

#9915  
October 1999

**Disabled Medicare Beneficiaries Under Age  
65: A Review of State Efforts to Provide  
Access to Medicare Supplemental Insurance**

by  
**Nicole Tapay  
Gerry Smolka**

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**AARP Public Policy Institute**

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## **Acknowledgments**

The authors would like to thank the following individuals and agencies for their assistance with this project. First, we acknowledge the National Association of Insurance Commissioners (NAIC) for permission to use their state survey as background for this project. Second, the authors would like to thank NAIC Immediate Past President Glenn Pomeroy (Insurance Commissioner, ND), Guenther Ruch of the Wisconsin Insurance Department, and Scott Kipper and Meredith Benedict, former staff of the NAIC, for their work on the NAIC survey and their assistance with this project. The authors would also like to thank the staff of the following state insurance departments (or otherwise denominated state agencies with regulatory jurisdiction over insurance): Connecticut, Kansas, Maine, Massachusetts, Michigan, Minnesota, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Texas, Vermont, and Wisconsin. Finally, the authors would like to thank those who reviewed the draft report including Jennifer O'Sullivan, Jeff Crowley, Marcia Marshall, and Bruce Abbe and extend general thanks to all who assisted in the project.

### **Authors' Note**

The research for this project was completed in 1997. Subsequently, several states made changes to their laws or regulations related to providing Medicare beneficiaries under age 65 with access to Medigap coverage. Louisiana, Missouri and Maryland enacted such measures in 1998. Information on any state changes since 1997 could not be incorporated in this report.

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## Executive Summary

### Background

Medicare beneficiaries age 65 and older have a right under federal law to an open enrollment period in which to buy Medicare supplemental coverage, commonly called Medigap<sup>1</sup>. Medicare beneficiaries *under* age 65, who qualify for Medicare on the basis of disability (including End Stage Renal Disease), do not have the same federal right. In the 105<sup>th</sup> Congress, legislative proposals to provide Medicare beneficiaries under age 65 with the same guarantee to open enrollment available to older beneficiaries were not passed. However, a number of states have enacted laws or implemented regulations to improve access to and affordability of coverage for beneficiaries under age 65.

*Individually purchased private health insurance* specifically designed to cover an individual's cost-sharing liabilities under Medicare's fee-for-service program is referred to variously as "Medicare supplemental," "Medicare supplement," or "Medigap" insurance. In this paper, the term Medigap is used. Medigap insurance is sold to Medicare beneficiaries to reimburse them for expenses not covered by Medicare (e.g. deductibles, coinsurance, and certain other non-covered services).

Some beneficiaries may have access to other sources of health care coverage to supplement Medicare. When an individual has *employer-sponsored health insurance* or *Medicaid* along with Medicare coverage, reimbursements for benefits under either of the two types of coverage are coordinated with Medicare benefits. In this paper, when referring to any of the types of coverage that supplement fee-for-service Medicare, including Medigap, the term "supplemental coverage" is used.

In 1997, the National Association of Insurance Commissioners (NAIC) surveyed its members to identify those states that had enacted enrollment and rating requirements exceeding those in NAIC's Medicare Supplement Insurance Minimum Standards Model Act. A number of states in NAIC's survey reported that they had requirements that guarantee Medicare beneficiaries under age 65 the opportunity to buy Medigap coverage.

### Purpose

This research was initiated to build on the NAIC survey that was conducted earlier in 1997 and to learn what information states have on the impact of their efforts to give Medicare beneficiaries under age 65 access to Medigap. Specifically, this project undertook to learn more about the details of the state requirements, and whether states had information related to the number of Medicare beneficiaries under age 65 with Medigap coverage, the cost of coverage for this group compared to that for Medicare beneficiaries age 65 and older, and the effect of such coverage on the Medigap market.

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<sup>1</sup> This discussion is about supplementing fee-for-service Medicare. Discussion concerning coverage opportunities for Medicare beneficiaries under age 65 in other Medicare health plan options, such as managed care plans, is beyond the scope of this paper.

## Methodology

This research was conducted in the fall of 1997, and involved a telephone survey of state insurance regulators in the states identified by NAIC's survey as having implemented requirements guaranteeing disabled Medicare beneficiaries under age 65 access to Medigap insurance. Analysis of the relevant laws, regulations, and state insurance department publications was also undertaken as part of the research. Other secondary sources were used where relevant.

## Results

Our research reconfirmed that 14 states had mandates in 1997 requiring that Medigap insurers give Medicare beneficiaries under age 65 the opportunity to purchase Medigap coverage. In one additional state, a limited number of insurers voluntarily made coverage available to this population.

None of the regulators surveyed had information on the number of Medicare beneficiaries under age 65 who had purchased Medigap coverage. They had limited information on the cost of coverage, and the market effect of offering this coverage.

An unexpected finding of this research was that state high-risk pools also play a role in supplementing Medicare for beneficiaries under age 65 in 12 states. Nine states that do not require private insurers to offer Medigap insurance to Medicare beneficiaries under age 65 do make Medigap or other supplemental coverage available to this population through their state high-risk pools. Three states require Medigap insurers to offer coverage to Medicare beneficiaries under age 65, and also make supplemental coverage available to some Medicare beneficiaries under age 65 through their high-risk pool. The information contained in this report about these state provisions is limited to what was available from a secondary source.

