KAISER FAMILY FOUNDATION

Medicare Policy

MEDIGAP:

Spotlight on Enrollment, Premiums, and Recent Trends

APRIL 2013

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Prepared by:

Jennifer T. Huang
Gretchen A. Jacobson
Tricia Neuman
The Henry J. Kaiser Family Foundation

and

Katherine A. Desmond
Thomas Rice
The University of California, Los Angeles

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EXECUTIVE SUMMARY

Medicare supplemental insurance, also known as "Medigap," is an important source of supplemental coverage for nearly one in four people on Medicare. Traditional Medicare has cost-sharing requirements and significant gaps in coverage; Medigap helps make health care costs more predictable and stable for beneficiaries by covering some or all Medicare costs, including deductibles and cost-sharing.

This policy brief provides an overview of the Medigap market, national trends in enrollment and premiums, variations across plan types and states and by different beneficiary characteristics. Lastly, the brief examines whether Medigap policyholders are enrolled in the lowest-cost plans available in their states.

This brief, issued in April 2013, is a revision to an earlier brief from February 2013. The revisions reflect updated methods for estimating Medigap premiums and for comparing plans within states. It is authored by researchers at the Kaiser Family Foundation and the University of California at Los Angeles.

Medigap enrollment

- Nationally, Medigap enrollment stayed relatively steady in the last several years, declining slightly from 9.5 million policyholders in 2006 to 9.3 million in 2010.[i]
- In 2010, nearly one in four Medicare beneficiaries (23%) had a Medigap policy; however, Medigap penetration varies by state, ranging from 2 percent of beneficiaries in Hawaii to 51 percent in North Dakota. In several states in the Plains and Midwest, nearly half of all Medicare beneficiaries had a Medigap policy.
- Plans F and C were the most popular plans nationwide, accounting for 40 percent and 13 percent of all Medigap policies, respectively. These two plans cover both the Medicare Part A and Part B deductibles completely, and are commonly described as providing "first-dollar coverage." The share of Medigap policyholders with plans that have first-dollar coverage, 54 percent nationwide, also varies by state, ranging from 12 percent of all Medigap policyholders in Alabama to 91 percent in North Dakota, among states with federally-standardized plans.

Medigap premiums

- Across all plan types, the average Medigap premium was $183 per month in 2010. As might be expected, average Medigap premiums vary by plan type, in part due to the difference in benefits covered by each plan. Nationwide, average premiums ranged from $140 per month for Plan A to $196 per month for Plan I.
- Average Medigap premiums for a given plan type vary across states, despite a standardized benefit package. Even ignoring the least expensive and most expensive states, average premiums for Plan A vary across states by as much as $79 per month. Similarly, Plan F premiums averaged $181 per month nationwide, but ranged from about $155 to $197 per month across most states.
- Between 2007 and 2010, national average Medigap premiums increased moderately, from $162 per month to $183 per month, with some variations by state. With an average annual growth rate of 4.1 percent per year during this period, average Medigap premiums grew at the same rate as Medicare per capita spending.

[i] These national figures do not include California, which was excluded because companies in that state are not required to report to the National Association of Insurance Commissioners (NAIC), leading to incomplete data on Medigap enrollment and premiums in California.

Variation in premiums by age, gender, and smoking status

Medigap premiums vary by age, gender, and smoking status in non-community rated states, based on an analysis of premium data from several states with attained-age and issue-age rating requirements. While premiums vary by state and by insurance company, our analysis of premiums for Plan F in 10 states found that:

- Premiums were generally higher for beneficiaries who are under age 65 (with disabilities) than for beneficiaries ages 65 and over. Plan F premiums for beneficiaries under age 65 were, on average, 73 percent higher than premiums for beneficiaries age 65.
- Premiums were generally higher for 80-year old beneficiaries than 65-year old beneficiaries. Premiums for 80-year old beneficiaries averaged 52 percent higher than those listed for 65-year olds.
- Premiums were eight percent higher, on average, for men than women, among 65-year olds.
- Premiums were 12 percent higher, on average, for smokers than non-smokers, among 65-year olds.

The differences in Medigap premiums across these demographic characteristics may reflect differences in Medicare costs.

Distribution of enrollees, by Medigap premium levels, in five states with community rating

Medigap enrollment tends to be concentrated in plans with relatively low premiums. Based on an analysis of beneficiaries enrolled in the most popular plan (Plan F) in five states that required community-rated pricing, a prerequisite for conducting such an analysis, the study finds that beneficiaries tend to enroll in one of the lowest-premium plans offered in their state. In four of the five states examined, the majority of Plan F enrollees were in the least expensive plan in the state (the lowest premium plan was offered by the same firm in each of the four states.) In the state where this firm did not offer the lowest-premium plan, this insurer still had the highest Plan F enrollment in the state, garnering 20 percent of the market.

It is not entirely clear how beneficiaries choose among Medigap plans, whether they are motivated mainly by low premiums, a comfort level with a brand, or some combination of factors. To the extent enrollment is driven by beneficiaries' sensitivity to premiums, the decisions in this particular marketplace are greatly enhanced by the standardization of benefits, which makes it relatively easy to compare Medigap benefits and premiums between different plans.

Discussion

Medigap plays an important role for many Medicare beneficiaries and remains a viable supplemental coverage option for those in traditional Medicare without employer-sponsored retiree coverage or Medicaid. Between 2006 and 2010, Medigap enrollment remained fairly stable nationwide. Currently, nearly one in four Medicare beneficiaries has a Medigap policy, with higher enrollment rates among beneficiaries living in rural states. Changes to Medigap would affect a significant share of the Medicare population, and would have cost implications for beneficiaries. Some policymakers have suggested discouraging or prohibiting first-dollar coverage for new enrollees. Plans with first-dollar coverage, however, are the most popular plan types, and changes to these plans could affect the majority of Medigap policyholders.

Looking ahead, Medigap may continue to play an important role in supplementing Medicare, particularly if enrollment in other sources of supplemental coverage declines (such as Medicare Advantage or employer-sponsored insurance). Conversely, the demand for Medigap could diminish over time if policymakers enact changes to discourage or prohibit beneficiaries from purchasing Medigap policies as part of the broader effort to reduce the growth in Medicare spending and address the federal debt and deficit.

MEDIGAP: Spotlight on Enrollment, Premiums, and Recent Trends

INTRODUCTION

Since the inception of Medicare, Medigap has been an important source of supplemental coverage for beneficiaries. About one in four Medicare beneficiaries has a Medigap policy. Beneficiaries purchase Medigap policies because they seek and value coverage that helps to make health care costs more predictable, as Medigap pays some or all of Medicare's deductibles and cost-sharing requirements. Beneficiaries also value the way in which Medigap, in conjunction with Medicare, helps to minimize the paperwork burden associated with medical bills.

Medigap is expected to continue to play a role as a supplement to traditional Medicare in the future, although the exact nature of its future role is difficult to predict. On the one hand, the share of beneficiaries with Medigap may increase over the next several years as other sources of supplemental coverage erode. For example, the share of large employers offering benefits to Medicare-eligible retirees has declined and is projected to continue to decline, which may cause the demand for Medigap to rise.[1] Similarly, a growing share of the Medicare population may turn to the Medigap market for supplemental coverage as an alternative to Medicare Advantage plans, particularly if enrollment in Medicare Advantage plans declines in response to reductions in payments enacted in the Affordable Care Act (ACA) of 2010, which has been predicted by the Congressional Budget Office (CBO) and the Department of Health and Human Services' Office of the Actuary (OACT).[2]

On the other hand, many have proposed taxing Medigap plans as part of broader efforts to reduce the federal debt and deficit. If these proposals continue to be part of the debt reduction agenda, Medicare beneficiaries may be discouraged from purchasing Medigap policies. For the first time in many years, policymakers have shown an increased interest in proposals to reform the Medigap market as part of broader efforts to reduce the national debt generally, and Medicare spending more specifically. Several leading debt reduction proposals would prohibit or discourage Medigap plans from offering first-dollar coverage.[3,4,5] Proponents of these reforms note that first-dollar coverage results in higher utilization of medical services and higher Medicare spending. For example, the National Commission on Fiscal Responsibility Reform proposed unifying the Part A and Part B deductibles and restricting Medigap coverage of Medicare cost sharing. In 2008, CBO examined a similar proposal in its *Health Care Budget Options*,[6] and estimated savings of $3.2 billion in its first year, and $73 billion over the ten-year period between 2010 and 2019.[7] The Obama administration, in its fiscal year 2013 budget proposal, took a different approach by recommending a surcharge on Part B premiums for new Medicare beneficiaries who purchase near first-dollar coverage, beginning in 2017, and estimated it would save $2.5 billion over 6 years. This is similar to an approach outlined by the Medicare Payment Advisory Commission (MedPAC) in June 2012, which recommended imposing an additional charge on supplemental policies that fill in Medicare's cost sharing, including Medigap and employer plans.[8]

The National Association of Insurance Commissioners (NAIC) reviewed Medigap Plans C and F, as required by the ACA, to determine whether Plans C and F should be modified to include nominal cost sharing (rather than cover both the Part A and Part B deductibles). In a letter to Secretary Sebelius, the NAIC recommended that "no changes should be made to Plans C and F at this time," and said the NAIC did not agree "with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries."[9]

Previous studies, including those released by America's Health Insurance Plans (AHIP) and the Assistant Secretary for Planning and Evaluation (ASPE), have provided information about the Medigap market. The AHIP 2012 report describes the distribution of Medigap policies by plan type in each state, the distribution of policies by the number of states they cover, and the popularity of new policies in 2011.[10] The ASPE 2011 report analyzes trends in Medigap enrollment, penetration, plan type, and premiums from 2007 to 2010.[11]

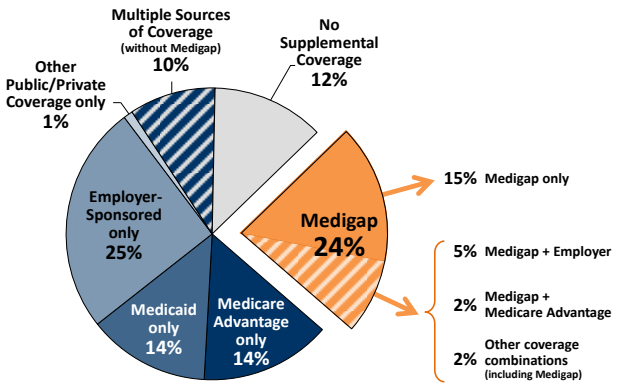
This policy brief uses data collected by the NAIC to provide an overview of the Medigap market, present national trends in enrollment and premiums between 2006 and 2010, and describe variations by plan type, across states, and by various beneficiary characteristics (age, gender, and smoking status), with a different methodology than used in previous studies. This brief also compares the growth in Medigap premiums to the growth in other Medicare premiums. Lastly, one part of our study that is unique is that we examine the extent to which Medigap policyholders are choosing the lowest premium plans available. This brief is a revised version of a similar brief issued in February 2013. The revisions reflect an improved method for estimating average monthly premiums from NAIC data, described below in Data and Methods and in Appendix II. In addition, the brief uses an improved methodology for examining whether policyholders choose the cheapest plan available, which has revised some conclusions.

Background

The benefit design of traditional Medicare includes substantial cost-sharing requirements, including a Part A deductible ($1,184 in 2013), a Part B deductible ($147 in 2013) and 20 percent coinsurance for Part B (physician and outpatient) services. There are also copayments for inpatient hospital stays and hospital stays longer than 60 days, no annual maximum on out-of-pocket costs, and no coverage for most long-term care services. As a result, most Medicare beneficiaries supplement their coverage in some way. In 2009, 88 percent of Medicare beneficiaries had some additional coverage to supplement Medicare's benefit package (**Exhibit 1**). Nearly one in four beneficiaries (24%) had supplemental coverage through Medigap, including 15 percent of Medicare beneficiaries with Medigap only, and 9 percent who had supplemental coverage in addition to Medigap, such as an employer plan (5%), a Medicare Advantage plan (2%), or other coverage, including Medicaid (2%).

