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Medigap Enrollment and Consumer Protections Vary Across States

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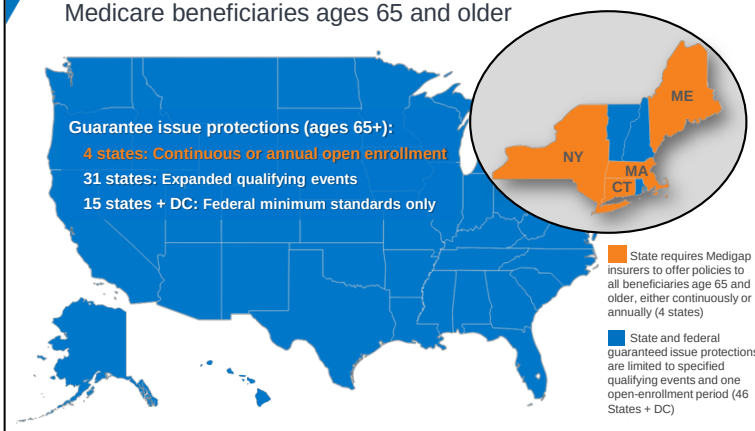
One in four people in traditional Medicare (25 percent) had private, supplemental health insurance in 2015—also known as Medigap—to help cover their Medicare deductibles and cost-sharing requirements, as well as protect themselves against catastrophic expenses for Medicare-covered services. This issue brief provides an overview of Medigap enrollment and analyzes consumer protections under federal law and state regulations that can affect beneficiaries' access to Medigap. In particular, this brief examines implications for older adults with pre-existing medical conditions who may be unable to purchase a Medigap policy or change their supplemental coverage after their initial open enrollment period.

Figure 1

Only 4 states (CT, MA, ME, NY) have guaranteed issue protections for Medigap either continuously or annually, for all Medicare beneficiaries ages 65 and older



NOTE: Connecticut, Massachusetts, and New York require continuous guaranteed issue for Medigap; Maine requires guaranteed issue for one month every year for at least Medigap Plan A, and has expanded qualifying events for guaranteed issue protections in the other months.
SOURCE: Kaiser Family Foundation collection and analysis of publicly available information, 2017.

Key Findings

- The share of beneficiaries with Medigap varies widely by state—from 3 percent in Hawaii to 51 percent in Kansas.
- Federal law provides limited consumer protections for adults ages 65 and older who want to purchase a supplemental Medigap policy—including, a one-time, 6-month open enrollment period that begins when they first enroll in Medicare Part B.
- States have the flexibility to institute consumer protections for Medigap that go beyond the minimum federal standards. For example, 28 states require Medigap insurers to issue policies to eligible Medicare beneficiaries whose employer has changed their retiree health coverage benefits.
- Only four states (CT, MA, ME, NY) require either continuous or annual guaranteed issue protections for Medigap for all beneficiaries in traditional Medicare ages 65 and older, regardless of medical history **(Figure 1)**. Guaranteed issue protections prohibit insurers from denying a Medigap policy to eligible applicants, including people with pre-existing conditions, such as diabetes and heart disease.
- In all other states and D.C., people who switch from a Medicare Advantage plan to traditional Medicare may be denied a Medigap policy due to a pre-existing condition, with few exceptions, such as if they move to a new area or are in a Medicare Advantage trial period.

Medigap is a key source of supplemental coverage for people in traditional Medicare

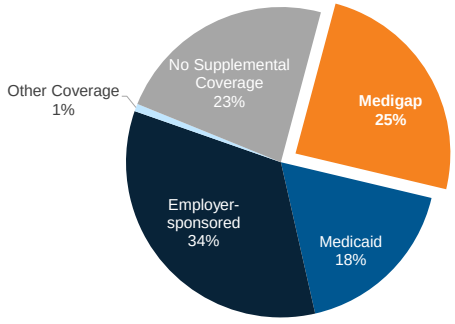
Medicare beneficiaries can choose to get their Medicare benefits (Parts A and B) through the traditional Medicare program or a Medicare Advantage plan, such as a Medicare HMO or PPO. Roughly two-thirds of Medicare beneficiaries are in traditional Medicare, and most have some form of supplemental health insurance coverage because Medicare's benefit design includes substantial cost-sharing requirements, with no limit on out-of-pocket spending. Medicare requires a Part A deductible for hospitalizations ($1,340 in 2018), a separate deductible for most Part B services ($183), 20 percent coinsurance for many Part B (physician and outpatient) services, daily copayments for hospital stays that are longer than 60 days, and daily copays for extended stays in skilled nursing facilities.

To help with these expenses and limit their exposure to catastrophic out-of-pocket costs for Medicare-covered services, a quarter of beneficiaries in traditional Medicare (25 percent) had a private, supplemental insurance policy, known as Medigap in 2015 **(Figure 2).** Medigap serves as a key source of supplemental coverage for people in traditional Medicare who do not have supplemental employer- or union-sponsored retiree coverage or Medicaid, because their incomes and assets are too high to qualify. Medicare beneficiaries also purchase Medigap policies to make health care costs more predictable by spreading costs over the course of the year through monthly premium payments, and to reduce the paperwork burden associated with medical bills.[1]

Figure 2

1 in 4 people with traditional Medicare had a Medigap supplemental policy in 2015

Share of Traditional Medicare Beneficiaries by Type of Supplemental Coverage



2015 Total = 39 million traditional Medicare beneficiaries*

NOTE: * Roughly one-third of the Medicare population is enrolled in a Medicare Advantage Plan and is excluded from this analysis. Coverage is assigned in the following hierarchical order: Medicaid, Employer-Sponsored, Medigap, other coverage, no supplemental coverage. Medicaid groupings reflect enrollment in March 2015.
SOURCE: KFF analysis of the centers of Medicare & Medicaid Services Medicare Current Beneficiary Survey, 2015.

