Lori K. Wing-Heier, Chair  
NAIC Senior Issues Task Force  
Attn: David Torian, Health Policy Analyst and Counsel

Dear Chairwoman Wing-Heier:

California Health Advocates has a public position opposing any new benefits being embedded inside a standardized Medicare Supplement (Medigap) contract. California Health Advocates (CHA) is a not-for-profit organization dedicated to providing quality Medicare, Medicare Supplement, and long-term care insurance information, training, and education. CHA supports the local Health Insurance Counseling and Advocacy Programs (HICAP) with materials, training, and technical assistance. HICAP is one of the federally designated State Health Insurance and Assistance Programs (SHIP).

CHA has been engaged for decades, first in the creation of standardized Medigap policies that became effective in 1992, and later in the protection of standardization that provides quality, reliable and easily understandable supplement insurance for Medicare beneficiaries. CHA hears regularly from its members about the issues and concerns that Medicare beneficiaries bring to the local programs, and the work the local programs do in counseling Medicare beneficiaries of all ages as part of SHIP.

We understand that the NAIC is being asked to respond to questions from Chairman Neal of the House Ways and Means Committee about the possibility of including benefits for some long term services and supports (LTSS) in Medigap policies.

While we share Chairman Neal’s concerns about the cost of long-term care for middle income families, we are convinced that adding benefits for this care to Medigap plans is not the right approach. Adding a benefit for LTSS to Medigap plans would drive up the cost of a Medigap contract beyond the affordability of most Medicare beneficiaries. To make such a benefit even moderately priced the eligibility trigger would have to be very restrictive to control access, and the benefit very brief to control costs.

To illustrate, the proposed benefit trigger and threshold for benefits in both the now defunct Home Recovery benefit in older Medigap plans and the Minnesota proposal are based on eligibility and use of Medicare’s home health care benefit.

The Medicare home health benefit is intended to help people recover from an illness or injury and prevent further hospitalization. It has a very restrictive eligibility trigger that requires a need for skilled care services, and a medical requirement to be homebound. While this standard is intended to prevent further hospitalization it is not a standard that is likely to be met and maintained by people needing care at home. A home care benefit predicated on these strict standards is likely to result in people feeling cheated by a very high threshold of eligibility if they don’t qualify for that benefit;
and by a very short benefit period if they use it and it quickly runs out because their needs are not for skilled care services but for personal care needs.

It’s important to note that the care needed by many people today is maintenance and personal care services that will help them stay in their own home when they can no longer perform the activities of daily life that we all take for granted. The other important need is for those who need supervision due to dementia. This kind of care has nothing to do with skilled care services.

Skilled care provided by the Medicare home health benefit is what people need postsurgical or post-hospitalization at high thresholds of impaired health, or when individuals have serious medical conditions. Skilled care for most people is quickly replaced by the need for lower levels of care not covered by Medicare after skilled care services are no longer medically necessary. Home and community based care (HCBC) is not skilled care. About half of all Medicaid spending for long-term care, for low income individuals who qualify for those benefits, is for home and community based care that is not covered by Medicare.

If Congress is interested in lower cost protection to help middle income families deal with the cost of care it should consider reforming the Medicare home health benefit and copayment structure to spread the risk across the largest possible risk pool, 60 million Medicare beneficiaries. Maintaining people in their home can be made more affordable by spreading the cost across this very large risk pool of millions, not a small number of individuals with Medigap coverage. Making eligibility less restrictive and adding a modest copayment for each visit would accomplish Chairman Neal’s objective of making home care benefits more affordable to middle income families.

In 2018, there were 5,125,575 million beneficiaries who qualified for Medicare covered home health benefits under Medicare’s restrictive eligibility benefit. A limited expansion of the existing benefit could meet all of the criteria policymakers have been proposing to mitigate costs for middle income families. Our recommendation for improving the Medicare home health benefit below limits benefits to those most at risk of institutional care and the resulting need to spend-down.

Our recommendation for a limited expansion of the Medicare home health benefit is more restrictive than typical benefits for long term care, but less restrictive than some proposals for a Medigap benefit that are currently under discussion. The resulting cost may be higher than some current proposals, depending on how strictly eligibility is determined. The greater the restriction on eligibility the lower the cost of providing a benefit; and the greater the discrepancy between a perceived and actual benefit.