Thus, in 1997, disabled Medicare beneficiaries under age 65 in states have access to some form of private health coverage to supplement Medicare. In states where access is mandated through the Medigap market, Medicare beneficiaries under age 65 most commonly have the same opportunity to purchase Medigap as beneficiaries age 65 and older have under federal law, that is, during the first six months after their enrollment in Medicare Part B. Some states require that only certain Medigap plans, rather than all Medigap plans available in the marketplace, be offered to Medicare beneficiaries under age 65.

State rating requirements for Medigap policies offered to beneficiaries under age 65 vary. States differ in whether they place specific restrictions on the rates that may be charged Medicare beneficiaries under age 65. When in place, the rating restrictions offer disabled beneficiaries under age 65 a measure of protection against being charged higher premiums than beneficiaries age 65 and older.

There is somewhat limited information about the impact of these measures. Data on how many Medicare beneficiaries under age 65 have purchased Medigap coverage are not available from the states<sup>2</sup>. The cost of coverage for this population in comparison to the cost to beneficiaries age 65 and over can be gauged by premium information in some states' consumer guides. Rate regulations have an impact on the price of coverage to the disabled. States do not, however, generally have catalogued information that allows them to assess the underlying claims costs of beneficiaries under age 65 compared to those over age 65, or the interaction of the claims costs and rate regulations on premiums for those under and over age 65. As a result, it is not possible to draw any firm conclusions about the impact of the measures on either disabled Medicare beneficiaries under age 65, or on the Medigap insurance market. Regulators did not report significant market disruption, such as many insurers leaving the market. Isolated examples of insurers experiencing problems were, however, reported. These examples suggest the need to use caution in attributing the problems to a single cause such as insuring the population under age 65; other historical, market and regulatory elements also were at work.

By the end of 1997, nearly two dozen states had undertaken to provide access to some form of supplemental coverage for disabled Medicare beneficiaries under age 65, either through the individual Medigap market or through state high-risk pools. However, this coverage may not be affordable for all beneficiaries. Whether certain state approaches are more effective than others in making coverage affordable to Medicare beneficiaries under age 65 is a question requiring further research.

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<sup>2</sup> National surveys such as the Current Population Survey, the Medicare Current Beneficiary Survey, and the Health and Retirement Survey include data on health insurance coverage of Medicare beneficiaries under age 65. But the samples used in these surveys are not designed to be representative of the population of Medicare beneficiaries under age 65 *at the state level*.

## Introduction

### Background

The Medicare program provides government-sponsored health care coverage to persons age 65 and over as well as to eligible disabled individuals younger than age 65, including persons with end-stage renal disease (ESRD). For individuals enrolled in the traditional fee-for-service Medicare program, the beneficiary is required to share in the cost of the hospital, medical, and post-acute services they use through deductibles and coinsurance. Because Medicare covers only a portion of aggregate total health care spending for Medicare beneficiaries (roughly 50 percent and 40 percent respectively for beneficiaries over age 65 and those under age 65, on average)<sup>3</sup>, the majority of beneficiaries turn to other sources to help pay for Medicare deductibles and coinsurance amounts, as well as for benefits not covered by Medicare, such as prescription drugs.

There are three major sources of coverage to supplement fee-for-service Medicare: individually purchased private coverage, employer-sponsored coverage, and Medicaid.

Individually purchased private health insurance specifically designed to cover an individual's cost-sharing liabilities under Medicare's fee-for-service program is referred to variously as "Medicare supplemental," "Medicare supplement," or "Medigap" insurance. In this paper, the term Medigap is used. Medigap insurance is sold to Medicare beneficiaries to reimburse them for expenses not covered by Medicare (e.g. deductibles, coinsurance, and certain non-covered services). Access to Medigap coverage was the focus of this research.

Some beneficiaries may have access to other sources of health care coverage to supplement Medicare. When an individual has employer-sponsored health insurance or Medicaid along with Medicare coverage, reimbursements for benefits under the two types of coverage are coordinated. In this paper, the term "supplemental coverage" refers to any of the types of coverage that supplement fee-for-service Medicare, including Medigap.

Medicare managed care plans are another option that can help beneficiaries with health costs not covered by Medicare. However, since these plans typically provide Medicare benefits as well as other benefits, they are not considered supplemental coverage as that term is used in this paper.

While the majority of Medicare beneficiaries age 65 and older have supplemental coverage through an employer-sponsored plan or Medigap, the picture differs among disabled Medicare beneficiaries under age 65. As Figure 1 shows, among Medicare beneficiaries under age 65, Medicaid is the most prevalent source of supplemental coverage; three times more beneficiaries under age 65 supplement Medicare with Medicaid than do beneficiaries age 65 and older.

