

Health Care Delivery

Medigap: Are We Cheating the Nation's Elderly?

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You should know your Medicare benefits as well as you know how much money you have in the bank.¹ This comment, made in 1969, typifies the nation's wishful thinking in the early stages of the Medicare program. Unfortunately, it has become clear today that having a thorough knowledge of Medicare benefits is virtually impossible, and that for the elderly to uncover the complexities of the program approaches an exercise in futility.

Since 1965 Medicare has been providing the elderly with some form of assistance in dealing with rising health care costs. Medicare, however, was never designed as a comprehensive program. Instead, it was meant to provide payments primarily for acute, short-term illnesses. As a result, the benefit structure of Medicare is inconsistent and often confusing to the elderly. There exist many gaps in Medicare coverage. This fact has understandably led many older persons to purchase private health insurance for protection in filling these gaps so that the health care needs not funded by Medicare will be covered by some other source. Problems in representation of these Medicare supplement health insurance policies, called Medigap policies, are the main focus of this paper. The Medigap problem involves a segment of the insurance industry which may have exploited the needs and anxieties of the elderly. More than 70% of the nation's Medicare recipients have some form of supplemental insurance, yet it seems that in many instances the elderly may be wasting their money on unnecessary, superfluous private coverage.¹

As costs for medical care continue to rise sharply, Medicare pays less and less of the total bill. Those over 65 pay much more out of pocket for the medical care today than they did in 1965 when Medicare began. In 1969 Medicare paid for 50% of the total national bill for senior citizens, while by 1980 the total dwindled to 38%.² There has been a corresponding increase in the number of seniors who buy private insurance. The United States House of Representatives, at the 95th Congress, concluded that about a fourth of the elderly

buy more than one Medigap policy, while some have as many as 30 different policies, most supplying overlapping benefits.³ They buy out of fear that the cost of an illness will deplete their low incomes and limited assets.³

The seniors are often not in the best position to find the most sensible policy to buy among Medigap policies. It is difficult for any consumer, much less a senior citizen, to determine the worth of the product by reading an insurance policy.⁴ Both the structure and wording of such drafts are often unclear to an untrained, timid customer, and it is often an effective sales pitch, rather than the facts of the policy, that convinces an older customer to buy. A second factor rests in the psyche of the purchasers. For the most part, when seniors buy an insurance policy it is a "reflex action."³ Rarely will an elderly person take the time to comparison shop. Because they are motivated by fear and intimidated by the high costs of medical care, they stock up on Medigap policies as if they believe the more they have, the better their health will be and the less they will have to worry. Sadly, the distorted logic "if one is good then two must be better" has led to a tremendous waste of money for older Americans, contributing to the Medigap crisis.

Yet it is the structure and function of Medicare that are partially responsible for there being a Medigap problem in the first place, and with this in mind it becomes clear that any explanation of Medigap abuses must start with a look at Medicare. The federal insurance program consists of two parts. Part A, the hospital insurance component, helps pay for inpatient hospital care. It also covers a limited amount of posthospital convalescence in a skilled nursing facility (SNF) certified by the Medicare program, for some home health care and since 1973 for victims of end-stage renal disease. Of the eligible elderly population 98% are covered by Part A.⁴ Part B, supplementary medical insurance, includes physician and ancillary services and assorted nonhospital services. Part B is voluntary, and

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participation requires payment of a small monthly fee. There are 97% covered by both parts of Medicare.⁴

At present Medicare suffers from a weak financial structure which has been slowly toppling in the past few years. As Senator Robert Dole of Kansas has recently said, "The Medicare trust fund is sure to go broke within a short period of time if we don't take appropriate action."⁵ By 1975, ten years after Medicare was instituted, the average cost for treating the elderly rose nearly 300%.² Today that figure is much higher. Furthermore, the proportion of the American elderly population is growing as a result of two factors: declining fertility and increasing life spans.⁵ With an increasing number of seniors living longer, there exists an increasing demand for federal assistance, leading to a rapid depletion in Medicare funds. This depletion of funds coincides with Administration proposals to lessen the role of the federal government with regard to social welfare programs. For example, Medicare would absorb 64.2% of the fiscal 1983 budget cuts coming from the \$3.9 billion used to benefit the nation's elderly.⁵

