is omitted from the table.)

TABLE 2
Individual Medigap Products and Monthly Premium Rates:
Plans Being Sold as of March, 1998

Carrier	Type of Product and Monthly Rate	Type of Product and Monthly Rate	Type of Product and Monthly Rate
a. Medicare Supplement Plans	**Medicare Supplement Core**	**Medicare Supplement 1**	**Medicare Supplement 2**
Blue Cross Blue Shield Medex	$57.22	$106.87	$260.48
United/AARP*	$55.75	$105.75	$238.25
b. HMO Plans**		**Without drugs**	**With drugs**
Aetna/US Healthcare		$15.00	$75.00
Fallon Community HP		$ 0.00	$72.50
Harvard Pilgrim		$0-61.00 (depending on county of residence)	$71.00-132.00 (depending on county of residence)
Harvard Pilgrim/NE		$65	$112
HMO Blue		$0-30 (depending on county of residence)	$75-105 (depending on county of residence)
Tufts Associated HP		$0	$74
United HealthCare		$0	$124

* Individuals must be members of AARP to purchase coverage.

** Rates are shown for HMO plans with a $5 copayment for office visits. Several HMOs offer plans with different office visit copayments; the rates for these plans are somewhat higher or lower.

Under Massachusetts law, direct pay medigap plans must be community-rated (i.e., carriers must charge the same premium to each policyholder, regardless of the age, gender, health status, or any other characteristic of the policyholder). Medicare supplement policies are significantly more expensive than HMO Medicare products. In general, premium rates are similar for the same type of product. HMO premium rates are more expensive in counties that have lower rates of payment from the federal Medicare program (the so-called "Adjusted Average Per Capita Cost," or "AAPCC"). These lower-AAPCC counties include most of the southern and western regions of the state.

c. Massachusetts Medicare beneficiaries by type of medigap coverage

An estimate of the number of Medicare beneficiaries by type of medigap coverage, as of year-end 1996, is shown in Table 3. (1996 is the most recent year for which complete and detailed enrollment data are available for all carriers. Selected enrollment information as of year-end 1997 are, however, available, and are shown in Table 4.)

TABLE 3

Medicare Beneficiaries in Massachusetts:

Total and by Type of Additional Coverage: As of 12/31/96

Type of Coverage	Total Number	% of Total Medicare Eligibles	Number aged 65+	Number aged <65
All Medicare Eligibles	**973,000**	**100%**	**861,000**	**112,000**
Medicare Only	**195,000**	**20%**	**173,000**	**22,000**
Medicare Supplement	**342,000**	**35%**	**336,000**	**6,000**
Direct Pay	241,000	25%	235,500	5,500
Group-insured	59,000	6%	58,700	300
Group-other	42,000	4%	41,900	100
HMO	**161,000**	**17%**	**152,600**	**8,400**
Direct Pay	119,000	12%	112,600	6,400
Group	42,000	4%	40,000	2,000
Medicaid	**160,000**	**16%**	**101,000**	**59,000**
Other: employer,VA	**115,000+**	**12%**	**???**	**???**

Note: Individuals may be double counted in this table because some Medicare beneficiaries have more than one type of medigap coverage, or more than one policy of the same type. For example, some individuals are covered by Medicaid and have Medicare Supplement policies.

Sources: Division of Insurance Medicare supplement enrollment report; Division of Medical Assistance; Executive Office of Elder Affairs; Blue Cross Blue Shield; and Health Care Financing Administration.

At year-end 1996, approximately one in five Medicare beneficiaries, or 20%, had only Medicare coverage, which means that they have no coverage to provide protection for the cost-sharing and gaps in Medicare benefits. Approximately one-third of Medicare beneficiaries had Medicare supplement policies, most as individual policyholders. Seventeen percent of beneficiaries were enrolled in HMO plans. In total, approximately 37% of those with Medicare coverage purchased medigap coverage in the direct pay or individual marketplace. Medicaid covered another 16% of beneficiaries (the so-called "dually eligible" beneficiaries). While there are no data available on the number of individuals who receive coverage through employer plans that are not Medicare supplements or HMO products, the number is estimated to be at least 115,000 people, based subtracting from total Medicare beneficiaries the number of beneficiaries who are known to have other sources of medigap coverage or only Medicare coverage.

d. Medigap members by carrier

Blue Cross Blue Shield is the dominant carrier in the medigap market, enrolling approximately 26% of Medicare beneficiaries in Massachusetts as of year-end 1997. (See Table 4.) However, BCBS's Medex membership and market share have declined significantly in recent years. Since 1992, Medex lost nearly one-third of its members; almost all of these losses have been in its direct pay Medex products, which have lost over 40% of total membership since 1992. Most of BCBS's Medex losses appear to have occurred to HMO plans, which have grown dramatically. HMOs enrolled 20% of Medicare beneficiaries as of December 31, 1997.

Based on the data in Table 4, the total number of beneficiaries with some type of Medicare supplement or HMO plan increased between 1992 and year-end 1997 by approximately 9,000 people. However, since the total number of Medicare beneficiaries in Massachusetts has also increased, it also appears that the proportion of Medicare beneficiaries who have medigap coverage has stayed the same or fallen slightly.

e. Trends in medigap premium rates

Premium rates for Medex and most other Medicare supplement plans have increased significantly in recent years. (See Table 5 for premium rate trends for the most popular medigap plans. Comparative rates for AARP products are not available for this period because AARP did not sell the standardized benefit plans in 1992.)

The premium for Medex Gold, long the most popular medigap product in the state, has more than doubled since 1992, an average annual increase of approximately 16%, and nearly triple the rate of premium increase for Medex Bronze. BCBS was recently granted a 13.2% rate increase for Medex Gold and a 11.5% increase for Medex Bronze. Rates for the AARP/United Medicare supplements have also increased significantly, with the recent approval of more than an 18% rate increase for all its products.

In contrast, rates for HMO Medicare plans that have been in existence for a number of years have generally gone down or been fairly stable. In addition, many HMOs are now offering no-cost or low-cost plans without prescription drug coverage, which were not available several years ago.