Disabled beneficiaries under age 65 are less likely to have employer-sponsored coverage than older beneficiaries (19percent v. 33percent); disabled beneficiaries are four times less likely to have individually purchased insurance (either Medigap or other health coverage such as a major medical

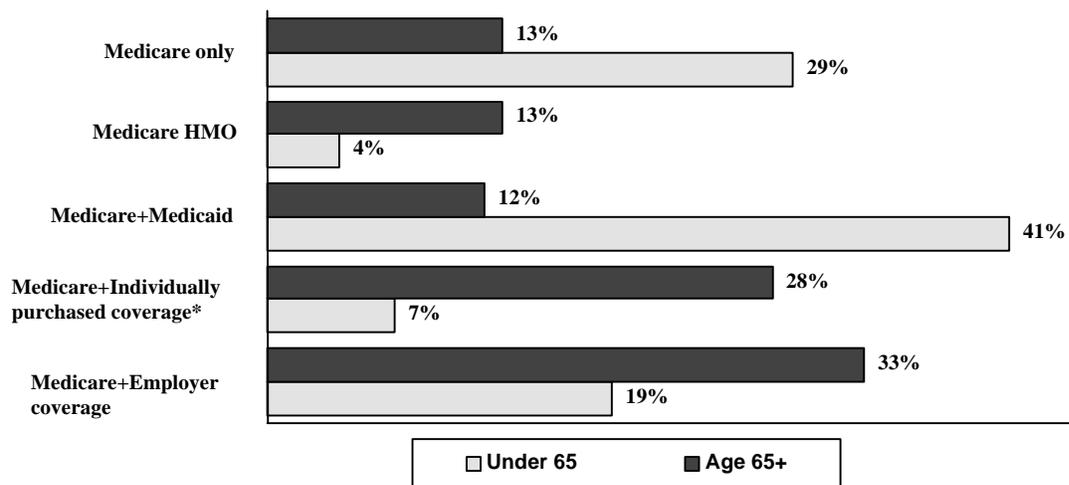
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<sup>3</sup> AARP Public Policy Institute 1997 estimates using Medicare Benefits Simulation Model.

policy) to supplement Medicare than their older counterparts. They are also twice as likely as older beneficiaries to have neither public nor private supplemental coverage.

Among possible explanations for these coverage differences are socioeconomic differences between the two groups, as well as differences in federal and state policy governing Medigap coverage for Medicare beneficiaries age 65 and older and Medicare beneficiaries under age 65.

**Figure 1 - Insurance Status of Medicare Beneficiaries by Age, 1997**



\*Medigap or other health coverage such as major medical.

Source: AARP Public Policy Institute analysis using Medicare Benefits Simulation Model.

Federal law guarantees all eligible individuals the opportunity to purchase any Medigap plan offered by an insurer within the first six months after they are: Medicare entitled; age 65 or older; and enrolled in Part B. During this six-month period, referred to as the “open enrollment” period, a beneficiary age 65 or older cannot be denied a Medigap policy, have its effectiveness conditioned upon, or be charged more than other applicants because of a medical condition or claims history.<sup>4</sup> In addition, no Medigap policy can exclude coverage for a pre-existing condition for longer than six months.<sup>5</sup> Current federal law does not guarantee an open enrollment period to those Medicare

<sup>4</sup> Social Security Act §1882(s)(2)(A). The recently enacted Balanced Budget Act of 1997 (BBA) requires that such individuals be given credit toward the exclusion period if they have been continuously insured prior to enrolling in a Medigap plan. However, the requirements for crediting prior coverage contained within the BBA portability provisions described above were not extended to policies issued to the under-65 population.

<sup>5</sup> National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, Section 7. Federal law incorporates the provisions of this NAIC model. The model requires that policies not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment recommended or received from a physician within the 6 months before coverage became effective.

beneficiaries who first attain Medicare eligibility due to disability or End Stage Renal Disease (ESRD) *before* age 65. However, upon reaching age 65, they have the same guaranteed opportunity to enroll in a Medigap plan during the six-month open enrollment period as do other beneficiaries age 65 and older.

Even when Medigap coverage is made available to Medicare beneficiaries age 65 and older, they may find it unaffordable. Federal law only prohibits insurers from setting rates based upon an applicant's health status during the open enrollment period; beyond this, there are no federal standards that govern rate setting. Hence, Medigap insurers may set Medigap premiums in a variety of ways subject to state requirements.

The primary methods used in the Medigap market to establish premiums are "issue age" rating, "attained age" rating, and "community" rating. Under issue age rating, premiums are set according to the beneficiary's age at the time (s)he buys the policy. Under attained age rating, premiums are set according to the actual age of the policyholder at the time of purchase and the time of each renewal. Under pure community rating, the same premium is charged all eligible members of a group, regardless of individual health status. However, community rating practices vary; for instance, some states allow the rate to vary based upon age and geography.

To improve access to and affordability of coverage for beneficiaries under age 65, a number of states have enacted laws or implemented regulations that go beyond the minimum federal requirements. Several states have expanded the requirements regarding guaranteed access to a Medigap product by requiring at least one "open enrollment period"<sup>6</sup> during which those under the age of 65 who are newly enrolled in Medicare Part B are assured access to at least one Medigap product. Other states, including some of the states that expanded access to Medigap coverage for this population, also limit the types of permissible rating methodologies or prohibit certain rating practices.

