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DataWatch

Evaluating The New Medigap Standardization Regulations
by Thomas Rice and Kathleen Thomas

The Omnibus Budget Reconciliation Act (OBRA) of 1990 included a number of provisions that will have a profound impact on the Medicare supplemental insurance ("Medigap") market. Most notably, OBRA 1990 required that all policies include benefits that conform exactly to one of up to ten prototypes that were subsequently developed by the National Association of Insurance Commissioners (NAIC). This is in sharp contrast to previous federal regulations, which established only minimum benefit levels and which were voluntary rather than mandatory.

In this DataWatch, we describe these new requirements and analyze them in the context of three research questions. First, we examine the types of policy benefits that were being offered to and purchased by consumers before OBRA 1990. Second, we explore how Medigap policies are likely to change as a result of the legislation. Finally, we evaluate the extent to which the ten NAIC policy prototypes are consistent with the statutory requirements established by Congress.

Regulation Of The Medigap Market

Medigap policies. Although Medicare benefits are substantial, gaps remain in coverage for medical care expenses. Most notably, patients are required to pay a $628 deductible (in 1991) on hospital stays; sizable daily copayments ($157–$314) for hospital stays in excess of sixty days; a $100 annual deductible on physician charges; and 20 percent coinsurance on additional physician charges that are deemed “reasonable” by the program. Furthermore, several expenses are not covered by Medicare. The most important of these are prescription drugs, physician charges in excess of the amount Medicare defines as reasonable, hospital stays over 150 days, and most long-term care services.

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Soon after Medicare’s enactment, commercial insurers and Blue Cross and Blue Shield (BC/BS) plans began to sell insurance policies specifically designed to fill some of these gaps (Medigap policies). Approximately 70 percent of elderly Medicare beneficiaries own such policies.\(^1\) Policies typically range in price from a few hundred dollars to more than a thousand dollars annually. In 1989, the mean annual premium was $718.\(^2\) The total size of the market was estimated to be on the order of $13 billion in 1986 and is now approaching the $20 billion level.\(^3\)

**Federal requirements.** Like other types of insurance, the Medigap market originally was regulated almost entirely at the state level. However, as a result of congressional hearings in the late 1970s that documented a number of sales abuses, federal legislation was enacted in 1980.\(^4\) This legislation (P.L. 96-265, Sec. 507) is known as the Baucus Amendment, after its sponsor, Sen. Max Baucus (D-MT). Among other things, it established minimum requirements for a policy to be certified as meeting federal standards. Although the standards were deemed voluntary in the legislation, almost all state insurance departments eventually adopted them.\(^5\)

A variety of regulatory changes in the Medigap market occurred throughout the 1980s, primarily through updates made by the NAIC in its model regulations. What seems to have prompted the inclusion of such major changes in Medigap regulations as part of OBRA 1990 was the renewed interest in the Medigap market generated by the repeal of the Medicare Catastrophic Coverage Act.\(^6\) The repeal of the act, which would have extended Medicare coverage in a number of ways, made it clear to the industry and consumers alike that Medigap policies would remain a central feature of the health insurance market for many years to come.\(^7\) This, in turn, spurred consumer groups and legislators to call for further regulation of this segment of the market.

Features of OBRA 1990 that directly affect the Medigap market include raising loss-ratio requirements, preventing the sale of duplicative policies, establishing a six-month open enrollment period for policy purchase when a person turns age sixty-five, allowing Medicare beneficiaries in fifteen states to enroll in a preferred provider organization (PPO) option, and funding state consumer-counseling programs. The most dramatic change, however, is the way in which the benefits are to be regulated through the policy standardization requirements.