What is Medigap? Medigap is Medicare supplemental insurance, which is a type of private health insurance designed to supplement traditional Medicare. Medigap policies help cover out-of-pocket costs for services covered under Medicare Parts A and B. There are 10 different types of Medigap Plans (labeled A through N), each having a different, standardized set of benefits. Most cover some or all of the Part A deductible. Some are high deductible plans with an out-of-pocket maximum, and a few cover some overseas travel **(Table 1)**. Three states, Massachusetts, Minnesota, and Wisconsin, have a different set of standardized plans, through a federal waiver.

Table 1: Standard Medigap Plan Benefits, 2018										
BENEFITS	**MEDIGAP POLICY**									
	A	**B**	**C**	**D**	**F**	**G**	**K**	**L**	**M**	**N**
Medicare Part A Coinsurance and All Costs After Hospital Benefits are Exhausted	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medicare Part B Coinsurance or Copayment for Other than Preventive Service	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes*
Blood (First 3 Pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Hospice Care Coinsurance or Copayment (Added to Plans A, B, C, D, F, and G in June 2010)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled Nursing Facility Care Coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Medicare Part A Deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Medicare Part B Deductible	No	No	Yes	No	Yes	No	No	No	No	No
Medicare Part B Excess Charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign Travel Emergency (Up to Plan Limits)*	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-Pocket Limit	N/A	N/A	N/A	N/A	N/A	N/A	$5,240	$2,620	N/A	N/A

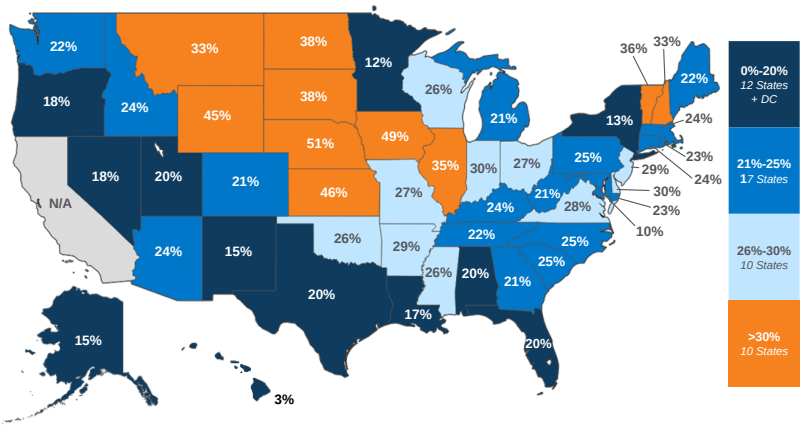
NOTE: These plans are effective on or after June 1, 2010. Plans E, H, I, and J are no longer offered to new applicants, as of 2010. Starting in 2020, Plans C and F will no longer be offered to new applicants. "Yes" indicates 100 percent of benefit coverage. * Plan N pays 100% of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits.
SOURCE: Centers for Medicare & Medicaid Services, How to compare Medigap policies, 2018.

Medigap policy benefits were standardized through the Omnibus Budget Reconciliation Act of 1990, which also included additional consumer protections discussed later in this issue brief.[2] Of the 10 standard Medigap policies available to beneficiaries, Plan F is the most popular, accounting for over half of all policyholders in 2016, because it covers the Part A and B deductibles (as does Plan C), and all cost-sharing for Part A and B covered services.[3]

The share of all Medicare beneficiaries with Medigap coverage varies widely by state—from 3 percent in Hawaii to 51 percent in Kansas in 2016 **(Figure 3, Appendix Table)**. In 20 states, at least one-quarter of all Medicare beneficiaries have a Medigap policy. States with higher Medigap enrollment tend to be in the Midwest and plains states, where relatively fewer beneficiaries are enrolled in Medicare Advantage plans.[4]

Figure 3

In 20 states, at least 25 percent of Medicare beneficiaries have Medigap—often highest in Midwest and plains states, 2016

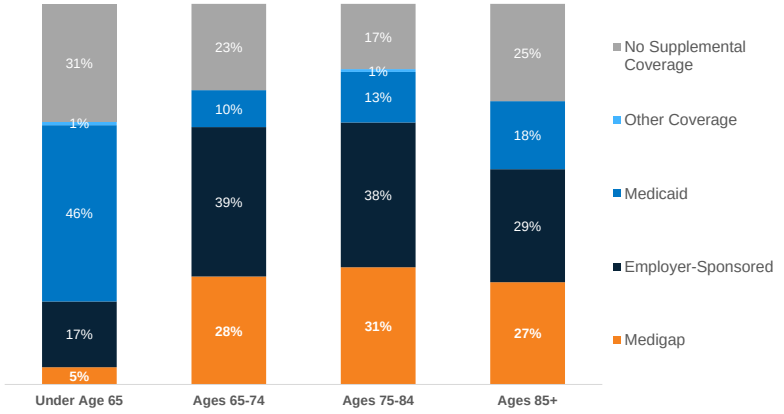


NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardization plans A-N, policies existing prior to federal standardization (Pre-Standardization), and plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program; includes plans that identified as Medicare Select; excludes plans with less than 20 covered lives.
SOURCE: Kaiser Family Foundation analysis of 2016 National Association of Insurance Commissioners (NAIC) Medicare Supplement Data and CMS State/County Market Penetration Files for December 2016.