During the 104th and 105th Congresses, several congressional and administration proposals sought to strengthen federal requirements in the area of access to and affordability of Medigap coverage. In particular, several proposals sought to require insurers to extend the six-month open enrollment period for Medigap to Medicare beneficiaries under age 65. During the federal policy debate, questions were raised about the impact on the Medigap market of mandating access to coverage for disabled beneficiaries under age 65. In particular, concerns were raised by insurers that the overall cost of Medigap coverage would increase as a result of expanded coverage to Medicare beneficiaries under age 65, and that this could force individuals and possibly insurers out of the Medigap market. Consumer organizations, insurers, and congressional and administration policy makers presented differing perspectives on the risks of proposed federal requirements in this area. Ultimately, the Balanced Budget Act of 1997 did not extend guaranteed issue of Medigap policies during an initial open enrollment period to the Medicare population under age 65, although it did make other changes in Medigap law.

In the course of this debate, members of Congress and their staff inquired into the activities and experiences of the states that had already acted in this area. In response to some of these queries, the

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<sup>6</sup> Open enrollment periods are a specified time period during which insurers must make certain policies available, such as the six-month period following a beneficiary's initial enrollment in Medicare Part B.

National Association of Insurance Commissioners (NAIC) surveyed its members in the spring of 1997 to identify those states that had enacted enrollment and rating requirements exceeding those in NAIC's Medicare Supplement Insurance Minimum Standards Model Act (The model is part of federal Medigap requirements.) including requirements relating to access to coverage for Medicare beneficiaries under age 65. A number of states in NAIC's survey reported that they had requirements that guarantee Medicare beneficiaries under age 65 the opportunity to buy Medigap coverage.<sup>7</sup>

### Purpose

This research was initiated to build on the NAIC survey that was conducted earlier in 1997 and to learn what information the states with Medigap enrollment requirements for Medicare beneficiaries under age 65 have on the impact of their efforts to expand access to Medigap. Specifically, this project undertook to learn more about the details of the state requirements, and the information the states had relating to the number of Medicare beneficiaries under age 65 with Medigap coverage, the cost of coverage for this group compared to that for Medicare beneficiaries age 65 and older, and the effect of such coverage on the Medigap market. It was hoped that the results of this study, and any follow-up research, would shed light on certain issues in the continuing policy debate about supplemental insurance coverage at the state and federal levels.

### Methodology

Using the list of states identified in the NAIC Medigap survey as requiring access to Medigap for beneficiaries under age 65, we conducted a telephone survey of insurance regulators in the fall of 1997. The survey gathered information about the regulatory requirements in those states and the regulators' perspectives on the impact of these requirements. The regulators were also asked whether they collected or were aware of information that might be useful in determining the impact of their state's regulations on Medicare beneficiaries under age 65 and on the Medigap insurance marketplace. Analysis of the relevant laws, regulations, and state insurance department publications was also undertaken as part of the research. To verify the accuracy of the information in this report, state regulators reviewed the text relating to their state.

In this report, information about supplemental coverage available through state high-risk pools is largely based on information obtained from a secondary source.<sup>8</sup> In several instances, primary materials in the form of either laws or information published by the states concerning their high-risk pools supplemented this secondary source. However, systematic primary research concerning state risk pool offerings to Medicare beneficiaries was beyond the scope of this project.

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<sup>7</sup> NAIC "Medigap Survey," NAIC, 1997. The NAIC survey also identified expanded access to coverage in Vermont. However, while Medigap policies are available to the under-65 population in Vermont, the state does not require that such policies be offered.

<sup>8</sup> Communicating for Agriculture, "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis", 11<sup>th</sup> ed., 1997.

## Principal Findings

### State Regulatory Requirements

The research found that states have approached the issue of expanding access to supplemental coverage to Medicare beneficiaries under age 65 in two ways. The two primary routes that states have used to provide this population with access to supplemental coverage are: (1) Medigap market requirements and (2) high-risk pools.

#### Medigap Market Requirements

Fourteen states have extended access to this population through requirements placed upon Medigap insurers. The states are:

|               |               |              |           |
|---------------|---------------|--------------|-----------|
| Connecticut   | Michigan      | New York     | Texas     |
| Kansas        | Minnesota     | Oklahoma     | Wisconsin |
| Maine         | New Hampshire | Oregon       |           |
| Massachusetts | New Jersey    | Pennsylvania |           |

Table 1 summarizes the requirements by state. An additional state, Vermont, appears at the end of the table. Access to coverage for disabled beneficiaries under age 65 is available in Vermont on a voluntary basis rather than as a requirement of state law. More detailed descriptions of each state's requirements appear in Appendix A.

One aspect of such requirements relates to the requirements about the *number or type of Medigap plans available* to disabled Medicare beneficiaries under age 65. Some states require access to only a single Medigap plan; others require access to several or all of the ten standardized plans permitted under federal law to be offered to beneficiaries age 65 and older.

- Four states guaranteed access to only one plan. Two of these states did not specify offering of a particular plan, which effectively guaranteed access to the least generous of the standardized plans, Plan A. One of the four states did not specify a particular plan initially, but, effective October 1998, required access to plans B and C. One state required access to Plan C.
- Nine states required access to all Medigap products the insurer offers. One state mandated that its Blue Cross/Blue Shield plan make all of its Medigap products available.