Many market observers have expressed the hope that these lower cost options would be more affordable, particularly to lower-income individuals, and might increase the number Medicare beneficiaries with medigap coverage. As discussed above, this seems to have

Table 4

Number of Medigap Members by Plan: 1997 and 1992

Carrier	Members: 12/97	Members: 6/92	Percent Change in members: 1992-97	Percent of Medicare Beneficiaries: 1997
Medicare Supplement Plans	**310,900**	**424,000**	**-27%**	**32%**
BCBS Medex	251,900	366,000	-31%	26%
Individual	157,900	269,000	-41%	16%
Group	94,000	97,000	-3%	10%
AARP	24,300	50,000	-51%	2%
Banker's Life	21,900	3,500	+626%	2%
Miscellaneous	12,800	4,900	+161%	1%
HMO Plans	**192,600**	**70,700**	**+172%**	**20%**
Tufts	68,300	1,500	+4500%	7%
Fallon	30,500	18,000	+69%	3%
Harvard Pilgrim	50,200	15,700	+220%	5%
HMO Blue	17,000	11,300	+50%	2%
Aetna/USHC	17,300	--	--	2%
United	3,700	--	--	--
Kaiser	2,700	2,200	+23%	--
Community	1,800	2,200	-18%	--

Other	1,100	16,100	--	--
TOTAL: ALL PLANS	**503,500**	**494,700**	**+2%**	**52%**

Source: Division of Insurance; Report of Medigap Working Group, 1992.

happened: there has been an increase in the number of Medicare beneficiaries who have medigap coverage. However, the proportion of Medicare beneficiaries with some form of medigap coverage has not increased significantly and may actually have fallen slightly.

Table 5

Monthly Premium Rates

for Most Popular Direct Pay Medigap Plans: 1992 and 1998

Type of Product	Monthly Premium August 1992	Monthly Premium March 1998	Percent change 1992-1998
Medicare Supplements			
Medex Gold	$116.61	$260.48	+123%
Medex Bronze	$ 74.10	$ 106.87	+44%
HMO Plans			
Fallon	$ 89.00	$72.50	-19%
HCHP	$ 97.00	$71.00	-27%
HMO Blue*	$ 90.00	$74.00	-18%

* The 1992 rate for HMO Blue is an average of the rates for the Medical East and Medical West Medicare products.

Tufts is not included in the table because it did not have a direct pay Medicare product in 1992, so no rate comparison is possible.

Source: Division of Insurance and 1992 Medigap Reform Working Group Report

III FACTORS AFFECTING PREMIUMS FOR MEDICARE SUPPLEMENT PLANS

There appear to be three major reasons for rapidly increasing premiums for Medicare supplement plans:

- rising costs for prescription drugs and the coinsurance for Medicare Part B services;
- risk selection within the Medicare supplement plans, particularly between individuals purchasing plans with and without drug coverage; and,
- risk selection between Medicare supplement plans and HMO plans.

a. Rising Costs for Medicare Part B Coinsurance and Prescription Drugs

Table 6 shows the increase between 1991 and 1998 in the Medex Gold pure premium for the three major medical cost components of the Medex Gold rate: the Medicare Part A deductible; the Medicare Part B coinsurance; and the prescription drug benefit.

For the Medex Gold product, the costs of both the Part B coinsurance and the prescription drug benefits[3] have been increasing at an average annual rate of approximately 18%. This rate of increase far exceeds the cost trend for the other significant Medex benefit, the Part A deductible. The pure premiums for Part B coinsurance and prescription drugs now account for almost two-thirds of the total cost of

Table 6

Direct Pay Medex Gold Monthly Pure Premium by Benefit Category:

1991 and 1998 (as projected in BCBS rate filing)*

Benefit Category	1991 Pure Premium	1998 Pure Premium (projected)	Increase 1991-98	1998 Pure Premium as a % of 1998 Rate
Part A Deductible	$15.93	$23.86	50%	9%
Part B Coinsurance	$31.53	$90.20	186%	32%
Prescription Drugs	$34.50	$93.44	171%	33%

* 1998 data are based on the projections in BCBS's rate filing, not the pure premium approved by the Division after the Medex hearing.

Source: BCBS 1998 Medex rate filings

Medex Gold. (See footnote 6 on page 12 for a discussion of other factors that have affected the rate.)

Although there are no comparable publicly available data on the pure premium cost trends for other Medicare supplemental products, or for HMO Medicare plans, informal discussions with several other commercial carriers indicate that rising costs for drugs and Part B services are also driving the increase in premiums for other medigap plans. Thus, any proposed strategies for moderating the cost increases of Medicare supplemental coverage need to be targeted in particular at these two benefits.

Part B services: Medicare supplement carriers have more limited ability to affect rising costs for Part B services than do HMOs, since coverage and payment decisions of the federal Medicare program are a major determinant of costs for traditional medigap carriers. This is a particular problem for hospital outpatient department services, the major component of increasing Part B premium costs because Medicare rules require that carriers pay 20% of hospital outpatient department charges, rather than 20% of Medicare's allowed charges. Without changes in federal law, BCBS and other Medicare supplement carriers cannot change the unit cost of outpatient services and, given the supplemental nature of their products, they also have limited ability to reduce utilization through medical management. If Medicare would permit supplemental insurers to pay 20% of the Medicare approved charge, this would result in substantial cost savings, and premium reductions, for supplemental plans (as well as for uninsured Medicare beneficiaries, who must pay for the Part B coinsurance themselves).

Prescription drug costs: In contrast, since Medicare does not cover prescription drugs, Medicare supplemental carriers have far greater flexibility to take actions to contain costs for this benefit (although they are prohibited from reducing the unlimited level of coverage or increasing consumer cost-sharing levels, both of which are mandated by state law and/or regulation).

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[3] The increase in Medex Gold drug costs is caused by an increase both in the number of prescriptions per member (projected to be 26 scripts per member per year in 1998), and the average cost per prescription.