Medigap coverage is substantially more common for Medicare beneficiaries ages 65 and older than it is for younger Medicare beneficiaries, many of whom qualify for Medicare because of a long-term disability. Only 5 percent of traditional Medicare beneficiaries under age 65 had Medigap in 2015—considerably lower than the shares in older age brackets **(Figure 4)**. The low enrollment in Medigap by beneficiaries under age 65 is likely due to the absence of federal guarantee issue requirements for younger Medicare beneficiaries with disabilities (discussed later in this brief) and higher rates of Medicaid coverage for people on Medicare with disabilities who tend to have relatively low incomes.

Figure 4

A relatively small share (5 percent) of under-age 65 adults in traditional Medicare have a Medigap policy, 2015



NOTE: Numbers may not sum due to rounding. Coverage is assigned in the following hierarchical order: Medicare Advantage, Medigap, Medicaid, Employer-Sponsored, other coverage, no supplemental coverage. Beneficiaries that reported having Medicare Advantage and Medigap plans were grouped into Medicare Advantage. Medicare Advantage and Medicaid reflect enrollment in March 2015.
SOURCE: Kaiser Family Foundation analysis of the Centers of Medicare and Medicaid Services Medicare Current Beneficiary Survey, 2015.

Federal law provides limited consumer protections for Medigap policies

In general, Medigap insurance is state regulated, but also subject to certain federal minimum requirements and consumer protections. For example, federal law requires Medigap plans to be standardized to make it easier for consumers to compare benefits and premiums across plans. Federal law also requires Medigap insurers to offer “guaranteed issue” policies to Medicare beneficiaries age 65 and older during the first six months of their enrollment in Medicare Part B and during other qualifying events (listed later in this brief). During these defined periods, Medigap insurers cannot deny a Medigap policy to any applicant based on factors such as age, gender, or health status. Further, during these

periods, Medigap insurers cannot vary premiums based on an applicant's pre-existing medical conditions (i.e., medical underwriting). However, under federal law, Medigap insurers may impose a waiting period of up to six months to cover services related to pre-existing conditions, only if the applicant did not have at least six months of prior continuous creditable coverage.[5] As described later in this brief, states have the flexibility to institute Medigap consumer protections that go further than the minimum federal standards.

Federal law also imposes other consumer protections for Medigap policies. These include "guaranteed renewability" (with few exceptions), minimum medical loss ratios, limits on agent commissions to discourage "churning" of policies, and rules prohibiting Medigap policies to be sold to applicants with duplicate health coverage.[6] (For further details on these requirements and a history of federal involvement in the Medigap market, see *Medigap: Spotlight on Enrollment, Premiums, and Recent Trends, April 2013*.)

When does federal law require guaranteed issue protections for Medigap?

Federal law provides guaranteed issue protections for Medigap policies during a one-time, six-month Medigap open enrollment period for beneficiaries ages 65 and older when enrolling in Medicare Part B, and for certain qualifying events. These limited circumstances include instances when Medicare beneficiaries involuntarily lose supplemental coverage, such as when their Medicare Advantage plan discontinues coverage in their area, or when their employers cancel their retiree coverage. Beneficiaries who are in a Medicare Advantage plan also have federal guaranteed issue rights when they move to a new area and can no longer access coverage from their Medicare Advantage plan. In these qualifying events, people ages 65 and older in Medicare generally have 63 days to apply for a supplemental Medigap policy under these federal guaranteed issue protections.

Federal law also requires that Medigap polices be sold with guaranteed issue rights during specified "trial" periods for Medicare Advantage plans. One of these trial periods is during the first year older adults enroll in Medicare. During that time, older adults can try a Medicare Advantage plan, but if they disenroll within the first year, they have guaranteed issue rights to purchase a Medigap policy under federal law. Another trial period applies to Medicare beneficiaries who cancel their Medigap policy to enroll in a Medicare Advantage plan. These beneficiaries have time-limited guaranteed issue rights to purchase their same Medigap policy if, within a year of signing up for a Medicare Advantage plan, they decide to disenroll to obtain coverage under traditional Medicare.

States have the flexibility to institute Medigap consumer protections that go further than the minimum federal standards, such as extending guaranteed issue requirements beyond the open enrollment period or adding other qualifying events that would require insurers to issue policies, as discussed later in this brief.

When does federal law not provide guaranteed issue protections for Medigap?

Broadly speaking, after 6 months of enrolling in Medicare Part B, older adults do not have federal guaranteed issue protections when applying for Medigap, except for specified qualifying events described earlier (**Table 2)**. Therefore, older adults in traditional Medicare who miss the open enrollment period may, in most states, be subject to medical underwriting, and potentially denied a Medigap policy due to pre-existing conditions, or charged higher premiums due to their health status.