Another aspect of the state requirements relates to *eligibility*. Generally, when states have expanded access to Medigap coverage to the disabled Medicare population under age 65, they have included all beneficiaries under age 65. In two states, however, access to Medigap coverage is not available to all Medicare beneficiaries under age 65. Massachusetts, for example, excludes Medicare beneficiaries with ESRD from the expanded access requirements<sup>9</sup>. New Jersey, on the other hand, requires access to coverage for those under age 65 in two different ways, depending upon the age of the beneficiary. Medicare beneficiaries age 50 to 64 are provided access to coverage through the

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<sup>9</sup> It is interesting to note that, under the BBA, access to Medicare+Choice plans is similarly available to all Medicare beneficiaries, *except* those with ESRD [Social Security Act s. 1851(a)(3)(B)].

Medigap market, while Medicare beneficiaries under age 50 are provided access to Medigap coverage through a separate state-run program.

Another area of variation relates to the *enrollment period* during which Medicare beneficiaries under age 65 are assured access to coverage. All fourteen states with expanded access requirements provide disabled beneficiaries under age 65 the opportunity to buy coverage during the initial six months following enrollment in Medicare Part B, paralleling the federal open enrollment requirement for beneficiaries age 65 and over. Connecticut and New York provide for continuous open enrollment for disabled beneficiaries under age 65; thus, these beneficiaries may enroll in the plans required to be available to them throughout the year. Massachusetts provides an annual two-month open enrollment period in addition to the six-month enrollment period when an individual first enrolls in Medicare. Maine provides an annual open enrollment period for Plan A only.

Two states have rules governing *pre-existing condition exclusions* that are more generous than federal law requires. New Jersey limits such exclusions to three months. Minnesota prohibits the imposition of any pre-existing condition exclusion.

Finally, several states with enhanced access to coverage for disabled Medicare beneficiaries under age 65 have bolstered their requirements by also addressing the affordability of the products through *rating restrictions*. Five states (CN, ME, MA, MN, and NY) impose community rating requirements upon Medigap insurers that offer coverage to this population (with some variation in permitted adjustments); these same requirements also apply to Medicare beneficiaries age 65 and over. Michigan imposes such a requirement only upon Blue Cross and Blue Shield. An additional six states (KS, NJ, OR, PA, TX, WI) impose some restriction, other than community rating, on the rates charged these individuals. Hence, eleven of the fourteen states that have imposed guaranteed issue requirements on the private insurance market for the Medicare population under age 65 have coupled them with some rating restrictions.

The variations in state requirements to provide disabled Medicare beneficiaries under age 65 with access to Medigap coverage are summarized in Table 1. As the Table indicates, most state requirements have been enacted or implemented fairly recently. The passage of time may provide additional insights into the impact of these requirements on both beneficiaries under age 65 and the Medigap market.

### High-Risk Pools

An unexpected finding of the research was that state high-risk pools also play a role in supplementing Medicare for beneficiaries under age 65 in twelve states. The role of state high-risk pools was not an initial focus of this research. However, in the course of the telephone survey, it was learned that high-risk pools play a role in providing access to coverage for Medicare beneficiaries under age 65 in some states. A full inquiry into state high-risk pools was beyond the scope of this paper. However, through a secondary source, it was possible to identify state high-risk pools in twelve states that offer some form of coverage that supplements Medicare.<sup>10</sup>

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<sup>10</sup> Communicating for Agriculture, "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis", 11<sup>th</sup> ed., 1997.

Many states have high-state high-risk pools that offer coverage to populations lacking access to other insurance options, or whose insurance options may be seriously limited. Eligibility requirements for coverage through a high-risk pool most often relate to health status or a past history of difficulty in obtaining insurance (such as insurers' repeated rejection of an application). While the focus of these programs is to offer health insurance to persons without another source of health coverage, some states also offer coverage to individuals with Medicare coverage. Some of these states allow Medicare beneficiaries to renew or obtain health insurance available through the high-risk pool, which is coordinated with the beneficiary's Medicare coverage (supplementing Medicare much as employer-sponsored retiree health plans do). Others offer a Medigap policy.

These state high-risk pools may require applicants to demonstrate that they were rejected for coverage by one or more insurers or were able to get coverage only at premiums above those charged by the risk pool. State risk pool eligibility requirements for Medicare beneficiaries may differ from general risk pool eligibility requirements. In addition, an enrollment cap may limit access to these pools; therefore, some potential entrants could be placed on a waiting list.

State high-risk pools in the following three states make *Medigap* coverage available to disabled Medicare beneficiaries under age 65 who meet state-specific risk pool eligibility requirements:

|        |           |              |
|--------|-----------|--------------|
| Alaska | Minnesota | North Dakota |
|--------|-----------|--------------|

State high-risk pools in nine other states make *comprehensive health coverage that coordinates benefits with Medicare* available through their high-risk pools when individuals meet certain requirements. These states are:

|             |                       |          |
|-------------|-----------------------|----------|
| Connecticut | Florida <sup>11</sup> | Illinois |
| Iowa        | Mississippi           | Montana  |
| Washington  | Wisconsin             | Wyoming  |

For example, Mississippi allows an individual under the age of 65 who is covered through the risk pool and subsequently becomes eligible for Medicare to retain the risk pool coverage as a supplement that coordinates benefits with Medicare.<sup>12</sup> Where the risk pool coverage is health coverage that coordinates benefits with Medicare rather than Medigap coverage, states may charge Medicare beneficiaries a lower premium than the full premium in recognition of the fact that the risk pool is the secondary payer of claims for this population.