Increasing drug costs are also a problem for Medicare HMO plans. Despite the moderate increases in premiums for HMO Medicare products with drug coverage, informal conversations with several HMOs revealed that their prescription drug costs are also increasing rapidly. In fact, the premiums currently being charged by several HMOs for their products that include drug coverage may not fully reflect the cost of the drug benefit. A few HMOs commented that they had decided to absorb losses on their Medicare drug products rather than raise premiums to reflect rapidly rising drug costs, at least for 1998. But this suggests that rising drug costs may result in less affordable HMO products in the future, particularly as reductions in the rate of growth of federal AAPCC payments reduce the opportunity for HMOs to subsidize drug premiums from Medicare revenues, and from the profits HMO may be making on their Medicare products that do not cover prescription drugs.

It should, of course, be noted that rising drug prices are one significant cause of increasing drug premiums, and that the rising cost of drugs is affecting premium rates for all types of health insurance, not just medigap policies. However, the ability of individual insurers to deal effectively with the pricing policies of drug companies is quite limited.

b. The rising number of medigap members without drug coverage

Many Medicare beneficiaries have reacted to rising Medicare supplemental premiums by dropping coverage for prescription drugs. (Given the structure of medigap benefits, the major price and benefit trade-off that beneficiaries can make in both Medicare supplemental and HMO products is between plans that do and do not cover drugs.) According to data collected by the Division of Insurance, as of December 31, 1996, the majority of consumers (57%) who had medigap coverage had prescription drug coverage. (See Table 7) However, in the direct pay medigap market, the majority of consumers (52%) did not have drug coverage. In contrast, in the group medigap market, 89% of members had drug coverage. The proportion of consumers who lacked drug coverage was slightly higher among HMO members than among those with Medicare supplement plans, 53% versus 51%, respectively in the direct pay market, and 14% versus 9% among group members.

From available data, the trend toward eliminating drug coverage can be seen most dramatically in the Medex population, where the proportion of direct-pay Medex members with drug coverage has been declining steadily since 1990. (See Table 8) At year-end 1997, less than half of direct pay Medex members had coverage for prescription drugs, compared to 85% in 1989. (Prior to 1990, the proportion of Medex members with drug coverage was at least 85% in every year going back to 1980, the last year for which data by product were readily available.) The decline in the number of Medex members with drug coverage began in 1990, when the premium rate for Medex Gold increased by 64% as a result of the repeal of the federal Medicare Catastrophic law, and has continued unabated ever since as existing Medex Gold members have downgraded coverage to Medex Bronze, and the majority of new Medex members have purchased Medex Bronze.

Table 7

Proportion of Medigap Members with and without drug coverage: 12/31/96

Type of Medigap Plan	% of members with drug coverage	% of members without drug coverage
TOTAL: ALL PLANS	**57%**	**43%**
Direct pay plans	48%	52%
Group plans	89%	11%
HMO Plans: Total	57%	43%
Direct pay plans	47%	53%
Group	86%	14%
Medicare Supplements: Total	57%	43%
Direct pay plans	49%	51%
Group	91%	9%

Source: Division of Insurance enrollment reports

Table 8

Percent of Direct Pay Medex members with Drug Coverage: Selected Years

Year	% Medex Members with Drug Coverage
1985	86%
1989	85%
1990	77%
1997	49%

There has also been a dramatic increase in the number of HMO Medicare members who do not have drug coverage. Until the last few years, virtually all HMO Medicare products included prescription drug coverage. However, beginning with the introduction of the Tufts/Secure Horizons zero premium product in 1994, most HMOs are now marketing plans that do not cover prescription drugs, in addition to offering the drug plans required by state law. In most counties, these no-drug products are available at little or no cost to consumers, and they have been very popular.

Assuming that all HMO Medicare members had drug coverage until the introduction of the no or low premium risk contracts, the percent of all direct pay medigap members without drug coverage increased from approximately 30% in 1992 to 52% as of year-end 1996.

Drug coverage by carrier: However, the proportion of direct pay medigap members with and without drug coverage varies significantly by carrier, both for Medicare supplement products and HMO plans, from a high

of 98% at Aetna/US Healthcare to a low of 7% at United Healthcare. (See the second column of Table 9.)[4] Some plans have a significantly higher proportion of members with drug coverage than the overall average, while others have a relatively low percentage of members with drug coverage.

These differences result in a significant difference in the distribution of the "drug burden" across carriers. The last column in Table 9 shows a "drug burden index," which is calculated as the carrier's proportion of all Massachusetts direct pay medigap members with drug coverage, divided by the carrier's proportion of all Massachusetts direct pay medigap members. There are two large plans, AARP and Tufts/Secure Horizons, that have a much lower than expected proportion of the Massachusetts medigap members who have drug coverage, while several other plans, including Banker's Life, Fallon and HMO Blue, have a disproportionate share of medigap members with drug coverage. The

Table 9

Percent of Direct Pay Members with Drug Coverage by Carrier: 12/31/96

Carrier	Percent of carrier's members with drug coverage	Carrier's % of all medigap individuals with drug coverage	Carrier's % of direct pay medigap market	Carrier's "Drug Burden Index" (Col.4/ Col 3)
BCBS	49%	52%	52%	1.0
AARP	20	3	8	0.4
Banker's Life	96	12	6	2.0
Tufts	23%	5	12	0.4
Fallon	72	10	6	1.6
HPHC	49	6	6	1.0
HMO Blue	80	6	3	2.0
Aetna/USHC	98	--	--	--
Pilgrim	41	3	3	1.0
United Health Care	7	--	--	--
Kaiser	69	--	--	--
Community	79	--	--	--

differences among carriers may reflect consumer preferences and/or differences in the marketing focus and strategy of the plans. However, as discussed below, the distribution of the drug burden affects not only drugs costs but the distribution of costs for other medigap benefits as well.

[4] Please note that these data are as of year-end 1996, the most recent year for which complete data are currently available. It is possible that the proportion of members with drug coverage may have changed somewhat at different plans. Although complete data for year-end 1997 are not yet available, the Division of Insurance has received more recent data from several of the largest medigap carriers. Based on a review of the 1997 data for these carriers, it does not appear that the proportion of members with and without drug coverage changed significantly for any of the carriers.

c. Risk Selection as a Reason for Rising Premiums for Medicare Supplement Plans

Growing risk selection[5] is a major cause of rising premiums for Medicare supplement plans such as Medex. This risk selection takes two forms: selection between Medicare supplement products that do and do not include prescription drug coverage, and selection between Medicare supplements and HMO plans.