EXHIBIT 1

Sources of Supplemental Coverage Among Medicare Beneficiaries, 2009



Total Medicare Beneficiaries, 2009 = 47.2 Million

NOTES: Numbers do not sum due to rounding.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2009.

In addition to the 24 percent of beneficiaries with Medigap, 64 percent of beneficiaries had some other form of supplemental coverage, such as an employer-sponsored plan, Medicare Advantage, Medicaid, or some combination of coverage. About one in eight beneficiaries (12%) had no form of supplemental coverage.

Medigap is the primary source of supplemental coverage for beneficiaries in traditional Medicare who do not have employer-sponsored coverage or retiree health benefits, do not meet the eligibility requirements for Medicaid, and want an alternative to enrolling in a Medicare Advantage plan.

The History and Role of Federal Involvement in the Medigap Market

As a result of scandals in the marketing and quality of supplemental insurance policies, Congressional hearings in the 1970s led to passage of the first of two key sets of federal regulations. In 1980, the Social Security Disability Amendments, also referred to as the "Baucus Amendments," were enacted. The Amendments provided voluntary certification for Medigap policies that met minimum benefit and medical loss ratio standards,[12] limited the duration of pre-existing condition exclusions, and required specific information to be disclosed to prospective purchasers.[13]

Although nearly all states adopted the Baucus Amendments, problems remained, the largest one of which was the variation across benefits offered by Medigap insurers that made "apples-to-apples" comparisons across plans difficult. Moreover, some researchers determined that the benefits included in some Medigap policies provided little value, such as coverage for skilled nursing facility stays in excess of 100 days.[14]

The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) included the second key set of federal regulations for Medigap, which are still largely in effect today. The law directed the NAIC to establish a standardized set of plans; Medigap policies had to conform exactly to particular lists of benefits. Unlike the voluntary Baucus Amendments, this standardization was mandatory for all but three states—Massachusetts, Minnesota, and Wisconsin—that already had some form of standardization in effect. The NAIC specified ten Medigap policy types, labeled A through J, which have been modified and modernized over time. Companies are not required to sell all plan types, but the ones they do sell must conform to the standardization rules. All companies that sell Medigap policies must sell plan type A, and may choose to sell other plan types as well.

In addition to directing the NAIC to create standardized plans, OBRA-90 included a number of other requirements:

- Guaranteed plan renewability (with few exceptions);
- Medical loss ratio requirements of at least 65 percent for individual policies and 75 percent for group policies; that is, insurance companies selling Medigap plans are required to spend at least 65 percent of their premium income from individual policies, or 75 percent of premium income from group policies, on health care claims and quality improvement, leaving the remaining share of premiums for administration, marketing, and profit. These requirements have remained unchanged since 1990; Penalties on agents and insurers who knowingly sell duplicate coverage;
- Limits on agent commissions during the first year of coverage to discourage the "churning" of policies;
- Institution of a six-month open enrollment period after a beneficiary's initial eligibility for Medicare, for beneficiaries ages 65 and older; and
- Limits the exclusion period for pre-existing conditions to six months.[15]

In 1995, the Act to Amend the Omnibus Budget Reconciliation Act of 1990 authorized "SELECT" plans to be offered as a Medigap plan option; SELECT plans were initially introduced in OBRA-90 as a demonstration. SELECT plans have the same benefit structure as other Medigap plans; however, SELECT plans have preferred provider networks, and beneficiaries receiving care from providers outside of the plans' networks may have additional cost-sharing.

Two years later, in 1997, the Balanced Budget Act (BBA) authorized high-deductible Medigap plans as options for Plan F and Plan J. These high-deductible plans offer the same benefits as Plans F and J but require the beneficiary to pay for Medicare-covered costs up to a deductible ($2,110 in 2013) before the Medigap plan begins to pay for covered benefits.

Two new plans, K and L, were added in 2005; each included patient cost-sharing for most services but also contained limits on annual out-of-pocket costs.

As a result of the expansion of Medicare benefits to cover prescription drugs beginning in 2006, plans H, I, and J, the three plan types that previously covered prescription drugs, were modified. Drug benefits were no longer included in Medigap Plans H, I, and J sold after January 1, 2006.

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 eliminated at-home recovery benefits beginning 2010, and expanded the Part A hospice benefit to all Medigap plans, beginning in 2010. This resulted in some redundant plan types (Plans E, H, I, and J). As a result, these four plans were no longer sold after June 30, 2010; however, beneficiaries who owned these plans prior to June 2010 were allowed to

renew their policies. MIPPA also established two more new plans, M and N, which include copayments rather than coinsurance. Also in 2010, preventive benefits were no longer covered by Medigap plans because the ACA required the Medicare benefit to include full coverage of preventive benefits for all Medicare beneficiaries.

Exhibit 2 shows a list of plans and benefits, and includes all standardized plans offered from 1990 to 2013.

EXHIBIT 2

Standard Medigap Plan Benefits

BENEFITS	MEDIGAP POLICY													
	A	B	C	D	E[1]	F	G[2]	H[1]	I[1]	J[1]	K[3]	L[3]	M[4]	N[4]
Medicare Part A Coinsurance and all costs after hospital benefits are exhausted	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment for other than preventive services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓*
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Care Coinsurance or Copayment (added to Plans A, B, C, D, F, and G in June 2010)	✓	✓	✓	✓		✓	✓				50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓			✓				✓				
Medicare Part B Excess Charges						✓	✓		✓	✓				
Foreign Travel Emergency (Up to Plan Limits)*			✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Out-of-Pocket Limit											$4,620	$2,310		

NOTES: Check marks indicate 100 percent benefit coverage. Amount in table is the plan's coinsurance amount for each covered benefit after beneficiary pays deductibles or cost-sharing amounts, where applicable. The Affordable Care Act eliminated cost-sharing for preventive benefits rated A or B by the U.S. Preventive Services Task Force, effective 2011. [1]After June 1, 2010, Medigap Plans E, H, I, and J are no longer available for purchase by new policyholders; existing policyholders may remain in these plans. [2]Benefits for Plan G reflect the standard benefit after June 1, 2010 (Part B excess charges changed from 80% to 100%). [3]Medigap Plans K and L available for purchase in 2005. [4]Medigap Plans M and N available for purchase after June 1, 2010. *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, 2011 Guide to Health Insurance, March 2011.

Consumer protections for Medicare beneficiaries aged 65 and older

Medicare beneficiaries ages 65 and over have a federally-required, one-time, 6-month open enrollment period, which begins with the first month of Medicare Part B coverage. During the open enrollment period and in certain other defined times, beneficiaries have guaranteed issue rights; this means that insurance companies selling Medigap policies cannot refuse to sell a Medigap policy to any applicant, regardless of age, gender, or health status. Also during the open enrollment period, insurance companies offering Medigap policies cannot use medical underwriting to change premiums due to past or present medical problems.

Consumer protections for beneficiaries under the age of 65

While guaranteed issue requirements for Medicare beneficiaries ages 65 and older are set by federal law, requirements vary by state for beneficiaries under the age of 65. Insurers are not required by federal law to sell any of their Medigap policies to beneficiaries under the age of 65. Across all 50 states and the District of Columbia, 30 states require insurance companies to offer at least one Medigap policy to beneficiaries under age 65 who are disabled or who have end-stage renal disease (ESRD) (**Appendix I**).

As noted, federal law requires insurance companies to provide a six-month open enrollment period for Medicare beneficiaries when they are age 65. However, there is no federal law requiring an open enrollment period for beneficiaries who qualify for Medicare before they turn age 65. Of the 30 states with guaranteed issue requirements, 28 states have laws that require open enrollment periods for beneficiaries under age 65. Among states with this requirement, the scope of the requirements can vary by state. For example, not all states offer open enrollment periods for both disabled and ESRD beneficiaries; some states only require certain plan types to be available during the open enrollment periods. A few states also have continuous open enrollment periods, or annual open enrollment periods.

Some states require insurance companies to offer policies to non-senior beneficiaries at the same premium as beneficiaries age 65; other states limit the extent to which insurance companies can charge higher premiums to non-seniors. Most states, however, do not have this requirement. Fourteen states restrict the degree to which beneficiaries under age 65 can be charged more than senior beneficiaries.

Similarly, 22 states require insurance companies to charge the same premium for all beneficiaries under the age of 65, regardless of how the beneficiary qualified for Medicare (through disability, amyotrophic lateral sclerosis [ALS], or ESRD). In these states, companies cannot use medical underwriting to change premiums based on disability or reason for eligibility, for beneficiaries under age 65.

For a list of states and their consumer protections for Medicare beneficiaries under the age of 65, see **Appendix I.**

Premium Rating

Rating rules for Medigap policies are generally determined at the state level, rather than the federal level. There are three different "age rating" systems to price policies:

- **Community rating:** insurers charge all policyholders within a plan type the same amount without regard to age or health status; insurers can raise premiums only if they do so for everyone enrolled in the plan type, but in some of these states premiums may still vary by smoking status (e.g., Maine) or by region (e.g., New York);
- **Issue age rating**: premiums are based on the age of the beneficiary when the policy is first purchased; and
- **Attained age rating**: premiums may rise as a beneficiary ages.

Currently, eight states (AR, CT, MA, ME, MN, NY, VT, and WA) require premiums to be community rated. Four states (AZ, FL, GA, and ID) require premiums to be issue age rated, although insurers in these states would be permitted to make policies community rated, if they preferred. Thirty-eight states and the District of Columbia allow attained age rating for premiums. Insurers in these states are permitted to use issue age or community rating for premiums, but generally do not do so. For a list of states by rating rules, see the **Appendix I**.

STUDY OVERVIEW

This brief provides information on the current state of the Medigap market, including variation in enrollment and premiums nationally and by state, using data collected by the NAIC. Specifically, the brief examines enrollment and premiums in 2010, and trends since 2006. Particular attention is paid to differences between plan types and across states.

The NAIC data are supplemented with data from websites of the various state insurance departments to examine how Plan F premiums vary by age, sex, and smoking status.

DATA SOURCES AND METHODS

For the analysis of Medigap enrollment and premiums, we used data collected by the NAIC. These data include the number of policyholders as of December 31 of each year, total premiums, and total claims for each insurance company and type of plan sold. Our analyses are based on five years of annual data: 2006 to 2010. Most insurance companies selling Medigap policies are required to report information to the NAIC. This analysis uses data from 49 states and the District of Columbia; we excluded California because a minority of companies in California reported data to the NAIC. We excluded data from Guam, Puerto Rico, the Virgin Islands, and American Samoa. We also excluded plans reporting fewer than 20 enrollees, as these were unlikely to represent currently viable insurance products.[ii]*

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. SELECT plans were also grouped together in some analyses because, while the policies cover the same benefits as the other policies, SELECT policies have preferred provider networks and thus may have lower premiums than other policies of the same type. With one exception, we did not attempt to separate regular and high-deductible Plans F and J policies, as they are not clearly differentiated in the NAIC data, and relatively few policyholders nationwide have purchased the high-deductible options.[16] The exception, which represents a departure from methods used in the earlier version of this brief, is that we made every attempt to identify and eliminate high-deductible Plan F policies in our investigation of whether policyholders are enrolled in the lowest premium plan in five community-rated states.

Estimates of Medigap enrollment are based upon total covered lives reported as of December 31 of each year. They represent a snapshot of enrollment at that time, rather than average enrollment over the course of the year. Estimates of average monthly premiums are calculated by dividing premiums collected during the year by the number of covered lives. In the February 2013 version of this brief, year-end covered lives were used in this calculation, which assumed stable numbers of enrollees over the course of the year. For this brief, mid-year covered lives were used to estimate premiums, which were calculated by averaging the year-end enrollment from the current and prior years. Therefore premiums are calculated for 2007-2010 only. More information on the methodology using the data from the NAIC is contained in **Appendix II**.