Under OBRA 1990, insurers will have to offer policies that conform to one of up to ten specific prototypes. The first prototype—which must be offered—includes only a “core group of basic benefits.”\(^8\) Companies have the option of offering any or all of the remaining prototypes. Furthermore, individual states can limit to fewer than ten the number of prototypes sold. The legislation further stipulated that the prototypes
arrived at must:

provide for benefits that offer consumers the ability to purchase the benefits that are currently available in the market and balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

Congress gave the NAIC nine months to draw up the specifications for the policy prototypes; had it not accomplished this task within the allotted time, the Health Care Financing Administration (HCFA) would have been given this responsibility. The standards were approved by the NAIC on 30 July 1991. States have one year to implement them.10

The development of a draft of the standardization requirements was given to two committees: the NAIC task force that dealt with Medigap issues and a newly established, ad hoc advisory committee. This NAIC-appointed committee comprised an equal number of consumer and insurance industry representatives. Each group worked separately to develop a set of standardized packages and ultimately arrived at somewhat different configurations. A compromise was then reached in time to meet the deadline established by Congress.

One of the first decisions that had to be made by these committees was the overall method by which to construct the standardized packages. There were two choices: a “prepackaged” approach and a “rider” approach. Under the former, which was ultimately adopted, the committee would construct up to ten unique benefit packages. Under the latter, there would be a core package of benefits, and consumers would choose whether or not to purchase any of several additional benefits, or riders.

There were two problems with the latter approach. The first one was pragmatic; Congress specified that there could be a maximum of ten benefit packages. This would allow consumers to choose only three riders.11 With the prepackaged approach, different combinations of ten optional benefits were eventually included. The second problem with a rider approach was the potential for adverse selection. In the case of a prescription drug rider, only those people who expected to be heavy prescription drug users might opt to purchase that benefit.

Exhibit 1 shows the ten policy prototypes, A–J, mentioned above. The core benefits, which are included in all of the prototypes, are essentially the same as required under the Baucus Amendment (states may limit the number of packages available). Benefits include coverage of Part A hospital daily copayments for stays lasting between 61 and 150 days; coverage for hospital stays lasting an additional 365 days; coverage for the 20 percent Part B coinsurance on allowable physician charges; and coverage for the costs of the first three pints of blood received each
Exhibit 1
Benefits Covered In The Ten Medigap Policy Prototypes Under OBRA 1990

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\(^a\) Core benefits include coverage of all Part A (hospital) coinsurance for stays over sixty days, the 20 percent Part B coinsurance, and the Parts A and B blood deductible.

\(^b\) SNF is skilled nursing facility.

\(^c\) Low excess charge coverage pays 80 percent of the difference between the physician’s charge and the Medicare-allowable rate; high coverage pays 100 percent of the difference.

\(^d\) Low prescription drug coverage has a $250 annual deductible, 50 percent coinsurance, and a maximum annual benefit of $1,250; high coverage is similar except that it has a $3,000 maximum annual benefit.

Coverage for the following expenses is included in some or all of the other nine policy prototypes: (1) the $628 Part A hospital deductible; (2) the $78.50 Part A skilled nursing facility daily copayment; (3) the $100 Part B deductible; (4) medical emergencies while traveling outside the United States; (5) either 80 percent or 100 percent of nonassigned physician charges, up to any limitations established by the Medicare program or state law; (6) 50 percent of prescription drug costs, subject to a $250 annual deductible and a maximum annual benefit of either $1,250 or $3,000; (7) preventive services; (8) and at-home recovery services.

Coverage for preventive and at-home recovery visits is essentially new; at the time the legislation passed, almost no Medigap policies provided these benefits. The preventive medical benefit is limited to $120 per year. Within this limit, the benefit can cover an annual preventive physician visit and any of several tests or preventive services.

The at-home recovery benefit is designed to supplement Medicare-covered home health visits. Recovery benefit visits, which are designed to aid the patient in performing activities of daily living, can be carried out by home health aides, homemakers, personal care aides, or nurses. Coverage is limited to $40 per visit and forty visits per year; however, the number of visits cannot exceed the total number of Medicare-approved home health care visits during a home care treatment plan.