Selection between drug and no drug products: As discussed above, the proportion of medigap members who have drug coverage has declined rapidly in recent years. This has had two major effects on premium rates. First, the insured costs of prescription drugs are now being spread over a smaller number of covered members. Because the people who have chosen drug coverage have, on average, higher drug costs than those who do not, the average cost of providing drug coverage has increased.

Second, individuals who have higher than average drug costs also have higher costs for other benefits provided by medigap plans. According to BCBS's most recent Medex rate filing, the average cost of Medex benefits other than drugs for Medex members who have drug coverage are 55% higher than those of Medex members who do not have drug coverage.[6] HMOs also appear to be experiencing this same type of adverse selection between products. For example, one HMO plan reported that average medical costs for its members with drug coverage are nearly double the costs of members in its product without drug benefits.

The carriers offering Medicare supplement plans, BCBS and AARP, are attempting to pass along these costs differences in their premium rates. In contrast, at least some HMOs appear to have made strategic decisions to incur losses on their drug plans rather than increase rates, at least for 1997 and 1998. The ability of HMOs to absorb losses on their drug products may be enhanced to the extent that the HMOs have positive financial results on their zero or low premium plans. However, reduced rates of payment to HMOs from Medicare may diminish the ability or willingness of HMOs to provide cross-subsidies in the future to Medicare members who select prescription drug coverage.

The result of adverse selection is that the cost difference between products which do and do not cover drug benefits continues to increase, creating a selection spiral. The selection spiral is exacerbated by the fact that all direct pay medigap members may, under state law, change medigap plans every year with no medical underwriting. Individuals with low drug costs can select a lower-priced plan that provides no drug coverage, knowing that they will be able to upgrade annually to a product with drug coverage if their drug costs increase. A rational consumer will base his or her purchasing decision on the additional cost of drug coverage compared to monthly prescription drug costs. As the cost difference widens between medigap plans with and without drugs, there are more and more medigap members for whom it makes financial sense to purchase plans without prescription drug coverage.

Risk selection among carriers

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[5] "Adverse risk selection," refers to the phenomenon of individuals of different health status and expected health care costs selecting different plans in unequal proportions. For instance, if individuals with significant and predictable use of certain prescription drugs elect to purchase a policy that covers those services, while individuals who do not anticipate significant drug expenditures can purchase policies that do not cover drugs, the plan providing drug coverage experiences adverse risk selection.

[6] Another reason for the increasing disparity in rates between Medex Gold and Medex Bronze is a requirement imposed by the 1990 federal OBRA standardization law that all medigap products be rated on their own experience. Prior to this change, BCBS was permitted to pool the experience of the Medex members in all products to rate benefits common to all. Thus, if individuals in Medex Bronze were better risks, they subsidized the Medex Gold members. Now Medex Gold members alone share the costs of their higher costs for all benefits, not just prescription drugs.

Among Medicare supplement carriers: In addition to the adverse selection due to the drug benefit, BCBS has historically been subject to adverse selection due to its different regulatory requirements. Until recently, BCBS was the only Medicare supplement carrier required to hold an annual open enrollment period and accept all applicants. Enrollees during this period were frequently on Medicare due to disability or persons well over the age of 65. Until the 1994 passage of the state's medigap reform law, M.G.L. c.176K, BCBS was required to community rate its products while commercial carriers frequently used age rating. A commercial carrier's rate for persons age 65 was generally less expensive than the Medex rates. But as the enrollees of commercial carriers' medigap plans aged, there came a point (usually in the mid-to-late 70s) when a senior received a better rate from a BCBS community-rated product than from an age-rated plan. BCBS's Medex risk pool thus aged more quickly than would otherwise have been the case solely due to the aging of its own members.

Between Medicare supplement carriers and HMOs: The existence of positive risk selection in HMO Medicare plans, regardless of regulatory requirements, is a well-documented phenomenon nationally, and is one of the major reasons for the recent changes in the federal AAPCC HMO payment methodology. A recent study by the General Accounting Office found that positive selection to Medicare HMOs continues to occur even in medigap markets with high HMO penetration.

Although there are few publicly available data with which to assess the existence or extent of positive selection in Massachusetts HMOs, it seems irrefutable that this type of selection has occurred. For example, according to testimony presented before the Joint Committee on Insurance in April, 1997, Medex Gold members have an average cost level for non-drug services that is about 40% above the state average for all Medicare eligibles; only 7 percentage points of the 40% difference is accounted for by the age and gender characteristics of Medex members.[7] Overall, BCBS's spiraling Medex costs for all its products appear to demonstrate that the members leaving Medex to join HMO Medicare plans are, on average, younger and less costly than the members remaining in the Medex risk pool. The lower rates for competitive HMO products have also led to a decrease in the number of people joining Medex and other Medicare supplements when they turn 65 and initially become eligible for Medicare. As fewer new entrants are available to improve the risk pool of Medicare supplement plans, the premium impact of the aging of existing members is exacerbated.

Since M.G.L. c. 176K was enacted in 1994, all medigap carriers have been subject to the same rules in the medigap market, including open enrollment periods, community rating, rate review and approval standards and processes, and minimum benefit requirements (including the requirement that carriers must offer a product that includes drug coverage). These changes have created a more level playing field for carriers and consumers. However, carriers that previously were subject to more stringent requirements, such as BCBS, still insure risk pools that reflect the past regulatory differences.

Overall, the reform law seems to have had very little impact on the proportion of Medicare beneficiaries that have medigap coverage, and little success in moderating premium increases or reducing risk selection. In fact, these problems seem to have gotten worse in recent years.

IV. POTENTIAL OPTIONS FOR DEALING WITH PROBLEMS IN THE MEDIGAP MARKET IN MASSACHUSETTS

The previous sections indicate that there are a number of significant problems in the medigap market, including: lack of coverage for a significant proportion of Medicare beneficiaries; rapidly rising premiums for traditional Medicare supplements; the growing proportion of medigap insureds who have no coverage for prescription drugs; and risk selection among plans and carriers.