For the analyses of premium variation by age, sex, and smoking status, we reviewed Medigap premium information posted on each state's website. Our analysis focuses on states that list premiums for Plan F effective in 2011. We selected Plan F because, among the various plan types available to beneficiaries, Plan F is the most popular nationwide. High-deductible plans and Medigap SELECT plans were excluded from these analyses because the different benefit structure in high-deductible plans and the existence of preferred provider networks in SELECT plans makes these plan types less comparable to standard Plan F. States that require community rating were also excluded from the analyses, since premiums in community rated states do not vary by age or gender. For states that listed different premiums for different zip codes, counties, or cities, we selected the zip code, county, or city with the largest number of Medicare beneficiaries.

We defined a "reference" beneficiary as a 65-year old, non-smoking woman. To compare the difference in premiums by a given demographic characteristic, we collected Plan F premiums listed for the reference beneficiary and the corresponding premiums of her "matched" counterpart for each plan, took a ratio of these premiums, and computed the mean of the ratios. More information on the methodology using the state Medigap premium comparison guides is contained in **Appendix III**.

[ii] There were about 45,000 beneficiaries in plans with fewer than 20 enrollees, accounting for less than 0.5 percent of all policyholders in the United States, excluding territories and California.

Finally, we used data from the Centers for Medicare and Medicaid (CMS) 2009 Medicare Current Beneficiary Survey (MCBS) Cost and Use File to find the sources of supplemental coverage of Medicare beneficiaries, and to determine whether the difference in premiums reflect the difference in health care costs. The MCBS is a nationally-representative survey of approximately 11,000 Medicare beneficiaries, including those living in long-term care facilities. In our analysis of beneficiaries' sources of supplemental coverage, we focus on beneficiaries with Medigap coverage, including beneficiaries who also have other sources of supplemental coverage during the same calendar year. Thus, the assignment of supplemental coverage was not coded in a mutually exclusive, hierarchical fashion.

RESULTS

Medigap Enrollment

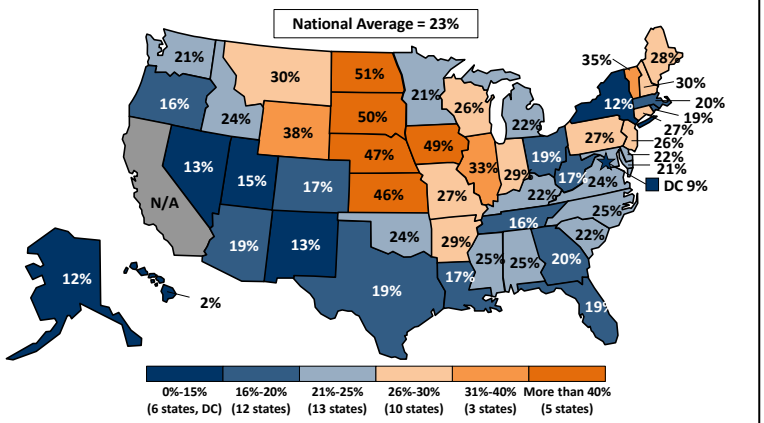
Nearly one in four Medicare beneficiaries has a Medigap policy, but penetration varies by state. Nationwide, 23 percent of Medicare beneficiaries had Medigap policies in 2010 (**Exhibit 3**).[iii] There is large variation across states, with enrollment rates as low as 2 percent in Hawaii and as high as 51 percent in North Dakota. Penetration was highest in the Midwest and Plains states (IA, KS, ND, NE, and SD).

The most distinct pattern is an inverse relationship between Medigap and Medicare Advantage enrollment.[17] For example, half of all Medicare beneficiaries in North Dakota and South Dakota had Medigap policies, while less than 7 percent of beneficiaries in these states were enrolled in a Medicare Advantage plan in 2010. In contrast, 2 percent of Medicare beneficiaries in Hawaii had Medigap policies, while 41 percent had Medicare Advantage plans in 2010.

Of the plan types available to beneficiaries, Plan F and Plan C, the two plans with first-dollar coverage, are the most popular. In 2010, Plans F and C together accounted for 54 percent of policyholders (**Exhibit 4**).[iv] Both of these plans provide first-dollar coverage; that is, they cover the Medicare Part A and Part B deductibles completely.

EXHIBIT 3

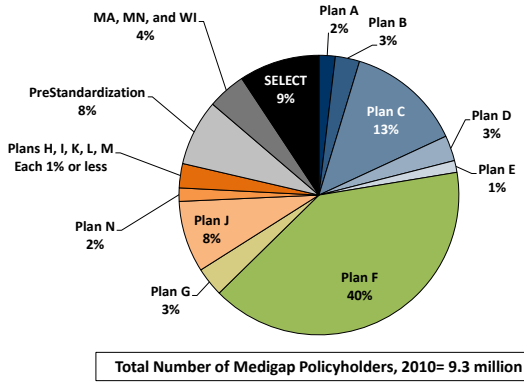
Percent of Medicare Beneficiaries with Medigap by State, All Plans, 2010



NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization, plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program, and plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20. Number of Medigap policyholders as of December 31, 2010, as reported in the NAIC data.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data. Kaiser Family foundation and Mathematica Policy Research analysis of CMS State/County Market Penetration Files.

EXHIBIT 4

Share of Medigap Policyholders by All Plan Types, 2010



Total Number of Medigap Policyholders, 2010= 9.3 million

NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization (PreStandardization), 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 where number of covered lives was less than 20. Number of Medigap policyholders as of December 31, 2010, as reported in the NAIC data.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

[iii] This differs from the 24 percent figure (15% with Medigap only and 9% with Medigap and other sources of coverage) shown in Exhibit 1 (which is based upon the Medicare Current Beneficiary Survey [MCBS]), in part because the NAIC data does not include data for California.

[iv] Percentages shown for Plan C and Plan F in Exhibit 4 do not sum to 54% due to rounding. This also includes policyholders with high-deductible Plan F policies; however, relatively few policyholders nationwide have purchased high-deductible Medigap policies.

No other standardized plan type (other than Plan J, which is no longer sold to new policyholders) enrolled more than 3 percent of Medigap policyholders. Nearly one in ten Medigap policyholders had a SELECT plan. Few beneficiaries are enrolled in a high-deductible Medigap Plan (e.g., high-deductible Plan F or high-deductible Plan J); less than 3 percent of newly-purchased plans between 2007 and 2011 were high-deductible plans.[18]

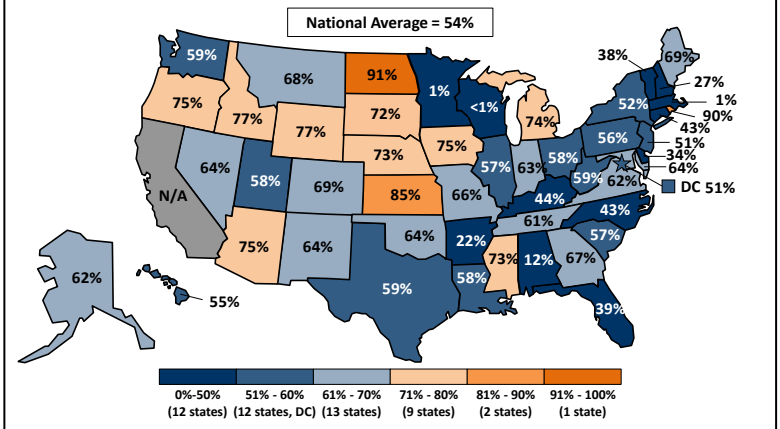
Enrollment is low in the newer plans that have greater patient cost-sharing. Plans K and L, which have been in existence since 2006, account for less than one percent each of total Medigap enrollment. Plans M and N also had low penetration in 2010; however, Plan N accounted for 15 percent of newly purchased Medigap policies in the first quarter of 2011.[19] Because Plans M and N first became available in the middle of 2010, it is too early to make conclusions about their popularity in the long run.

The share of all Medicare beneficiaries with Medigap plans that offer first-dollar coverage (F and C) varies by state. Among all Medicare beneficiaries, 12 percent were enrolled in Plans C or F in 2010.[20] In five states (IA, KS, ND, NE, and SD), more than one-third of all Medicare beneficiaries had a Medigap Plan C or Plan F policy with first-dollar coverage. In contrast, among states with federally-standardized Medigap plans, only Alabama, the District of Columbia, and Hawaii had 5 percent or fewer Medicare beneficiaries with a Medigap policy that was either of these plan types.

Among Medigap policyholders, more than half (54%) have first-dollar coverage (Plan C or F), although the share with first-dollar coverage varies across the states. In 37 states and the District of Columbia, more than half of all Medigap policyholders had either Plan C or Plan F (**Exhibit 5, Appendix IV**), including three states that had more than 80 percent of policyholders in one of the two plans with first-dollar coverage (KS, ND, and RI). In 25 states, more than half of all Medigap policyholders had a Plan F policy; in two other states, more than half of all policyholders had Plan C.

EXHIBIT 5

Share of Medigap Policyholders with Medigap Plans C and F, 2010

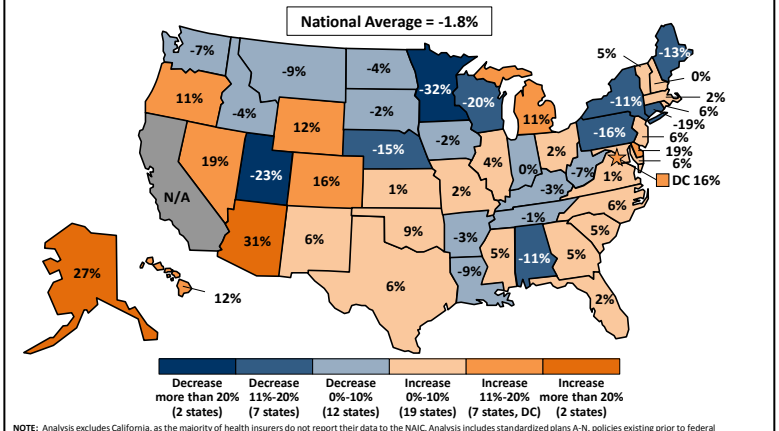


NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization (PreStandardization), and plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program; excludes plans that identified as Medicare Select, and excludes plans where number of covered lives was less than 20. Number of Medigap policyholders as of December 31, 2010, as reported in the NAIC data.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

Nationwide, Medigap enrollment remained fairly steady between 2006 and 2010. Between 2006 and 2010, the total number of Medigap policyholders in our analysis of the NAIC data was relatively constant from 9.5 million in 2006 to 9.3 million in 2010, which was about 23 percent of the U.S. population (excluding California which is not in the NAIC dataset).

EXHIBIT 6

Change in Number of Medigap Policyholders by State, All Plans, 2006 – 2010



NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization, plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program, and plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20. Number of Medigap policyholders as of December 31, 2006 and December 31, 2010, as reported in the NAIC data.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2006-2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data. CMS Medicare and Medicaid Statistical Supplement: Medicare Enrollment 2009, released September 30, 2010.

Enrollment patterns varied across states between 2006 and 2010 (**Exhibit 6, Appendix V**). For example, the number of Medigap enrollees declined by more than 20 percent in two states (reflecting about 78,000 fewer policyholders in Minnesota, and about 12,000 fewer in Utah), while the number of policyholders increased by more than 20 percent in two states (reflecting about 1,700 more policyholders in Alaska, and nearly 39,000 more policyholders in Arizona).

The distribution of policies by plan type remained fairly similar between 2006 and 2010. National enrollment by plan type did not change greatly between 2006 and 2010. Most plan types accounted for a similar share of Medigap enrollees over that period, with the exception of Plan F and Pre-standardized plans. Plan F has been the most popular plan type since 2006, accounting for 32 percent of Medigap policyholders that year; by 2010, 40 percent of Medigap policyholders were in Plan F. In contrast, fewer policyholders have Pre-standardized policies now than in 2006; Pre-standardized policies accounted for 13 percent of policyholders in 2006, compared to 8 percent in 2010.