Table 2: When do people seeking a Medigap policy have guaranteed issue protections under federal law?

Beneficiaries' coverage status	Guaranteed issue rights	
	Federally-required	**NOT federally-required**
In traditional Medicare	• In first 6 months of enrolling in Medicare Part B at age 65 or older	• After the first 6 months of enrolling in Medicare Part B
In a Medicare Advantage Plan or PACE	• When their plan withdraws from their area • When moving to a new area not covered by their plan • When voluntarily disenrolling from a plan within a trial period[a]	• After one year of enrollment in any plan
Has employer-sponsored supplemental (retiree) coverage	• When their employer cancels their supplemental coverage	• When their employer changes (but does not drop) retiree coverage benefits • When beneficiaries drops retiree coverage
Medigap	• Medigap insurance company goes bankrupt or no longer offers Medigap coverage	• When beneficiaries voluntarily drop Medigap coverage
Has Medicaid	• None[b]	• When Medicaid coverage or eligibility is lost or changed[b]
Under age 65 in Medicare	• None[c]	• In all cases[c]

NOTE: Beneficiaries typically have a 63-day period of guaranteed-issue rights for Medigap when a Medicare Advantage plan withdraws from their area or when an employer group plan (including COBRA) or union cancels coverage. Beneficiaries have guaranteed issue rights if their Medicare Advantage or Medigap insurer commits fraud.
[a]Trial rights apply to beneficiaries who canceled their Medigap policy to join a Medicare Advantage plan and to beneficiaries who enrolled in Medicare Advantage during their first year on Medicare and disenrolled within a year.
[b]Beneficiaries may suspend Medigap for up to two years if they become eligible for Medicaid, in which case they have no new medical underwriting or waiting periods for pre-existing conditions when they restart their Medigap.
[c]When beneficiaries under age 65 turn 65, they have the same federally-guaranteed issue protections for Medigap as people age 65 and older, regardless of whether or not they had Medigap when they were under age 65.

SOURCE: KFF analysis of federal requirements for Medigap insurers.

Medical Underwriting. Insurance companies that sell Medigap policies may refuse to sell a policy to an applicant with medical conditions, except under circumstances described above. The **Text Box** on this page provides examples of health conditions that may lead to the denial of Medigap policies, derived from underwriting manuals/guides from multiple insurance companies selling Medigap policies. Examples of conditions listed by insurers as reasons for policy denials include diabetes, heart disease, cancer, and being advised by a physician to have surgery, medical tests, treatments, or therapies.

Barriers for Beneficiaries Under Age 65 with Disabilities. Under federal law, Medigap insurers are not required to sell Medigap policies to the over 9 million Medicare beneficiaries who are under age of 65, many of whom qualify for Medicare based on a long-term disability. (However, when these beneficiaries turn age 65, federal law requires that they be eligible for the same six-month open enrollment period for Medigap that is available to new beneficiaries age 65 and older.)

Beneficiaries Choosing to Switch from Medicare Advantage to Traditional Medicare. There are no federal guarantee issue protections for individuals who choose to switch from a Medicare Advantage plan to traditional Medicare and apply for a Medigap policy, except under limited circumstances described in Table 2. In most states, therefore, beneficiaries who want to switch from their Medicare Advantage plan to traditional Medicare may be subject to medical underwriting and denied coverage when they apply for a Medigap policy because they do not have guaranteed issue rights, with some exceptions (e.g., if they have moved or if they are in a limited trial period). In states that allow medical underwriting for Medigap, Medicare Advantage enrollees with pre-existing conditions may find it too financially risky to switch to traditional Medicare if they are unable to purchase a Medigap policy. Without Medigap, they could be exposed to high cost-sharing requirements, mainly because traditional Medicare does not have a limit on out-of-pocket spending (in contrast to Medicare Advantage plans).[7]

Potential medical conditions for which a Medigap Insurer may deny coverage without guaranteed issue protections

- ALS (Lou Gehrig's Disease)
- Alcohol/drug abuse
- Alzheimer's disease or other dementias
- Chronic lung/pulmonary disorders (e.g. chronic bronchitis, COPD, cystic fibrosis)
- Cirrhosis
- Congestive heart failure
- Diabetes (insulin dependent)
- Emphysema
- End Stage Renal Disease (ESRD)
- Fibromyalgia
- Heart disease
- Hepatitis
- Immune disorders (e.g. RA, MS, Lupus, AIDS)
- Kidney disease requiring dialysis
- Mental/nervous disorder
- Myasthenia gravis
- Organ transplant
- Osteoporosis (if severe/disabling)
- Stroke
- Advised by a physician to have surgery, medical test, treatment, or therapy
- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of nebulizer
- Asthma requiring continuous use of 3+ medications including inhalers

NOTE: Uninsurable health conditions vary by plan. This list is not an extensive list of all possible conditions/reasons for denial.
SOURCE: Kaiser Family Foundation collection and analysis of numerous insurance companies' 2016-2017 Medicare supplemental underwriting manuals/guides.