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[7] Testimony of Ronald Harris, actuary for Milliman and Robertson, before the Joint Insurance Committee, testifying on behalf of Blue Cross and Blue Shield, on April 30, 1997.

There are a variety of potential policy options for dealing with problems in the medigap market; these include:

- Letting market forces work, and increasing education and outreach to improve the functioning of the market
- Implementing a premium subsidy for lower-income Medicare beneficiaries
- Requiring all medigap products to provide prescription drug benefits
- Limiting benefits for prescription drugs
- Implementing a drug deductible, linked to the Senior Pharmacy Program
- Implementing a reinsurance plan for prescription drug costs

Each of these options is discussed below. The options are intended to provide a basis for discussion, rather than to be an exhaustive list of all possible changes. Cost estimates are provided where possible, although lack of data makes it difficult to develop estimates for several options. In addition, the options are not necessarily mutually exclusive, but could be combined in different ways. With readily available data, however, it is impossible to develop cost estimates for combinations of options.

Option 1: Have faith in the market forces underway; increase education and outreach to improve the functioning of the market

Rationale: Since the enactment of c. 176K and the proliferation of HMO Medicare risk products, the medigap market is, in many ways, more "appropriately" competitive than in the past. There is a range of HMO products available to most Medicare beneficiaries that are considerably less costly than Medex and other Medicare supplements. Medicare beneficiaries are already moving rapidly to select HMO plans, and this enrollment growth shows no signs of abating. While the cost difference is increasing between Medicare supplements and HMO plans, there may be no compelling reason to interfere with the movement away from traditional Medicare supplements to HMO products. Instead, the state could continue to permit individuals who are price sensitive to choose the product that is most affordable or the best value, based on their individual preferences. After all, managed care plans have become the major, and often only, choice available to most other insured people, often for reasons of cost. Almost half of the under-65 population in Massachusetts is now enrolled in HMOs, compared to 20% of Medicare beneficiaries. HMOs generally produce more efficient use of medical care services and lower overall costs, with comparable quality, than is possible under traditional, unmanaged plans. In addition, the ability of Medicare supplement plans to manage costs and quality is severely limited by the gap nature of coverage and the constraints imposed on carriers by the Medicare program.

Education and outreach: Although the number of Medicare beneficiaries with medigap coverage seems to be increasing, available data suggest that there are a significant number of low-income elders who are foregoing supplemental coverage altogether when they are eligible for no or low-cost HMO plans, or perhaps eligible for Medicaid or the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLIMB) programs. [8]

[8] Medicare Beneficiaries with incomes below 100% of poverty level and limited assets (less than $4,000 per individual) are eligible under the QMB program to have Medicaid pay the Part B premium ($43.80 per month), and all Medicare deductibles and cost-sharing. Specified Low-Income Medicare Beneficiaries, who must have incomes between 100-120% of poverty and limited assets, are eligible to have Medicaid pay the Medicare Part B premium. According to a recent study, a relatively high proportion of individuals in Massachusetts (85%) who are eligible for QMB are taking advantage of the program. However, as many as 84% of Massachusetts Medicare beneficiaries who are eligible for SLIMB are not enrolled. If these individuals were enrolled, they could save $43.80 per month by not paying the Medicare Part B

Some Medicare beneficiaries may not have considered HMO Medicare plans because of lack of information or misunderstandings about HMOs. In particular, many HMOs have significantly expanded their provider networks in the last year, but beneficiaries may not be aware of these expansions. Additional educational and outreach efforts might provide more Medicare beneficiaries with current information about HMO Medicare options, as well as identify beneficiaries who are eligible for other programs, such as QMB and SLIMB. There is clearly an untapped market for low-cost HMO products: the proportion of Medicare beneficiaries with medigap coverage has remained constant or perhaps even declined at a time of greater availability of low cost alternatives to traditional Medicare supplemental coverage. Although HMO plans with drug coverage are far more affordable for most beneficiaries than traditional Medicare supplements with or without drug coverage, many consumers are purchasing more costly products or foregoing coverage altogether.

Countervailing considerations: It may, however, not be sufficient to rely on market forces and additional education and outreach efforts:

- Existing market forces have not been adequate to ensure that all Medicare beneficiaries have some type of medigap coverage. Almost one in five Medicare beneficiaries have no coverage to supplement Medicare. Based on available data, these beneficiaries have, on average, significantly lower incomes than those who have medigap coverage. (Based on one recent survey, 70 percent of Medicare-only beneficiaries have incomes below $15,000, compared to only one-third of individuals with some form of medigap coverage.) Although HMO plans with drug coverage are far more affordable for most beneficiaries than traditional Medicare supplements with or without drug coverage, there are a large number of lower-income individuals who cannot afford the cost of an HMO plan offering prescription drug coverage.

- There are certain areas of the state where the choice of HMO products is quite limited, and HMO penetration varies greatly by county. As of year-end 1996, the proportion of Medicare beneficiaries enrolled in HMOs varied from a high of 35% in Worcester county to a low of 7% in Berkshire, 4% in Barnstable and 0% in Dukes and Nantucket. As noted earlier, HMO premium rates are also much higher in counties with low AAPCCs (although still considerably less expensive than Medicare supplements such as Medex).

- HMOs are not now a viable choice for some Medicare beneficiaries, particularly those who travel frequently or reside outside of Massachusetts for more than three months every year. (This may change as a result of recent changes to federal law that will permit HMOs to offer Point of Service type products to Medicare beneficiaries, as well as the development by some HMOs of "reciprocal" arrangements with HMOs in other states.)

- Medicare beneficiaries must often disrupt relationships with providers when they join HMO plans. Most of the Medicare HMOs have provider networks that are considerably smaller than those in other HMO products. (According to the HMOs, the reason for the smaller provider network is to enable better management of costs and quality.) For instance, only one-quarter of the all Primary Care Physicians (PCPs) contracting with one of the state's largest HMOs participate in that HMO's Medicare product. One-quarter of the new Medicare members who join this HMO have changed their PCP in order to enroll in the plan. While changing providers may be acceptable to many members, it would be a serious disruption for others, particularly those with serious, on-going medical conditions. There were, for example, only about 8,000 disabled Medicare beneficiaries who had joined HMOs as of year-end 1996, or approximately 7% of total disabled beneficiaries, compared to approximately 18% of Medicare beneficiaries aged 65 or older who had selected a Medicare HMO plan.