Eligibility triggers: Prior receipt of skilled care within the last 20 days or, imminent need for institutional care, or 3 ADLs, or cognitive impairment requiring supervision.

Waiting period: None if Medicare home health benefits, prior hospital or nursing home stay was received within last 10 days; 20 day waiting period without prior hospital, nursing home, or home health care.
Services: Personal care services provided by nurse’s aide, with some supportive care services (to be determined) such as home delivered meals

Benefit: Limit the amount of daily benefits to $50 daily.

Duration: Limit benefit period to 3 months with evaluation for an additional 3 months. Maximum benefits of 1 year (365 days).

Copayments: 20% of Medicare’s approved amount for each hour of care provided up to a maximum of 4 hours daily during the first 3 months of care, 25% of Medicare’s approved amount for each hour of care for a second 3 months of care, and 30% for any remaining months of care received up to the lifetime maximum of 1 year.

Supplemental insurance: Consider the development of a standardized rider and Medigap benefit for payment of the copayment for home care benefits

Consider development of a Medigap rider with more comprehensive wrap around services for this basic Medicare benefit.

Congressional standardization of Medigap plans is the direct outcome of varying and complex Medigap plan and benefit designs, and abusive sales practices due to an inability of Medicare beneficiaries to directly compare the benefits of one Medigap plan with the benefits of another Medigap plan. Adding very restrictive home care benefits to a Medigap contract will at best reach a fraction of Medicare beneficiaries, and an even smaller number if such a benefit was limited to one or more Medigap plans.

Medigap plans currently pay defined amounts only after Medicare has paid based on Medicare’s determination of eligibility and payment. Adding a benefit that is not provided by Medicare would leave Medigap insurers deciding eligibility and medical necessity standards; creating a new claims and reimbursement system; guessing about pricing and utilization; and constructing an appeals process for services they don’t now cover.

Insurers would need to establish relationships and contracts with providers, something many Medigap companies have no experience with now. Insurers would be faced with pricing issues based on assumptions for similar benefits or experience, leading to insecure pricing and the potential for future turmoil for consumers, their benefits, and their underlying out-of-pocket medical costs. Consumers would be at the mercy of a Medigap insurer for a brand new benefit with no history and no previous experience.

Reaching the largest number of the Medigap buyers could only be accomplished by requiring a mandatory benefit that would be included in every Medigap standardized benefit package. The benefit itself would have to be standardized to prevent adverse selection and to avoid complex and abusive comparisons and potential marketing and sales abuses.
While we understand the need for Medigap companies to compete with Medicare Advantage plan carriers we don’t think adding these non-Medicare benefits to a Medigap plan is the answer for middle income seniors and their families trying to finance this kind of care. Medigap plans have been a very stable and predictable insurance product for decades; for consumer, agents, and insurance companies. Adding what some might perceive to be a benefit for long-term care to a Medigap plan might cause a spillover effect of confusion for consumers and generate at least some sales and marketing abuses due to agent ignorance about long-term care and the limited extent of a Medigap benefit to pay for that care. Adding additional cost to a Medigap plan, no matter how minimal, will price at least some people out of the market, driving them to lower cost MA plans, or spending down through out-of-pocket costs.

Educating consumers about long term care costs is happening by default as more and more families are faced with needing care or providing care. People not yet eligible for Medicare are shocked to find that the program doesn’t cover this kind of care, and that the only public option is spending down to Medicaid. Educating the public on an array of issues around the risk of needing care, finding care, and paying for care only to point to an array of complicated insurance products that many people cannot buy because of existing health conditions, or that they cannot afford is not helpful. At some point there must be a national approach to this kind of care with supplemental insurance for those who can afford it.

We would be happy to participate in any discussion about making benefits for Long-term services more affordable to middle income beneficiaries and their families, preventing or delaying spend down, helping to maintain the lives of impaired people in their own homes and communities for as long as possible, and helping caregiving adult daughters continue their employment and avoid reducing their own ability to pay for their future retirement and care needs.

Sincerely,

Bonnie Burns, CHA Consultant
NAIC Consumer Representative

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1 See: https://www.bettermedicarealliance.org/sites/default/files/2018-08/CareInTheHome_2018_08_30%20ISSUE%20BRIEF.pdf