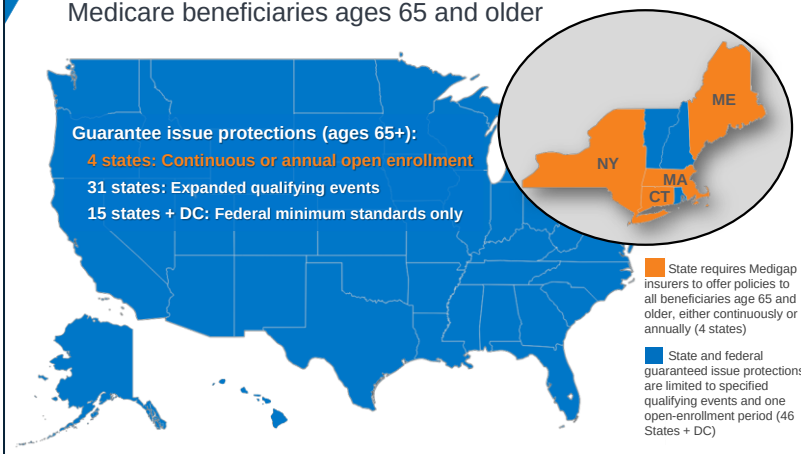
Some states require guaranteed issue and other consumer protections for Medigap beyond the federal minimum requirements

States have the flexibility to institute Medigap consumer protections that go further than the minimum federal standards. While many states have used this flexibility to expand guarantee issue rights for Medigap under certain circumstances, 15 states and the District of Columbia have not, relying only the minimum guarantee issue requirements under federal law **(Table 3)**.

Only four states require Medigap insurers to offer policies to Medicare beneficiaries age 65 and older **(Figure 5)**. Three of these states (Connecticut, Massachusetts, and New York) have continuous open enrollment, with guaranteed issue rights throughout the year, and one state (Maine) requires insurers to issue Medigap Plan A (the least generous Medigap plan shown earlier in Table 1) during an annual one-month open enrollment period. Consistent with federal law, Medigap insurers in New York, Connecticut, and Maine may impose up to a six-month "waiting period" to cover services related to pre-existing conditions if the applicant did not have six months of continuous creditable coverage prior to purchasing a policy during the initial Medigap open enrollment period.[8] Massachusetts prohibits pre-existing condition waiting periods for its Medicare supplement policies.

Figure 5

Only 4 states (CT, MA, ME, NY) have guaranteed issue protections for Medigap either continuously or annually, for all Medicare beneficiaries ages 65 and older



NOTE: Connecticut, Massachusetts, and New York require continuous guaranteed issue for Medigap; Maine requires guaranteed issue for one month every year for at least Medigap Plan A, and has expanded qualifying events for guaranteed issue protections in the other months.
SOURCE: Kaiser Family Foundation collection and analysis of publicly available information, 2017.

Some states provide additional guaranteed issue rights for current Medigap policyholders. Two states (CA and OR) allow beneficiaries to switch each year to a different Medigap plan with equal or lesser benefits within 30 days of their birthday, and another state (MO) allows policyholders to switch to an equivalent plan within 30 days before or after the annual anniversary date of their policy. Medigap policyholders in Maine can switch to a policy with equal or less generous benefits at any time during the year (not only during the annual open enrollment period) if there is less than a 90 day gap in coverage. Some Medigap insurers may also provide guaranteed issue rights to their policies that go beyond the state requirements. In Illinois, Blue Cross Blue Shield of Illinois and Health Alliance provide ongoing guaranteed issue rights for all beneficiaries ages 65 or older.

Many other states have expanded on the federal minimum standards in more narrow ways by requiring Medigap insurers to offer policies to eligible applicants during additional qualifying events **(Table 3)**. For example, 28 states require Medigap insurers to issue policies when an applicant has an involuntary change in their employer (retiree) coverage. (This qualifying event is more expansive than federal law,

which applies only when retiree coverage is completely eliminated.) Nine states provide guaranteed issue rights for applicants who lose their Medicaid eligibility.[9]

While federal law does not require Medigap insurers to issue policies to Medicare beneficiaries under the age of 65, 31 states require insurers to provide at least one kind of Medigap policy to beneficiaries younger than age 65 (typically through an initial open enrollment period).[10]