- HMO products, particularly those with prescription drug coverage, are likely to become more costly in the future as a result of several factors, including: reductions in the rate of increase of AAPCCs in high cost areas like Massachusetts; the growing inability or unwillingness of HMOs to incur financial losses on drug

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premium, which is more than half the cost of an HMO Medicare plan that includes prescription drug coverage.

products, which now appear to be underpriced at some HMOs; and the changing nature of HMO risk and costs as more and more Medicare beneficiaries enroll in HMOs plans.

Option 2: Implement a premium subsidy for lower-income Medicare beneficiaries; require beneficiaries to enroll through a neutral third party enrollment counseling program to obtain the subsidy

Rationale: The number of Medicare beneficiaries without medigap coverage is large, and appears to be increasing. There are significant gaps in coverage and cost-sharing in the Medicare program, and these result in considerable out-of-pocket expenses for Medicare beneficiaries who do not have medigap protection, especially for low-income elders. In order to make medigap coverage more affordable to lower income Medicare beneficiaries, the state could implement a premium subsidy program. Such a program would be consistent with the recent actions by the Commonwealth to devote significant resources to providing insurance coverage and subsidies to many categories of non-elderly, uninsured individuals. A medigap subsidy program could be linked to a mandatory counseling and enrollment program, similar to the present program of the Division of Medical Assistance for MassHealth beneficiaries, to ensure that eligible individuals are fully informed about all of their medigap options, as well as their eligibility for any other state or federal health insurance programs.

The cost of a subsidy program would depend on the amount of the subsidy, the criteria for eligibility, and the number of eligible Medicare beneficiaries who actually apply. One approach could be to:

- establish the amount of the subsidy so that eligible individuals would not have to pay more than a certain percentage of their income toward the cost of purchasing medigap coverage (e.g., 10%);

- cap the maximum subsidy amount at some level (e.g., no more than the average cost in each county of obtaining an HMO Medicare plan that provides drug coverage);

- permit eligible individuals to use the subsidy toward the purchase of any medigap plan that meets certain standards established by the Division of Insurance, Executive Office of Elder Affairs, or another state body.

We estimated the cost of a sliding scale premium subsidy program targeted at aged Medicare beneficiaries who currently have no medigap coverage or who purchase direct pay plans (i.e., the estimate excludes from eligibility any individuals who obtain medigap coverage through employer groups, in order to prevent "crowding out', or the substitution of public subsidy funds for private premiums now paid by employers). Medicare beneficiaries who are disabled were excluded because they are generally eligible for MassHealth or the CommonHealth program.

Cost estimates were calculated for two scenarios:

Scenario 1: a subsidy of up to $75 per month (the approximate current average cost of an HMO Medicare plan that includes drug benefits); and,

Scenario 2: a subsidy of up to $100 per month, to account for possible current underpricing of HMO Medicare plans, the impact of recent changes in federal AAPCC payments, and the likely increase in HMO Medicare plan premiums that could occur if large numbers of uninsured beneficiaries, or those who now have traditional medigap coverage, were to switch to HMO plans.

The income eligibility criterion was an annual income o1rogram. In addition, the cost of a subsidy program could be reduced, perhaps significantly, by combining a premium subsidy with one or more of the options discussed below (e.g., requiring all medigap plans to include prescription drug coverage).

Countervailing considerations: Depending on its design, a subsidy program could be costly. The major obstacle to implementing a program of this type would be identifying a politically viable funding source, although there are many possibilities (e.g., general revenues, increases in tobacco and/or alcohol taxes, surcharges on health insurance premiums). An additional political consideration is the equity of implementing

a subsidy program only for Medicare beneficiaries, when many other low income individuals are uninsured or have difficulty paying health insurance premiums. Even individuals who have only Medicare coverage are insured for 80-100% of the cost of covered medical care services (although Medicare beneficiaries have significantly higher costs than younger individuals, as well as no Medicare coverage for important services, such as prescription drugs). The cost calculations include only individuals who now have only Medicare or direct pay medigap plans; the cost of extending a subsidy to group medigap plans would be significant.

Option 3: Require all medigap products to provide prescription drug benefits[9]

Rationale: Unless all medigap plans have drug coverage, there will continue to be selection among products based on the need for coverage. As a result, the medical costs (for both drugs and other medigap-covered services) of the most expensive Medicare beneficiaries will not be spread broadly across the entire population of individuals with medigap coverage.

There would most likely be a significant reduction in the premium for Medex Gold if all Medex members were required to purchase this product. It is impossible to calculate the exact impact of this change because there are no data available on the drug costs of Medex members who do not have drug benefits. (Although these members do not now submit drug claims, if they were required to purchase drug benefits it is likely that at least some of them have drug expenses that would be covered.) However, the proposed monthly pure premium for non-drug benefits in the 1998 proposed Medex Gold rates would decline by approximately $35, from $153 to $118, if the risk pools for Medex products with and without prescription drugs were combined. (The increase in the pure premium for Medex Bronze members would be $19.) It seems reasonable to assume that the pure premium for prescription drugs could decline by an equivalent amount. Thus, this change could have a substantial impact on Medex premium rates.

Countervailing considerations: Although the Medex Gold rate would decline if the Medex risk pools for all Medex products were combined into one large pool, the new combined rate would still be considerably higher than the current premium rate for Medex Bronze. The premium rates for other medigap carriers, including HMOs, would also be higher than the current rates for products that do not include prescription drugs. Assuming that most medigap members buy the plan that is most affordable, these higher rates may not be within the financial reach of many current medigap members, and could force these members to either drop coverage or, in the case of current Medicare supplement insureds, switch to a more restrictive HMO plan (if they are eligible for one). The impact of premium increases for some medigap insureds would be moderated if a premium subsidy of the type discussed in Option 2 above were available to lower-income Medicare beneficiaries.

