ISSUE BRIEF
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Senior Prescription Drug Coverage: The State of the Medigap Markets In Massachusetts and New Hampshire

NO. 7

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Issue Brief prepared by Michael Miller, Policy Director for Health Care for All, and Nancy Turnbull, Lecturer in Health Policy and Management, Harvard School of Public Health.

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Executive Summary

While the federal Medicare program has been under intense scrutiny in the past few years, a growing crisis in the medigap insurance market has gone largely ignored by federal and state policy makers. Medigap insurance[1]—health insurance offered by various private carriers to supplement the Medicare program—is an important source of financial protection for the elderly. It both protects Medicare beneficiaries against some or most of the cost-sharing features of the Medicare program (e.g., deductibles, coinsurance), and often provides coverage for certain services, such as prescription drugs, that Medicare does not cover.

In the past decade, the federal government has taken an extremely active role in regulating medigap insurance, a significant departure from the past in which regulation was left largely to individual states. Despite the attempt to standardize regulation of medigap insurance, the medigap market in every state is somewhat different, in terms of the number of commercial insurers and managed care companies offering coverage, the rules that govern access to policies, the premium rates that may be charged, and the protections for consumers who want to change plans.

This report examines recent trends in the medigap markets in Massachusetts and New Hampshire. Although neighbors geographically, these two states have very different medigap markets and have pursued different regulatory and public policy approaches. New Hampshire's approach mirrors the predominant approach nationally, with the state's implementation of the federal regulatory scheme and protections enacted by Congress in 1990. In contrast, Massachusetts obtained an exemption from the federal requirements, and has adopted a regulatory scheme that is significantly different in terms of the requirements imposed on Medicare supplement insurers and, in some cases, managed care plans.

Yet despite these different approaches, a comparison of the situations in Massachusetts and New Hampshire reveals many common problems, and a growing crisis in the medigap markets in both states. Among the most serious problems are:

- **Most people with individual medigap coverage lack comprehensive drug benefits.** In New Hampshire, as in most of the rest of the country, there are no individual medigap products available that provide comprehensive drug coverage. In Massachusetts, where there are several medigap plans that provide comprehensive drug coverage, only 20% of elders with individual medigap policies now have comprehensive drug coverage, down from 48% in 1996 and 40% in 1998.

- **In a new survey of elderly consumers conducted for the Forum, one of three elders with medigap coverage reported they have no coverage for prescription drugs**.[2] The proportion of elders who had medigap coverage without benefits for drugs was nearly twice as great in New Hampshire (42%) as in Massachusetts (23%) (Appendix Table 12A). When elders who reported having no medigap coverage are counted, almost half of all elders have no drug coverage. The proportion is even higher in New Hampshire at 56%, compared to 40% in Massachusetts (Appendix Table 12A).

- **The cost of providing comprehensive drug coverage is increasing rapidly for the dwindling number of elders who have such coverage.** In the few medigap products that provide comprehensive drug coverage, the cost of the prescription drug benefit now accounts for almost half of the total premium.

- **One-third of elders report they worry "very often" or "fairly often" about not being able to afford prescription drugs,** according to the Forum's survey of elders (Appendix Table 1A).

- **One-quarter of the elderly Medicare beneficiaries in Massachusetts and New Hampshire**

[1] The term "medigap" will be used throughout the paper to include both traditional Medicare supplements, such as those offered by Blue Cross Blue Shield and AARP, and Medicare managed care plans, including HMOs.

[2] See Appendix Tables 1A-25A for survey results.

report they have no medigap coverage at all. In Massachusetts, 25% report they have no coverage, compared to 27% in New Hampshire (Appendix Tables 2A and 3A).

- Elders with low incomes are much more likely than those with higher incomes to report they have no medigap coverage. Of elders who reported their incomes, 41% of those with household incomes below $20,000 reported having no medigap coverage, compared to 28% of elders with household incomes above $20,000. In addition, a smaller proportion of lower-income elders have drug benefits: only 41% of elders with household incomes below $20,000, compared with 64% of elders with household incomes above $20,000. (Appendix Table 17A).

- **Premiums have increased rapidly, an average of 25-30% since 1996, for traditional Medicare supplement coverage, even for products with no drugs.** The premium for Medex Gold, the most popular product in Massachusetts that provides comprehensive drug coverage, has increased 57%. In New Hampshire, which permits age-rating, Medicare beneficiaries in older age categories pay considerably higher premiums than younger beneficiaries. For products offering drug coverage, the oldest elders pay as much as twice the premium as the youngest elders.

- **Medicare managed care plans, a lower cost option for many elders, have disappeared from some parts of Massachusetts, and there is only one HMO still offering coverage in New Hampshire, down from five plans just two years ago. Plan withdrawals have affected roughly 40,000 beneficiaries across the two states.**

- **The protections that exist under state and federal law for Medicare members when managed care plans withdraw from the Medicare program are inadequate to ensure that beneficiaries can obtain comparable coverage.**

- **Even where Medicare managed care plans are still available, provider withdrawals have disrupted continuity of care for some plan members. There are inadequate protections for consumers under state and federal law when providers withdraw from Medicare managed care plans.**

- **In Massachusetts, differences in regulatory requirements between Medicare HMOs and traditional Medicare supplement permit, and even encourage, healthier beneficiaries to enroll in managed care plans, and sicker ones to enroll in Medicare supplemental insurance.**

Background

In April 1998, the Massachusetts Health Policy Forum issued a report on "The State of the Medigap Market in Massachusetts." The report identified five major concerns:

- the large number and proportion of Medicare beneficiaries who had no medigap coverage;

- the rising cost of medigap policies;

- the growing number of medigap policyholders who had 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 might not be a viable alternative to less affordable Medicare supplement coverage for some Medicare beneficiaries.

In the past 18 months, these concerns have remained and, in many cases, have gotten worse, while new problems have developed. In particular, there has been tremendous instability in the Medicare managed care market, with the withdrawal of Medicare HMOs, and drastic reductions in prescription drug coverage by remaining HMOs as a result of the federal Balanced Budget Act of 1997 (BBA).

While Massachusetts has some unique features to its medigap market, many of the problems in the Massachusetts medigap market are occurring nationally as well. But, this growing crisis in the medigap market has been relatively ignored. There are many dimensions to the medigap crisis—a large and, it appears, growing number of Medicare beneficiaries with no medigap coverage; rising premiums; dwindling coverage for prescription drugs; withdrawals of carriers, particularly

HMOs, from the medigap business; the termination by providers of their contracts with Medicare managed care plans; and a conflict between state and federal regulation, resulting from the BBA, that impedes the ability of states to take actions to address some of these problems.

The purpose of this report is to update the Forum's 1998 medigap report, both by re-examining the market in Massachusetts and by contrasting the situation in Massachusetts with New Hampshire, its bordering state. Although neighbors geographically, these two states have very different medigap markets and have pursued different regulatory and public policy approaches.

Unfortunately, it was not possible to document the medigap market in New Hampshire in as much detail as the market in Massachusetts because the state does not collect and make available detailed data on medigap enrollment by carrier and type of coverage. As suggested in the final section of this report, we recommend that New Hampshire collect and make available more detailed information on the medigap market in the state.

Table 1
Profile of Medicare Beneficiaries in Massachusetts and New Hampshire
(1998 Data Unless Otherwise Indicated)

Characteristic	Massachusetts	New Hampshire	United States
State population	6.1 million	1,185,000	275 million
Total population 65+ (1995)	861,000	136,000	33 million
Total projected state population 65+ in year 2025	1,252,000	273,000	Not available
Total number of Medicare beneficiaries	977,700	168,800	39 million
% of total population	16%	14%	14%
Number of beneficiaries 65+	836,300	144,700	Not available
Age distribution of Medicare beneficiaries			
Under 65 years old	15%	14%	14%
65-74 years old	42	45	45
75-84 years old	31	30	30
85+ years old	12	11	11
Sex distribution			
% Female	58	56	57
% Male	42	44	43
Low income Medicare beneficiaries			
Medicare beneficiaries with Medicaid	160,000	6,300	Not available
As % of all Medicare	16%	4%	13%
Aged SSI recipients	46,100	1,100	Not available
As % of total 65+ population	6%	<1%	4%
Elderly with Incomes less than 100% Federal Poverty Level (1995)	114,000	17,000	Not available
As % total 65+ population	15%	12%	16%

Source: Henry J. Kaiser Family Foundation, "Medicare State Profiles." September 1999; Massachusetts Division of Medical Assistance

We were able to supplement the public information with results of a survey of elders in Massachusetts and New Hampshire, conducted for the Forum by Bannon Communications Research, a Washington-based polling firm (See Appendix Tables 1A-25A) for survey results). The results of the survey, combined with the information available in Massachusetts and New Hampshire, reveal that the two states share many common problems in their medigap markets. In some cases, state action can address these problems, but there are other problems that only federal action can solve.

This 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 two markets, 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 insurance.

Number and Characteristics of Medicare Beneficiaries in Massachusetts and New Hampshire

There are 978,000 Medicare beneficiaries in Massachusetts and almost 169,000 in New Hampshire. The characteristics of Medicare beneficiaries in both states are very similar to national averages (See Table 1). Medicare beneficiaries account for more than 14% of the total state population in New Hampshire, and nearly 16% in Massachusetts, almost identical to the national average of 14%. The vast majority of beneficiaries in each state qualify for Medicare by virtue of age—831,000 elders in Massachusetts and more than 145,000 elders in New Hampshire. In each state 14-15% of Medicare beneficiaries are eligible because of disability.[3] New Hampshire has a much smaller proportion of Medicare beneficiaries who are also eligible for Medicaid—so-called "dually-eligible" beneficiaries—only 4%, compared to 16% in Massachusetts and 13% in the U.S. A much lower proportion of elderly residents of New Hampshire is enrolled in the federal Supplemental Security Income (SSI) program,[4] less than 1% of elders, compared to 6% in Massachusetts and 4% in the U.S. overall, despite New Hampshire having approximately the same proportion of elders living below the poverty line as in Massachusetts or the country as a whole.

These data suggest that the sources of state support for low-income Medicare beneficiaries in New Hampshire are considerably less broad than in Massachusetts. In particular, the relatively low proportion of Medicare beneficiaries who are also eligible for Medicaid means that there may be no source of prescription drug coverage for many low-income elders who would be eligible for the Medicaid program in many other states, including Massachusetts.

Background on Medigap Insurance

Private health insurance to supplement Medicare, so-called "medigap" insurance, is an important source of financial protection for the elderly. 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 (non-group) 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 Medicare managed care plans.

I. Medicare Supplement Plans

Commercial insurers and Blue Cross Blue Shield sell Medicare supplement plans. These plans fill gaps in Medicare coverage but permit the beneficiary to continue to receive care from any provider.

[3] This report focuses on elder Medicare beneficiaries because of the greater difficulty of collecting data on the under-65 Medicare population.

[4] SSI is a federal income assistance program for low-income individuals who are 65 years old or older, or blind, or have a disability, and who have limited assets.

Table 2
Benefits in Standardized Nongroup Medicare Supplement Policies: New Hampshire

Benefit	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Core benefits*	•	•	•	•	•	•	•	•	•	•
Part A Deductible		•	•	•	•	•	•	•	•	•
Skilled Nursing Facility Coinsurance			•	•	•	•	•	•	•	•
Part B Deductible			•			•				•
Part B Excess Charges						•	•		•	•
Emergency care outside the US			•	•	•	•	•	•	•	•
At-home recovery				•			•		•	•
Preventive Medical Care					•					•
Prescription Drugs-Basic†								•	•	
Prescription Drugs-Extended‡										•

Source: "1999 New Hampshire Buyer's Guide to Medicare Supplement Insurance" New Hampshire Insurance Department

*Core benefits include coverage of all Part A coinsurance for stays longer than 60 days and the Medicare lifetime reserve days; the 20% part B coinsurance, and the Parts A and B blood deductibles
†Basic drug coverage: $250 annual deductible, 50% coinsurance and a maximum annual benefit of $1,250
‡Extended drug coverage: same as basic but with a maximum annual benefit of $3,000

Congress enacted legislation in 1990 that dramatically changed the rules for selling Medicare supplemental policies.[5] Incorporated into the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), these changes for the first time gave the federal government substantial authority for regulating the medigap market. The most important provision of OBRA 90 resulted in the development of ten standardized benefit packages. These standardized products are the only types of nongroup Medicare supplement policies that could be sold after July 30, 1992. (Individual states may restrict the number of plan designs to fewer than ten if they want.) In addition, three states, Massachusetts, Minnesota and Wisconsin, had medigap standardization programs in place before the passage of OBRA 90 and were granted exemptions from the federal standardization requirements and permitted to keep their own unique standardization programs in place. This means that there are some significant differences between Massachusetts and New Hampshire in the range of Medicare supplemental products available.

Medicare Supplement Products in New Hampshire

The New Hampshire regulatory structure is based on the scheme enacted in the 1990 OBRA law. New Hampshire permits the sale of all ten OBRA standardized Medicare supplemental policies. The benefits required in each policy are outlined in Table 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.)