Both of these benefits were favored by the consumer representatives on the advisory committee, although industry concerns were responsi-
ble, in part, for limitations of the total dollars that would be covered. Consumers were interested in a preventive service benefit, to encourage the elderly to seek treatment earlier. The home care benefit, on the other hand, was designed to provide services beyond those contained in the Medicare home health care benefit. Consumer representatives favored the home care benefit as a way of encouraging home care.

Additional benefits that are deemed innovative by an insurance commissioner can also be sold in a state. This was included to help ensure that benefit design innovations were not stifled by the requirements.

**Data And Methods**

To obtain the most accurate picture of what types of benefits were included in Medigap policies when OBRA 1990 was approved, we attempted to collect information from the largest commercial insurance companies and BC/BS plans. For commercial companies, we used data from a Health Insurance Association of America (HIAA)-sponsored survey of some of the largest firms in the Medigap market, which obtained data from thirteen of the twenty largest companies in the market. To supplement this information, we collected similar information on the ten BC/BS plans with the largest Medigap market shares. We obtained this information not from the plans themselves but from each of ten state insurance departments. Thus, these data represent policies sold by twenty-three of the largest insurers in the Medigap market.

For each company, we sought to obtain copies of each Medigap policy (including riders) currently being sold and the number of purchasers for each policy. In a few cases, however, we only obtained the total number of purchasers for all policies, with no breakdown by policy type. In such cases, when examining the frequency with which consumers purchase particular benefits, we provide ranges rather than point estimates.

The twenty-three companies sold a total of eighty-three different Medigap policies. These policies had a total of 6.3 million purchasers—the majority of the ten million elderly who have purchased individual coverage (that is, who do not receive coverage through an employer or former employer). The primary reason that the data do not include more policies on the market is that we confined the study to policies currently being offered. Many individuals own policies that are no longer offered by the surveyed companies. We excluded such policies from the analysis because our focus is on how the new regulations will affect policies that were being sold when the legislation was approved.

Our last study question addresses whether the ten policy prototypes developed by the NAIC are consistent with the statutory requirements specified by Congress in OBRA 1990. The legislation lists several crite-
ria. First, it states that the benefits included in the policy prototypes allow consumers to purchase benefits that were available on the market when the legislation was approved. In addition, the NAIC is to “balance” several other, possibly conflicting goals: simplifying the market to facilitate policy comparisons; avoiding adverse selection; providing consumer choice; providing market stability; and promoting competition. In our analysis, we add one further goal: that policy benefits provide protection against potentially catastrophic costs—the primary purpose of insurance.

Study Findings

Benefits before OBRA 1990. Exhibits 2 and 3 provide a summary of the types of benefits included in the Medigap policies sold by the companies in our sample. In almost all cases, these policies were for 1990. In Exhibit 2, we show the proportion of companies offering a particular kind of benefit, while Exhibit 3 provides the proportion of policyholders who had each kind of benefit. All policyholders had coverage for Part A hospital copayments for stays lasting between 61 and 150 days, stays lasting another 365 days, and the 20 percent Part B

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Always offered</th>
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<th>Not offered</th>
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<td>Hospital copayment</td>
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<td>Stays over 150 days</td>
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<td>Hospital deductible</td>
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<td>SNF copayment*</td>
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<td>SNF stays over 100 days*</td>
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<td>Part B coinsurance</td>
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<td>Part B nonassigned charges</td>
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<td>Prescription drugs</td>
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<td>Travel outside U.S.</td>
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<td>Private-duty nursing</td>
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<td>Vision care</td>
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Source: Data on commercial insurers were obtained by the Health Insurance Association of America from member companies. Data on Blue Cross Blue Shield plans were obtained by the authors from state insurance departments.