A less dramatic option for reducing risk selection would be not to allow elders to upgrade from a no-drug to a drug product without a penalty. Various types of penalties are possible, including a more limited drug benefit, a waiting period for drug coverage, and/or a premium surcharge. While it is difficult to estimate the rate impact of these changes, it is likely to be relatively small.

Option 4: Limit the benefit for prescription drugs

Rationale: The drug benefit required in Massachusetts direct pay Medicare supplemental plans such as Medex Gold is, by all accounts, the most generous direct pay drug benefit in the country. In contrast, the federal

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[9] The state would continue to be required to offer the Core benefit package mandated by the federal OBRA law, which does not include drug coverage. However, the impact of this requirement would be minimal since very few Medicare beneficiaries have purchased the Core products that have been available. However, it may be impossible under the federal OBRA law to require individuals who are now enrolled in Medicare supplement plans with no drug coverage to switch to products with drug coverage, although any future enrollment in the no-drug plans could be closed. This legal limitation under OBRA would not apply to HMO plans.

standardized Medicare supplement plans developed by the National Association of Insurance Commissioners (NAIC), and adopted by most states, have an annual limit on prescription drug coverage, ranging from $1,250 to $3,000, and much higher consumer cost-sharing (50%) than the plans in Massachusetts. The higher drug benefit in Massachusetts is one reason why Medicare supplement premium rates in the state are higher than in most other parts of the country.

One potential way to lower premium rates, and rate increases, for members of medigap plans would be to limit the prescription drug benefit. It appears, however, that this change, by itself, would not have a significant effect on premium rates, largely due to the risk selection that has already occurred. For example, in 1996 the monthly pure premium for the Medex drug benefit would have declined by only $3, from $67.45 to approximately $64.50, if the drug benefit had been limited to $3,000 per year. This change would have affected approximately 6% of Medex members who had drug coverage. Limiting the benefit to $1,500 a year would have reduced the drug pure premium of the Medex Gold rate to $54.85, a reduction in the total Medex Gold rate of approximately 6%. One-quarter of Medex member with drugs would have been affected by this change. Thus, the imposition of a $1,500-3,000 annual drug limit would have reduced the total Medex Gold rate by only 1-6%. However, if a benefit limit were combined with higher coinsurance for the member (e.g., the 50% coinsurance mandated in the federal standardized benefit packages) and/or a requirement that all medigap members purchase drug coverage, the impact on premiums could be considerably greater.

Although comparable drug cost data are not publicly available for HMO Medicare plans, it is likely that the premium impact of a benefit limit on HMO premiums would be somewhat greater, although still relatively small. Unless a similar benefit limit were imposed on all medigap plans, the plans with more generous drug benefits would experience adverse risk selection.

Countervailing considerations: Imposing a limit on the benefit for prescription drugs appears to have limited potential as a means to reduce premiums, and does little more than shift costs to Medicare beneficiaries, particularly to those with the greatest health care needs and costs. In addition, the lack of insurance coverage for high drug costs may make it difficult or impossible for many individuals to comply with recommended drug regimens, thereby increasing costs for other medigap services (e.g., inpatient benefits).

Option 5: Implement a deductible for prescription drugs, linked to the Senior Pharmacy Program

Rationale: Another method to reduce medigap premiums would be to permit, or require, higher levels of consumer cost-sharing. One possible option would be to introduce a higher annual drug deductible, linked to the state's Senior Pharmacy Program (SPP). The SPP provides up to $750 in drug benefits annually to elders who meet eligibility criteria. Elders must have an annual income that is less than 150% of the federal poverty guideline (approximately $11,800), and not have any insurance coverage for prescription drugs. As of March, 1998, approximately 20,000 elders had enrolled in the program. The FY 1998 appropriation for the program is sufficient to cover 40,000 elders.

It is difficult to estimate precisely the effect of a $750 deductible on medigap premiums. Based on data provided by BCBS, approximately 80% of Medex members with drug coverage received some benefits for prescriptions in 1996, and so would have been affected by the introduction of a drug deductible. The 1996 monthly drug pure premium for Medex members with drug coverage would have declined from $67 to approximately $36 if a $750 annual deductible had been in place. This would have represented nearly a 20% decline in the Medex Gold rate. The impact on 1998 premiums would be even greater because of the increase in Medex drug costs in the last two years.

If a $750 deductible had been combined with mandatory drug coverage for all Medex members (i.e., combining all Medex members into one risk pool with the same benefits), the monthly pure premium for the Medex drug benefit could have declined to as low as approximately $18, a decline of nearly $50, or 75% of the cost of the drug pure premium. (This is an estimate of the maximum effect because it assumes all Medex members remain in the risk pool, rather than switching to other products, and that all members who were enrolled in products without drug coverage would have drug expenses of less than $750. However, the total effect of these two changes on the monthly Medex rate could well exceed the $50 estimate because, as

discussed in Option 3, combining the Medex risk pool would also reduce the average cost of other non-drug benefits compared to current Medex Gold experience.)

Countervailing considerations: The effect of a high drug deductible is similar to a limited benefit in that costs are shifted to Medicare beneficiaries. However, if the deductible were linked to the SPP, the impact on lower income elders would be moderated. In addition, medigap members would have comprehensive drug benefits after meeting the deductible, ensuring that individuals with the highest drug costs would be protected. There would, however, be a large number of elders who were not eligible for the SPP. According to a recent survey, less than 30% of elders who currently have medigap coverage have incomes that would meet the eligibility criteria for the SPP.

Option 6: Implement a reinsurance program for prescription drug costs

Rationale: Unlike the Medicare program, which is a broad-based, intergenerational cost sharing mechanism, private medigap insurance spreads its cost only to those who have coverage, mainly elderly individuals. This lack of broad-based, intergenerational cost sharing is particularly problematic because the elderly have much higher health care costs than younger people, but, under the current medigap insurance structure, must themselves fully bear these higher costs for covered medigap benefits. The result is most extreme for benefits that are not covered at all by Medicare, such as prescription drugs.

One approach to spread the cost of prescription drugs more broadly would be to establish a state-funded reinsurance program for prescription drugs. Such a program would require that medigap insurers, and thus medigap members, bear prescription drug costs up to some amount per member per year, and then would assume fully or share the cost of members who exceeded the threshold amount. Medigap premiums would include the costs borne by the medigap plans; the amount reinsured would be funded by state revenues (e.g., general revenues).