Only three of the ten OBRA benefit packages require coverage of prescription drugs, and this coverage is subject to significant cost-sharing and an annual benefit limit. Plans H and I provide the so-called "basic" drug benefit—an annual benefit paid by the medigap insurer of up to $1,250, after a $250 deductible and with 50% coinsurance for the policyholder. Plan J provides the "extended" drug benefit, with the same cost-sharing features as Plans H and I, but an annual benefit of $3,000.

Medicare Supplement Products in Massachusetts

Under Massachusetts law, Medicare supplement carriers may sell three types of plans in the nongroup market.[6] Medicare Core, Medicare Supplement One, and Medicare Supplement Two. Table 3 provides a brief summary of the benefits covered in each of the

[5] The federal Health Insurance Portability and Accountability Act (HIPAA) also extended additional protections to Medicare supplement policyholders.

[6] State law and regulation (M.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.

Table 3
Benefits in Standardized Nongroup Medicare Supplement Policies: Massachusetts

Benefit	Core (same as Plan A in NH)	Supplement One	Supplement Two
Part A 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

Source: Massachusetts Division of Insurance

*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.

three standardized Medicare supplemental plans. (Medex Bronze is BCBS's Supplement One and Medex Gold is a Supplement Two.) As in New Hampshire, 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.

One of the most significant differences between New Hampshire and Massachusetts is that products with comprehensive drug benefits are available in Massachusetts. The Medicare Supplement Two policy provides drug coverage, subject to a $35 quarterly deductible, and coinsurance of 20% for brand name drugs, with no annual or lifetime cap on benefits. There is no coinsurance for generic drugs, and prescriptions filled through mail order are not subject to the quarterly deductible but rather a copayment of $5 for generic drugs and $15 for brand name drugs.

II. Medicare Managed Care Plans

The second type of medigap coverage is Medicare managed care plans. In counties where managed care plans are available, Medicare beneficiaries may choose to enroll in a managed care plan instead of staying in the regular Medicare program. Members of Medicare managed care plans generally have more comprehensive benefits, often at a lower cost, but relinquish freedom of choice of provider and must comply with the care management requirements of the managed care plan.

Medicare managed care plans are not subject to the same standardized benefit requirements as Medicare supplemental plans. Instead, managed care plans must meet specific requirements of federal law, including provisions enacted as part of the BBA. Medicare managed care products are also subject to state laws in both Massachusetts and New Hampshire.

Prior to 1999 Massachusetts required all HMOs in the Medicare market to offer comprehensive prescription drug coverage. However, a federal court ruled in October 1999 that a provision of the BBA preempted state regulation of Medicare HMO benefits.[7] As a result, all Medicare HMOs in Massachusetts eliminated their comprehensive drug coverage with the exception of Kaiser Permanente/Community Health Plan, which withdrew from Massachusetts as of December 31, 1999.

The loss of comprehensive drug coverage for HMO subscribers is a major contributor to the decline in the overall availability of comprehensive drug benefits, especially because HMOs were offering the drug benefit at substantially lower premiums than were traditional Medicare supplement carriers. (This decline has been offset somewhat by the inclusion in all HMO plans of a capped pharmacy benefit—generally about $600 per year—and a recently enacted expansion of the state

[7] Massachusetts Association of Health Maintenance Organizations v. Linda Ruthardt, Commissioner of Insurance, 194 F.3d 176 (1999)

pharmacy assistance program). The withdrawal of HMO drug benefits has also created a structural imbalance between Medicare supplement plans, which offer comprehensive drug coverage, and HMOs, which do not. The variation in benefit packages creates an invitation for elders to choose a no- or low-cost HMO unless or until they incur high prescription drug costs, at which point they can switch to a Medicare supplement plan during the annual open enrollment period.

III. Other Major Features of the Medigap Regulatory Structure in Massachusetts and New Hampshire

In addition to the benefit differences for Medicare supplement policies described above, there are several other significant differences in the medigap regulatory schemes in Massachusetts and New Hampshire. Again, New Hampshire is similar to most other states in having implemented the scheme enacted in OBRA 90, while Massachusetts has adopted a number of more stringent regulatory requirements. The major provisions in each state are outlined in Table 4.

The Massachusetts regulatory provisions are more stringent in the following areas:

Rating: In Massachusetts, 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). Policies in New Hampshire may be rated using attained age, issue age or community rating. This means that premiums may be lower for younger policyholders but can rise dramatically over time as people age.

Underwriting: In Massachusetts, direct-pay medigap plans may not reject an applicant for coverage

Table 4
Comparison of Regulatory Requirements in Massachusetts and New Hampshire

Requirement	Massachusetts	New Hampshire
Medical Underwriting	Not permitted	Not permitted during initial open enrollment or during subsequent required open enrollment periods
Renewability	Must be guaranteed renewable	Must be guaranteed renewable
Open Enrollment Periods	Annual coordinated two-month period required of all carriers for all products	No requirements beyond federal OBRA and BBA (6-month open enrollment period when first enroll in Part B)
Rating	Community rating required of all carriers	Issue age and attained age rating permitted*
Rate Regulation	State review required of rate increases =10+%	No state rate review required; may hold rate hearing
Medical Loss Ratio Standards	Minimum standards for Medicare supplemental policies of 90% for BCBS; 65% for individual policies and 75% for group policies issued by commercial insurers	Minimum standards for Medicare supplemental policies of 65% for individual policies and 75% for group
Pre-existing Conditions	Not permitted	6-month exclusion with 6-month look-back permitted; no new limit may be imposed when person switches carriers

*Attained age: Premiums are determined by the age of the policyholder.
Issue-age: Premiums are based on policyholder's age at the time the policy was first purchased.

based on medical history nor impose any limitations for preexisting conditions. In New Hampshire, carriers can impose preexisting condition exclusion periods for up to six months in certain situations, which can include switching to a medigap plan with more comprehensive coverage. Also in New Hampshire, at any time after an individual's open enrollment period (the six months following enrollment in Medicare Part B), or during any subsequent renewal open enrollment period, a carrier can refuse to issue a medigap policy based on age or health status.

Open enrollment: All medigap carriers in Massachusetts must participate in an annual, two-month, coordinated open enrollment period, during which any Medicare beneficiary may join any plan offered by any carrier serving the geographic area in which they live. There is no open enrollment requirement in New Hampshire beyond first six months of Part B enrollment.

The implication of these regulatory differences is that elders in New Hampshire may find it more difficult to switch medigap plans, particularly if they have medical problems, and may experience significant increases in their premiums as they age.

Carriers that Sell Medigap Coverage

Massachusetts

There are currently three insurance carriers and five HMOs actively marketing medigap policies in Massachusetts, for a total of up to 14 available products, depending on the county in which an individual Medicare beneficiary resides. The types of coverage and current premium rates are listed in Table 5. Enrollment by carrier is shown in Table 6. Medicare supplement policies are significantly more expensive than HMO

Table 5
Individual Medigap Products and Monthly Premium Rates:
Plans Being Sold as of January 2000

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	$59.38	$111.25	$286.26
Allianz Life*	$52.00	$98.50	$222.42
United/AARP†	$55.75	$113.75	$286.00
b. HMO Plans	**1999 Premium**	**2000 Premium**	**Drug benefits**
Fallon Community Health Plan	$ 0	$ 0	$175/quarter; $700 per year $8 for generic $15 for brand
Harvard Pilgrim	$0-30 (depending on county of residence)	$0-50 (depending on county of residence)	$200 per quarter; $800 per year $5 generic; $10 brand $25 brand/non-formulary
HMO Blue (BCBS)	$0-30	$25 (depending on county of residence)	$125 per quarter; $500 per year No copayment
Tufts Associated Health Plan	$0	$0-35 (depending on county of residence)	$150 per quarter; $600 per year; $8 generic; $15 preferred brand; $35 non-preferred brand
United HealthCare of New England	$0	$0	NONE

*Available only to members of certain associations
†Individuals must be members of AARP to purchase coverage.
Source: Massachusetts Division of Insurance; HCFA's "MedicareCompare" Website, http://www.medicare.gov/comparison

Medicare products, although it is difficult to compare rates because of the significant differences in coverage for prescription drugs.[8]

New Hampshire

There are 16 carriers selling Medicare supplemental coverage in New Hampshire. The number of products offered by each carrier ranges from three to ten, with a total of 90 different Medicare supplemental policies available. (See Table 7 for a list of carriers and premium rates for the most popular plans.) As noted earlier, current enrollment data by carrier and plan were not available from the New Hampshire Insurance Department. However, according to data for 1997 from the National Association of Insurance Commissioners, enrollment was very concentrated among a few insurers. Blue Cross Blue Shield of New Hampshire (now Anthem) insured more than half of policyholders with Medicare supplemental plans, and AARP/Prudential (now United Health Care) and Banker's Life accounted for another 40% of covered lives.

As of January 1, 2000, there is only one Medicare managed care plan offered in New Hampshire— Harvard Pilgrim Health Care of New England. The HPHC of New England Medicare plan provides only $300 per year in prescription drug coverage (see Table 8).

Table 6
Number of Massachusetts Medigap Members by Plan: 1992, 1997 and 1999

Carrier	Members: 6/92	Members: 12/97	Members: 9/99	Percent Change in members: 1992-99
Medicare Supplement Plans	424,000	310,900	264,300	-38%
BCBS Medex	366,000	251,900	218,600	-40%
Individual	269,000	157,900	128,900	-52%
Group	97,000	94,000	89,700	-8%
AARP	50,000	24,300	21,700*	-57%
Banker's Life	3,500	21,900	15,400	340%
Miscellaneous	4,900	12,800	8,600*	76%
HMO Plans	70,700	192,600	249,300	253%
Tufts	1,500	68,300	102,000	6700%
Fallon	18,000	30,500	35,300	96%
Harvard Pilgrim	15,700	50,200	70,500	349%
HMO Blue	11,300	17,000	17,700	57%
Aetna/USHC	—	17,300	0	Not applicable
United	—	3,700	14,400	289%
Kaiser	2,200	2,700	2,600	18%
Community	2,200	1,800	3,000	36%
Other	16,100	1,100	3,800	-76%
TOTAL	494,700	503,500	513,600	4%
As % Medicare beneficiaries	Not available	Not available	53%	Not available

*Enrollment data as of 9/99 not available; membership as of 12/98.

[8] 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 Massachusetts and all of New Hampshire.

Problems in the Massachusetts and New Hampshire Medigap Markets

Problem # 1: Most people with individual medigap coverage lack comprehensive drug benefits. In New Hampshire, as in most of the rest of the country, there are no individual medigap products available that provide comprehensive drug coverage. In Massachusetts, where there are several medigap plans that provide comprehensive drug coverage, only 20% of elders with individual medigap policies now have comprehensive drug coverage, down from 40% in 1998 and 48% in 1996.

According to data collected by the Massachusetts Division of Insurance, as of December 31, 1998, only half of the consumers who had medigap coverage had comprehensive prescription drug coverage, down from 57% in 1996 (see Table 9). In the direct-pay medigap market, only 40% had drug coverage, compared to 48% in 1996. In contrast, in the group medigap market, 92% of members had drug coverage, an increase of 3% since 1996.

The situation as of September 1999 was even worse, although actual data are not available for all carriers. However, since all Medicare HMOs in Massachusetts eliminated their unlimited drug benefits in 1999, and the proportion of Medex members in Medex Gold has been declining steadily, the proportion of direct-pay medigap members who now have comprehensive drug coverage appears to be approximately 20%.[9]

From available data, the trend toward eliminating drug coverage can be seen most dramatically in the Medex population in Massachusetts, where the number and proportion of direct-pay Medex members with drug coverage has been declining steadily since 1990 (see Table 10). As of September, 1999, only 38% 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.

The survey results confirmed these trends in Massachusetts and provided additional data for New Hampshire (see Appendix). Based on the survey:

- One of three elders with medigap coverage reported they have no benefits for prescription drugs (Appendix Table 11A).
- The proportion of elders who had medigap coverage without benefits for drugs was nearly twice as great in New Hampshire (42%) as in Massachusetts (23%) (Appendix Table 12A).
- When elders who reported having no medigap coverage are counted, almost half of all elders have no drug coverage. The proportion is even higher in New Hampshire at 56%, compared to 40% in Massachusetts.
- Eight-four percent of elders who receive their medigap coverage through an employer or former employer had drug coverage, compared to only 44% who purchased medigap plans themselves.
- Annual limits on drug benefits are much more common in medigap plans purchased directly than in employer-provided coverage. Sixty-three percent of elders who purchased coverage directly had an annual cap, compared to only 32% of elders with employer-provided coverage

Problem #2: The cost of providing comprehensive drug coverage is increasing rapidly for the dwindling number of elders who have such coverage. In Massachusetts, the cost of the prescription drug benefit in the Medex Gold product now accounts for almost <u>half</u> of the total premium.