In nine of the dozen states (AK, FL, IL, IA, MS, MT, ND, WA, WY) that allow Medicare beneficiaries to enroll in their high-risk pool, the risk pool is the sole mechanism providing access to private supplemental coverage. These states do not require private insurers to offer Medigap insurance to Medicare beneficiaries under age 65. The remaining three states (CT, MN and WI) have

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<sup>11</sup> The Florida high-risk pool is closed for new enrollment, but covers Medicare beneficiaries who enrolled prior to its closure to further enrollment.

<sup>12</sup> Id.

used both their risk pool and Medigap market requirements to provide access to supplemental coverage for Medicare beneficiaries under age 65. The respective roles of the risk pool and the Medigap market in covering the Medicare population under age 65 were not directly explored with the regulators in these three states. However, since some portion of risk pool costs are subsidized, risk pool premiums for supplemental coverage may potentially be more affordable than the market price of a Medigap policy. The state high-risk pools may also impose fewer restrictions relating to pre-existing conditions than is typical in the marketplace, and may also offer more extensive benefits in some areas than are available through Medigap. Further research would be necessary to determine the relative costs<sup>13</sup> and advantages of these coverage options.

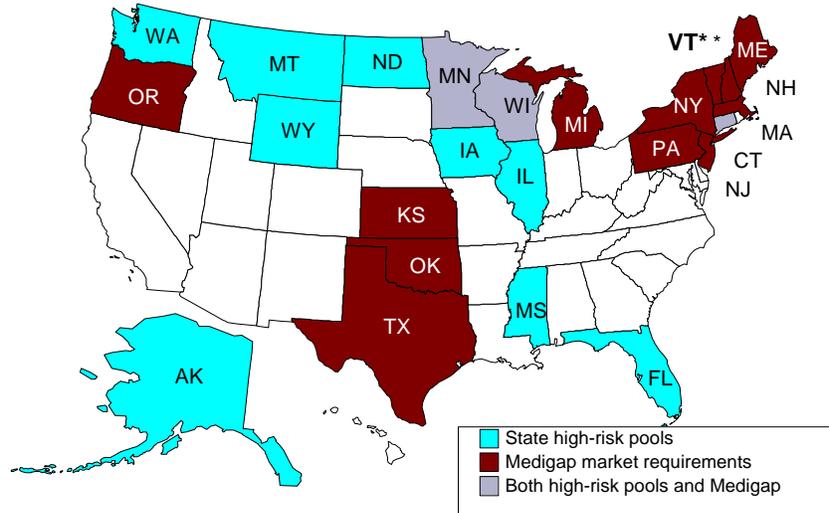
Additional primary research could determine if there are additional states whose high-risk pools allow Medicare beneficiaries under age 65 to purchase comprehensive coverage that coordinates with Medicare or Medigap coverage. Furthermore, to the extent they are available, utilization data for those beneficiaries insured by the risk pool may shed some light on the claims costs associated with this population.

When the states with Medigap market requirements for disabled Medicare beneficiaries under age 65 are combined with states that provide access to coverage solely through a high-risk pool 23 states had adopted one or more means of giving Medicare beneficiaries under age 65 access to some form of private coverage to supplement Medicare by the end of 1997.

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<sup>13</sup> While an exhaustive look at the risk pools and the rates they charge for Medigap coverage is beyond the scope of this paper, the authors note that one state's risk pool (North Dakota) offers a Medigap policy to those under age 65 at the same rate as that charged to those age 85 and older. Medigap premiums in the Comprehensive Health Association of North Dakota (CHAND) in 1997 were \$128.60 monthly.

**Figure 1 - Mechanisms Used to Give Medicare Beneficiaries under Age 65 Access to Supplemental Insurance, 1997**



Note: In Vermont Medigap is available in the market on a voluntary basis, not as a legal requirement.

**Table 1- Summary of State Medigap Requirements for Disabled Medicare Beneficiaries Under Age 65, 1997**

| State | Effective date  | Plans available  | Eligibility   | Open enrollment  | Rating  |
|-------|---|--|---|--|---|
| CT    | 1/94 for plan A;<br>10/98 for plans B and C                           | At least one plan (effectively Plan A). As of 10/1/98, if insurers offer plans B and C to beneficiaries age 65 and older, they also must offer them to those under age 65. | All disabled Medicare beneficiaries under age 65.                             | Continuous.  | Community rating for Plans A-G.   |
| KS    | 4/96  | All products.  | All disabled Medicare beneficiaries under age 65.                             | 6 months from initial Part B enrollment.   | For policies predating the regulation, rates are capped at 150% of rate charged to those age 80; post-regulation, rates for beneficiaries under age 65 cannot exceed rates charged to those age 65 and older. |
| ME    | 10/93   | All products guaranteed issue during 6 mo. open enrollment period; annual open enrollment for Plan A.  | All disabled Medicare beneficiaries under age 65.                             | 6 months from initial Part B enrollment, and 1 month open enrollment annually.   | Community rating.   |
| MA    | 1/95  | All policies available in Mass. (federal standardization requirements waived <sup>14</sup> ).  | All disabled Medicare beneficiaries under age 65, except for those with ESRD. | 6 months from initial Part B enrollment, and 2-month open enrollment annually.   | Community rating.   |
| MI    | BCBS guarantee issue requirement derives from statute effective 4/81. | All Blue Cross Blue Shield policies (BCBS); plans A or C available on a conversion basis under certain circumstances from other insurers.                                  | All disabled Medicare beneficiaries under age 65.                             | BCBS plans must be issued year round; conversion policies are available to those who request coverage within 90 days before or after attaining Medicare eligibility or within 180 days of losing group coverage. | BCBS plans are community rated.   |