Table 3: Medigap Guaranteed Issue Requirements for Medicare Beneficiaries Ages 65+, by State, 2017					
	Federal Minimum Standards Only	Guaranteed Issue Rights (continuous or annual)	Qualifying Events For Guaranteed Issue Rights Beyond Minimum Federal Standards		
			Upon Retiree Benefit Changes	Upon Loss of Medicaid Eligibility	Other*
Total State Counts	16	4	28	9	14
Alabama	Yes				
Alaska	No	No	Yes	No	Yes
Arizona	Yes				
Arkansas	No	No	Yes	No	No
California	No	No	Yes	Yes	Yes
Colorado	No	No	Yes	No	Yes
Connecticut	No	Continuous	n/a	n/a	n/a
Delaware	Yes				
District of Columbia	Yes				
Florida	No	No	Yes	No	Yes
Georgia	Yes				
Hawaii	Yes				
Idaho	No	No	Yes	No	No
Illinois	No	No	Yes	No	No
Indiana	No	No	Yes	No	No
Iowa	No	No	Yes	No	No
Kansas	No	No	Yes	Yes	Yes
Kentucky	Yes				
Louisiana	No	No	Yes	No	Yes
Maine[1]	No	One month/year	Yes	Yes	Yes
Maryland	Yes				
Massachusetts	No	Continuous	n/a	n/a	n/a
Michigan	Yes				
Minnesota	No	No	Yes	No	No
Mississippi	Yes				
Missouri	No	No	Yes	No	No
Montana	No	No	Yes	Yes	Yes
Nebraska	No	No	Yes	No	No
Nevada	No	No	Yes	No	No
New Hampshire	Yes				
New Jersey	No	No	Yes	No	No
New Mexico	No	No	Yes	No	No
New York	No	Continuous	n/a	n/a	n/a
North Carolina	Yes				
North Dakota	Yes				
Ohio	No	No	Yes	No	No
Oklahoma	No	No	Yes	No	Yes
Oregon	No	No	Yes	Yes	Yes
Pennsylvania	No	No	Yes	No	No
Rhode Island	Yes				
South Carolina	Yes				
South Dakota	Yes				
Tennessee	No	No	No	Yes	No
Texas	No	No	Yes	Yes	Yes
Utah	No	No	No	Yes	No
Vermont	No	No	Yes	No	No
Virginia	No	No	Yes	No	No
Washington	No	No	No	No	Yes
West Virginia	No	No	Yes	No	No
Wisconsin	No	No	Yes	Yes	Yes
Wyoming	No	No	No	No	Yes

NOTE: [1]In Maine, Medigap insurers must offer guaranteed-issue policies, at least for Plan A during one month of their choosing each year. *Examples of "Other" qualifying events include: beneficiary's health plan changes its benefits, a participating hospital leaves the network of a beneficiary's health plan.
SOURCE: Kaiser Family Foundation analysis of state insurance regulations, 2017.

Some states provide stronger consumer protections for Medigap premiums than others

States also have the flexibility to establish rules on whether or not Medigap premiums may be affected by factors such as a policyholder's age, smoking status, gender, and residential area. Federal law allows states to alter premiums based on these factors, even during guaranteed issue open enrollment periods.

There are three different rating systems that can affect how Medigap insurers determine premiums: community rating, issue-age rating, or attained-age rating (defined in the **Text box** below). States can impose regulations on which of these rating systems are permitted or required for Medigap policies sold in their state. Of the three, community rating provides the strongest consumer protection for Medigap policies because it does not allow premiums to be based on the applicant or policyholder's age or health status. However, insurers in states that require community rating may charge different premiums based on other factors, such as smoking status and residential area. In states that allow attained age rating, older applicants and policyholders have considerably less protection from higher premiums because premiums may increase at unpredictable rates as policyholders age.

PREMIUM RATING SYSTEMS

Community rating: Insurers must charge all policyholders within a given plan type the same premium without regard to age (among people age 65 and older) or health status. Insurers can raise premiums only if they do so for all policyholders of the given plan type. Insurers may still adjust premiums based on other factors, including smoking status, gender, and residential area.

Issue-age rating: Insurers may vary premiums based on the age of the policyholder at the time of purchase, but cannot increase the policyholder's premium automatically in later years based on his/her age. Additionally, insurers may charge different premiums based on other factors, including health status, smoking status, and residential area.

Attained-age rating: Insurers may vary premiums based on the age of the policyholder at the time of purchase and increase premiums for policyholders as they age. Additionally, insurers may charge different premiums based on other factors, including health status, smoking status, and residential area.

Currently, eight states (AR, CT, MA, ME, MN, NY, VT, and WA) require premiums to be community rated among policyholders ages 65 and older. This means that Medigap insurers cannot charge higher premiums to people because they are older or sicker, and therefore, must charge an 80-year old policyholder the same as a 70-year old policyholder regardless of health status **(Table 4)**. Insurers may still adjust premiums based on other factors, including smoking status, gender, and residential area. A state's community rating requirement does not, in itself, guarantee that applicants will be issued a policy

in the state. However, as described earlier, four of the states that have community rating (CT, MA, ME, NY), have guarantee issue protections and require insurers to issue Medigap policies to eligible applicants either continuously during the year, or during an annual enrollment period.

Table 4: Medigap Premium Rating Rules

Community Rating Required	Issue Age Rating or Attained Age Rating		
Arkansas	Alabama	Kentucky	Oklahoma
Connecticut	Alaska	Louisiana	Oregon
Maine	Arizona	Maryland	Pennsylvania
Massachusetts	California	Michigan	Rhode Island
Minnesota	Colorado	Mississippi	South Carolina
New York	Delaware	Missouri	South Dakota
Vermont	District of Columbia	Montana	Tennessee
Washington	Florida	Nebraska	Texas
	Georgia	Nevada	Utah
	Hawaii	New Hampshire	Virginia
	Idaho	New Jersey	West Virginia
	Illinois	New Mexico	Wisconsin
	Indiana	North Carolina	Wyoming
	Iowa	North Dakota	
	Kansas	Ohio	

NOTE: The 8 states listed in the left-hand column prohibit issue age and attained age rating. States that require issue age rating do not allow attained age rating; but states that allow attained age rating, typically allow issue age ratings. All states permit insurers to use community rating.
SOURCE: Kaiser Family Foundation collection and analysis of publicly available information, 2017.