In the past several years, the premiums for Massachusetts Medicare supplemental plans providing comprehensive drug benefits have increased rapidly. As shown in Table 11, since 1996 premiums for the three

[9] Using September 1999 enrollment: Assuming 82% of the 249,300 Medicare HMO members were direct-pay, approximately 204,400 Medicare HMO members did not have a comprehensive drug benefit. Approximately 80,000 Medex direct pay members (62% of 129,000) lacked comprehensive drug coverage. Extrapolating from Division of Insurance data for 12/31/98, 20,800 AARP members lacked comprehensive drug benefits (96% of 21,700), as did approximately 600 Banker's Life members (4% of the 15,400 covered lives as of 9/99), and 5,200 elders enrolled in other miscellaneous plans (69% of 7,500). This means a total of 311,000 of the 378,000 direct-pay medigap members did not have comprehensive drug coverage, or 82%.

Table 7
Medicare Supplement Plans Available in New Hampshire
Plans A, C, F, I and J
Monthly Premiums for Policyholder Aged 74*

Carrier	Rating and Underwriting Terms	Plan A	Plan C	Plan F	Plan I	Plan J
American Republic	Attained age No pre-ex	$65.56	$106.40	$102.13 underwritten	Not offered	Not offered
Bankers Life	Attained age No pre-ex	$77.08	$124.69	$135.12	Not offered	Not offered
Bankers United	Attained age Pre-ex	$54.46	$89.94	$103.83	$158.66	Not offered
Blue Cross Blue Shield	Attained age No pre-ex	$72.79	$106.51	$106.84	Not offered	$167.76
Central States	Attained age No pre-ex	$65.94	$109.56	$120.18	Not offered	Not offered
Combined	Issued age No pre-ex	$76.57	$128.76	$156.25	Not offered	Not offered
Life Investors	Attained age Pre-ex	$64.00	$105.00	$121.00	$172.00	$249.00
Monumental	Attained age Pre-ex	$63.00	$104.00	$121.00	$170.00	$248.00
Mutual of Omaha†	Attained age Pre-ex	$72.93	$116.87	$120.73	Not offered	Not offered
Mutual Protective	Issue age No pre-ex	$65.01	$112.93	$136.24	Not offered	Not offered
Physicians Mutual (direct sales)	Attained age No pre-ex	$57.33	$116.75	$136.02	Not offered	$229.79
Pioneer Life	Attained age No pre-ex	$63.33	$143.76	$134.90	$238.86	Not offered
State Farm	Attained age No pre-ex	$62.39	$94.09	$108.20	Not offered	Not offered
United American	Issue age Pre-ex (6/2)	Not offered	$144.00	$147.00	Not offered	Not offered
United Health/AARP	Community rated Pre-ex of 3 months/3 months	$58.75	$100.50	$101.50	$127.75 (medically underwritten except during initial Medicare open enrollment)	$146.75 (medically underwritten except during initial Medicare open enrollment)
USAA†	Pre-ex	$47.26	Not offered	$96.22	Not offered	Not offered

*74 is the median age of elder Medicare beneficiaries in New Hampshire; For carriers using issue age-rating, rates are for a new policyholder
†Non-smoker rates

Source: "1999 New Hampshire Buyer's Guide to Medicare Supplement Insurance" New Hampshire Insurance Department

Table 8
Medicare Managed Care Plans in New Hampshire as of January 2000

HMO	1999 Premium	2000 Premium	Drug benefits
Harvard Pilgrim Health Care of New England	$45 per month	$ 55 per month	$75/quarter; $300 per year $5 for generic $10 for brand/formulary $25 for brand/nonformulary

Source: http://www.medicare.gov/comparison

Table 9
Proportion of Medigap Members with Comprehensive Drug Coverage
Year-end 1996 and 1998 and September 1999

Type of Medigap Plan	Year-end 1996	Year-end 1998	September 1999
TOTAL: ALL PLANS	**57%**	**50%**	**n.a.**
Direct-pay plans	48%	40%	20% (est)
Group plans	89%	92%	n.a.
HMO Plans: Total	57%	49%	n.a.
Direct-pay plans	47%	38%	0%
Group	86%	96%	n.a.
Medicare Supplements: Total	57%	51%	n.a.
Direct-pay plans	49%	41%	39% (est)
Group	91%	90%	n.a.

Source: Massachusetts Division of Insurance enrollment reports

Table 10
Percent of Direct-Pay Medex members
with Comprehensive Drug Coverage: Selected Years

Year	% of Members with Comprehensive Drug Coverage
1985	86
1989	85
1990	77
1997	49
1998	40
1999 (September)	38

Source: Blue Cross Blue Shield of Massachusetts

Medicare Supplement 2 plans with the largest number of policyholders have increased from 57-113%, depending on the carrier. If the recently requested rate increase for Medex Gold is approved by the Division of Insurance, the monthly premium rate for Medex Gold will be almost $315, or an annual premium of almost $3,800. Banker's Life has requested a 46% increase, effective August 2000.

The cost of prescription drugs is the major factor fueling the increase in premiums for Massachusetts Medicare supplement plans with comprehensive drug coverage, increasing much more rapidly than coverage for Part A or Part B benefits (see Table 12). According to Blue Cross Blue Shield's most recent Medex filing, the prescription drug benefit will soon account for nearly half the Medex Gold premium.

The Medex Gold experience appears consistent with other carriers offering comprehensive drug coverage. For example, in its recent rate filing with the Division of Insurance, Banker's Life reports that the drug benefit accounts for more than 40% of the premium for its most popular plan with unlimited drug benefits.

The increase in the cost of the Medex comprehensive drug coverage is being fueled by both an increasing number of prescriptions per member and an increase in the cost of each prescription (see Table 13). This is true in every category of prescriptions, for both brand name and generic drugs, and both retail pharmacies and mail order. Since 1995, the average annual number of prescriptions per Medex Gold member has increased from 19.7 to 30.2, an increase of 49%. The average cost of a prescription (weighted across categories) increased 53%. In total, the average cost of prescriptions per member has more than doubled.

These trends are being affected both by underlying increases in drug utilization and cost, as well as by the growing number of older and sicker enrollees in Medex Gold as younger and less costly members drop out to join Medex Bronze and HMOs.

Problem #3: One-quarter of elderly Medicare beneficiaries in Massachusetts and New Hampshire report they have no medigap coverage at all, according to the survey conducted by the Forum (Appendix Table 2A). In Massachusetts, 25% report they have no coverage, compared to 27% in New Hampshire (Appendix Table 3).

Table 11
Premium Increases for most popular Massachusetts Medicare Supplement Plans with Comprehensive Prescription Drug Coverage: 1996 and January 2000

Carrier	Monthly Premium as of January 1996	Monthly premium as of January 2000	Percent Change 1996-January 2000	Premium requested in filings with Division of Insurance	Percent increase 1996-2000 after requested rate increase
Blue Cross Blue Shield Supplement 2 (Medex Gold)	$182.70	$286.26	57	$314.59 (for 3/15/00 effective date)	72
AARP Supplement 2	$173.50	$286.00	65	None requested yet	None requested yet
Banker's Life*	$139.00	$296.09	113	$432.71 (for 8/1/00 effective date)	211

*Although Banker's Life no longer sells Medicare supplement coverage in Massachusetts, the carrier has a significant number of policies in force that offer a comprehensive prescription drug benefit.

Source: Massachusetts Division of Insurance

Table 12
Direct-Pay Medex Gold Monthly Pure Premium by Benefit Category: 1991, 1998 and 2000 (as projected in BCBS rate filing)*

Benefit Category	1991 Pure Premium	1998 Pure Premium	2000 Pure Premium	Increase 1991-2000	Increase 1998-2000	2000 Pure Premium as % of 2000 Rate
Part A Deductible	$15.93	$23.86	$25.54	60%	7%	8%
Part B Benefits	$31.53	$90.20	$100.40	218%	11%	32%
Prescription Drugs	$34.50	$93.44	$142.20	312%	52%	45%

*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: BCBSMA 1998 and 2000 Medex rate filings

Elders with low-incomes are much more likely than those with higher incomes to report they have no medigap coverage. Of elders who reported their incomes, 41% of those with household incomes below $20,000 reported having no medigap coverage, compared to 20% of elders with household incomes above $20,000. In addition, a smaller proportion of lower-income elders have drug benefits: only 41% of elders with household incomes below $20,000, compared with 64% of elders with household incomes above $20,000 (Appendix Table 17A).

Problem #4: Premiums have increased rapidly—an average of 25-30% since 1996—for traditional Medicare supplement coverage, even for products with no drugs. In New Hampshire, which permits age-rating, Medicare beneficiaries in older age categories pay considerably higher premiums than younger beneficiaries. For products offering drug coverage, the oldest elders pay as much as twice the premium as the youngest elders.

In the last few years, the premium rates for the most popular Medicare supplement plans in Massachusetts and New Hampshire have increased significantly. As shown in Table 14, rates have increased an average of 25-30% since 1996, during a time when health insurance premiums for most employers and individuals under 65 have remained fairly constant. Premium increases have been even greater in Massachusetts, especially for products with comprehensive drug coverage.

In New Hampshire, which permits age-rating, elders in the oldest age categories who purchase policies providing prescription drug coverage must pay premiums that are as much as twice as high as those paid by younger elders (see Table 15). The use of medical underwriting by United Health Care/AARP limits the availability of its products with drug coverage but moderates premiums.

Problem #5: Medicare managed care plans, a lower cost option for many elders, have disappeared from parts of Massachusetts, and there is only one HMO still offering coverage in New Hampshire, down from five plans just two years ago.

Medicare managed care plans have, in recent years, provided a less costly and often more comprehensive, alternative to traditional Medicare supplement policies for some beneficiaries. However, in the past two years, dozens of HMOs nationally have terminated their Medicare products, and many others reduced their service areas. These changes affected over 700,000 Medicare beneficiaries in the U.S. The withdrawals of HMOs from the Medicare market have been caused by a combination of concerns over the adequacy of Medicare payments, new regulatory requirements, and, in some cases, financial impairment of the HMOs. According to a recent study, most beneficiaries affected by these withdrawals suffered a reduction in coverage and an increase in their premiums and at least some disruption in their care.[10]

[10] Mary Laschober et. al., "Medicare HMO Withdrawals: What Happens to Beneficiaries?" Health Affairs November/December 1999, pp. 150-157.

Table 13
Utilization and Cost Trends for Medex Gold Prescription Drug Benefit
1995 and 2000

Component of Drug Cost	1995 (Actual)	2000 (Projected)	Percent increase 1995-2000	Most recent annual trend
Number of brand name prescriptions per member: retail	9.2	13.0	42%	9.0%
Cost per prescription	$33.04	$52.63	59%	9.3%
Number of generic prescriptions per member: retail	5.5	9.5	73%	13.8%
Cost per prescription	$10.57	$15.06	42%	7.0%
Number of brand name prescriptions per member: mail order	3.1	4.4	42%	6.6%
Cost per prescription	$98.99	$153.69	55%	11.0%
Number of generic prescriptions per member: mail order	1.9	3.3	74%	9.0%
Cost per prescription	$24.18	$38.55	59%	9.8%
TOTAL				
Number of prescriptions/member	19.7	30.2	49%	n.a.
Cost per script	$36.29	$54.00	53%	n.a.
Average cost of prescriptions per member	$715	$1,631	128%	n.a.

Note: Retail benefit is up to a 30-day supply; Mail order benefit is up to a 90-day supply
Source: Blue Cross Blue Shield of Massachusetts rate filings with Division of Insurance

As shown in Table 16, approximately 43,000 Medicare beneficiaries in Massachusetts and New Hampshire have been affected in the past two years by the withdrawal or reduction in the service area of a number of Medicare HMOs.

Massachusetts

Since 1998, two HMOs have withdrawn from the Medicare market in Massachusetts. Aetna/USHC stopped offering its Medicare plan as of January 1, 1999 and Kaiser/Community Health Plan withdrew from the Medicare market as of January 1, 2000. In addition, several Medicare HMOs have reduced their service areas in Massachusetts. Harvard Pilgrim withdrew from western Massachusetts, and United Health Plans of New England ended its plan in central Massachusetts. As a result of the Kaiser withdrawal and reduction of Harvard Pilgrim's service area, there is now no Medicare managed care plan available to Medicare beneficiaries in Berkshire county and some zip codes in Hampshire county. Although there are still Medicare HMO options in other parts of the state, the premiums for many of these plans have increased significantly as of January 1, 2000, and now cost members $30-50 per month, particularly in southeast and central Massachusetts.