*SNF is skilled nursing facility.
支付。^{17} 这是不令人惊讶的，因为这些都已经由Baucus修正案所要求。在可选覆盖中，最典型的（用括号表示百分比）是覆盖Part A（医院）自付额度（78-93%），中级护理设施的自付额度（81%），以及在美国境外旅行中的医疗紧急情况（82%）。^{18} 排在第二位的是超100天的中级护理设施停留费（66%）和私人护理（49%）。

一些支付很少有。81%的支付者不具有Part B自付额度的覆盖。6%的支付者有此覆盖，我们不能确定覆盖的剩余13%的支付者。只有3-12%的支付者有非指定医生费用的覆盖，4-17%的支付者有处方药的覆盖。这两种政策支付因几乎每家公司提供的不同方式而具有不同性质。对于处方药，我们发现年度免赔额为$50, $100, $200, or $250; 患者共付比例为20%, 25%, or 50%; and 最高公司年度负债为$300, $500, and
unlimited. Only about 1 percent of policyholders, however, had an unlimited prescription drug maximum.

With respect to coverage for nonassigned physicians charges, some companies paid for physician charges up to a particular percentage of the Medicare reasonable charge (120 percent, 125 percent, 140 percent, or 145 percent). Others paid a specific percentage of the difference between the insurance company’s usual and customary charge and the Medicare-allowed charge (20 percent, 80 percent, or 100 percent).

Three benefits were extremely rare: vision coverage, preventive care, and home health benefits. Only 1 percent of policyholders possessed vision coverage, and when it was offered, benefits tended to include an eye examination and eyeglasses or contact lenses once every year or two years. It is difficult to gauge prior availability of preventive care and home health benefits because the few examples on the market do not neatly conform with the definitions included in the NAIC model regulations. Only three companies had any sort of coverage for preventive care; two covered only mammography examinations (now a service with some Medicare coverage), and one covered only immunizations, but with a maximum reimbursement of $100 per year. Of the two companies that offered home health coverage, one covered home health aide services (as prescribed by a physician) up to an annual cost of $500; the second offered an optional rider that covered expenses of up to $30 per visit for forty visits by a nurse, therapist, or home health aide or homemaker (as prescribed by a physician).

Implications for Medigap policies. Medigap policies will change in four ways as a result of the standardization requirements: (1) some previously unavailable benefits will become available; (2) some benefits that were purchased previously will no longer be available; (3) for particular types of coverage (for example, prescription drugs), a more limited choice of benefit levels will be available; and (4) there will be a more limited combination of benefits available.

Two new benefits were added to some of the policy prototypes. As shown in Exhibit 1, the preventive care benefit is available in two of the ten prototypes, and the at-home recovery benefit is available in four. It is impossible to know how many companies will offer these benefits and how many people will purchase them. But one reason to believe that many companies will sell the benefits is that both are available in otherwise “bare-bones” packages. Because these packages do not include coverage for prescription drugs, coverage for nonassigned services, or first-dollar coverage for the Part B deductible, insurance companies may believe that it is safe to sell these packages without worrying about adverse selection. It is true that both benefits are likely to be subject to substantial moral hazard. Nevertheless, companies will be somewhat
protected because both benefits have caps on the company’s total annual liability ($120 for preventive services and $1,600 for at-home recovery services).

The only significant service that will no longer be available to consumers after implementation of the policy standards is private-duty nursing. Forty-nine percent of policyholders in the sample had this coverage. The exact type of coverage, however, varied a great deal among companies, in terms of hours covered and payment per hour. Some policies did have fairly generous benefits—for example, coverage of 80 percent of charges for an unlimited number of hours.

One of the most important changes that will be brought about by standardization is, not surprisingly, that the benefits available on the market will be much more standardized. The two most important examples of this will be for prescription drugs and nonassigned services. Of the nine companies that offered prescription drugs, each offered a different combination of deductibles, coinsurance, and maximums. In the future, individuals who purchase prescription drug coverage will face a single deductible ($250), a single coinsurance rate (50 percent), and one of only two annual benefit maximums ($1,250 or $3,000). Thirteen companies offered coverage for nonassigned physician services. This benefit was written in seven different ways. In the future, there will be only two possible benefits: coverage of 80 percent or 100 percent of the difference between the physician’s billed charge and the Medicare-allowed charge, subject to any limitations established by Medicare or state law. However, because Medicare has substantially reduced physicians’ ability to bill patients extra in the future, having two policy standards for balance billing is not likely to restrict consumer choice very much.