All this bad news involving the collapsing financial structure of Medicare has led many to speculate that Medicare has become a broken promise to the elderly. The House of Representatives in November 1980 released a report by the Select Committee on Aging concerning the "shortcomings of the Medicare program."⁶ The analysis concluded that Medicare "is a highly successful Government program which is currently undergoing severe stress."⁶ This stress can most readily be seen in three areas, illustrating very clearly that Medicare has not lived up to its original expectations. The first area involves increasing copayments, or the growing deductibles the elderly must pay in order to receive aid. As shown in Table 1, the costs have escalated astronomically. It is a common myth that Medicare pays for a flat 80% of the elderly's physician's bill after they have satisfied the deductible fee, currently \$260. The truth of the matter, however, is best stated by a senior citizen from Oakland, California, in a letter to the *New York Times* appearing October 19, 1982:

As we over-65'ers have found to our sorrow, Medicare rarely accepts what doctors charge as the basis for calculating the 80

percent . . . Having had considerable experience with these rules, my wife and I have found that we average between 40 and 50 percent Medicare reimbursement of actual physician's fees.

A second area of concern is the trend of fewer doctors accepting assignment of full payment from Medicare for their services. By accepting assignment, a doctor commits himself to accept whatever payment Medicare deems "reasonable."⁷ Understandably, physicians do not like to be paid through such uncertain, arbitrary means, and hence the burden rests on the patient who must pay the doctor in full and then hope for adequate reimbursement directly from Medicare.

A third factor causing problems for the elderly concerns just what services are covered by Medicare. The program is designed to cover serious health problems, but it fails to cover a great deal of comparatively minor needs that stack up for the typical senior, including drugs prescribed for outpatients, dental care, eyeglasses and eye examinations, hearing aids and examinations, preventive services such as routine physical examinations and long-term institutional needs.⁷ It can thus be seen that a program intended to aid the elderly with the high cost of health care denies reimbursement for those services this group demands most.

Although the future of Medicare is uncertain at best, a variety of possible solutions to the many problems mentioned above have been proposed during the past few years. One of the more popular alternatives would not only bolster Medicare, but would also solve the Medigap abuses in one giant swoop: the addition of a Part C to the original draft.⁸ Claude Pepper, Chairman of the Select Committee on Aging, describes Part C:

It would be voluntary like Part B and funded by a premium equal to Part B. Additional revenues would be carried by a small excise tax on cigarettes and alcohol. Congress could, in effect, authorize a comprehensive Medicare supplemental health insurance policy which would cover eyeglasses, dental care, hearing aids and out-of-hospital prescription drugs. The measure would essentially be self-financing.⁸

Quite simply, Part C would eliminate the need for Medigap policies, and the abuses which exist today would end. The elderly would no longer have to fill the gaps on their own; instead, centralization under

TABLE 1.—Medicare Premium Costs, Deductibles and Coinsurance Rates (1966, 1981 and 1982)

| Cost Sharing Requirement | 1966 | 1981 | 1982 |
|---|-------------|--------------|--------------|
| Hospital insurance deductible (Part A) | \$40.00 | \$204.00 | \$260.00 |
| Monthly premium (Part A)* | NA | \$ 89.00 | \$113.00 |
| Hospital co-insurance 61st-90th day | \$10.00/day | \$ 51.00/day | \$ 65.00/day |
| Co-insurance (60 "lifetime" reserve days) | \$20.00/day | \$102.00/day | \$130.00/day |
| Co-insurance (21st-100th day, SNF care) | \$ 5.00/day | \$ 25.50/day | \$ 32.50/day |
| Medical insurance premium (Part B) | \$ 3.00/mo† | \$ 11.00/mo† | \$ 12.20/mo† |
| Medical insurance deductible (Part B) | NA | \$ 60.00 | \$ 75.00‡ |

SNF=skilled nursing facility

*For those 65 or older who are eligible for Social Security benefits.