New Hampshire

In the past two years, four of the five Medicare managed care plans offering coverage in New Hamp-

Table 14
Monthly Premium Rates
for Most Popular Direct-Pay Medigap Plans: 1996 and 1999

State and Carrier	Monthly Premium in 1996	Monthly premium as of January 2000	Percent Change 1996-January 2000
MASSACHUSETTS			
Blue Cross Blue Shield			
Supplement 1 (Medex Bronze)	$81.03	$111.25	37
Supplement 2 (Medex Gold)	$182.70	$286.26	57
AARP			
Supplement 1	$81.25	$113.75	40
Supplement 2	$173.50	$286.00	65
NEW HAMPSHIRE			
Plan C			
AARP All ages	$72.75	$100.50	38
Blue Cross Blue Shield Age 65 74 85	$62.00 $80.24 $98.47	$82.30 $106.51 $117.78	33 33 20
Banker's Life Age 65 74 85	$69.13 $94.08 $120.02	$91.53 $124.69 $159.16	32 33 33
Plan F			
AARP All ages	$80.75	$101.50	26
Blue Cross Blue Shield Age 65 74 85	$65.27 $84.46 $103.66	$82.56 $106.84 $145.70	26 26 41
Banker's Life Age 65 74 85	$77.52 $108.54 $138.94	$95.55 $135.12 $171.47	23 24 23
Plan I			
AARP* All ages	$111.50	$127.75	15
Plan J			
AARP*	$116.75	$146.75	26
BCBS Age 65 74 85	$112.82 $146.01 $179.19	$129.63 $167.76 $228.77	15 15 28

*Plan is medically underwritten and not available to Medicare beneficiaries who do not meet the medical screening criteria

Sources: 1995/1996 and 1999 "New Hampshire Buyer's Guide to Medicare Supplement Insurance" New Hampshire Insurance Department; and "Massachusetts Health Coverage for People with Medicare," Massachusetts Division of Insurance

Table 15
Monthly Premium Rates for New Hampshire Carriers Selling Plans with Prescription Drug Coverage (Plan I and Plan J): Premiums as of January 2000, for Selected Ages

Carrier and Plan	Monthly premium: age 65	Monthly premium: Age 75	Monthly premium: Age 85	Premium for age 75 compared to age 65	Premium for age 85 compared to age 65
Plan I					
Bankers United	$119.45	$158.66	$223.20	33% higher	87% higher
Life Investors	111.00	172.00	188.00	55% higher	69% higher
Monumental	96.00	170.00	198.00	77% higher	106% higher
Pioneer Life	172.34	238.86	301.89	39% higher	75% higher
United/AARP*	127.75	127.75	127.75	No difference	No difference
Plan J					
Blue Cross Blue Shield	$129.63	$167.76	$228.77	29% higher	76% higher
Life Investors	162.00	249.00	273.00	54% higher	69% higher
Monumental	140.00	248.00	288.00	77% higher	106% higher
Physician's Mutual	213.53	229.79	247.46	8% higher	16% higher
United/AARP*	146.75	146.75	146.75	No difference	No difference

* Medically underwritten

Source: "1999 New Hampshire Buyer's Guide to Medicare Supplement Insurance" New Hampshire Insurance Department

shire have withdrawn from the state. The latest termination, Tufts of New England, resulted from a decision by its Massachusetts-based parent company, Tufts Associated Health Plans, to close the HMO entirely. Medicare managed care plans have been a less costly alternative to traditional Medicare supplement plans. For example, the Tufts of New England Secure Horizons plan cost $25 per month, although it provided no prescription drug coverage.

Problem #6: The protections that exist under state and federal law for Medicare members when managed care plans withdraw from the Medicare program are inadequate to ensure the availability of comparable coverage at an affordable cost.

Members of Medicare HMOs have certain protections under state law and federal law if the managed care plan terminates its contract with the federal government. Under federal law, Medicare beneficiaries enrolled in a managed care plan that withdraws or is terminated from the Medicare program are entitled to enroll in any other locally available Medicare managed care plan, with no gap in coverage.

Under Massachusetts law, BCBS and other medigap insurers are required to permit Medicare beneficiaries who lose their coverage in this way to enroll in any medigap product, as of the effective date of the loss of HMO coverage. While this guarantees beneficiaries will have access to some type of medigap coverage, it does not ensure comparable coverage or premiums. For example, many members affected by the termination of Kaiser/Community Health Plan's Medicare plan have no other HMO options and must pay nearly $300 per month for Medex Gold or the comparable AARP/United policy, which provide the same type of unlimited drug coverage they had under the Kaiser Medicare product.

The situation in New Hampshire, and most other states, is even worse. Under federal law, most Medicare beneficiaries[11] have a guaranteed right to buy only certain Medicare supplemental policies (Plans A, B, C, and

[11] Members of withdrawing Medicare managed care plans who dropped out of a Medicare supplemental policy to join the managed care plan also have the right to return to their previous medigap plan, provided: the policy is still being sold by the same insurer; they had not been enrolled in the Medicare managed care plan for more than 12 months at the time of disenrollment; and, they apply for coverage no later than 63 days after they disenroll from the Medicare managed care plan. Beneficiaries who still have time left in their initial six-month Medicare open enrollment period also have guaranteed access to any medigap policy being sold in their state.

Table 16
Medicare Managed Care Plan Withdrawals and Service Area Reductions in Massachusetts and New Hampshire in 1999 and 2000

Managed Care Plan	Date of withdrawal or reduction	Counties affected	Number of people affected
Massachusetts			
Withdrawals			
Aetna/USHC	1/1/99	All counties	17,000
Kaiser/Community	1/1/00	All counties	3,000
Service area reduction			
Harvard Pilgrim	1/1/00	Franklin, Hampden, Hampshire	3,500
United Health Plans of New England	1/1/00	Worcester	2,100
New Hampshire			
Withdrawals			
Tufts of New England	Winter 00	All counties	1,000
Healthsource New Hampshire	1/1/00	All counties	13,400
Aetna/USHC	1/1/99	All counties	1,000
Matthew Thornton	1/1/99	All counties	2,300

Source: Health Care Financing Administration website, http://www.hcfa.gov

F) if their managed care plan leaves the Medicare program. None of these four guaranteed issue products includes any coverage for prescription drugs. If members of a withdrawing Medicare managed care plan want to buy any other type of Medicare supplemental policy, they may be subject to health screening and/or preexisting condition restrictions. In addition, as discussed above, most Medicare supplement policies in New Hampshire are age rated, which means older beneficiaries generally must pay significantly higher premiums to obtain Medicare supplemental coverage when they lose their HMO plans.

Problem #7: Provider withdrawals have disrupted continuity of care for thousands of members of Medicare HMO plans in Massachusetts. There are inadequate protections under state or federal law to ensure continuity of care for Medicare members when providers withdraw from Medicare managed care plans.

In 1999, there was an unprecedented number of provider withdrawals from Medicare managed care plans in Massachusetts. Table 18 details the major withdrawals (although there may be others). More than 11,000 Medicare beneficiaries were affected by these provider actions. Although the reasons cited by each provider group varied, among the common factors were: financial losses; adverse selection in their membership; lack of data from the HMOs to support medical management; and the unwillingness or inability of the HMOs to provide financial relief and/or address the underlying causes of these losses, such as rapidly increasing prescription drug costs.

Although members of a Medicare managed care plan have certain protections under state law and federal law if the managed care plan terminates its contract with the federal government, there are no protection for members if their provider terminates his/her contract with their Medicare HMO. Instead, members must wait until the next general open enrollment period. Massa-

Table 18
Recent Provider Withdrawals from Medicare Managed Care Plans in Massachusetts

Managed Care Plan	Provider Group/System	Provider	Area affected	Number of patients affected
Tufts	St Luke's/ Southcoast Health System	Hospital only	New Bedford	7,000
	UMass Memorial	Physicians and hospital	Worcester	Not available
	Brigham and Women's	44 Primary care physicians	Boston area	700
Harvard Pilgrim	St Luke's/ Southcoast Health System	185 PCPs and Hospital	New Bedford	2,000
	Mass. General	130 Primary care physicians	Boston area	1,400
	Brigham and Women's	44 Primary care physicians	Boston area	390
United Health Care	St Luke's/ Southcoast Health System	Hospital only	New Bedford	Not available

Source: Boston Globe

chusetts law requires all medigap carriers, including Medicare HMOs, to have an annual two-month open enrollment period in February and March, for coverage effective June 1. Federal law mandates a one-month open enrollment period for Medicare managed care plans in November of each year, for coverage effective January 1.

In Massachusetts, some of the patients affected by the contract terminations were able to maintain their current primary care physician relationships by switching immediately to other managed care plans, but only because:

a. their primary care physicians had a contract with another Medicare HMO;

b. the Medicare HMOs in Massachusetts have made the business decision to have continuous open enrollment; and,

c. Medicare HMO members are permitted to disenroll at any time from a Medicare managed care.[12]

Other members were able to join Blue Cross Blue Shield's Medex plans or the plans offered by AARP/United Healthcare because these companies decided to hold a special open enrollment period, although they had no legal obligation to do so.

Although the business practices of managed care plans and the good will of BCBS averted a crisis for patients in Massachusetts in 1999, consumers need additional protections when their providers withdraw from Medicare managed care plans. This problem could be addressed by federal and/or state legislation. Two options for addressing this problem are:

1. Limited approach:

[12] Beginning in 2002, beneficiaries will be unable to disenroll from a Medicare managed care plan at any time, but will be able to disenroll only during the first six months of the year and then be locked into the plan for the second half of the year. As of January 1, 2003, beneficiaries will be able to disenroll from a managed care plan during the first three months of the year and locked into the plan for the remaining nine months of the year.

- To require medigap carriers and HMOs to have an open enrollment period for beneficiaries whose providers terminate their contracts with Medicare HMOs. The legislation could include some minimum thresholds that need to be met (e.g., number of patients affected, inability to join another HMO with comparable coverage and rates, etc.). The commissioner of insurance could be given authority to determine if the "need" is great enough to trigger the open enrollment requirement.

2. Comprehensive approach:

- Change the state law open enrollment period to October and November, for coverage to be effective January 1 of the following year. This would make state law consistent with federal law, and with the contract term of Medicare managed care contracts. January 1 is the date on which the federal government changes its payment to Medicare managed care plans, on which managed care plans and most medigap carriers change benefits and premium rates, and on which managed care plans terminate contracts with the federal government.

- Allow provider contracts with Medicare managed care plans to be non-renewed or terminated only as of January 1 (except, perhaps, for a limited range of "for cause" reasons). Require sufficient notice by providers of non-renewal that beneficiaries will have this information in time to make informed choices during the open enrollment period.

- Ensure continuity of coverage for beneficiaries whose providers terminate their HMO contracts by requiring Medicare managed care plans to permit beneficiaries to continue to see these providers in certain situations (e.g., terminal illness, serious ongoing medical condition). The continuity of care language in the current managed care bills (House Bill 4525 and Senate Bill 1746) could serve as the basis for this section. (This section is important because it is unclear whether state law managed care protections would apply to Medicare managed care plans, even when enacted, particularly in light of the recent federal ruling in the Medicare HMO drug benefit case (see footnote 7, page 6).

Conclusion

The information gathered for this report suggests that the medigap market, including both traditional Medicare supplemental insurance policies and Medicare HMOs, is seriously flawed. Individuals seeking insurance to cover the gaps in Medicare coverage have enormous difficulty acquiring reliable affordable and comprehensive coverage. The problem is most acute with respect to coverage for prescription drugs. Comprehensive prescription drug coverage is essentially unavailable to hundreds of thousands of Medicare beneficiaries who arguably need such coverage more than does the general population for whom it is more readily obtainable. Such coverage is completely unavailable in New Hampshire, as in much of the rest of the country. In Massachusetts, such coverage is unavailable to enrollees of HMOs. While currently offered in the Medicare supplement market, rising costs and a deteriorating risk pool place such coverage increasingly beyond the means of most beneficiaries.

While the lack of prescription drug coverage is the most prominent problem in the medigap market, it is by no means the only one. Age rating and medical underwriting in New Hampshire make coverage difficult to obtain for older and sicker subscribers. In Massachusetts, members of Medicare managed care plans have inadequate protection when their providers withdraw from a health plan or if they seek to return to the traditional medigap market.

These problems can only be addressed through public action. Action is needed at both the federal and state levels:

At the federal level:

- Providing prescription drug coverage through Medicare and/ or

- Restoring the state's flexibility to regulate Medicare HMO benefits that was removed by the Balanced Budget Act of 1997;

- Strengthening the consumer protections in the Medicare supplemental insurance market, including eliminating age rating and medical underwriting and allowing beneficiaries to return from HMOs to Medicare supplement plans without penalty.

In Massachusetts:

- Ensuring that people whose providers withdraw from a managed care plan can gain access to a Medicare supplement plan without waiting for the annual open enrollment period;

- Establishing a catastrophic drug coverage program for Medicare beneficiaries as provided for in the FY2000 state budget;

- Reexamining the existing benefit packages in the Medicare supplemental insurance market, but only after a stable state program providing catastrophic protection has been established.

In New Hampshire:

- Collecting better data on the Medicare supplemental insurance market and making that data publicly available;

- Improving access for older and sicker enrollees by limiting or eliminating age rating and medical underwriting;

- Exploring ways to expand coverage for low income residents, particularly through the Medicaid program.