The standardization requirements result in a more limited combination of benefits. Perhaps the best way to illustrate how this constraint of ten standardized policies will affect policyholders is to examine the most popular policy in our sample. This policy had the following benefits over and above the Baucus Amendment’s requirements: coverage of the Part A deductible, skilled nursing facility coinsurance, medical emergencies while traveling outside the United States, and private-duty nursing. (Since private-duty nursing is not included in any of the prototypes, we ignore it here.) None of the prototypes shown in Exhibit 1 includes this exact set of benefits, although three are fairly close. Policy C is identical to our sample policy except that it also includes coverage for the Part B deductible. Policy D is the same as the sample policy, except that it also provides coverage for at-home recovery. Policy E is also identical, except that it includes the preventive care benefit. Consequently, individuals who own this most popular policy will be forced to purchase at least one other benefit if they wish to keep the coverage they previously had.
To evaluate the consistency of the NAIC prototypes with OBRA 1990’s intent, we rearrange and combine the criteria set forth by the legislation along with the additional goal that policy benefits provide protection against potentially catastrophic costs.

**Consumer choice.** The policy prototypes were to enable consumers to make more informed choices by simplifying the options. Compared to the policies now available, the prototypes do not simplify by reducing the number of benefits, but they do simplify the form of the benefits offered and the combinations of benefits from which to choose. Although two new benefits (home and preventive care) were added to the selection now available, two other benefits (private-duty nursing and vision care) were left out, so the number of benefits from which to choose did not change. The prototypes do simplify choice by standardizing the benefits that will be offered. In particular, the prototypes limit excess physician charges and prescription drugs to one or two levels of coverage. Finally, they simplify consumer choice by combining these benefits into a limit of ten prototypes. In addition, the combinations of benefits provided by each prototype are built up in a hierarchical way, so that consumers may purchase the basic coverage alone or supplemented with one, four, five, six, or eight additional benefits of differing composition, depending on the type and breadth of coverage they desire. This hierarchical set of choices culminating in Policy J, which provides the full set of benefit options, means that consumers need not give up one benefit to obtain another.

The prototypes also were to maintain consumer choice by retaining those benefits currently available. Although it would be nearly impossible to simplify choice and still provide all of the benefits currently available, the prototypes do retain the most popular benefits. Of the two benefits left out of the policy prototypes, only private-duty nursing was relatively popular (49 percent of policyholders had the benefit). However, it is difficult to make an argument that this was an important benefit, especially since private-duty nursing in the hospital is more of a luxury than a necessary feature of care. In fact, the companies we spoke with indicated that the cost of providing this benefit was only $20 a year, so they did not have a strong reason to advocate its inclusion in the limited number of benefit packages. Similarly, consumer groups were unenthusiastic about the benefit, in part because of its confusing nature.

On the other hand, the three currently most popular benefits, skilled nursing coinsurance, the Part A deductible, and foreign coverage (held by at least 78 percent of current policyholders) are each offered in at least eight of the nine prototypes that offer coverage above the basic
benefits. This allows consumers to purchase these popular benefits in various combinations with other desired benefits. Each of the remaining benefits are currently held by less than 20 percent of policyholders and thus are appropriately offered in fewer combinations.