The remaining 38 states and the District of Columbia do not require premiums to be community rated; therefore, Medigap premiums in these states may be subject to issue-age and attained-age rating systems, depending on state regulation. Medigap insurers are permitted to offer community rated policies in these states, but most do not.[11] Additionally, Medigap insurers may increase premiums due to inflation, regardless of the premium rating system.[12]

Discussion

Medigap plays a major role in providing supplemental coverage for people in traditional Medicare, particularly among those who do not have an employer-sponsored retiree plan or do not qualify for cost-sharing assistance under Medicaid. Medigap helps beneficiaries budget for out-of-pocket expenses under traditional Medicare. Medigap also limits the financial exposure that beneficiaries would otherwise face due to the absence of an out-of-pocket limit under traditional Medicare.

Nonetheless, Medigap is not subject to the same federal guaranteed issue protections that apply to Medicare Advantage and Part D plans, with an annual open enrollment period. As a result, in most states, medical underwriting is permitted which means that beneficiaries with pre-existing conditions may be denied a Medigap policy due to their health status, except under limited circumstances.

Federal law requires Medigap guaranteed issue protections for people age 65 and older during the first six months of their Medicare Part B enrollment and during a “trial” Medicare Advantage enrollment period. Medicare beneficiaries who miss these windows of opportunity may unwittingly forgo the chance to

purchase a Medigap policy later in life if their needs or priorities change.[13] This constraint potentially affects the nearly 9 million beneficiaries in traditional Medicare with no supplemental coverage; it may also affect millions of Medicare Advantage plan enrollees who may incorrectly assume they will be able to purchase supplemental coverage if they choose to switch to traditional Medicare at some point during their many years on Medicare.

Only four states (CT, MA, NY, ME) require Medigap policies to be issued, either continuously or for one month per year for all Medicare beneficiaries age 65 and older. Policymakers could consider a number of other policy options to broaden access to Medigap. One approach could be to require *annual* Medigap open enrollment periods, as is the case with Medicare Advantage and Part D plans, making Medigap available to all applicants without regard to medical history during this period. Another option would be to make voluntary disenrollment from a Medicare Advantage plan a qualifying event with guaranteed issue rights for Medigap, recognizing the presence of beneficiaries' previous "creditable" coverage. For Medicare beneficiaries younger than age 65, policymakers could consider adopting federal guaranteed issue protections, building on rules already established by the majority of states.

On the one hand, these expanded guaranteed issue protections would increase beneficiaries' access to Medigap, especially for people with pre-existing medical conditions. They would also treat Medigap similarly to Medicare Advantage in this regard, and make it easier for older adults to switch between Medicare Advantage and traditional Medicare if their Medicare Advantage plan is not serving their needs in later life. On the other hand, broader guaranteed issue policies could result in some beneficiaries waiting until they have a serious health problem before purchasing Medigap coverage, which would likely increase premiums for all Medigap policyholders. A different approach altogether would be to minimize the need for supplemental coverage in Medicare by adding an out-of-pocket limit to traditional Medicare.[14]

Ongoing policy discussions affecting Medicare and its benefit design could provide an opportunity to consider various ways to enhance federal consumer protections for supplemental coverage or manage beneficiary exposure to high out-of-pocket costs. As older adults age on to Medicare, they would be well-advised to understand the Medigap rules where they live, and the trade-offs involved when making coverage decisions.

DATA SOURCES AND METHODS

We analyzed data from the Centers for Medicare and Medicaid Services (CMS) 2015 Medicare Current Beneficiary Survey (MCBS) to examine the characteristics of Medicare beneficiaries, by source of supplemental coverage. The MCBS is a nationally representative longitudinal survey of Medicare beneficiaries, which provides information on beneficiary characteristics, coverage, service utilization, and spending.

We used data from the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance files for our analysis of Medigap enrollment by plan type and by state. These data include the number of policyholders as of December 31, 2016 for each state, insurance company, and type of plan sold. The number of covered lives represent a snapshot of enrollment at that time, rather than average enrollment over the course of the year. This analysis used data from 49 states and the District of Columbia excluding California because only a small share of companies reported California data to the NAIC. We also excluded data from all US territories and plans reporting fewer than 20 enrollees. In this analysis, Medigap policies issued prior to Medigap standardization in 1992 are treated as a single additional type of plan, “Pre-Standardized.” In addition, policies sold in the three states exempted from Medigap standardization (MA, MN, and WI) are also grouped together as “Waivered.”