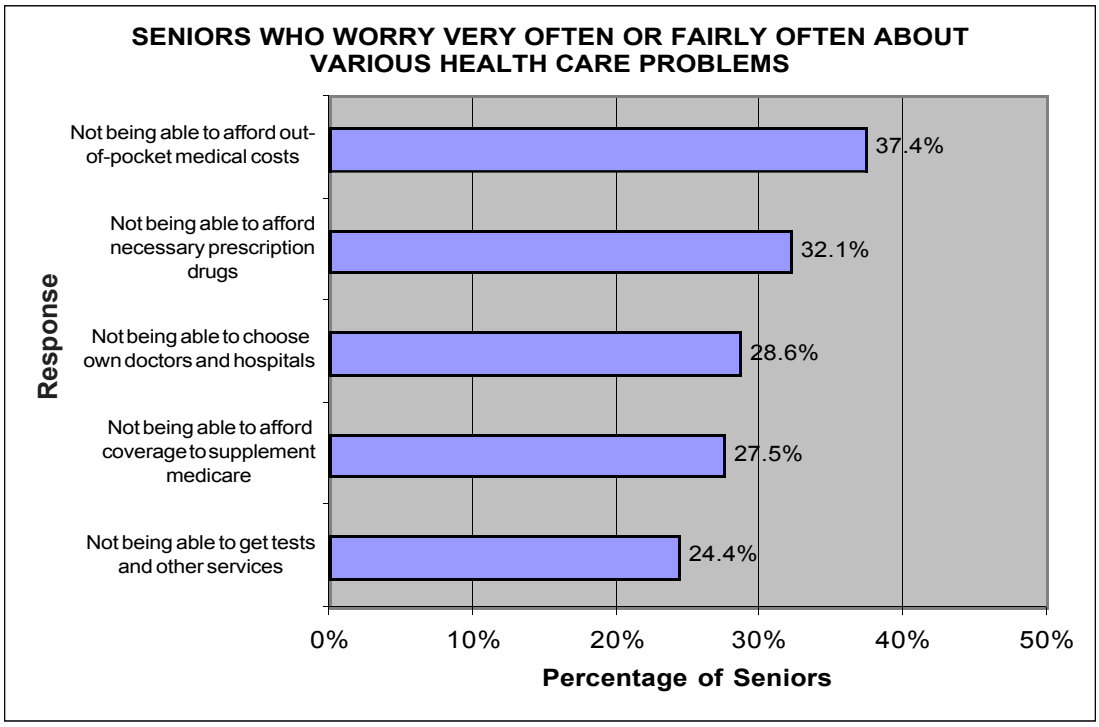
In addition to these policy steps there is a need for additional research on the current state of medigap coverage for Medicare beneficiaries, since good data on who has what level of coverage is not readily available. More attention also needs to be given to reducing the underlying growth of costs, particularly for prescription drugs.

Taken together, these steps will allow medigap coverage to fulfill its purpose of providing protection and security to Medicare beneficiaries. Failure to act will only lead to the continued deterioration of coverage.

Appendix

Massachusetts Health Policy Forum
Conducted by Bannon Communications Research
January 11 - January 18, 2000

Table 1A



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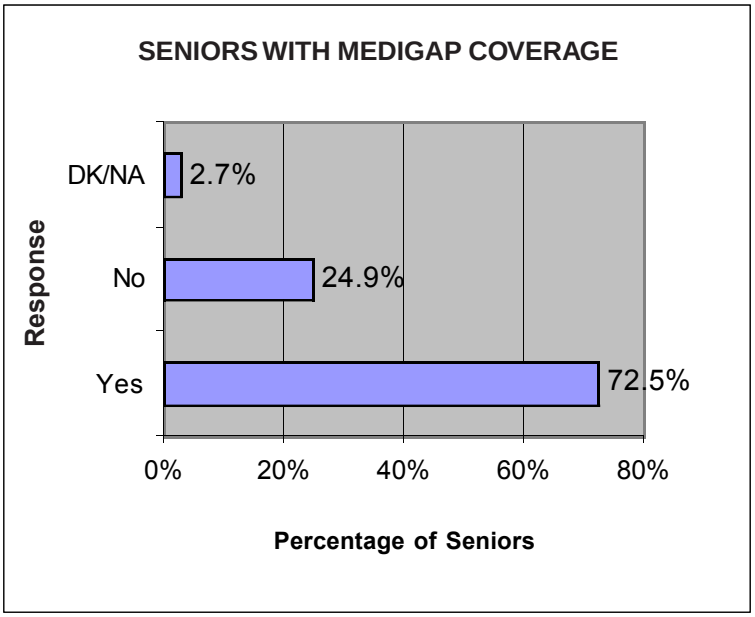

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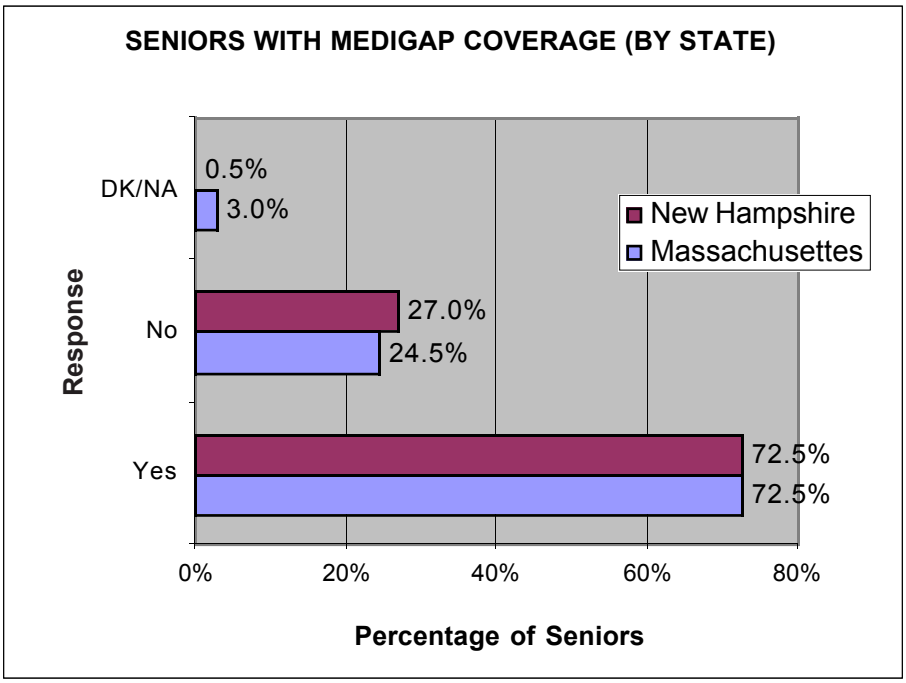

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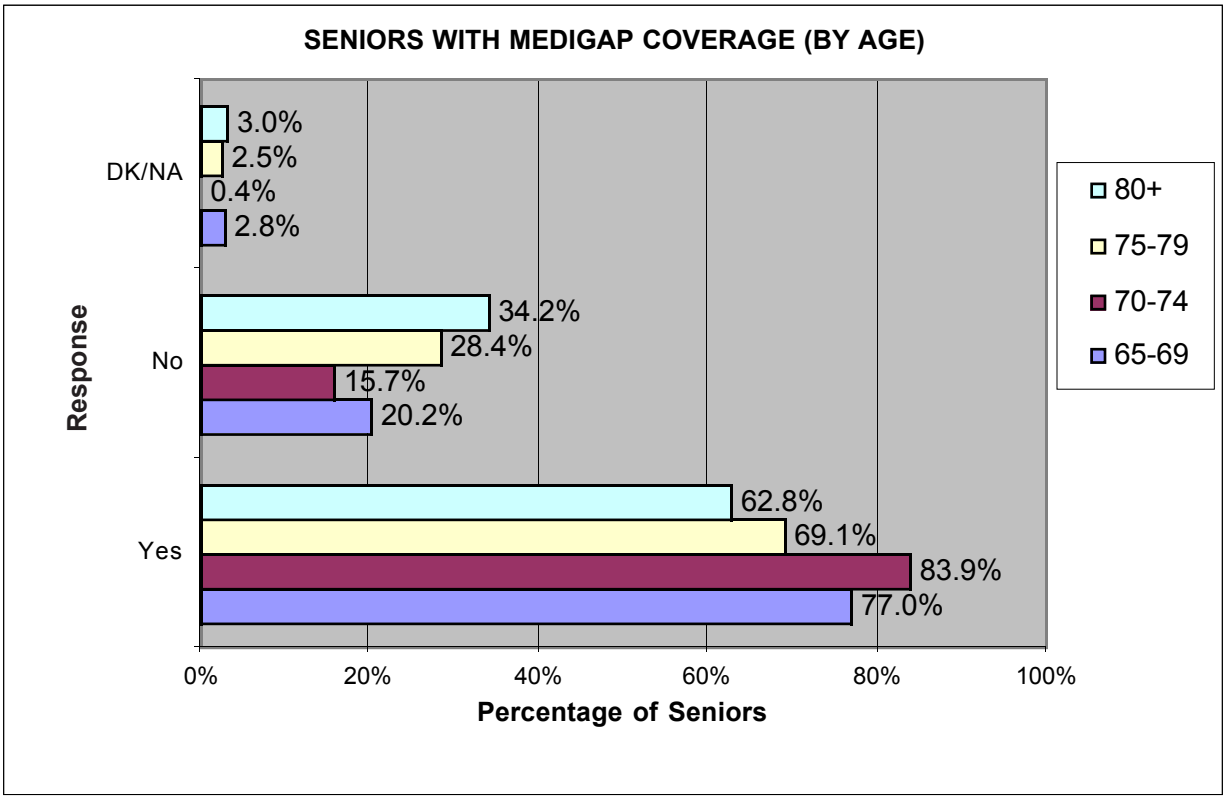

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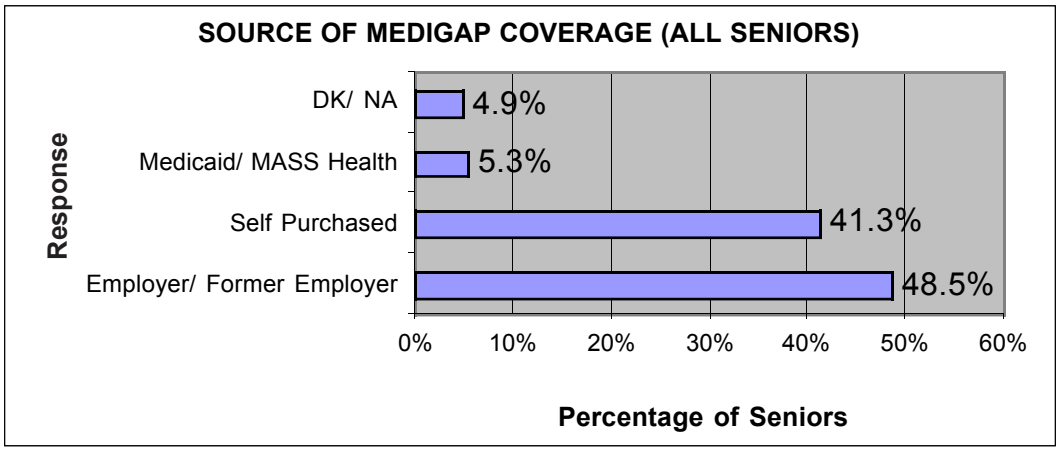

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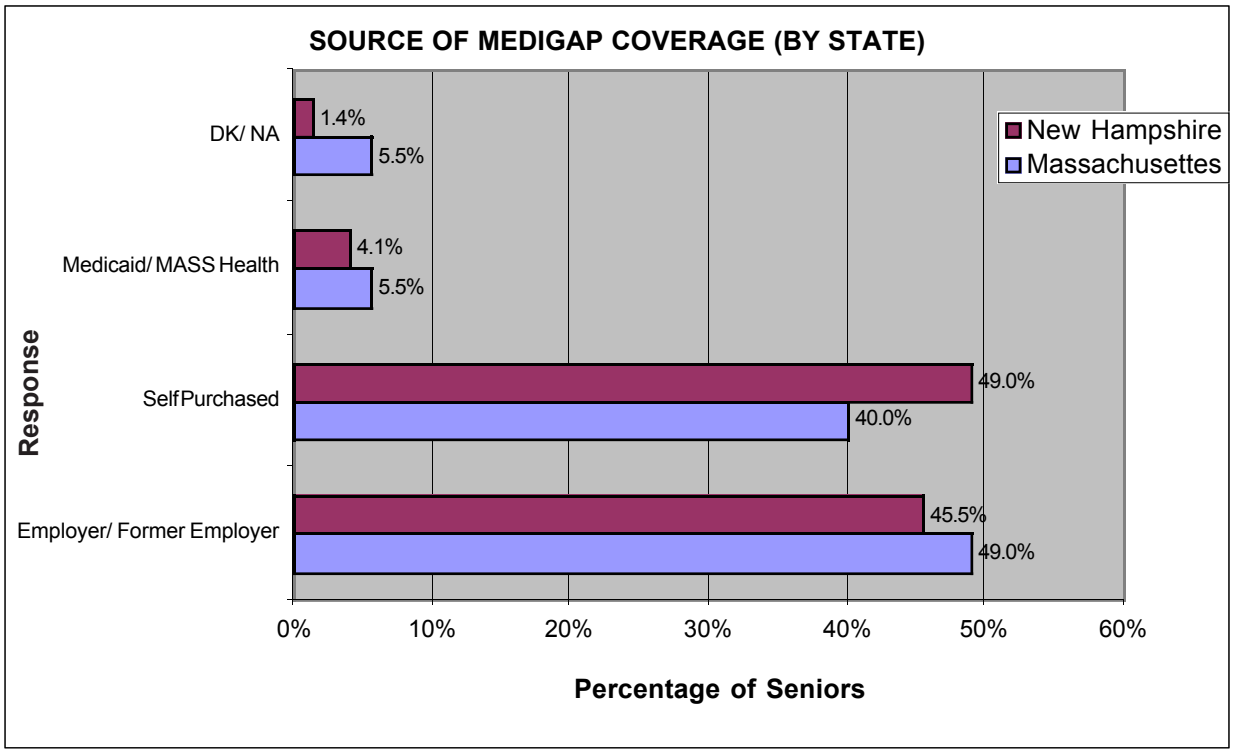

