AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-24)

Introduced by: Medical Student Section

Subject: Medigap Patient Protections

Referred to: Reference Committee A

Whereas, Medicare Supplement (Medigap) plans are used by 23% of Medicare beneficiaries (14 million) to make Traditional Medicare more affordable and avoid the myriad problems with Medicare Part C, including limited networks and prior authorizations[1-13]; and

Whereas, when seniors enroll in Medicare Part B, they are offered a one-time 6-month enrollment period for Medigap, during which they are protected by guaranteed issue and community rating, preventing price discrimination based on health, age, or gender[13-14]; and

Whereas, after the initial 6-month Medigap enrollment period, protections for guaranteed issue and community rating no longer apply, even though guaranteed issue and (modified) community ratings are permanent and universal in the Affordable Care Act (ACA) marketplace[13-16]; and

Whereas, Medigap plans are required to be offered to all Medicare beneficiaries over 65, but not to other Medicare beneficiaries under 65 on dialysis or with disabilities[17-18]; and

Whereas, several states have enacted Medigap protections for guaranteed issue, community rating, and eligibility for Medicare beneficiaries under 65 and demonstrated reduced switching from Traditional Medicare to Medicare Part C[19-25]; and

Whereas, Congress is currently investigating deceptive tactics by private Medigap insurers, presenting a timely opportunity for regulation of private health insurance companies' dubious marketing tactics to steer consumers into purchasing more expensive Medigap plans, representing a timely opportunity for regulatory reform[24,26]; and

Whereas, at I-23, the AMA passed H-390.832, "Saving Traditional Medicare," "recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion" and "acknowledg[ing] that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans"; therefore be it

RESOLVED, that our American Medical Association support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act for commercial insurance plans (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to expand access to Medigap policies to all individuals who qualify for Medicare benefits (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA Policy

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation:
(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
(5) Insured individuals should be protected by guaranteed renewability.
(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
(7) Guaranteed issue regulations should be rescinded.
(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
[CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 03, A-23]

Medicare Advantage Policies H-285.913
Our AMA will: 1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty; 2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or

equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and 3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy. [Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18]

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees. [BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19]

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. [CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 01, I-20]