**NAIC Senior Issues Task Force**

**February 29, 2024 Presentation on Medigap Eligibility**

Consumer Representatives: Bonnie Burns, Deborah Darcy, Kara Hinkley, Silvia Yee

Bonnie and Deborah have highlighted the many negative impacts on Medicare beneficiaries under and over 65 when they lack access to Medigap policies and explained the unfairness of this being the case. States have the capacity to help address this issue for Medicare consumers, and some states have done so, providing varying degrees of access. Making a decision to try Medicare Advantage should not be a one-way street where younger individuals with disabilities and older persons who are more likely to acquire a health condition are stuck with health coverage that many of them have paid into already, but that doesn’t meet their health needs or where the 20% Medicare co-pay threatens their financial stability. I’m going to spend a few minutes illustrating how Medicare beneficiaries who are currently excluded from purchasing Medigap products can be particularly impacted when states maintain narrow Medigap eligibility policies.

* Deborah explained the problem of narrow provider networks. People under 65 who are on Medicare across a range of disabilities are particularly impacted by practices such as narrow provider networks. They are more likely to need specialty care and providers, and have medical conditions and unique drug interactions that are not familiar to an MA plan’s reviewing providers, even if the MA member knew to file for an exception or make a grievance. Pediatric psychologists or obstetric providers can seem unnecessary for a Medicare network when Medicare as viewed purely as healthcare for those over 65, but there children and young adults with disabilities on Medicare, just as there are people who can and need to receive reproductive care. It can be very difficult to figure out if particular needed providers (& how many of them) are within a network and hard to have any needed options if those providers leave and the MA doesn’t do anything about it or moves very slowly.
* In addition, Medicare beneficiaries with mobility disabilities are likely to encounter providers in network that don’t have accessible equipment or problematically refuse to provide needed accommodations such as ASL. While there has been some slow improvement over the past 15 years, the percentage of even basic accessible weight scales and height-adjustable tables remains in the mid-teens and if those providers are not taking new patients, how long should a Medicare beneficiary have to wait for an MA plan to fix the situation? PWD can have serious reasons to want to return to FFS Medicare, but once they are there, they will find themselves forced to take the full financial impact of Medicare’s 20% copay without the option of Medi-Gap.
* Younger disabled people on Medicare may or may not be employed, but they are less likely to have employment insurance as a back-up to Medicare:
  + The U.S. Bureau of Labor Statistics reports that “**Workers with a disability were more likely to be employed part time than were those with no disability**. About 29 percent of those with a disability usually worked part time compared with about 16 percent of workers without a disability. About 3 percent of workers with a disability worked part time for economic reasons.” PWD – Labor Force Characteristics ([Bureau of Labor Statistics](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiQi8_wudCEAxV7OUQIHZXHCYUQFnoECA0QAw&url=https%3A%2F%2Fwww.bls.gov%2Fnews.release%2Fpdf%2Fdisabl.pdf&usg=AOvVaw3xxyqdGD6EPs7aGTE6Kx5t&opi=89978449));
  + People with disabilities not only face reduced income but also higher out-of-pocket costs. The [National Disability Institute in 2020 published a study](https://www.nationaldisabilityinstitute.org/wp-content/uploads/2020/10/extra-costs-living-with-disability-brief.pdf) by “Researchers at Stony Brook University, the University of Tennessee, the National Disability Institute, and the Oxford Institute of Population Ageing which estimated that a household containing an adult with a disability that limits their ability to work requires, on average, 28 percent more income (or an additional $17,690 a year) to obtain the same standard of living as a similar household without a member with a disability.”
* For those over 65, we are increasingly seeing low-income older individuals having to work into their 60s and 70s. According to the Pew Research Center, more and more people are working past age 65, from 11% in 1987 to 19% (1 in 5) in 2023 (<https://www.pewresearch.org/social-trends/2023/12/14/older-workers-are-growing-in-number-and-earning-higher-wages/>
* Pew Research looks at the rosy side of this, highlighting the fact that there are more older women in the workforce and more of those women have college degrees. This fails to take into account ongoing wage GAPS between men and women or the fact that for older workers who are earning far below average, working well into typical retirement age is not a real choice. or how many there are of these low-income older workers. The [National Council On Aging](https://www.ncoa.org/article/get-the-facts-on-economic-security-for-seniors) provides us with important context:
  + More than 17 million Americans age 65+ are economically insecure—living at or below 200% of the federal poverty level (FPL) ($29,160 per year for a single person in 2023).**1** These older adults struggle with rising housing and health care bills, inadequate nutrition, lack of access to transportation, diminished savings, and job loss. The burden of having to cover 20% of the costs of a single significant health event or condition can be catastrophic.
  + Older women are more likely to live in poverty than men as a result of wage discrimination and having to take time out of the workforce for caregiving.**3** On average, older women received about $9,900 less annually in retirement income in 2016 than older men due to lower lifetime earnings,  time taken off for caregiving, occupational segregation into lower wage work, and other issues. Older women of color fare even worse.
  + Over half of Black and Hispanic adults age 65+ have incomes below 200% of FPL.**2**
  + According to more accurate measures of elder poverty, millions of older adults struggling to meet their monthly expenses, even though they’re not considered “poor” because they live above the FPL.
  + In 2017, nearly half of adults age 55-66 had no personal retirement savings. About 50% of women age 55-66 had no personal retirement savings, compared to 47% of men in that age group.**13**
  + About one in four older adults over 65 scrimp on food, utilities, clothing, or medication due to health care costs. And in 2022, 37% of older adults were worried about affording health care in the coming year.**19**
  + To cover health expenses in retirement, the average couple 65+ would need $315,000 in after-tax savings.**20**
* In sum, Medicare beneficiaries, both those under and over 65, who are left without the option of obtaining a Medigap policy are the very individuals & families who are **least** able to get by without those policies. Medicare’s 20% co-pay can be sizeable for this group, and lead to healthcare that is delayed or entirely avoided, leading to worse health outcomes and expenses later on. This is a group that obviously needs affordable healthcare and also needs reasonable premiums.
* But we should not just automatically assume that allowing people over 65 and Medicare recipients under 65 to obtain a Medigap will make premiums unaffordable. Would $1 more PMPM make premiums unaffordable? Would $10 PMPM more make a policy that reduces Medicare’s copay burden make Medigap unaffordable? As Bonnie and Deb have shown, there are some states that make Medigap policies more readily available and the sky has not fallen.
* Moreover, giving people the healthcare they need, ensuring they aren’t skipping meds and not getting check-ups, will lead to better health outcomes and delay or prevent the onset of heavier health expenses. There is no reason for regulators and policymakers to just take the word of insurers that Medigap will be priced out of existence if the policies were more broadly subject to guarantee issue or if Medigap eligibility were expanded. If we don’t ask questions, the current unfair status quo will always prevail because consumers and advocates just don’t have access to the financial and actuarial information for ourselves.

\*\* One additional fact that was not in my presentation above, but is a relevant and related point (source: <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>)

* Compared to traditional Medicare beneficiaries in 2021, Medicare Advantage enrollees were more likely to be Black or Hispanic, have incomes below $20,000 per person, live in urban areas, and have lower levels of education (Figure 3, Appendix Table 1). In addition, dual-eligible individuals account for a larger share of Medicare Advantage enrollees (22%) than traditional Medicare beneficiaries (16%).