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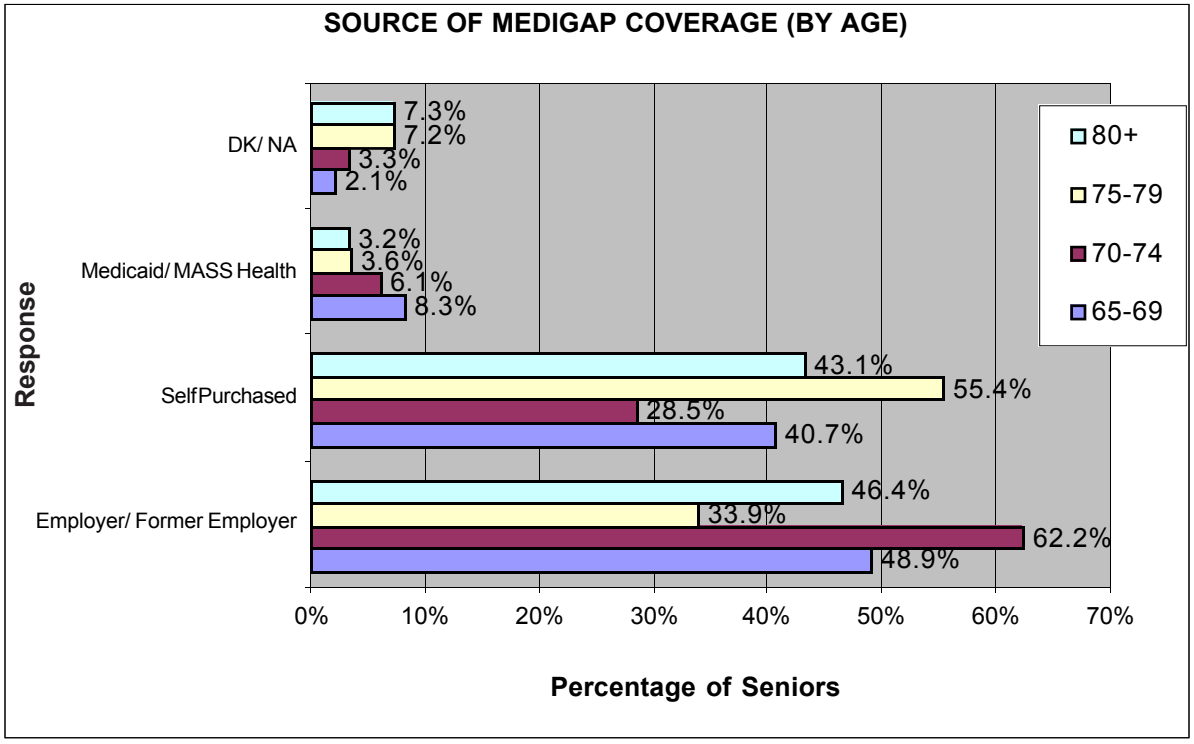

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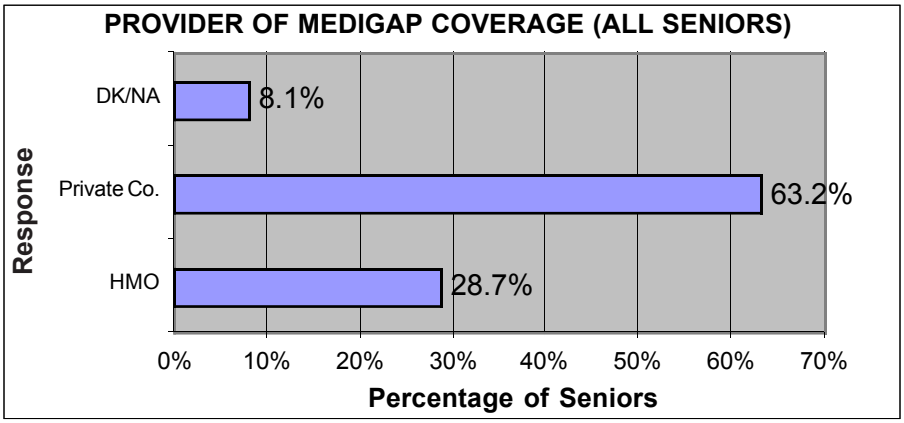

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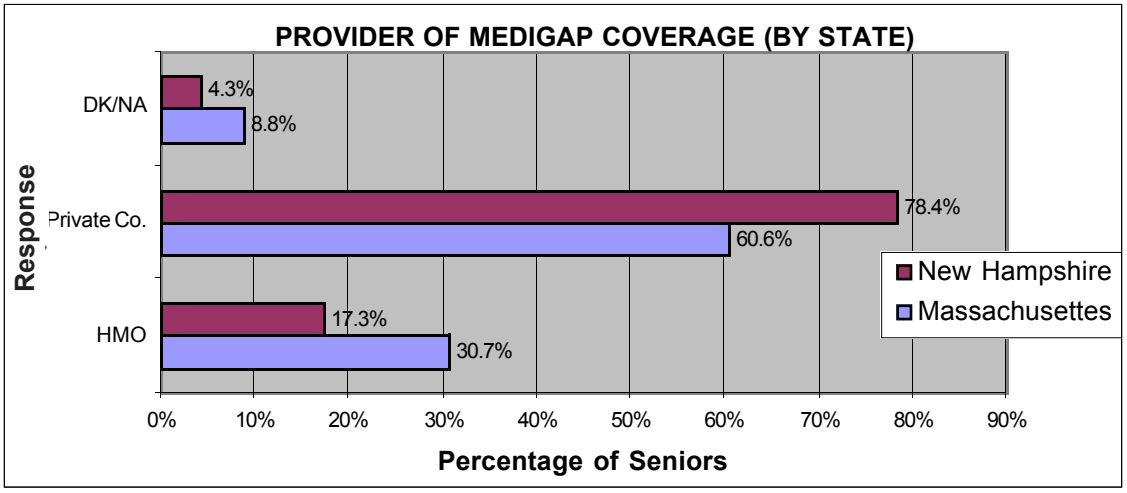

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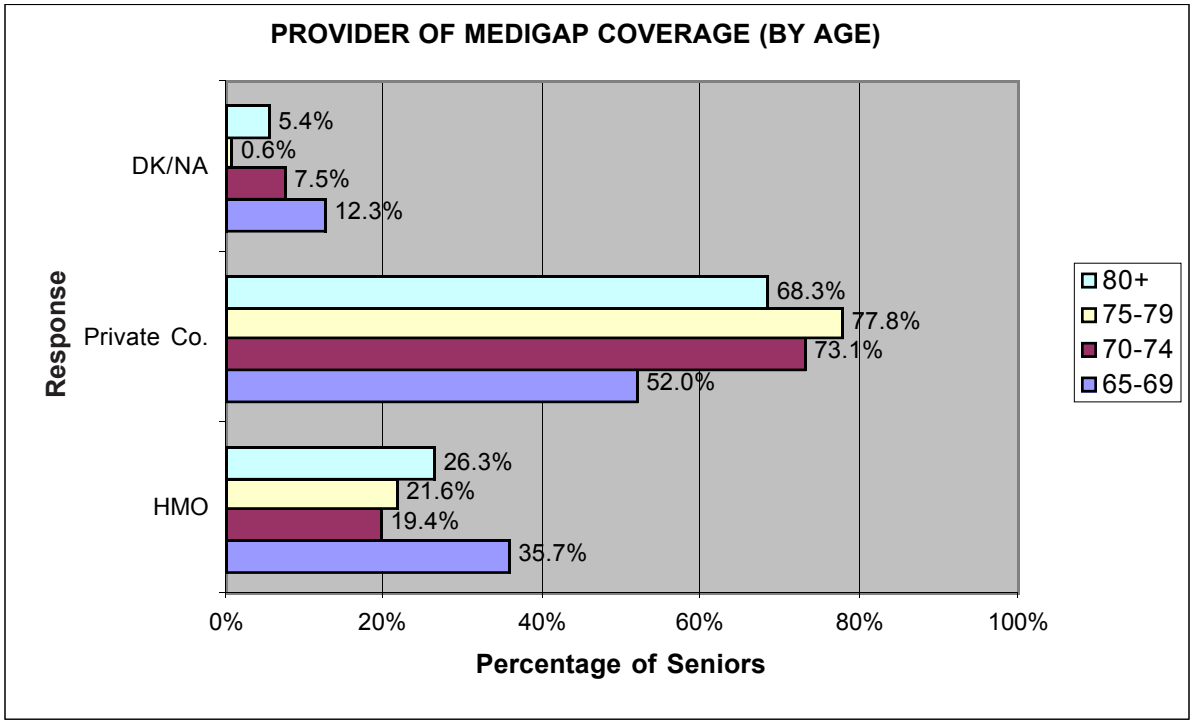