**Coverage of catastrophic costs.** We added the criterion that a benefit cover a potentially catastrophic cost; such benefits hold the most value for a risk-averse consumer. Four of the benefits included in the prototypes do not cover costs that have the potential to be catastrophic for most people: the Part A and B deductibles and the home and preventive care benefits. However, some justification exists for including two of these benefits. Coverage for the Part A deductible was one of the most popular benefits, so it is understandable that it was included. A similar justification does not exist for the Part B deductible (held by at most 19 percent of policyholders). Although the costs of home health care may be large in the long run, the limitations of this benefit, due to Medicare restrictions as well as policy maximums, reduce its value. In addition, the association with long-term care, within a Medigap policy, may be misleading. The preventive care benefit was included because advocacy groups for the elderly indicated that they desired it, to encourage use of preventive medical care. This is an unusual way to use insurance coverage, but since research indicates that this is not an expensive benefit (consistent with the fact that it does not cover potentially catastrophic costs), because it is limited to an annual maximum of $120 and because theoretically the use of preventive care could lower overall costs, this benefit may have value even if it does not reduce risk.21

**Competition.** Together, the set of ten policy prototypes was to promote competition. Since one of the tenets of competition is that consumers must have information about goods and their prices, the policy prototypes do appear to promote competition, by enabling more informed choice. A second tenet of competition is product homogeneity: for insurers to compete over sales, consumers must perceive the goods insurers are selling as being the same. Since all insurers will be selling from the same set of prototypes, this is a second way that the standardization should promote competition. A Medigap market composed of standardized prototypes should allow consumers to better judge the quantity of health insurance that they are purchasing and the price they are willing to pay.

**Adverse selection.** Competition in the Medigap market can only thrive if adverse selection—a predominance of high users of medical services in one or more of the policy prototypes—is avoided. It is impossible to know ahead of time how people will sort themselves amongst the different prototypes. However, if insurers fear that consumers who expect high expenses are more likely to choose a particular
prototype, they may choose not to sell that prototype. If all insurers respond this way, the choices available to consumers will be reduced.

The prescription drug benefit is feared to be the one most susceptible to adverse selection. Premium data collected along with the policies for this study indicate that the current median cost of a prescription drug benefit is $400.\textsuperscript{22} In one case, the benefit cost $500 even though the maximum amount the benefit paid was $300, indicating that the insurer expected those who bought the prescription drug benefit to spend more on medical care services above and beyond prescription drugs. In spite of this, the prescription drug benefit seems important to offer, since the costs are potentially catastrophic. One possible solution to this adverse selection problem would be for Medicare to cover prescription drugs. However, this seems unlikely in the current budgetary environment.

The prototypes that provide more extensive coverage are also more susceptible to adverse selection because people who expect to have large expenditures will tend to choose them. However, removing these prototypes would raise problems of choice, since this would force people to choose between different benefits rather than allowing them to purchase most or all of them. Nevertheless, the fact that the prototypes are limited to ten choices may make it easier for insurers to set appropriate premiums for these policies and account for adverse selection. For example, James Robinson and colleagues have shown how basic demographic data may be used to assess the difference in expected expenditures of groups of people choosing fee-for-service or prepaid health insurance plans before utilization data are available.\textsuperscript{23} Even though there will still be a time lag between setting an initial premium and finding out who wants to purchase extensive coverage prototypes, insurers may use information from initial purchasers to adjust the premium as needed.

**Market stability.** All of the goals of the legislation combine to promote market stability.\textsuperscript{24} Even though factors will undoubtedly arise that upset the stability of the market, good information and the simplicity of the market should allow it to regain its equilibrium quickly. There are no apparent characteristics of the Medigap market itself that would leave the market out of equilibrium, as long as adverse selection is not a problem. However, the market could also be disrupted from outside forces, which are difficult to predict. Nonetheless, the structure of the policy prototypes and their limited number appear to provide ways to limit these adverse consequences.
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NOTES


5. The only states that had not adopted the Baucus Amendment requirements from 1982 to 1989 were Massachusetts, New York, Rhode Island, and Wyoming, but they have standards of their own, some of which are even more stringent. U.S. General Accounting Office, Law Has Increased Protection against Substandard and Overpriced Policies, Pub. no. GAO/HRD97-8 (Washington, D.C.: GAO, October 1986).

6. For more information on the legislation’s repeal, see Rice et al., “The Medicare Catastrophic Coverage Act: A Post-Mortem.”