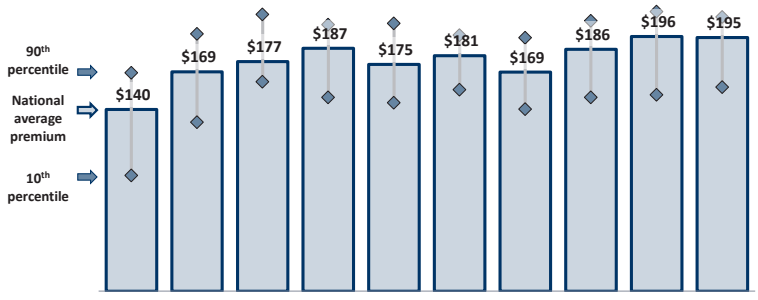
Medigap Premiums in 2010

Medigap premiums vary by plan type. This likely reflecting the relative generosity and popularity of each plan type's benefit structure. Nationally, among Plans A through J, Plan A has the lowest average premium of all plan types ($140), likely because it covers fewer services (**Exhibit 7**). Plan I has the highest average monthly premium, at $196.

Average Medigap premiums for a given plan type vary across states, despite a standardized benefit package. Even when ignoring the least expensive (in the lowest 10%) and most expensive (in the highest 10%) states, average premiums can vary by as much as $79 per month across states for the same plan, despite a standardized benefit package (Plan A, $89 to $168, **Exhibit 7**).[v] For example, the average Plan F premium across all states is $181 per month. Plan F premiums range from a low of $129 per month in Vermont, to a high of $226 in neighboring New York (**Exhibit 8**); both Vermont and New York require premiums to be community-rated, indicating that states' rating rules do not seem to exclusively determine whether states' average premiums are relatively low or high. In 80% of all states, the average monthly premium for Plan F was between $155 and $197. Similarly, average Plan C premiums nationwide are $177 per month, and in most states, the average monthly premium for Plan C was between $161 and $213 (**Appendix IV**).

EXHIBIT 7

Distribution of Monthly Medigap Premiums, Plans A – J, 2010

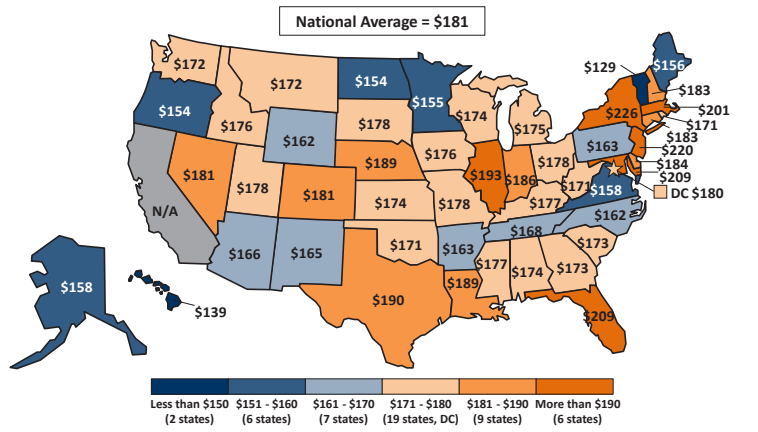


	A	B	C	D	E	F	G	H	I	J
10th percentile	$89	$130	$161	$149	$145	$155	$140	$149	$151	$157
90th percentile	$168	$198	$213	$205	$206	$197	$195	$208	$215	$211

NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-J; excludes plans K-L because of the small number of policyholders enrolled in these plans; excludes policies existing prior to federal standardization; excludes plans in Massachusetts, Minnesota, and Wisconsin; excludes plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2008-2009 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

EXHIBIT 8

Average Monthly Medigap Premiums for Plan F, by State, 2010



NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plan F; excludes plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2008-2009 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

[v] Plans K – N are not displayed due to the small number of policyholders with these plans. Estimated premiums for Plans F and J are averaged over those in the regular plan and in the high-deductible option.

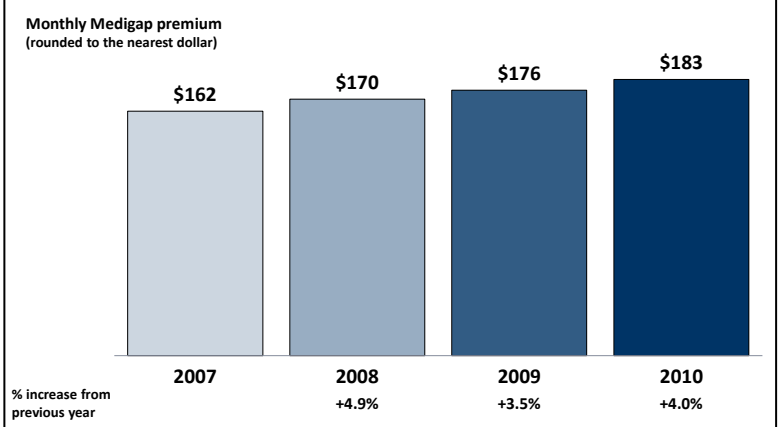
While premiums vary within a state, prior studies have shown that most premium variation occurs across states, rather than within states.[21] The variations by state are likely due to multiple factors, including the different rating practices, the relative competitiveness of each state's insurance market, and differences in health care spending, demographics, and health status of the beneficiaries with Medigap policies.

Medigap Premium Trends, 2007 – 2010

Medigap premiums increased an average of 4.1 percent per year between 2007 and 2010.[vi] National average premiums across all plan types increased modestly between 2007 and 2010 (**Exhibit 9**). National average premium levels rose fairly slowly over the four-year study period – from $162 per month in 2007 to $183 per month in 2010. Median premium growth was similar over the study period; median Medigap premiums were $160 per month in 2007, and grew an average of 4.6 percent per year, to $183 per month in 2010.

EXHIBIT 9

Average Monthly Medigap Premiums for All Plan Types, 2007 – 2010



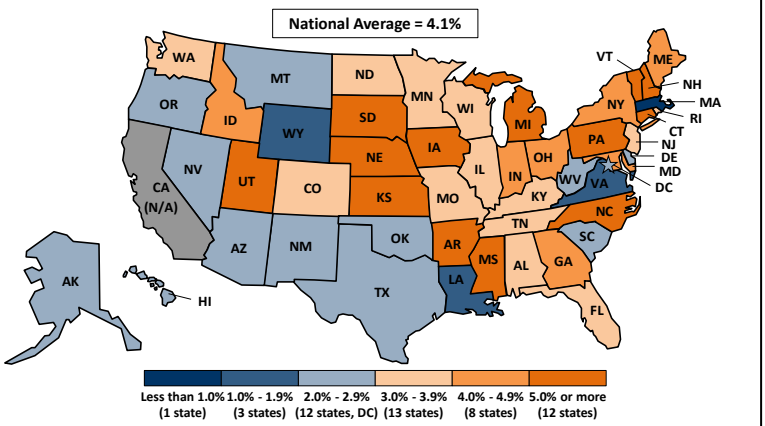
NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization, and plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program; excludes plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2006 – 2010 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

National average Medigap premiums have grown at the same rate as Medicare per capita costs between 2007 and 2010, as might be expected in that Medigap is designed as a supplement to Medicare**.** Medigap premiums, as well as Medicare per capita costs, had an average annual growth rate of 4.1 percent between 2007 and 2010.

Change in average premiums vary by state, by state rating rules, and by plan type. The average change in Medigap premiums varied moderately across the states (**Exhibit 10**). Between 2007 and 2010, average premiums declined in one state (MA), and increased less than 2 percent per year in three other states (LA, VA, and WY). Average premiums rose more than 5 percent per year in 12 states (AR, CT, IA, KS, MI, NC, NE, NH, PA, SD, UT, and VT).

EXHIBIT 10

Average Annual Change in Mean Premiums, by State, 2007 – 2010



NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Analysis includes standardized plans A-N, policies existing prior to federal standardization, and plans in Massachusetts, Minnesota, and Wisconsin that are not part of the federal standardization program; excludes plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2006 – 2009National Association of Insurance Commissioners (NAIC) Medicare Supplement data. CMS Medicare and Medicaid Statistical Supplement: Medicare Enrollment 2009, released September 30, 2010.

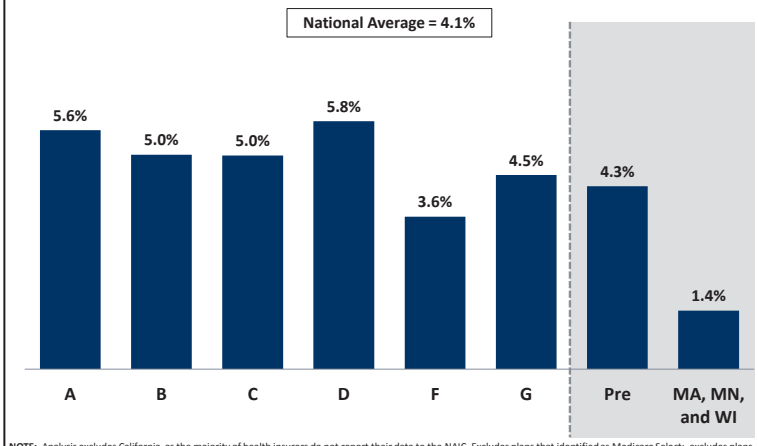
Changes in premiums were fairly similar across states when grouped by different rating rules. The average annual increase in premiums was lowest among states with issue age requirements (3.4% per year), slightly higher for states with community rating requirements (3.7% per year), and highest for states with attained age requirements (4.4% per year).

[vi] All growth rates in this report are compound annual growth rates.

The increase in average premiums differed slightly by plan type (**Exhibit 11**). Average premium increases among the standardized plan types over the four-year study period were generally in the range of 4 percent to 6 percent.[vii] Plan F, the plan type with the largest number of policyholders, experienced relatively low growth in premiums, with an average annual premium increase of 3.6 percent.

EXHIBIT 11

Average Annual Increase in Mean Premiums, by Plan Type, 2007 – 2010



NOTE: Analysis excludes California, as the majority of health insurers do not report their data to the NAIC. Excludes plans that identified as Medicare Select; excludes plans where number of covered lives was less than 20.
SOURCE: K. Desmond, T. Rice, and Kaiser Family Foundation analysis of 2006 – 2009 National Association of Insurance Commissioners (NAIC) Medicare Supplement data.

The greater apparent growth in premiums within most plan types (as compared to growth among the aggregate of Medigap plans) is more consistent with growth in Part B premiums and the Medicare program's per capita costs. The finding that overall Medigap premiums have increased more slowly than premiums within most plan types could be due to the possibility that the distribution of beneficiaries among plan types has changed over the years. Some beneficiaries with more expensive plans may be switching to less expensive plans and plan types, or dropping out of Medigap altogether. In addition, new enrollees could be enrolling in lower premium plans.

Impact of Age on Medigap Premiums

In most states, Medigap premiums vary among beneficiaries of different ages. Premiums for beneficiaries under age 65 were generally higher than premiums for 65-year olds. Similarly, premiums for 80-year old beneficiaries were also generally higher than premiums for 65-year olds.

Using premiums for a 65-year old beneficiary as a reference, we looked at variations in premiums by age, using Plan F premium information posted on state websites. Note that these premiums are advertised rates as listed in the states' premium comparison guides, and not necessarily equal to the premiums actually being paid by beneficiaries. State health insurance programs typically make this information publicly available to help inform beneficiaries' selection of Medigap policies. More information on the methodology using the state Medigap premium comparison guides is contained in **Appendix III**.