Table 11A

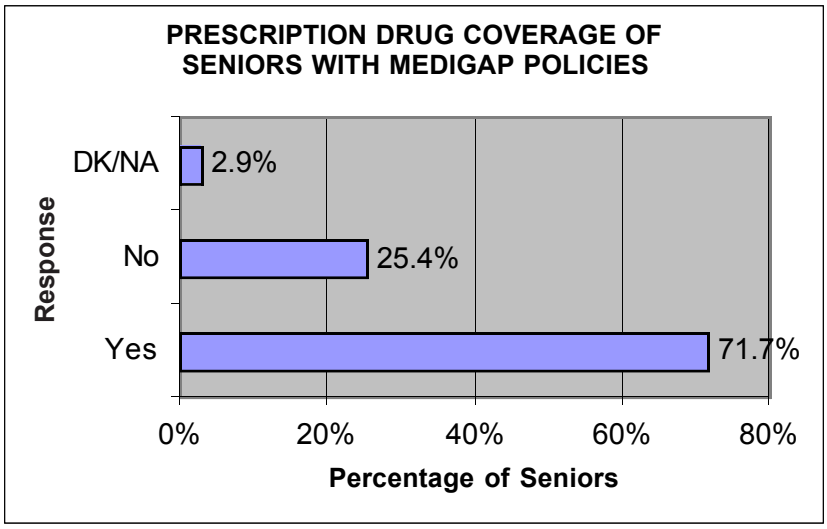


Table 12A

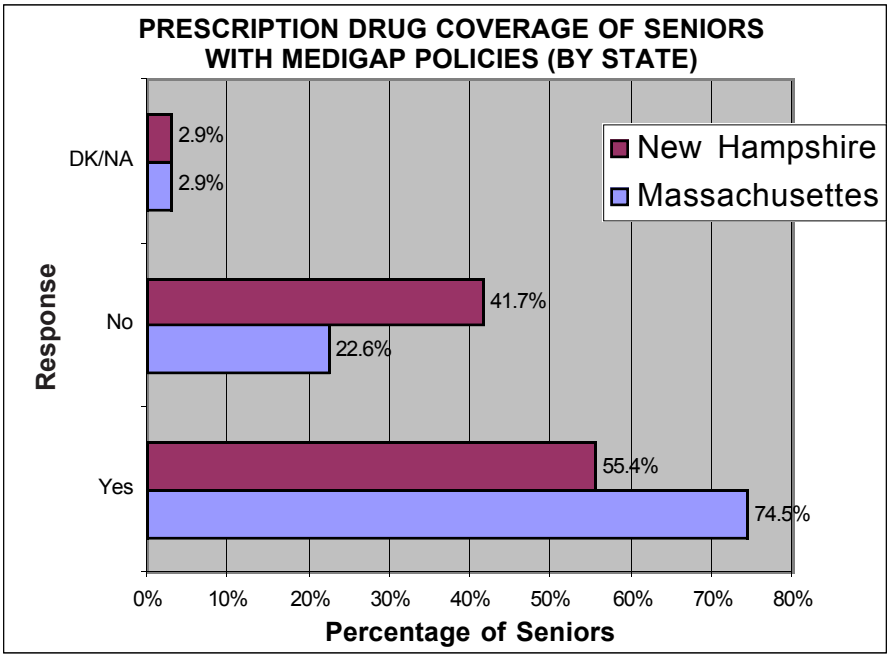


Table 13A

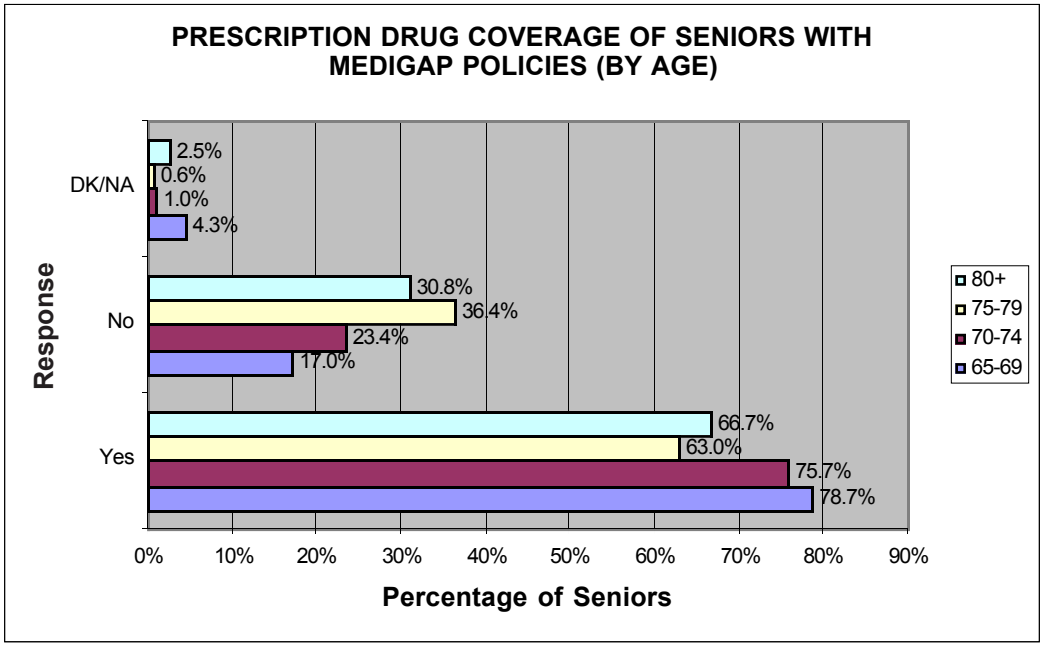


Table 14A

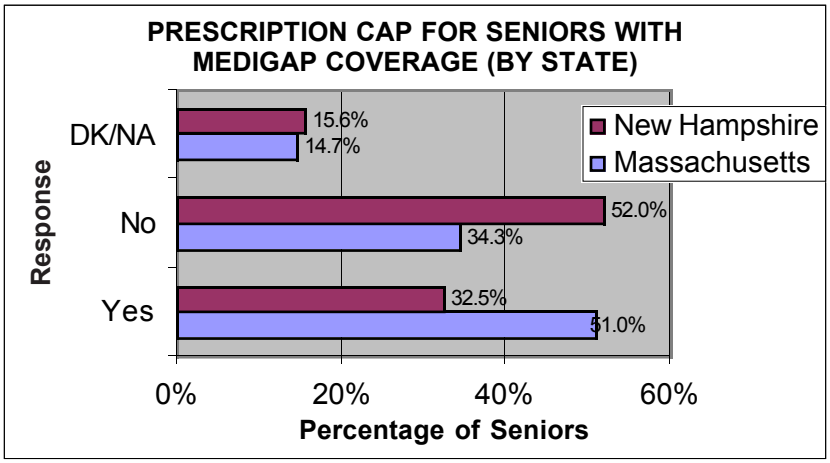


Table 15A

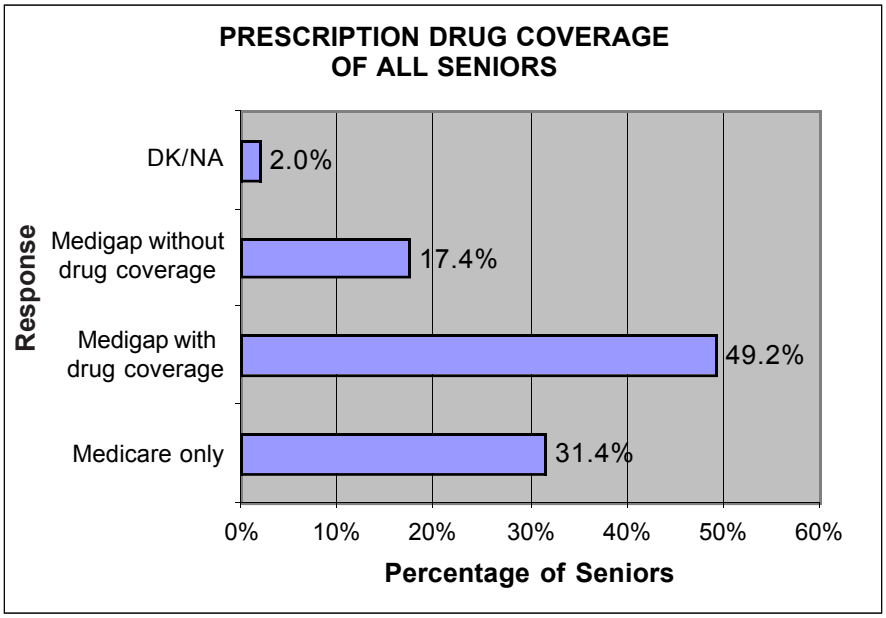


Table 16A

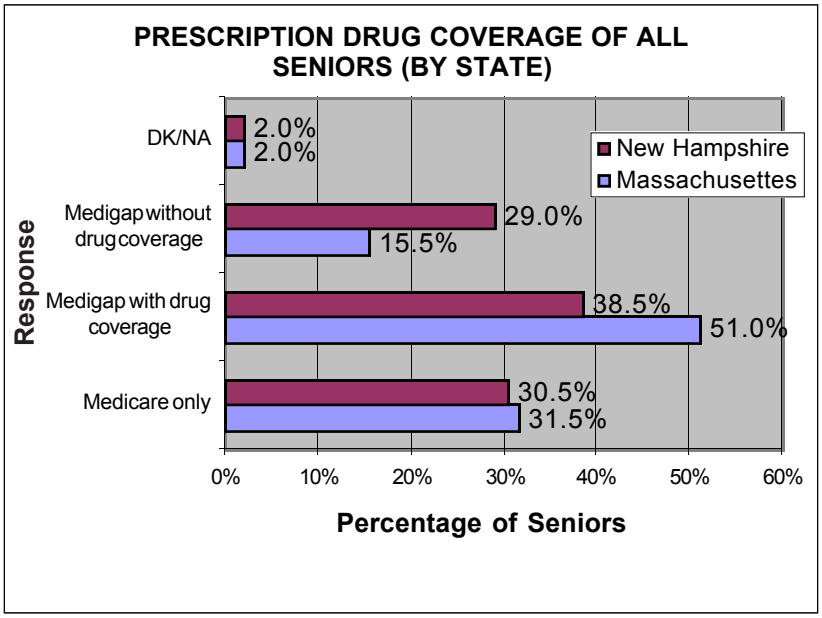


Table 17A

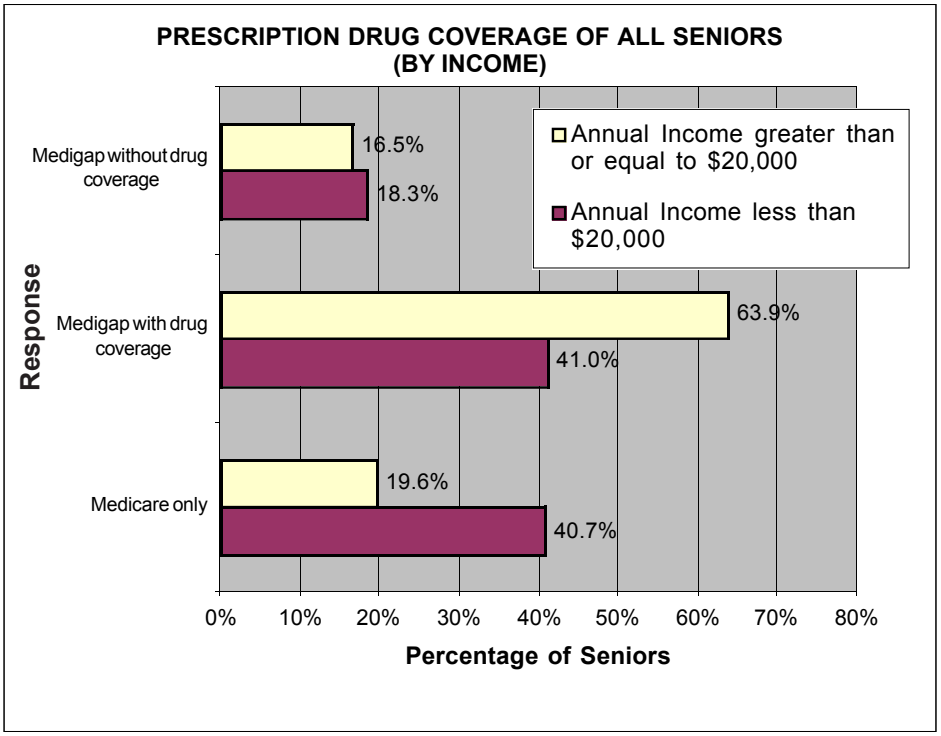


Table 18A

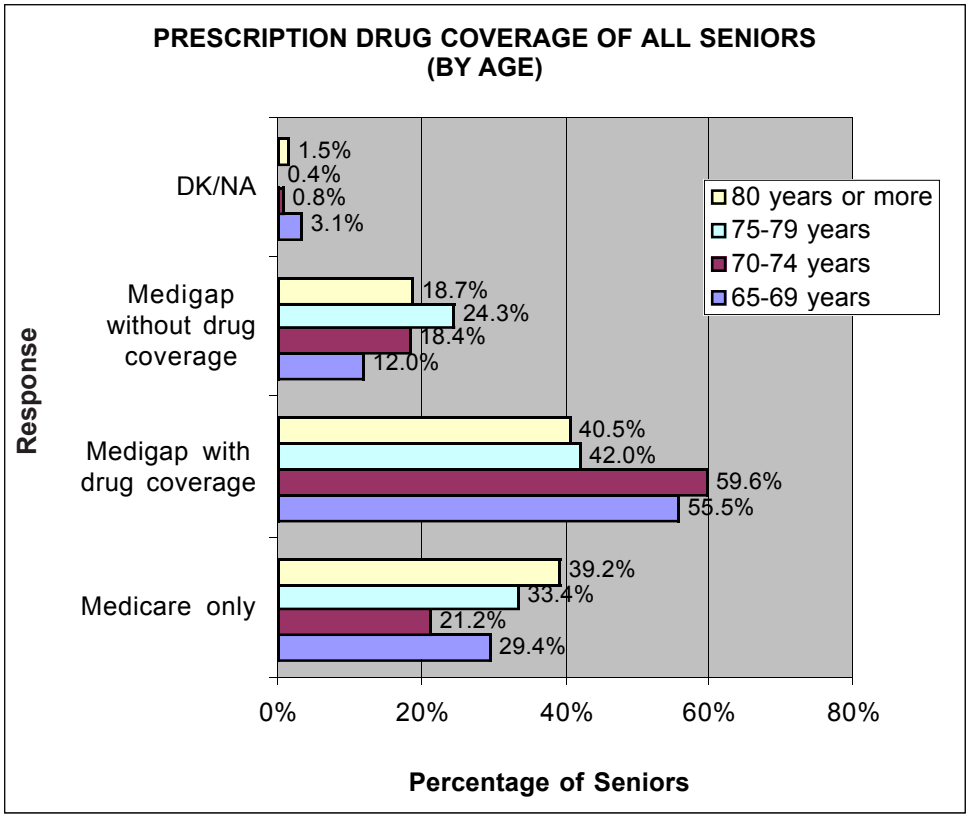


Table 19A

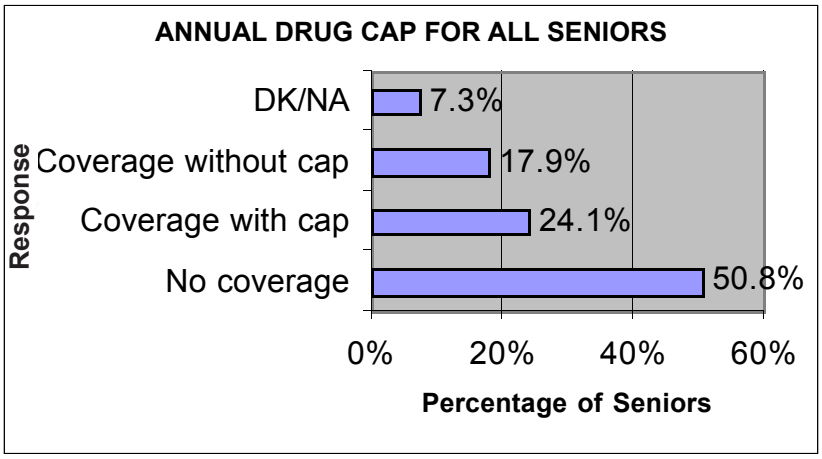


Table 20A

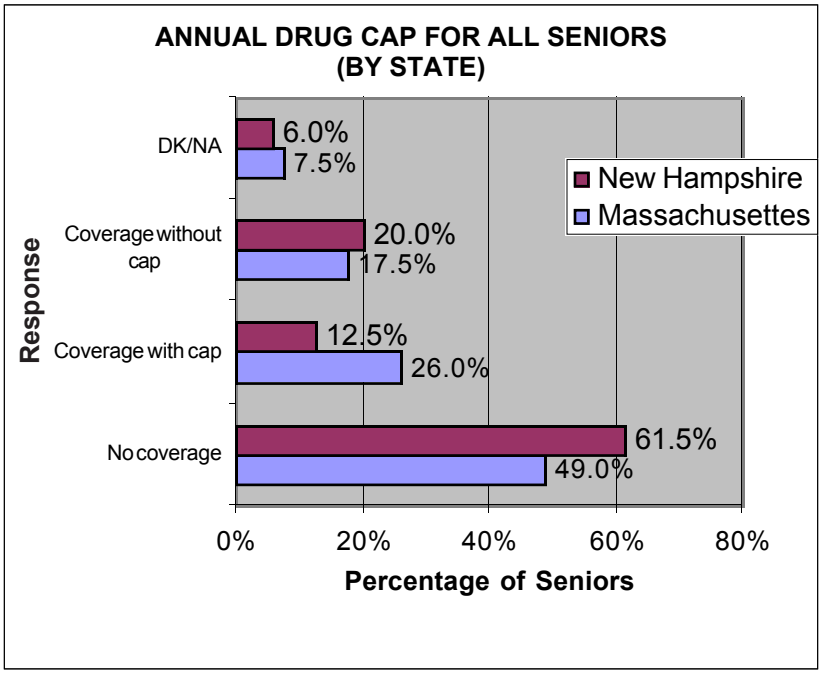