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Appendix Table: Number and Share of Medicare Beneficiaries with a Medigap Policy, 2016			
State	**Number of Medigap Beneficiaries**	**Share of All Beneficiaries in Medigap**	**Share of all Traditional Medicare Beneficiaries in Medigap**
Alaska	12,881	15%	15%
Alabama	197,535	20%	27%
Arkansas	176,662	29%	36%
Arizona	282,623	24%	38%
California	n/a	n/a	n/a
Colorado	175,770	21%	33%
Connecticut	154,390	24%	33%
DC	9,449	10%	12%
Delaware	57,472	30%	34%
Florida	831,573	20%	33%
Georgia	343,639	21%	32%
Hawaii	8,736	3%	6%
Iowa	290,255	49%	59%
Idaho	72,810	24%	36%
Illinois	745,608	35%	45%
Indiana	363,080	30%	41%
Kansas	231,674	46%	54%
Kentucky	212,505	24%	33%
Louisiana	138,624	17%	25%
Massachusetts	304,012	24%	31%
Maryland	226,815	23%	26%
Maine	71,292	22%	30%
Michigan	418,914	21%	33%
Minnesota	115,430	12%	27%
Missouri	312,279	27%	38%
Mississippi	148,569	26%	30%
Montana	70,138	33%	41%
North Carolina	466,027	25%	36%
North Dakota	46,862	38%	48%
Nebraska	166,692	51%	58%
New Hampshire	92,613	33%	37%
New Jersey	452,538	29%	35%
New Mexico	57,471	15%	22%
Nevada	84,016	18%	27%
New York	461,459	13%	21%
Ohio	609,567	27%	44%
Oklahoma	185,745	26%	32%
Oregon	141,662	18%	32%
Pennsylvania	657,714	25%	42%
Rhode Island	47,346	23%	37%
South Carolina	247,745	25%	33%
South Dakota	62,984	38%	49%
Tennessee	287,321	22%	35%
Texas	772,368	20%	30%
Utah	70,941	20%	30%
Virginia	391,440	28%	34%
Vermont	49,001	36%	39%
Washington	272,306	22%	31%
Wisconsin	279,958	26%	42%
West Virginia	90,815	21%	29%
Wyoming	45,150	45%	47%

NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis also excludes plans with less than 20 covered lives.
SOURCE: Kaiser Family Foundation analysis of 2016 National Association of Insurance Commissioners (NAIC) Medicare Supplement Data and CMS State/County Market Penetration Files for December 2016.

Endnotes

[1] J. Huang, G. Jacobson, T. Neuman, K. Desmond, and T. Rice "Medigap: Spotlight on Enrollment, Premiums, and Recent Trend" The Kaiser Family Foundation, April 2013. https://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf

[2] "The Omnibus Budget Reconciliation Act of 1990 (OBRA-90)," HR 5835, Public Law No: 101-508, November 1990. Available at: https://www.congress.gov/bill/101st-congress/house-bill/5835.

[3] The share of beneficiaries with Plan C and F is expected to decline in the future due to a change in law that prohibits insurers from issuing *new* policies that cover the full Part B deductible, as Plans C and F currently cover. Existing C and F policies will be grandfathered and therefore, renewable by current policyholders, but not sold to new purchasers. "Medicare Access and CHIP reauthorization Act of 2015 (MACRA)," HR 2, Public Law No: 114-10, April 2015. Available at: https://www.congress.gov/bill/114th-congress/house-bill/2/text.

[4] Jacobson, G, Damico A, Neuman T, and Gold M. "Medicare Advantage 2017 Spotlight: Enrollment Market Update," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

[5] Pre-existing conditions apply to conditions for which medical advice was given or treatment received within a "look back period" of six months before the effective date of coverage. For further details on federal requirements for Medigap with respect to pre-existing conditions, see https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf.

[6] "The Omnibus Budget Reconciliation Act of 1990 (OBRA-90)," HR 5835, Public Law No: 101-508, November 1990. Available here: https://www.congress.gov/bill/101st-congress/house-bill/5835.

[7] Neuman, Tricia, "Traditional Medicare…Disadvantaged?" Kaiser Family Foundation, March 2016. Available at: https://www.kff.org/medicare/perspective/traditional-medicare-disadvantaged/; Jacobson G, Rae M, Neuman T, Orgera K, Boccuti C. "Medicare Advantage: How Robust Are Plans' Physician Networks?," Kaiser Family Foundation, October 2017. Available at: http://files.kff.org/attachment/Report-Medicare-Advantage-How-Robust-Are-Plans-Physician-Networks.

[8] Pre-existing conditions apply to conditions for which medical advice was given or treatment received within a "look back period" of six months before the effective date of coverage. Continuous coverage means that the applicant had no break in coverage greater than 63 days over the prior six-month period prior to purchasing the Medigap policy. In New York, Medigap insurers must reduce the waiting period by the number of days that applicants had continuous creditable coverage.

[9] Under federa law, Medicare beneficiaries may suspend Medigap for up to two years if they become eligible for Medicaid, in which case they have no new medical underwriting or waiting periods for pre-existing conditions when they restart their Medigap.

[10]Centers for Medicare & Medicaid Services and the National Association of Insurance Commissioners, "2017 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," 2017. Available at: https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf.

[11] J. Huang, G. Jacobson, T. Neuman, K. Desmond, and T. Rice "Medigap: Spotlight on Enrollment, Premiums, and Recent Trend" The Kaiser Family Foundation, April 2013. https://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf

[12] Some states may allow Medigap insurers to charge higher premiums if they offer added coverage options, such as dental or vision coverage.

[13] Neuman, Tricia, "Traditional Medicare…Disadvantaged?" Kaiser Family Foundation, March 2016. Available at: https://www.kff.org/medicare/perspective/traditional-medicare-disadvantaged/

[14] Proposals to add an out-of-pocket limit have been discussed by the Medicare Payment Advisory Commission. See, for example, its chapter, "Reforming Medicare's benefit design," *Report to the Congress: Medicare and the Health Care Delivery System* (June 2012). http://medpac.gov/docs/default-source/reports/jun12_ch01.pdf?sfvrsn=0