Premiums for beneficiaries with disabilities who are under age 65 were generally higher than premiums for beneficiaries age 65, for the same Plan F policy. In fact, across all policies in the 10 states, average premiums for beneficiaries under age 65 were 73 percent higher than average premiums for 65-year old beneficiaries (**Exhibit 12**).[viii] However, this ratio varies by state and by insurance company.

[vii] Plans E, H, I, and J were excluded, since these plans cannot be sold to new policyholders. Plans K and L were excluded due to the small number of policyholders enrolled in these plan types. Plans M and N were excluded, since these plans did not become available until June 2010.

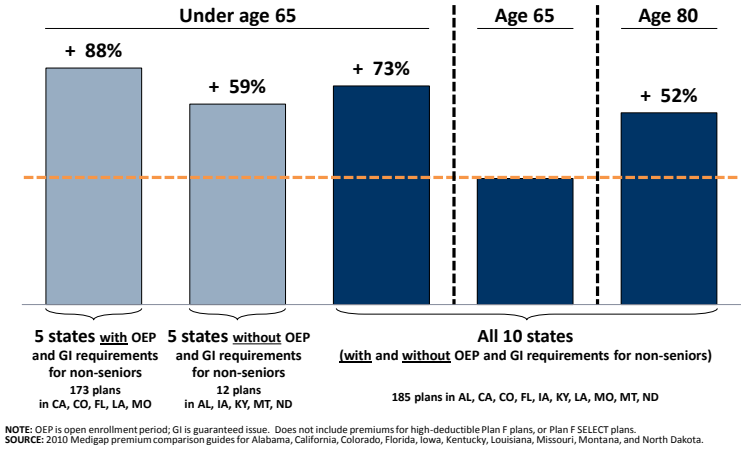
[viii] For each policy that reported premiums for beneficiaries under age 65, age 65, and age 80, we calculated two premium ratios (under age 65 compared to age 65, and age 80 compared to age 65). An unweighted average across all premium ratios was calculated for each state. This number (73%) is the unweighted average of the 10 states' ratios. For details on methodology, see **Appendix III**.

Variation in states with and without consumer protections for beneficiaries under age 65. In the five states with guaranteed issue and open enrollment requirements for Medicare beneficiaries under age 65 (CA, CO, FL, LA, and MO), premiums for beneficiaries under age 65 were, on average, nearly twice as much (88% higher) as premiums for beneficiaries age 65 for the same policy (**Exhibit 12**).

EXHIBIT 12

Plan F Premiums for a Female Non-Smoker, by Age, Relative to a 65-year old, in Selected States, 2010

in States With and Without Open Enrollment Periods (OEP) and Guaranteed Issue (GI) Requirements for Beneficiaries Under Age 65



NOTE: OEP is open enrollment period; GI is guaranteed issue. Does not include premiums for high-deductible Plan F plans, or Plan F SELECT plans.
SOURCE: 2010 Medigap premium comparison guides for Alabama, California, Colorado, Florida, Iowa, Kentucky, Louisiana, Missouri, Montana, and North Dakota.

In contrast, among the five states without guaranteed issue and open enrollment requirements for beneficiaries under age 65 (AL, IA, KY, MT, and ND), premiums for beneficiaries under age 65 were, on average, 59 percent higher than premiums for 65-year olds for the same policy. In these states, however, few insurers offered policies to beneficiaries under age 65. Alabama, Iowa, Montana, and North Dakota each only had one insurer that published premium data for beneficiaries under 65; Kentucky had eight insurers that listed premiums for these beneficiaries.

While on the surface, it seems that states without consumer protections for beneficiaries under age 65 have lower premiums for disabled beneficiaries, these states do not require the sale of Medigap policies to all beneficiaries under age 65. Thus, the insurance companies' selection of which beneficiaries to cover may influence the results of this analysis. For example, if insurance companies choose to only cover Medicare beneficiaries who are healthier, premiums would be lower than if the companies were required to cover all Medicare beneficiaries regardless of their health status.

Variation by state. The extent to which beneficiaries under age 65 had higher premiums than 65-year old beneficiaries varied considerably across states. For example, in Florida, the average monthly premium for a beneficiary under age 65 was nearly $740—more than twice the average monthly premium for a 65-year old beneficiary ($293). In comparison, the premiums listed for a disabled beneficiary in Missouri was only 13 percent higher than the premiums listed for a 65-year old for the same policy (about $190 and $170, respectively).

The relative difference in premiums paid by disabled beneficiaries and 65-year old beneficiaries can also vary by state, within an insurance company.[22] For example, beneficiaries with disabilities who are under age 65 were charged the same premium as 65-year olds, based on an examination of one firm's premiums for Plan F in Missouri; however, in Colorado and California, premiums offered by the same firm for Plan F policies were 22 percent and 174 percent higher for beneficiaries under age 65 than for 65-year old beneficiaries, respectively.

Variation by insurance company. Premiums for beneficiaries under age 65 relative to seniors also varied across insurance companies. In Colorado, for example, five insurance companies charged the same premium for under age 65 and 65-year old beneficiaries. However, one firm charged premiums that were nearly twice the amount for under age-65 beneficiaries with disabilities than for 65-year olds; another firm's premiums for beneficiaries with disabilities who were under age 65 were more than two and a half times the premiums for 65-year olds.

Relative Medicare costs for Medigap policyholders under age 65 (with disabilities) and age 65. The difference in premiums may be partly reflective of the differences in health care costs. When we used MCBS data to compare average Medicare spending for beneficiaries under age 65 with spending for older beneficiaries, we found that Medicare spent more than twice as much (103% more) per Medigap policyholder under age 65 than policyholders ages 65 to 69 in 2009.[23]

Premiums for older beneficiaries (age 80) were generally higher than those for beneficiaries age 65, for the same policy. Across the policies in the 10 states used in this analysis, premiums for 80-year olds averaged 52 percent higher than premiums for 65-year olds.

Variation by state. The extent to which 80-year old beneficiaries had higher premiums than 65-year olds varied by state. In Florida, the average monthly premium for an 80-year old beneficiary is $392, or about 34 percent higher than the average premium for a 65-year old ($293). In California, the average monthly premium for an 80-year old beneficiary was $279; while this premium is lower than the average premium for 80-year olds in Florida, it is nearly 60 percent higher than the average premium of $177 for 65-year olds in California.

The extent to which 80-year olds have higher premiums than 65-year olds can vary within an insurance company. Again, taking Humana's Plan F policy as an example, 80-year olds in Florida paid 23 percent more than 65-year olds in their state, whereas 80-year olds in California paid 63 percent more than 65-year olds.

Variation by insurance company. Premiums for 80-year old beneficiaries relative to 65-year old beneficiaries also varied across insurance companies. Using Colorado as an example, 80-year olds may pay premiums from 24 percent to 109 percent higher than 65-year olds, for the same policy in 2011.

Relative Medicare costs for Medigap policyholders age 65 and age 80. The difference in premiums could likely reflect the differences in health care costs for this age group. We examined the costs for beneficiaries age 80 or older, and compared this to the average cost of beneficiaries ages 65 to 69. In this case, the premium ratio is the same as the ratio of average per capita Medicare spending for Medigap policyholders in these two age groups. That is, in 2009, Medicare spent 52 percent more per Medigap policyholder age 80 or older, compared to policyholders ages 65 to 69.[23]

Impact of Gender on Premiums

We examined plan F premiums listed for 65-year old females and males to examine the effect of gender on premiums. Among younger adults, health care premiums tend to be higher for women than men; however, Medigap premiums are typically lower for female policyholders than for male policyholders.

Premiums for male beneficiaries were generally higher than those for female beneficiaries for the same policy. Among the plans that were used in this analysis, premiums for men were generally somewhat higher than those for women, based on Plan F. For example, premiums for male beneficiaries in the five states used in this analysis were 8 percent higher than premiums for female beneficiaries for the same policy, on average. Some insurance companies charged men and women the same premiums, whereas other insurance companies charged men premiums up to 20 percent higher than premiums for women. Premiums for men relative to women ranged from 6 percent higher for men than women in Florida, to 10 percent higher for men than women in Louisiana.

This difference in Medigap premiums may reflect the difference in Medicare costs. Among beneficiaries with Medigap, Medicare spent 8 percent more per male policyholder, compared to female policyholders, based on the analysis of the MCBS 2009 Cost and Use File.

Impact of Smoking on Premiums

Premiums for smokers were generally higher than those for non-smokers. Premiums for beneficiaries who smoke were 12 percent higher than for non-smokers with the same policy. The difference between smokers' premiums and non-smokers' premiums ranged from 6 percent in Florida, to 14 percent in Louisiana. The difference between smokers' and non-smokers' premiums also varied by plan: while smokers sometimes paid the same Medigap premiums as non-smokers, some smokers paid premiums that were 50 percent higher than premiums for non-smokers for the same policy.

As with age and gender, the difference in Medigap premiums between smokers and non-smokers may reflect differences in Medicare costs. When we compared the per capita Medicare costs for smoking and non-smoking beneficiaries, we found that among Medigap policyholders, Medicare spent 16 percent more on smokers than non-smokers, based on the Kaiser Family Foundation analysis of the MCBS 2009 Cost and Use File.

While smoking status plays a larger role than gender in determining premiums, the effect of age on premiums was greater than the effects of smoking status or gender.

Are Beneficiaries Choosing the Lowest-Premium Policies?

We examined whether Medicare beneficiaries were choosing Medigap policies with low premiums among the many plans offered in their area. To conduct this analysis, we looked at the subset of states that require premiums to be community-rated. If premiums are issue-age rated, they are based on the age at initial purchase, and if they are attained-age rated, they are based on current age of the beneficiary. As a result, beneficiaries in states that do not require premiums to be community-rated could have different premiums within the same plan type in the same state, due to differences in age, gender, or other factors. In states that require premiums to be community-rated, however, all beneficiaries face the same premium,[ix] and so premiums paid by each enrollee would be equal to the average premium calculated over all beneficiaries. To study this issue, we focused on Plan F, the most popular of the standard Medigap policies.

For this analysis, we calculated Plan F average premiums collected by each company in the community-rated states, by dividing total annual premium receipts by the number of covered lives. We also calculated market share, or percent of total Plan F enrollees in the state that are enrolled in each company. We compared each company's market share to their premiums relative to those of other companies in the state. In the prior version of this brief, we calculated average premiums by summing total premium receipts for policies sold in the past three years over all product lines for a company in 2010, and then dividing by number of covered lives at the end of the year. The revised methodology aims to correct for plans that enter and exit a market in a given year. The previously used methodology produced inaccurate results for a number of reasons.[x]

We made several adjustments to our premium calculations to address fluctuations in the market that are likely to affect premium estimates:

- We now conduct this analysis of plan choice using 2009 data, since the Medigap market was more stable during that year than in 2010.

[ix] However, in some states that require community rating, premiums may still vary by smoking status or by region.

[x] Under the previous methodology, year-end covered lives were used when calculating average premiums. This approach does not account for changes in enrollment that occur over the course of a year. This was a particular problem in 2010, as there were changes in the marketplace, and enrollment, due to the MIPPA of 2008 and the ACA of 2010. For example, companies could introduce plans during the year, and thus collect less than a full year's premiums from the people enrolled at year's end, resulting in calculated average premiums that are artificially low. Further, this approach does not account for enrollees or companies dropping their plans during the year, which could result in inflated estimates of average premiums.

- We include policies sold at any time to increase the reliability of the estimates; previously, we had only included policies sold in the past three years.
- When calculating average premiums, we no longer divide by year-end enrollment, but by the value at mid-year, calculated as the midpoint between enrollment in December of 2008 and December of 2009. This has two effects: (1) by limiting the analysis to companies that had 20 or more covered lives at both the beginning and end of 2009, we are including only companies that were in the market the entire year; and (2) by using mid-year covered lives, we can account to some extent for growth or decline in enrollment over the course of the year.
- We include in the analysis only companies that had a market share of 1 percent or greater, further ensuring that we are looking at stable, established products. We did not combine the market shares of subsidiaries with the same parent company because we assumed the subsidiaries priced their policies independently.