†Effective July 1 of calendar year.

‡First increase since 1973.

Adapted from Merritt and Potemken.⁹

the federal government would provide every American with uniform benefits.

The Reagan administration is thinking along different lines. Government analysts claim that runaway costs will not be checked until patients who can afford to are instructed to pay a bigger share. This concept, called a means test, would link benefits to income and wealth, with most Americans contributing some part of the first few thousand dollars of their medical bills. In September 1982 the Senate, however, voted 70 to 29 to reject any means test in Medicare.

Another option would "set fixed payment rates for 467 diagnostic categories, ranging from hemorrhoids to heart attacks" (*The Wall Street Journal*, November 17, 1982, p 1). Yet studies of the hospitals in New Jersey which have had such a program since 1981 show that only one in 26 said fixed rates have truly lowered costs (*The Wall Street Journal*, November 17, 1982, p 1). Essentially, these "diagnosis related groups," or DRGs, create an incentive for hospitals to hold down costs, but the quality of care has been questioned (J. Iglehart, lecture, Brown University November 18, 1982). Based on the many problems faced in New Jersey with DRGs, this alternative seems an unlikely one.

Despite these potential cures for Medicare's ailments, however, the fact still remains that because little is being done at present, the need for Medigap coverage increases daily. Until some other plan can be enacted, the elderly can buy into three kinds of Medigap policies: the exclusive Medicare supplement, the indemnity and the limited or dread disease policy.⁹

Medicare supplement policies are forms of "wrap-around coverage," designed to pay for some of Medicare's deductible and coinsurance requirements and assorted payments not otherwise covered. None of these policies cover physician charges above the rates allowed by Medicare, or services such as routine check-ups and custodial care.

Indemnity policies pay a fixed amount for each day in hospital. Yet these benefits are not structured to reflect the actual charges for an inpatient stay in a hospital. With the average cost of a day of hospital care at \$266 in 1981,⁹ the usual indemnity benefit of \$20 to \$50 a day fails to provide any true protection for a patient. Moreover, considering that in 1979 the average hospital stay for those over 65 was 11.5 days, the amount of aid given by an indemnity policy is quite limited.³

Perhaps the most shockingly unfair form of Medigap coverage is the limited or dread disease policy. Cancer insurance is the most prevalent kind of limited policy. The main reason these policies are unjust rests in the fact that most benefits are geared toward hospital admission (thus technically making them a subset of the indemnity policy). In selling their limited policies, agents promise their company will pay \$60 per day for the first 12 days the patient is confined in a hospital with cancer, and \$40 per day thereafter. This seems

attractive to the consumer because there is no limit to the number of confinements, and for each new admission to the hospital the policy starts again by paying \$60 per day. What is not mentioned is that the average stay in a hospital is only about seven days and the average patient with cancer is only admitted to hospital 1.8 times in a two-year period.³ Unfortunately, the rate of return to limited policyholders is so low that only one in six people in whom cancer actually develops ever break even on the money paid in premiums. Two states, Connecticut and New Jersey, have already prohibited the sale of these policies because of their questionable worth.

The elderly's plight is worsened when Medigap policies have a preexisting clause, or a clause that limits or excludes payment for conditions existing at the time of purchase.⁹ Because many elderly persons have long-term illnesses (and recall that Medicare coverage is not equipped for long-term payment), this clause can void much of their insurance protection. Moreover, it is common practice for the elderly to buy new coverage and discontinue what they have, simply because they are rarely satisfied with what is paid for when a policy is put to the test. In purchasing new policies, many seniors are left totally uninsured because one preexisting clause or another is always in effect. In essence, they may give up on a poor policy and spend their money on one that is worthless.