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<sup>14</sup> Under federal law, since 1992 only ten standard Medigap products (labeled by letters A through J) can be sold in the US, except in states in which this requirement was waived by the federal government. Three states (MA, MN, WI) that had standardized Medigap products prior to federal reform have such waivers.

| State | Effective date  | Plans available   | Eligibility   | Open enrollment   | Rating  |
|-------|---|---|---|---|---|
| MN    | 11/91   | Basic plan and Extended Basic plan must be made available during open enrollment period (federal standardization requirements waived <sup>15</sup> ). | All disabled Medicare beneficiaries under age 65.   | 6 months from initial Part B enrollment, and upon re-enrollment by disabled beneficiaries involuntarily disenrolled due to loss of disability status.       | Community rating.   |
| NH    | 7/93  | All products during open enrollment.  | All disabled Medicare beneficiaries under age 65.   | 6 months from initial Part B enrollment.  | No rating restrictions other than federal/NAIC standards.   |
| NJ    | 8/95 for beneficiaries age 50 and over;<br>1/97 for beneficiaries under age 50. | Plan C to that age 50 and older.<br>State plan C for those under age 50.  | Different programs for disabled Medicare beneficiaries under age 50 and those between ages 50 and 64. | 6-month open enrollment for disabled beneficiaries age 50 and older, and<br>6-month open enrollment in state plan C (both begin upon enrollment in Part B). | Plans for those over age 50 cannot exceed insurer's lowest rate for same policy issued to persons age 65 and older; state plan's rates are not based on health status and cannot exceed lowest rate insurer charges for Plan C to the age 65 and older group. Loss apportionment and assessment scheme. |
| NY    | 4/93  | Plans A and B must be offered; any other plan offered by insurer must be available to all beneficiaries.  | All disabled Medicare beneficiaries under age 65.   | Continuous.   | Community rating with adjustment permitted for geography only.  |
| OK    | 7/94  | At least one plan must be available to population under age 65.   | All disabled Medicare beneficiaries under age 65.   | 6 months from initial Part B enrollment.  | No rating restrictions other than federal/NAIC standards.   |
| OR    | 9/93  | All plans.  | All disabled Medicare beneficiaries under age 65.   | 6 months from initial Part B enrollment.  | Rates for beneficiaries under age 65 cannot exceed rates for those age 65 and older, and these policies are pooled together; beneficiaries under age 65 with attained age policies must be charged same rate as other Medicare beneficiaries.   |

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<sup>15</sup> Ibid.

| State | Effective date | Plans available  | Eligibility                                       | Open enrollment                          | Rating   |
|-------|----------------|--|---|--|--|
| PA    | 11/94          | All plans during open enrollment period.   | All disabled Medicare beneficiaries under age 65. | 6 months from initial Part B enrollment. | During open enrollment, insurers must provide beneficiaries under age 65 with “best available rate” (i.e., rate charged for those age 65 and older).   |
| TX    | 1/97           | Plan A.  | All disabled Medicare beneficiaries under age 65. | 6 months from initial Part B enrollment. | No rating restrictions beyond federal/NAIC standards.  |
| WI    | 9/94           | Same riders as available under state law (federal standardization requirements waived <sup>16</sup> ). | All disabled Medicare beneficiaries under age 65. | 6 months from initial Part B enrollment. | No rating restrictions beyond federal/NAIC standards, except that an insurer’s rates for beneficiaries under age 65 must be uniform for same policy. At age 65, policies for disabled are pooled with rest of population age 65 and older. |
| VT    | 1/1/98         | Plans available to those under age 65 <i>without mandate</i> .   | N/A   | N/A                                      | Community rating with transition.  |

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<sup>16</sup> Ibid.

## Effects of State Medigap Market Requirements

Regulators in the states that expanded access to coverage for this population through Medigap market requirements were asked about the availability of information on:

- the size of the under age 65 population covered by Medigap
- the price of any such policies for those under age 65
- any market effects that were the result of open enrollment or guaranteed issue requirements.

The telephone survey of the insurance departments revealed that there is fairly limited information readily available at the state level to answer these questions. The information that state regulators have is contained, for the most part, within state consumer guides and insurer rate filings.

The state insurance regulators surveyed<sup>17</sup> stated that insurers' materials filed with regulators (rate filings and other materials) did not specifically indicate that the requirements expanding access to Medigap to younger disabled Medicare beneficiaries were the cause of significant increases in Medigap claims costs or premiums. However, in two different states, regulators mentioned exceptions. In one state, the source of the problem pre-dated the requirements; in the other, the source of the problem seemed to go beyond the requirements and related, at least in part, to the insurer's offering prescription drug coverage.