We also modified the methodology to account for the possibility that some of the Plan F premiums could be for high-deductible plans that would be expected to have lower premiums than the more commonly sold Plan F policies. We identified and removed the high-deductible product lines from the NAIC data for this analysis by using the policy's trade name for each company and comparing to state premium guides.[xi] In addition, we modified the analysis by focusing on five, rather than six community-rated states. We exclude Vermont from the analysis because, in contrast to the other community-rated states, Plan F was not the most popular Medigap plan in Vermont.

The results of this revised analysis show that Medicare beneficiaries tend to be enrolled in one of the lowest premium plans available to them. In four of the five states, the least expensive plan in each state was offered by the same insurance company; in 2009, this company garnered between 52 percent and 83 percent of the market for Plan F in those states – far more enrollees than any other plan. Specifically:

- **Connecticut**: There were four plans with at least 1 percent of the market share for Plan F. The plan with the lowest premium (based both on the NAIC data and the premiums listed on the state insurance department website) accounted for 64 percent of the total Plan F market share.
- **Maine**: There were only two plans with 1 percent or more of the market share for Plan F. The plan with the lowest premium (based on both data sources) had 77 percent of total Plan F enrollment.
- **New York**: There were six plans with at least 1 percent of the market share for Plan F. The plan with the lowest premium (based on both data sources) had 83 percent of total Plan F enrollment.
- **Washington**: There were eight plans with at least 1 percent of the market share for Plan F. The plan with the lowest premium (based on both data sources) had 52 percent of Plan F enrollment.

In Arkansas, there were 14 plans with at least 1 percent of the market for Plan F. Arkansas was the only one of the five states in which the company with the lowest premium was not the same insurer as in the other four states. Despite having a premium more expensive than the median premium offered in the state, this insurer still had the highest Plan F enrollment, garnering 20 percent of the market. The second-largest plan in Arkansas was almost as large, accounting for 19 percent of the Plan F market; the premium for this plan was among the lowest in the state.

[xi] We examined the NAIC data for these companies, and located the high-deductible option by comparing the trade name and matching it with the premiums listed in the state premium comparison guides; in this manner, we were able to identify and eliminate the high-deductible options, and to calculate and compare regular Plan F premiums to the values published in the state guides.

In summary, Medigap owners appear to be enrolled in plans with relatively low premiums; this was true in all five of the states examined. It is not entirely clear if beneficiaries choose Medigap plans based on premiums, comfort with familiar brands, or if they take multiple factors into account.

These results are not consistent with findings based on other health insurance markets in which Medicare beneficiaries participate. Numerous studies of stand-alone Part D plans have found that very few beneficiaries choose the lowest-cost plans. In one recent study, Zhou and Zhang found that only 5.2 percent of Part D enrollees were enrolled in the lowest-cost plan given their medication needs, which cost them, on average, an extra $368 per year.[24] Similarly, in the Medicare Advantage marketplace, about 35 percent of Medicare Advantage enrollees paid more than $50 per month for their plan, when a zero-premium plan was available, indicating that their plan selection may have been based on more factors than just the premium.[25] Several studies indicate that while premiums can be an important consideration in beneficiaries' Medicare Advantage plan choices, other factors, such as broader provider networks, lower cost-sharing, extra benefits, and familiarity or satisfaction with a particular company or firm, also play a role.

Why, then, do consumer choices appear to be more premium-sensitive in the Medigap market? One possible explanation is that Medigap benefits are standardized. With standardized benefits, the main difference between alternative plans is the premium because the benefits are identical. Standardization facilitates comparison shopping, allowing consumers to choose a benefit design, and then compare premiums. This is not the case for either the Medicare Part D or Medicare Advantage markets, where plans may differ across a number of different dimensions making price comparisons more challenging for beneficiaries.

DISCUSSION

Medigap continues to play a key role in providing supplemental coverage for people on Medicare, particularly among those who do not have access to employer-sponsored retiree health benefits and do not qualify for Medicaid. Today, nearly one quarter of the Medicare population (24%) has a Medigap policy, with higher Medigap enrollment rates among beneficiaries living in rural states. Medigap enrollment has remained relatively stable between 2006 and 2010, despite the growth of alternative sources of coverage, especially Medicare Advantage. The majority of Medigap policyholders are enrolled in plans that provide what is known as first-dollar coverage; these plans cover Part A and B deductibles along with other Medicare cost-sharing requirements. Plans with first-dollar coverage are relatively popular because they minimize enrollees' financial exposure to out-of-pocket costs for Medicare-covered services, and shield beneficiaries from some of the hassles associated with handling health insurance bills.

In recent years, some policymakers have proposed to restrict or discourage Medigap coverage, as part of a broader effort to reduce the debt and deficit. Restrictions on Medigap coverage would be expected to increase cost-sharing obligations among beneficiaries, which could discourage beneficiaries from seeking Medicare-covered services. Medicare savings would be achieved if beneficiaries forego services because of costs. Some have proposed a premium surcharge on supplemental policies, both Medigap and employer-sponsored retiree health coverage (e.g., MedPAC, 2012). Some would prohibit first-dollar Medigap coverage (e.g., Bowles-Simpson, 2010). Still others would impose a premium penalty on first-dollar Medigap coverage, but apply the surcharge prospectively to new enrollees rather than current policyholders (e.g., President Obama's Plan for Economic Growth and Deficit Reduction, 2011).

Proposals to restrict or discourage Medigap coverage could have cost implications for beneficiaries. For example, a surcharge on Medigap policyholders in 2010 would have raised premiums for as many as nine million beneficiaries (unless they dropped their policies to avoid the surcharge). A premium surcharge on beneficiaries with first-dollar Medigap coverage in 2010 would have raised premiums for as many as five million Medigap policyholders with Plans C or F. A premium surcharge applied prospectively would not affect

current Medigap policyholders; presumably fewer beneficiaries would choose first-dollar coverage in the future. Restrictions on first-dollar Medigap coverage could also result in a reduction in Medigap premiums, if policies cover a smaller share of total claims. As a result, some beneficiaries could see lower total out-of-pocket costs (including premiums). However, other policyholders in relatively poor health or with one or more hospital admissions during the year could see costs rise. Furthermore, if cost-sharing were required for all Medigap plans, there is some evidence that utilization would decrease across several types of services (including necessary services and preventive services), leading to more costly care in the long term.[26,27]

Looking ahead, Medigap may continue to play an important role in supplementing Medicare, particularly if Medicare Advantage coverage erodes in response to payment reductions in the ACA, or if employers continue to scale back on providing retiree health coverage. Further, if Medicare cost-sharing requirements are increased as part of deficit reduction efforts, the demand for Medigap may rise as beneficiaries seek additional financial protection against these costs. Conversely, the demand for Medigap could diminish over time if policymakers enact changes to discourage or prohibit beneficiaries from purchasing Medigap policies as part of the broader effort to reduce the growth in Medicare spending.

APPENDIX I: Age Rating Rules and Consumer Protections for Beneficiaries Under Age 65, by State

State	Premium Rating Rule	Requirements for Beneficiaries under age 65			
		Guaranteed Issue Requirement (insurance companies offer at least one plan to those under age 65)	Open Enrollment Period Requirement (period of time when beneficiary has guaranteed issue rights, and available policies cannot be underwritten)	Require same premium for seniors and non-seniors	Require same premium for all non-seniors
Alabama	Attained Age Rating	No requirement	None	No	No
Alaska	Attained Age Rating	No requirement	None	No	No
Arizona	Issue Age Rating	No requirement	None	No	No
Arkansas	Community Rating	No requirement	None	No	No
California*	Attained Age Rating	Disabled	Disabled	No	No
Colorado	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	Yes
Connecticut*	Community Rating	Disabled and ESRD	Disabled and ESRD	Same premium as all other Medicare beneficiaries	Yes
Delaware	Attained Age Rating	ESRD	ESRD	No	No
District of Columbia	Attained Age Rating	No requirement	None	No	No
Florida	Issue Age Rating	Disabled and ESRD	Disabled and ESRD	No	Yes
Georgia	Issue Age Rating	Disabled and ESRD	Disabled and ESRD	No	No
Hawaii	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	Same premium as beneficiaries age 65	Yes, during the open enrollment period
Idaho	Issue Age Rating	No requirement	None	No	No
Illinois	Attained Age Rating	Disabled and ESRD	Disabled	No more than highest advertised rate	Yes
Indiana	Attained Age Rating	No requirement	None	No	No
Iowa	Attained Age Rating	No requirement	None	No	No
Kansas	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	Same premium as beneficiaries age 65	Yes
Kentucky	Attained Age Rating	No requirement	None	No	No
Louisiana	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	No
Maine*	Community Rating	Disabled and ESRD	Disabled and ESRD	Same premium as all other Medicare beneficiaries	Yes

State	Premium Rating Rule	Requirements for Beneficiaries under age 65			
		Guaranteed Issue Requirement (insurance companies offer at least one plan to those under age 65)	Open Enrollment Period Requirement (period of time when beneficiary has guaranteed issue rights, and available policies cannot be underwritten)	Require same premium for seniors and non-seniors	Require same premium for all non-seniors
Maryland	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	Plan A premiums for individuals under age 65 may not be higher than the average Plan A premium charged to individuals over age 65; no requirements for other plan types	Plan A premiums are the same for all beneficiaries under age 65; no requirements for other plan types
Massachusetts*	Community Rating	Disabled	Disabled	Same premium as all other Medicare beneficiaries	Yes
Michigan	Attained Age Rating	Disabled and ESRD	None	No	No
Minnesota	Community Rating	Disabled and ESRD	Disabled and ESRD	Same premium as all other Medicare beneficiaries	Yes
Mississippi	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	Yes
Missouri*	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	Yes
Montana	Attained Age Rating	No requirement	None	No	No
Nebraska	Attained Age Rating	No requirement	None	No	No
Nevada	Attained Age Rating	No requirement	None	No	No
New Hampshire	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No more than highest advertised rate	Yes, during the open enrollment period
New Jersey	Attained Age Rating	Disabled and ESRD	Disabled and ESRD; only for Plan C for beneficiaries ages 50 and over	No more than lowest advertised rate for beneficiaries over age 65	No
New Mexico	Attained Age Rating	Disabled and ESRD	None	No	No
New York*	Community Rating	Disabled and ESRD	Disabled and ESRD	Same premium as all other Medicare beneficiaries	Yes
North Carolina	Attained Age Rating	Disabled and ESRD	Disabled and ESRD; only for Plans A, C, and F	No	Yes, during the open enrollment period
North Dakota	Attained Age Rating	No requirement	None	No	No

State	Premium Rating Rule	Requirements for Beneficiaries under age 65			
		Guaranteed Issue Requirement (insurance companies offer at least one plan to those under age 65)	Open Enrollment Period Requirement (period of time when beneficiary has guaranteed issue rights, and available policies cannot be underwritten)	Require same premium for seniors and non-seniors	Require same premium for all non-seniors
Ohio	Attained Age Rating	No requirement	None	No	No
Oklahoma	Attained Age Rating	Disabled and ESRD	Disabled and ESRD; only for Plan A	No	No
Oregon	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	Same premium as beneficiaries age 65	Yes
Pennsylvania	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	Same premium as beneficiaries age 65	Yes
Rhode Island	Attained Age Rating	No requirement	None	No	No
South Carolina	Attained Age Rating	No requirement	None	No	No
South Dakota	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	Same premium as beneficiaries age 75	Yes
Tennessee	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	No
Texas	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	Yes, during the open enrollment period
Utah	Attained Age Rating	No requirement	None	No	No
Vermont	Community Rating	Disabled	Disabled	No	Yes
Virginia	Attained Age Rating	No requirement	None	No	No
Washington*	Community Rating	No requirement	None	No	Yes
West Virginia	Attained Age Rating	No requirement	None	No	No
Wisconsin	Attained Age Rating	Disabled and ESRD	Disabled and ESRD	No	Yes
Wyoming	Attained Age Rating	No requirement	None	No	No

* Some states have additional open enrollment requirements for Medigap policyholders. California has an annual open enrollment period within 30 days after birthday each year, if the beneficiary is a current Medigap policyholder. Connecticut and New York have continuous open enrollment throughout the year. Maine has an annual open enrollment in June for Plan A only; beneficiaries can also change to a plan with the same or lesser benefits if they have no gaps in coverage of 90 days or more. Massachusetts has an annual open enrollment period between February 1 and March 31 every year. Missouri has an annual open enrollment period 30 days before and after Medigap purchase anniversary. Washington allows current Medigap policyholders to change to a plan with the same or lesser benefits throughout the year.