Table 21A

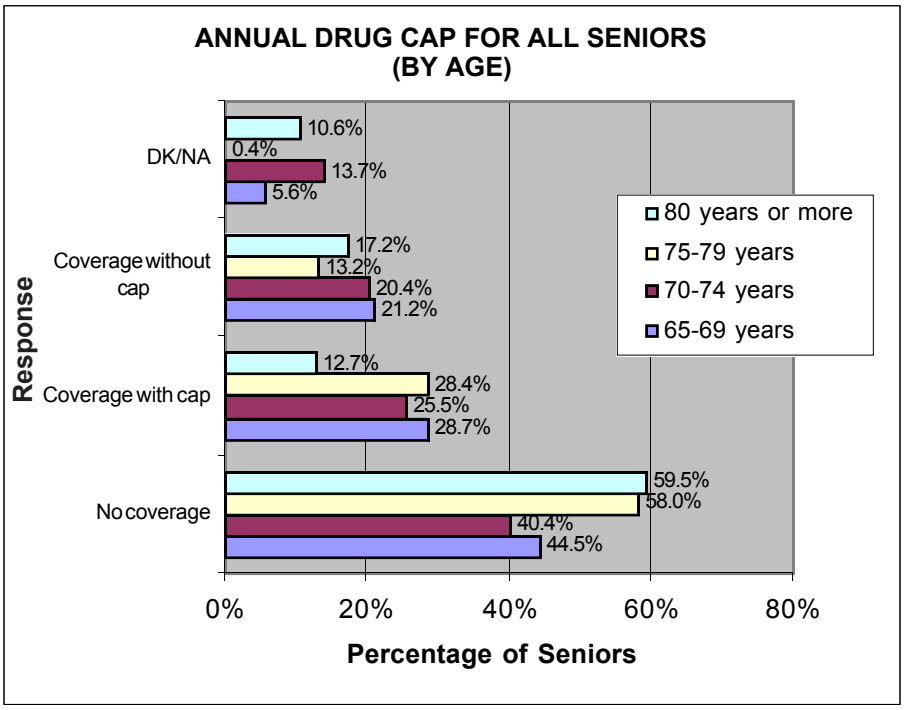


Table 22A

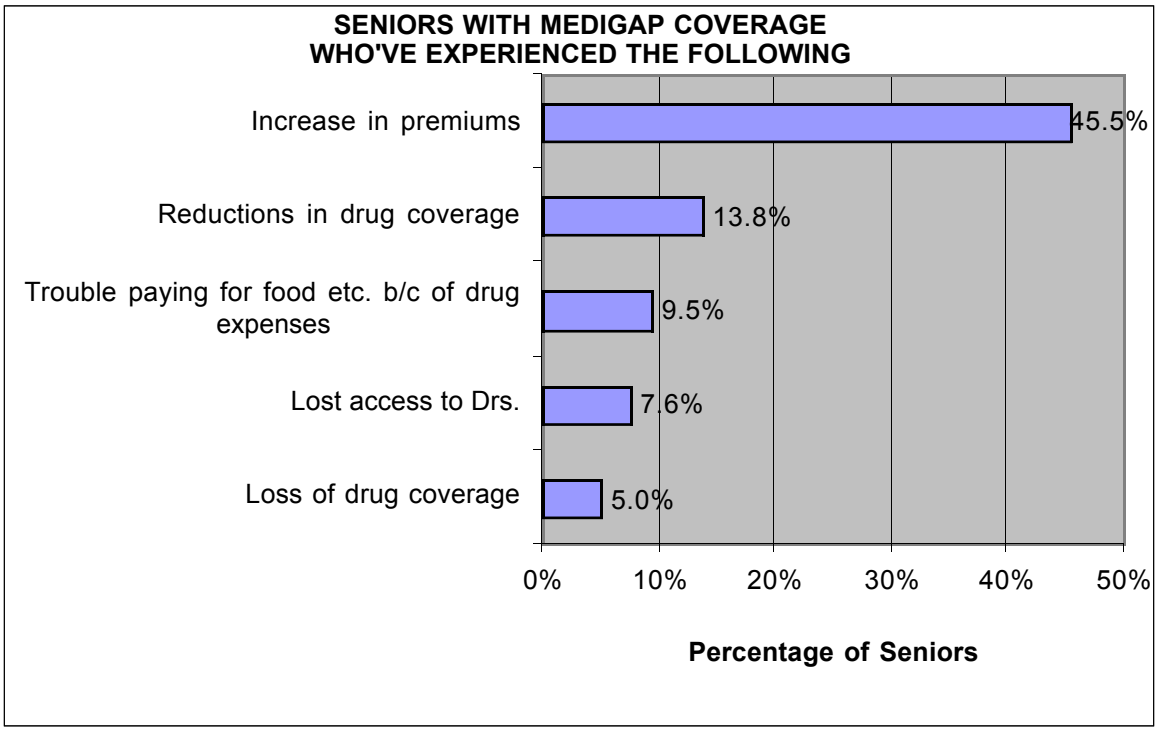


Table 23A

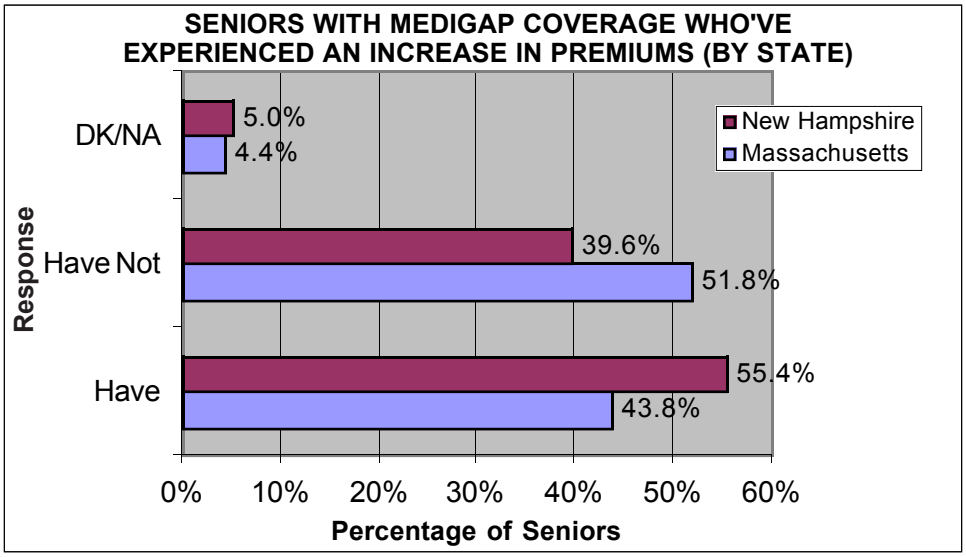


Table 24A

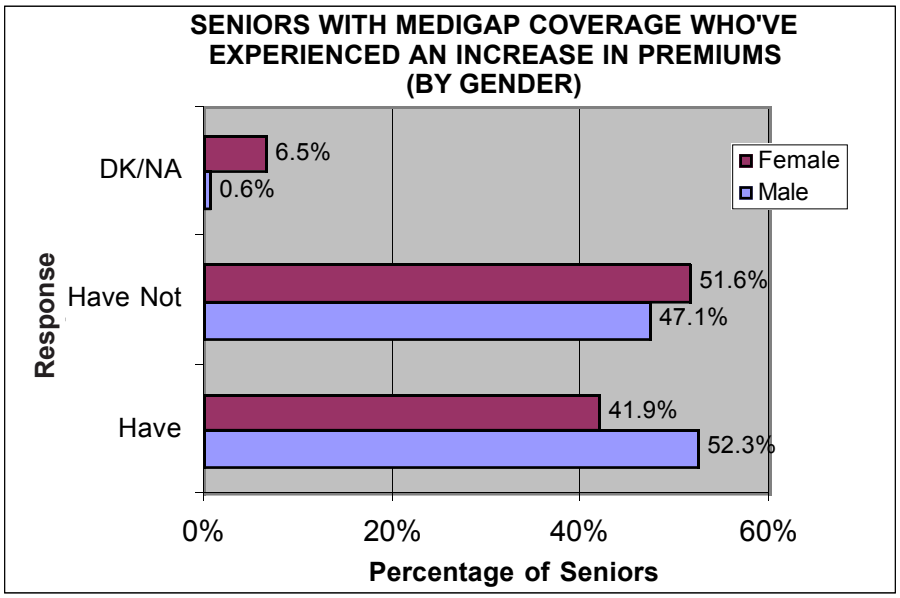
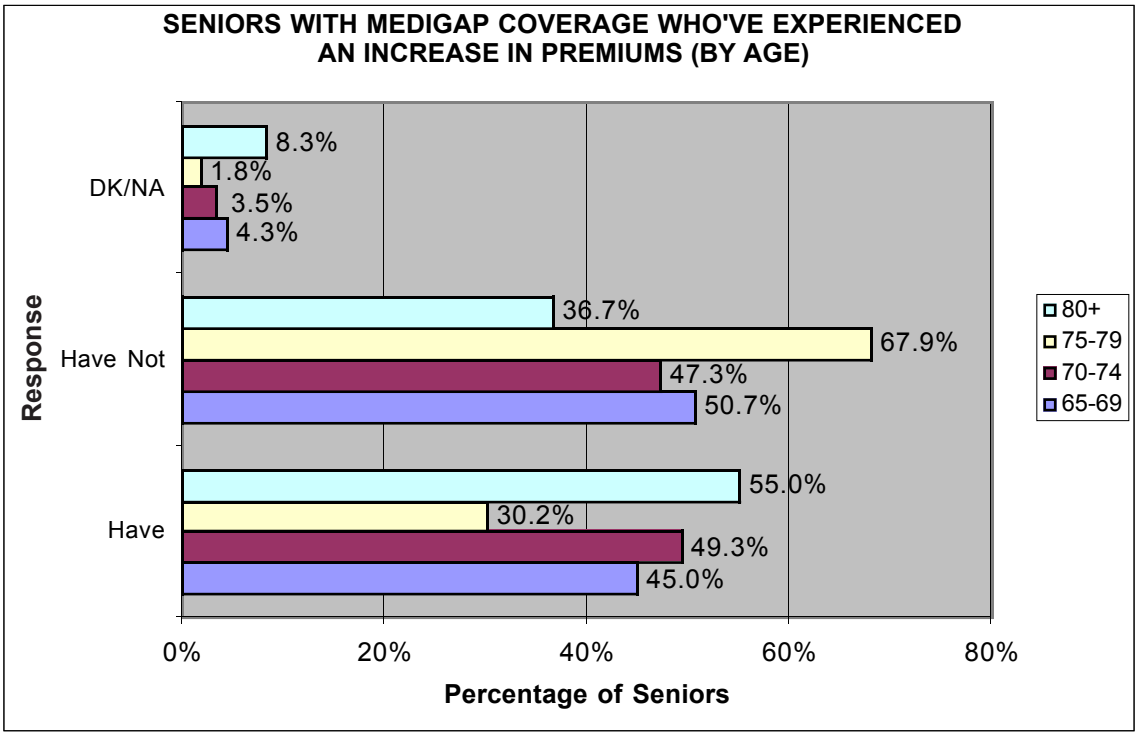


Table 25A


SENIORS WITH MEDIGAP COVERAGE WHO'VE EXPERIENCED AN INCREASE IN PREMIUMS (BY AGE)
Response
DK/NA
Have Not
Have
8.3%
1.8%
3.5%
4.3%
36.7%
67.9%
47.3%
50.7%
55.0%
30.2%
49.3%
45.0%
0%
20%
40%
60%
80%
Percentage of Seniors
80+
75-79
70-74
65-69