In an effort to better inform Medicare recipients about the pitfalls of Medigap policies, several voluntary and government-sponsored measures have arisen. The National Association of Insurance Commissioners in 1979, for example, enforced the drafting of model state regulations governing Medicare supplements. The Health Care Financing Administration (HCFA) conducts a nationwide training program for volunteers to assist Medicare beneficiaries wishing help in considering the purchase of Medigap coverage. By late 1981 HCFA had prepared more than 13,000 persons in each state to serve the elderly in this manner.⁹ HCFA's Office of Public Affairs is also preparing a public service campaign to acquaint beneficiaries of Medicare with state regulatory programs regarding Medigap policies. This campaign has thus far been very successful in reaching out to the nation's seniors, providing them with important information about supplemental insurance. In addition, HCFA created a Medigap Operations Staff (MOS) which maintains contact with private insurance companies and keeps them aware of progressing developments of laws and regulations and how they will affect the companies' modes of operation.

Of more significance, however, is the adoption in 1980 by the United States Congress of the Baucus Amendment creating a Voluntary Certification Program (VCP) for Medigap policies. The law requires the Health Care Financing Administration to set up the federal VCP and provide technical and administrative support to the Supplemental Health Insurance Panel (SHIP). Also, the program studies what regula-

tory measures states have taken toward Medigap policies and provides information to Medicare beneficiaries concerning the purchase of private health insurance.⁹

Criteria for certification include a statement guaranteeing that the specified policy will cover a major portion of Medicare Part A and Part B coinsurance charges. Second, there is a guarantee that the policy "will pay what it says it will pay."⁹ Third, certification is a statement that the policy does not contain preexisting clauses of more than six months. Fourth, it ensures that the policy is supplied with a detailed disclosure statement of all coverage, costs and limits, thus making it a bit simpler for the buyer to evaluate policy worth and comparison shop. Lastly, with certification the purchaser can return the policy with full premium refund within ten days of sale. Therefore it appears that certification confronts many of the biggest problems facing the nation's seniors when they search for Medigap coverage.

While VCP has several fine attributes, it also has its shortcomings. It fails to make supplemental policies more affordable and it does not remedy marketing abuses.

In addition to the federal programs, the states have passed at least some token legislation involving Medigap abuses which at first glance looks impressive. Upon closer study, however, it becomes clearer that the states simply cannot devote the time, energy and funds needed to truly enforce their goals of licensing all agents and prohibiting sales methods that "misrepresent the benefits, advantages, conditions, or terms of an insurance policy."⁹ Beyond the problem of a proper means of enforcement, the abuses continue because older victims of dishonest agents are usually poor witnesses in criminal enforcement proceedings.

The future of the Medigap program rests mostly on whatever impact the Voluntary Certification Program makes on the health care community. Ideally, the future may bring much better informed Medicare consumers, having an increased awareness of supplemental insurance plans. It is hoped that certification will make it easier for buyers to identify good policies and make wiser choices regarding their purchases. Most analysts

hope the Voluntary Certification Program has a short, but effective, future. When all states have complied by enacting a uniform set of programs, then involvement of the federal program will no longer be needed. As it stands today, many states interpret the Voluntary Certification Program as federal interference and an assault on their autonomy. Yet it is generally accepted that the program will be necessary until all 50 states enforce equivalent laws that protect the nation's senior citizens. The coming months will present an extreme test for the Reagan administration as well. No one can evaluate at this stage if the Voluntary Certification Program will be successful. There are many groups in favor of ending government's role in medical issues, while others favor expansion. Whichever view prevails, it appears from the numerous problems of Medigap policies dealt with in this paper that the situation will not simply remedy itself.

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