APPENDIX II:
Data Sources and Methodology – National Association of Insurance Commissioners

Analyses are based upon five years of annual data -- 2006 through 2010 -- from the Medicare Supplement reports collected by the NAIC. Insurance companies selling Medigap policies are required to report data to the NAIC, which aggregates and reports the information. These data include the number of policyholders (also called covered lives), total premiums, and total claims for each insurance company and type of plan sold.

For a given company/plan-type within a state (e.g., "Consolidated Healthcare," Plan F in Florida), there may be multiple lines of data reported, reflecting the history of the business such as mergers and acquisitions, regular and Medicare SELECT policies, and individual and group policies. Data are also reported separately for policies issued in the last 3 years, and for policies issued in prior years. With the exception of SELECT policies, which are counted separately, we aggregated data for each company/plan-type. The NAIC data do not allow us to analyze variations in premiums within geographic areas smaller than the state.

States included. With the exception of plans in California, most insurance companies selling Medigap policies are required to report data to the NAIC; thus, we focused only on data from the 49 states and the District of Columbia.[**] California was excluded because only a minority of companies in California reported data to the NAIC. We also excluded data from Guam, Puerto Rico, the Virgin Islands, and American Samoa.

Plan types. Plan types A-J were well-established in 2006, and were offered through June 2010. After that, plan types E, H, I and J could no longer be sold. Plan types K and L were first sold in 2006 and plan types M and N were added in 2010.

Beneficiaries enrolled in policies issued prior to Medigap standardization in 1992 were allowed to keep these non-standardized plans. Although the benefit structure of such plans may vary, they are treated, for purposes of the current analyses, as if they were a single additional type of plan, "Pre-standardized." It should be noted that holders of such policies are on average much older than those who own standardized policies.

Three states, Massachusetts, Minnesota and Wisconsin, were exempted from Medigap standardization because they had already established standardized plans. Policies sold in these states are also treated as a single additional type of plan, "MA, MN, and WI." Although the nationally standardized plan types are not sold in these grandfathered states, there are policyholders owning such plans who originally purchased them elsewhere. These data (i.e., premiums, claims, and covered lives for standardized plans in MA, MN, and WI) were included in our estimates, with one exception: when examining states by standardized plan type, grandfathered states were not considered.

Finally, enrollment in SELECT plans is reported. However, we do not include SELECT policies when analyzing premiums. Although these policies cover the same benefits as the standardized policies, SELECT policies have preferred provider networks, and are not comparable to the non-SELECT market.

Methodology. Covered lives and premiums were aggregated across multiple reported lines, across year of issue, and across individual and group policies for each type of plan, within each company, within each state. Each resulting record is referred to as a state/company/plan-type.

[**] In the NAIC data, there were nearly 286,000 Plan J policyholders with Health Alliance Plan of Michigan in 2006; this plan was not in NAIC 2007 – 2010. Health Alliance Plan of Michigan confirmed that they have never offered Plan J. Data for company 95844, Health Alliance Plan of Michigan, were excluded from this analysis. Information for the Anthem Insurance Company in Indiana was included in the NAIC data for 2006-2008, and for 2010, but was not available for 2009. Values for 2009 were interpolated as the midpoint between 2008 and 2010, and included in these analyses. The prior version of this brief did not include these interpolated values.

To reflect the experience of insurance products that are currently viable, and to reduce the likelihood of extreme or anomalous values, we discarded state/company/plan-type records with aggregated premiums that were less than or equal to zero, or that had aggregated covered lives of less than 20.

The summed values for state/company/plan-type were themselves summed to several levels of aggregation: plan types within state (state/plan-type); plan types across states (plan-type); states across plan types (state); and summed over all states, plans, and companies (US total).

In the prior version of this brief as well as this revision, enrollment is presented as reported in the NAIC data – as counts of covered lives as of December 31st of each year.

At the state and US total level, percent of Medicare beneficiaries covered by Medigap was calculated as

$$\left(\frac{Summed\ number\ of\ year{-}end\ covered\ lives}{Number\ of\ Medicare\ beneficiaries^{28}}\right) \times 100.$$

In this revised brief, we calculate average monthly premiums differently from the prior version. Monthly average premiums, as described below, are calculated by dividing total premiums collected during the year by the number of enrollees. In the earlier brief, we used year-end enrollment as the divisor. Although that method was not sensitive to enrollment changes between companies within a state/plan-type or higher level aggregation, it did not adequately control for overall growth or decline in enrollment over the course of a year. For example, if enrollment in a plan type declined during a year, the aggregated premiums collected during the year would include payments from enrollees no longer counted at the end of the year, and the estimated premium would be too high. Conversely, if enrollment grew, aggregated premiums would not reflect a full year of payment from those counted at year's end, and the estimated premium would be too low. Ideally, we would like to know average daily enrollment for the best estimate of average monthly premiums. Since the NAIC data include only year-end enrollment, we now approximate average enrollment by estimating the mid-year number of covered lives (i.e., the mid-point between current year December 31 enrollment and prior year December 31 enrollment). For this reason, we can no longer calculate premiums for 2006, our first year of NAIC data. §§§

The total number of Medigap enrollees in December of 2010 was 9.3 million. As noted above, when calculating premiums, we excluded those in Medicare SELECT policies, leaving 8.4 million enrollees in the analysis. With the revised method of premium calculation, companies were required to have data for the current and prior year in order to derive mid-year number of covered lives. For 2010, there were 8.0 million enrollees (95%) in plans with prior-year data. For 2007-2009, the percent of enrollees with prior-year data was 98 percent or higher.

At each level of aggregation, average monthly premiums were calculated as

$$\left(\frac{Summed\ premiums}{Estimated\ mid-year\ lives}\right) \div 12$$

Descriptive statistics on numbers of policyholders and average premiums are presented at the national, state, and plan-type level, and by state rating methods (community rating, issue age rating, and attained age rating). Analyses are conducted examining the most current available data (2010) as well as enrollment trends over the five-year period 2006-2010, inclusive. Trends in premiums are analyzed over the period 2007-2010.

§§§ Despite this adjustment in methodology, implausible values remained for some state/company/plan-type records that experienced significant changes in enrollment from one year to the next. For the most part, these were in situations where the number of covered lives was low, and the extreme values did not affect overall weighted estimates. In one case, Independence BCBS Plan A in Pennsylvania, reported enrollment dropped from 58,601 in 2009 to 708 in 2010. This company was excluded when calculating premiums for 2010.

Because these averages and percentages were calculated using summed values at each level of aggregation, they are effectively weighted by the relative market share of each company's product. When calculating percentiles (e.g., medians), it was necessary to explicitly weight by number of covered lives.

Increases in average premiums were calculated as

$$\left(\frac{Premium_{i,2010} - Premium_{i,2006}}{Premium_{i,2006}}\right) \times 100,$$

where *i* indicates the level of aggregation (such as nation, state, or plan-type), year and/or rating method.

In a final set of analyses, we wished to examine whether beneficiaries were price-sensitive when choosing to purchase policies from the array of companies offering them. These analyses had to be limited to community-rated states, where average premiums reflect the price of policies on offer to beneficiaries (as opposed to issue-age or attained-age states, where the premiums are allowed to differ between individuals). We did not include Vermont in this analysis, as the number of enrollees in Plan F was too low. We included the other community-rated states: Arkansas, Connecticut, Maine, New York, and Washington. We looked at Plan F only, and eliminated policies identifiable as high-deductible Plan F. For each company in a state, we calculated its 2009 premium as described above. We also calculated market share, or percent of Plan F policyholders in the state purchasing from that company. We limited the analysis to companies with a market share of 1 percent or greater. We compared market share against premiums. If beneficiaries are price-sensitive, we would expect that as premiums go up, market share will go down.

One limitation of using the NAIC data is that the findings are based upon aggregates, summed over all policyholders, for a particular company and a particular plan type. These figures therefore do not reflect the premiums charged to a particular individual or the specific claims filed by an individual. Premiums collected in a given calendar year may not reflect actual activity that year because there could be lags in premium credits. We do not know the number of covered lives over the course of the entire year, and must approximate mid-year values when calculating premiums. Inaccuracies in estimated covered lives could result in premium values that are too high or too low, depending on what happens in the insurance market. A second limitation is that in situations where there are few policyholders for a particular plan type for an insurer in a state, exceptionally high or low claims experiences will skew the results. For this reason, we limit the analysis to cases where there are at least 20 covered lives for a particular plan type for an insurer within a state. This reduced the number of covered lives included in the analysis by 0.5 percent. We also, when discussing ranges of estimates, examine the range between the 10th and 90th percentiles, to exclude extreme values that may result from problems in premium calculation. A further limitation is that the NAIC data may contain errors or misreported values. With the exception of three companies noted in the footnotes above, no effort was made to identify or correct such errors. A final limitation is that California is not included in the study because most insurers report to a state agency that is not required to share data with the NAIC.

APPENDIX III:
Data Sources and Methodology – State Medigap Premium Comparison Guides

For the analysis of premium variation by age, sex, and smoking status, we reviewed Medigap premium information posted on each state's website. Our analysis focuses on states that list premiums for Plan F effective in 2011. We selected Plan F because it has the highest number of policyholders, accounting for 44 percent of beneficiaries with Medigap in 2010. High-deductible plans and Medigap SELECT plans were excluded from this analysis, because the different benefit structure in high-deductible plans and the existence of preferred provider networks in SELECT plans makes these plan types less comparable to standard Plan F. States that require community rating were also excluded from the analyses, since premiums in community rated states do not vary by age, gender, or smoking status. For states that listed different premiums for different sub-state areas, we selected the zip code, county, or city with the largest number of Medicare beneficiaries.

We defined a "reference" beneficiary as a 65-year old, non-smoking woman. To compare the difference in premiums by a given demographic characteristic, we collected Plan F premiums listed for the reference beneficiary and the corresponding premiums of a counterpart who was matched on all characteristics except the characteristic of interest. We then took a ratio of these premiums, and computed the unweighted mean (average) of the ratios within each state. Every plan that reported premiums had the same weight as every other plan that reported premiums in the same state—that is, these averages are an average of what is offered in each state, not an average of the plans that are bought in each state. The ratio across states was calculated by computing the unweighted average of the states' premium ratios; thus, in analyzing premium ratios across several states, every state included in the analysis was given the same weight.

For the analysis of premium variations by age, we used only plans that reported premiums for beneficiaries under age 65 (nonelderly), age 65, and age 80; plans that did not list premiums for all three ages were excluded from the analysis. As stated earlier, some states have guaranteed issue requirements that require insurance companies to offer at least one kind of Medigap policy to beneficiaries under age 65; some states also require insurance companies to offer policies to non-senior beneficiaries at the same premium as beneficiaries age 65. We excluded states that "benchmarked" premiums for non-senior beneficiaries to premiums charged to senior beneficiaries. We conducted two analyses of premiums by age: one using states that had guaranteed issue and open enrollment requirements for all beneficiaries under age 65 (including both disabled and ESRD beneficiaries), and the other using states that did not have guaranteed issue requirements or open enrollment requirements. States that reported premiums as a range were also excluded.