7. Under the act, (1) patients would not have faced any of the large daily copayments for hospitals stays lasting more than sixty days; (2) there would have been a cap of approximately $1,400 annually on patient copayments for Part B services; and (3) 80 percent of prescription drug expenses would have been covered after an annual deductible of approximately $600 was met.

8. U.S. House of Representatives, Congressional Record 149, Part II (26 October 1990), H-12459.

9. Ibid., H-12460. One caveat is that states that had already approved standardization legislation prior to OBRA 1990 could apply to HCFA for a waiver from federal standardization requirements. At the time of this writing, only Wisconsin’s application for a waiver had been approved; those from Massachusetts and Minnesota were still pending.

10. If a state legislature does not meet during 1992, the state is given additional time to implement the legislation.

11. Three riders would use up eight of the ten allowed benefit packages: the core packages plus seven more combinations of the three riders.

12. For a small minority of skilled nursing facility stays that qualify for Medicare eligibility, Medicare pays the cost of the first twenty days in full and requires a daily copayment for the next eighty days. No coverage is provided once stays exceed 100 days. The benefit for services received outside the United States covers 80 percent of medical bills incurred where care commences within sixty days of leaving the country, subject
to a $250 annual deductible and a lifetime maximum benefit of $50,000. The 50 percent 
coincidence for prescription drugs was included to keep down the premium cost of the 

drug benefit. Insurance industry representatives feared that a more generous benefit 

would be prohibitively expensive (and would encourage adverse selection).

13. The conclusions in this section are based on the authors’ reading of the advisory 

committee meeting minutes.

14. Market share information is available on the Medigap market from the NAIC.

15. When aggregate premiums rather than the number of purchasers was obtained, we 

estimated the latter by dividing total premiums by the average policy premium.

16. We counted riders as separate policies. Suppose, for example, that a company offered 

two policies: a high option and a low option. Furthermore, assume that the policyholder 
could also purchase a rider that covered prescription drugs, a benefit that was not 
included in either of the policies. We would count this as four policies: the low option; 
the low option plus rider; the high option; and the high option plus rider.

17. Although the original NAIC standards required coverage of only 90 percent of costs 

for stays lasting a year beyond Medicare’s 150-day coverage period, over 90 percent of 
policyholders had policies that paid a full 100 percent of these expenses. The new 
NAIC standards require that policies pay at the 100 percent level.

18. As explained above, our inability to obtain precise point estimates was due to the fact 

that the data we obtained on eligibility sometimes were insufficient for determining 

exactly how many people purchased a benefit. For example, coverage of the Part A 
deductible is often obtained through a policy rider, but in most cases we were unable 
to obtain data on how many Medigap policyholders purchased riders.

19. Moral hazard refers to the fact that people tend to use more of a service when they are 

insured for that service.

20. By January 1993, six months after the implementation date of the policy standards, the 

most a physician can legally charge for nonassigned services will be 15 percent above 
the Medicare-allowed charge. A person who owns a policy with the 100 percent benefit 
should therefore face no out-of-pocket costs, whereas someone with the 80 percent 
visit will have to pay 3 percent out of pocket. A caveat is that HCFA is likely to 
reprimand physicians only if they willfully and repeatedly violate these limitations.

21. R. Chu and G. Trapnell, “Costs of Insuring Preventive Care,” Inquiry (Fall 1990): 
273–280.

22. To determine how individual policy benefits affected premiums, we used two sources 
of information. First, we asked actuaries in a few companies to provide a breakdown of 
total annual premiums into each of the benefits included in their Medigap policies. 
Second, when companies offered two policies that differed with respect to only one 
benefit, the difference in premiums was calculated and attributed to that benefit.

23. J. Robinson et al., “A Method for Risk-Adjusting Employer Contributions to Compet-

24. We focus only on how the standardization requirements affect market stability. An-
other component of OBRA 1990—the open enrollment period for individuals just 
turning age sixty-five—could create its own market instability. One way in which this 
could occur is that companies fearing adverse selection through the open enrollment 
period may decide not to market some of the more generous benefit packages.