Based on available data, it is impossible to estimate the total cost of such a reinsurance plan. But the potential impact on medigap premium rates appears to be significant, based on data provided by BCBS. Using 1996 data, it appears that a reinsurance plan that included a $1,000 deductible (i.e., the amount of costs per member retained by the carrier) would have reduced the monthly pure premium for the Medex drug benefit by approximately $29, or nearly 44%, which would have been a 15% reduction in the Medex Gold rate. (See Table 10) The total cost of this program for direct pay Medex members would have been approximately $32 million. If the design of the reinsurance program had included 10% risk-sharing for the carrier for any amount above $1,000 (a feature that would ensure that carriers remained at least somewhat concerned about prescription costs that exceeded the deductible), the pure premium for the drug benefit would have declined by $26, a drop of nearly 40%, representing a 14% decline in the Medex Gold premium. The cost of this design would have been approximately $28 million.

As shown in Table 10, the rate impact and cost of a reinsurance plan with a $2,000 annual deductible per member would have been lower, but still quite significant. We could not estimate the total cost of the program because we did not have data on the distribution of drug costs for medigap carriers other than Blue Cross Blue Shield. It is, however, likely that a substantial proportion of the costs of a reinsurance program would result from current Medex members because Medex has the greatest number of members, as well as in all likelihood a disproportionate number of individuals with the highest drug costs.

Table 10

Prescription Drug Reinsurance Plan: Total Cost and Impact on Premium Rates

Program design	Reduction in monthly drug pure premium	As % of total drug pure premium	As % total Medex Gold rate: 1996	Total cost of reinsurance for Medex members with drug coverage

$1,000 deductible				
No carrier coinsurance	-$29	-43%	-15%	$32 million
10% carrier coinsurance	-$26	-38%	-14%	$28 million
$2,000 deductible				
No carrier coinsurance	-$18	-27%	-10%	$19 million
10% carrier coinsurance	-$16	-23%	-9%	$17 million

Option 7: Implement a state purchasing program for drugs

It might be possible to lower medigap premiums somewhat if carriers could pool their purchasing power, perhaps by taking advantage of the rates of payment the Division of Medical Assistance (DMA) has negotiated with pharmacies and/or drug manufacturers. A statewide purchasing program could be run as a separate carve-out plan, under the auspices of the state, and administered by a private vendor selected through a competitive bidding process, or by DMA. Or medigap plans could continue to include prescription drug benefits, but use the state's purchasing power to obtain lower rates of payment.

The costs of the state pharmacy program could be distributed in a variety of ways, including funding the program partially or entirely through premium payments by covered individuals, a surcharge on state income taxes of covered members, and/or general revenues.

Unfortunately, it was not possible to obtain data from DMA to evaluate the potential cost savings, if any of this option.

Countervailing considerations: Even assuming that this option does have the potential to reduce costs, which is speculative, it would have the disadvantage of weakening the carriers' purchasing power for their non-Medicare members by reducing the number of covered lives and revenues covered by their contracts with pharmacy vendors. Carriers might also oppose a carve-out plan design on the grounds that it would complicate coordination of care, and be administratively complex, particularly in terms of ensuring carriers had access to accurate and timely data on drugs costs and utilization for medical management purposes.

V. CONCLUSIONS

There are a number of serious problems in the Massachusetts medigap market, and a variety of actions that could be taken to address these problems. Whether legislative or regulatory changes are required to deal with these issues, as well as an assessment of the relative attractiveness of potential changes, depends on the answers to several public policy questions:

- Is there a public policy rationale for ensuring that all Medicare beneficiaries have access to affordable medigap coverage?

- If so, is there a justification for ensuring that traditional Medicare supplements (like Medex) remain affordable for most Medicare beneficiaries, when there are HMO options available that are significantly less expensive?

- Is coverage for prescription drugs a vital benefit in medigap plans? If so, should the benefit be unlimited, as currently required by Massachusetts law?

- Who should bear the costs incurred by Medicare beneficiaries for medical care not covered by the Medicare program?

If action is warranted, there are a number of policy goals against which potential changes in the Massachusetts medigap market could be evaluated. These include:

- to make medigap coverage more affordable to lower-income Medicare beneficiaries;
- to maintain choice among medigap products without encouraging risk selection among products and carriers;
- to contain the cost of medigap benefits, particularly prescription drugs;
- to maintain equity between Medicare beneficiaries and other population groups (e.g., lower income working individuals).

The problems in the medigap market are not new, nor do they appear to be insoluble. But the time for action is now, before rising premiums, accelerating risk selection, and the increasing market fragmentation that may result from new product options permitted by the federal Balanced Budget Act, jeopardize access to affordable medigap coverage for more Medicare beneficiaries in Massachusetts.

APPENDIX: COST ESTIMATES FOR PREMIUM SUBSIDY PROGRAM

a. ELIGIBILITY ESTIMATES

Massachusetts Medicare eligibles aged 65+ 861,000	
Estimated percent with incomes < 200% Federal Poverty Guideline @35%	
Total estimated aged Medicare < 200% FPG 301,400	
Remove:	
Elders receiving Medicaid cash assistance	- 27,000
Remaining Medicaid/Medicare with incomes below 200% poverty (101,000-27,000) @35%	-26,000
Individuals <200% FPG with group medigap coverage	
HMOs: 40,000 x .35%	-14,000
Medicare supplements: 100,600 x .35%	-35,200
Other group plans: 115,000 x .65%	-40,300
TOTAL ESTIMATED NUMBER ELIGIBLE FOR SUBSIDY	158,900

b. COST ESTIMATES

Scenario 1: Subsidy of up to $75 per month ($900/year)	
Total subsidy if all eligibles received maximum subsidy	$143 million
Actual estimated subsidy with impact of sliding scale @ estimated 50% offset	**$72 million**
Scenario 2: Subsidy of up to $100 per month ($1,200/year)	
Total subsidy if all eligibles received maximum subsidy	$191 million
Actual estimated subsidy with impact of sliding scale @ estimated 50% offset	**$95 million**