The following states met all of the criteria listed above, and had 2011 Plan F premiums available at the time of the analysis. Data from these states were used for the following analyses:

- **Variation by age,** among states WITH guaranteed issue requirements for Medicare beneficiaries under age 65: California, Colorado, Florida, Louisiana, and Missouri; and
- **Variation by age,** among states WITHOUT guaranteed issue requirements for Medicare beneficiaries under age 65: Alabama, Iowa, Kentucky, Montana, and North Dakota.

For the analysis of premium variation by gender and smoking status, we used the five states with plans that had 2011 Plan F premiums listed for male and female smokers and non-smokers in the county with the largest number of Medicare beneficiaries: Florida, Kansas, Louisiana, Maryland, and North Carolina.

Premiums are estimates or examples of rates offered at the time data were downloaded, and do not reflect actual rates for the full year. Several states, including New Hampshire and Missouri, note that rates listed in their Medigap premium comparison guide were effective as of a certain date, but may change during the year. Not all companies are required to report in all states; for example, Kentucky notes that premiums for PacificCare Life and Health Insurance Company, State Farm Mutual Automobile Insurance Company, and Sterling Life Insurance Company, among others, are not listed in the Kentucky Medigap premium comparison guide.

APPENDIX IV: Medigap Plan C and Plan F Enrollment and Premiums, by State, 2010

State	Medigap Plan C, 2010			Medigap Plan F, 2010		
	Number of policyholders*	Share of all Medigap policyholders*	Average monthly premium	Number of policyholders*	Share of all Medigap policyholders*	Average monthly premium
United States	**1,244,864**	**13%**	**$177**	**3,738,483**	**40%**	**$181**
Alabama	5,467	3%	$205	18,957	9%	$174
Alaska	640	8%	$164	4,247	54%	$158
Arizona	12,297	8%	$184	109,044	67%	$166
Arkansas	2,818	2%	$199	30,720	20%	$163
*California***						
Colorado	5,002	5%	$186	66,773	64%	$181
Connecticut	17,796	12%	$205	48,879	32%	$183
Delaware	2,322	7%	$183	8,782	27%	$184
District of Columbia	639	9%	$208	2,860	42%	$180
Florida	93,361	15%	$205	159,275	25%	$209
Georgia	27,977	12%	$182	132,215	55%	$173
Hawaii	433	11%	$142	1,814	45%	$139
Idaho	2,703	5%	$176	38,800	72%	$176
Illinois	17,407	3%	$213	329,064	54%	$193
Indiana	20,588	7%	$201	162,923	56%	$186
Iowa	4,735	2%	$200	184,395	73%	$176
Kansas	20,820	11%	$193	145,773	74%	$174
Kentucky	16,582	10%	$190	58,323	35%	$177
Louisiana	3,971	3%	$220	63,145	55%	$189
Maine	19,654	26%	$170	31,736	43%	$156
Maryland	28,795	18%	$238	75,852	46%	$209
Massachusetts	1,560	1%	$177	1,139	1%	$201
Michigan	185,048	52%	$119	76,524	22%	$175
Minnesota	275	0%	$155	705	0%	$155
Mississippi	5,772	5%	$204	83,813	68%	$177
Missouri	20,721	8%	$199	155,642	58%	$178
Montana	7,406	15%	$168	27,239	53%	$172
Nebraska	5,744	4%	$202	88,934	69%	$189
Nevada	2,672	6%	$196	27,193	59%	$181
New Hampshire	3,812	6%	$204	14,220	22%	$183
New Jersey	105,610	31%	$218	68,430	20%	$220
New Mexico	2,918	7%	$158	22,475	56%	$165
New York	41,318	12%	$214	142,970	40%	$226
North Carolina	23,606	7%	$204	132,317	36%	$162
North Dakota	1,338	2%	$169	48,188	88%	$154
Ohio	92,832	26%	$201	115,073	32%	$178
Oklahoma	6,303	4%	$182	85,419	59%	$171
Oregon	5,878	6%	$174	67,996	69%	$154
Pennsylvania	283,163	47%	$143	55,946	9%	$163
Rhode Island	25,997	76%	$168	4,915	14%	$171
South Carolina	8,736	5%	$184	89,112	52%	$173
South Dakota	1,028	2%	$177	47,352	70%	$178
Tennessee	18,657	11%	$196	83,255	50%	$168
Texas	30,612	5%	$213	303,425	54%	$190
Utah	3,958	9%	$189	20,601	49%	$178
Vermont	13,517	35%	$167	978	3%	$129
Virginia	16,454	6%	$190	147,956	56%	$158
Washington	15,857	8%	$172	100,985	51%	$172
West Virginia	7,111	11%	$183	30,993	48%	$171
Wisconsin	406	0%	$178	633	0%	$174
Wyoming	2,548	8%	$167	20,478	68%	$162

* Enrollment as of December 31, 2010. **California was excluded from this study because companies in California are not required to report to NAIC, leading to incomplete data on Medigap enrollment and premiums in California.

APPENDIX V: Medigap Policyholders at Year-End, by State, 2006 – 2010

	2006	2007	2008	2009	2010
United States	**9,462,146**	**9,200,102**	**9,138,193**	**9,116,060**	**9,290,144**
Alabama	231,585	227,243	218,224	203,306	205,064
Alaska	6,224	6,514	7,013	7,421	7,921
Arizona	123,403	128,593	136,119	147,985	162,182
Arkansas	157,567	154,474	153,035	152,723	152,998
*California**					
Colorado	89,592	92,168	94,869	98,876	104,238
Connecticut	190,820	180,319	167,308	159,326	154,191
Delaware	27,421	27,580	28,545	30,310	32,593
District of Columbia	5,934	6,006	6,371	6,798	6,883
Florida	630,423	630,695	634,141	639,425	642,266
Georgia	228,872	225,609	227,447	233,255	239,223
Hawaii	3,644	3,666	3,760	3,923	4,065
Idaho	56,761	54,871	52,764	51,787	54,223
Illinois	583,961	579,572	578,731	591,008	608,096
Indiana	292,777	290,071	293,957	288,111 **	292,142
Iowa	256,827	249,980	245,832	246,559	252,843
Kansas	193,563	189,312	186,241	193,141	196,048
Kentucky	174,187	170,468	166,381	166,066	168,450
Louisiana	126,765	119,549	115,589	114,634	115,640
Maine	85,777	83,422	80,074	77,206	74,336
Maryland	155,391	155,044	156,817	160,382	164,198
Massachusetts	205,562	207,389	209,361	209,038	210,571
Michigan	319,752	304,103	309,107	328,421	355,692
Minnesota	243,450	227,379	209,274	196,392	165,742
Mississippi	116,436	116,758	117,246	117,508	122,608
Missouri	263,045	272,224	271,350	265,326	267,218
Montana	55,781	52,833	50,891	49,412	50,954
Nebraska	151,899	129,530	129,347	128,140	129,723
Nevada	39,030	40,221	41,873	43,861	46,390
New Hampshire	65,317	64,827	64,565	64,861	65,632
New Jersey	323,658	324,419	327,153	332,955	341,520
New Mexico	37,555	37,964	38,400	38,678	39,945
New York	400,429	387,732	373,063	364,598	356,360
North Carolina	341,697	338,202	338,418	345,216	362,909
North Dakota	57,274	56,292	55,794	55,653	54,716
Ohio	348,540	347,003	358,192	346,820	355,533
Oklahoma	132,326	132,191	133,576	139,408	144,292
Oregon	88,877	86,671	86,409	89,910	98,482
Pennsylvania	725,945	645,896	632,253	600,079	606,288
Rhode Island	32,225	32,477	32,719	33,179	34,180
South Carolina	162,769	159,641	160,932	165,259	170,556
South Dakota	68,585	65,262	64,398	67,333	67,191
Tennessee	168,914	160,135	158,752	160,469	166,518
Texas	534,668	527,985	530,967	545,466	566,289
Utah	54,703	51,938	45,202	41,168	42,323
Vermont	36,489	36,132	36,446	37,231	38,157
Virginia	262,205	257,363	253,824	255,398	265,844
Washington	215,454	208,627	198,303	195,448	199,318
West Virginia	69,358	65,668	63,784	62,322	64,200
Wisconsin	291,902	260,753	265,415	235,444	233,396
Wyoming	26,807	27,331	27,961	28,825	29,997

* California was excluded from this study because companies in California are not required to report to NAIC, leading to incomplete data on Medigap enrollment and premiums in California. ** Information for the Anthem Insurance Company in Indiana was included in the NAIC data for 2006-2008, and for 2010, but was not available for 2009. Values for 2009 were interpolated as the midpoint between 2008 and 2010, and included in these analyses. The prior version of this brief did not include these interpolated values.

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[6] The National Commission on Fiscal Responsibility Reform, in the report "The Moment of Truth," released on December 1, 2010, proposed creating a combined annual deductible of $550, setting a single coinsurance rate of 20%, setting coinsurance of 5% for costs between $5,550 and $7,500, and setting an annual out-of-pocket maximum of $7,500. Medigap plans would also be prohibited from covering the first $500 of cost sharing, and limited to covering 50% of the next $5,000.

In contrast, the 2008 Budget Options, released in December 2008, included an option to unify cost sharing for Part A and B beginning in 2011, by creating a combined annual deductible of $525, setting a single coinsurance rate of20%, and setting an annual out-of-pocket maximum of $5,250. Medigap plans would also be prohibited from covering the first $525 of cost sharing, and limited to covering 50% of the remaining cost-sharing requirements.

[7] The CBO also included several other Medigap reform options in 2008, including levying an excise tax on Medigap plans, projected to produce savings of $12.1 billion between 2009 and 2018. Congressional Budget Office. "Budget Options: Volume 1; Health Care." December 2008. https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf.

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This brief has a few key differences from the report ASPE released in December 2011. One part of our study that is unique is that we analyze the frequency with which Medigap policyholders choose the lowest cost plan available. In addition, there are a number of technical differences between our report and ASPE's. First, the rating rules of two states have been corrected: Arkansas uses community rating, and Arizona bans attained age rating. These two rating rules have been confirmed by their respective states and are also noted in each state's premium comparison guides. Second, we drop California from our NAIC analysis, because most insurers report to a state agency that is not required to share data with the NAIC. Third, we drop all plans in the states that are exempt from Medigap standardization in the analyses of premiums by plan type (Massachusetts, Minnesota, and Wisconsin); this is because the vast majority of Medigap enrollees have Medigap policies that are unique to the state and are not available elsewhere, which could significantly affect the pricing of the nationally-standardized plans in these three states. Fourth, we exclude SELECT plans from our analyses; where SELECT plans are included, they are treated as a separate plan type. This is because SELECT plans have preferred provider networks, and beneficiaries receiving care from outside the preferred provider networks may have additional cost-sharing. Fifth, for all of our analyses on average premiums, we use estimated mid-year enrollment, rather than year-end enrollment (as reported by

the NAIC). This is because with various plans entering and exiting the market during the year, using year-end enrollment can lead to exaggeration of average premiums. Sixth, we use imputed data for enrollment in Indiana in 2009; Anthem Health in Indiana was in the NAIC data in 2006, 2007, 2008, and 2010, but was not reported in 2009, though the plan was still available to Medigap policyholders. Finally, in cases where the Medicare Current Beneficiary Survey is used, we used the 2008 Cost and Use File (rather than the 2009 Access to Care File). The Access to Care files have not been reconciled and undercount new enrollees, people who die during the year, and people living in institutions. It is also unclear how ASPE codes the types of supplemental coverage; we include all Medicare beneficiaries with a Medigap policy at any point in the year as people with Medigap coverage.

[12] The medical loss ratio is the percentage of premiums collected by an insurer that are returned to policy holders in the form of health benefits.

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THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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