The following sections discuss the findings from the telephone survey of regulators as they relate to the number of Medicare beneficiaries under age 65 with access to coverage, the cost of coverage, and insurer participation in the market.

### Impact on the number of Medicare beneficiaries under age 65 with Medigap

The state insurance departments surveyed had very little information regarding the impact of their state's access requirements on the extent of coverage among Medicare beneficiaries under age 65. To comply with Medigap loss ratio reporting requirements, insurers report information on the numbers of covered lives, but the information is not reported by age. Hence, it is difficult to determine whether state requirements increased Medigap coverage among this population<sup>18</sup>.

National surveys collect some data on the extent of supplemental coverage among Medicare beneficiaries, including those under age 65, at different points in time. However, national surveys do not provide state-level data that would enable one to see the effect of different states' regulations. Further, to determine more reliably whether the states' access requirements resulted in increased

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<sup>17</sup> Regulators surveyed included many who are responsible for reviewing rate filings for Medicare supplemental policies.

<sup>18</sup> Two states had some information related to Medicare beneficiaries under 65 and Medigap coverage. In Kansas, at the time of debate in 1996 over the state's regulation of open enrollment, the Department of Insurance was informed that there were 28,000 Medicare beneficiaries under age 65 in the state, and that between 2,100 and 2,200 of these individuals, or just under 8 percent, had Medigap policies. At the time of this survey in 1997, it was not known if the percent of beneficiaries under age 65 with Medigap coverage had changed since the new requirements (which include rating limits) were implemented. In New York, at the time of this survey less than 3 percent of the Medigap policies sold were sold to the Medicare population under age 65. It is not clear whether this proportion changed as a result of the requirement.

coverage of disabled Medicare beneficiaries under age 65, information on the age of Medigap enrollees both before and after the requirements would be needed from insurers' coverage data.

Impact on the cost of Medigap coverage for Medicare beneficiaries under age 65 and for those age 65 and older

During discussions in 1997 of federal proposals to expand access to coverage for the Medicare population under age 65, insurers raised concerns that such measures might disrupt the market. They asserted that one market effect of such requirements could be Medigap price increases for all ages driven by cost increases arising from this population.

State rating requirements affect whether disabled beneficiaries under age 65 who purchase Medigap coverage are charged premiums that differ from those for Medicare beneficiaries age 65 and over. Where pure community rating requirements are in place, beneficiaries under age 65 face premiums that are equivalent to those paid by their counterparts age 65 and over. In the absence of community rating, disabled beneficiaries under age 65 may face higher premium costs than do at least some of their aged counterparts.

In states where unrestricted variation in rates on the basis of age is permitted, information from some state consumer guides demonstrates how the price of coverage charged to disabled beneficiaries under age 65 compares to that charged to Medicare beneficiaries age 65 and over. Table 2 provides examples of premiums from states that did not have community rating in effect at the time of the study; the examples show that beneficiaries under age 65 are often charged more than Medigap enrollees age 65 and older. How much more varies by insurer and by plan.

**Table 2- Comparison of Sample Medigap Premiums for Beneficiaries under Age 65 and Those Age 65 and Older in 1997**

| State | Insurer | Plan | Monthly premiums for: |          | Disabled premium as % of premium for 65+ |
|-------|---------|------|-----------------------|----------|--|
|       |         |      | Disabled under 65     | Age 65 + |  |
| OK    | 1       | A    | \$ 34.66              | \$ 28.75 | 121%                                     |
| OK    | 2       | A    | \$ 102.33             | \$ 72.08 | 142%                                     |
| NH    | 1       | A    | \$ 61.45              | \$ 43.90 | 140%                                     |
| NH    | 1       | G    | \$122.75              | \$ 78.45 | 156%                                     |
| NH    | 2       | A    | \$ 64.23              | \$ 40.44 | 159%                                     |
| NH    | 2       | J    | \$179.19              | \$112.82 | 159%                                     |
| VT    | 1       | A    | \$ 77.40              | \$ 61.90 | 125%                                     |
| VT    | 2       | B    | \$114.66              | \$ 66.66 | 172%                                     |

Source: Consumer guides from Oklahoma, New Hampshire, and Vermont.

In Kansas, after the requirements were implemented in 1996, premiums for policies sold to beneficiaries under age 65 were required to be the same as those charged 65-year-old beneficiaries. The law capped rates for policies bought before this new requirement was in place at 150 percent of the rate for that age 80 and over. According to a Kansas regulator, the rating requirement for existing policies sold prior to the requirements decreased the cost of coverage for beneficiaries younger than 65; prior to the requirements these beneficiaries had been charged between 300 and 400 percent of the rate

for those age 65 and older. The regulator did not know whether insurers had increased their premiums for those age 65 and older as a direct result of the requirements giving beneficiaries under age 65 access to Medicare.

In Michigan, rates for Medicare beneficiaries under age 65 must be filed separately if companies charge them a different rate from that applying to those age 65 and older. Generally, it appears that premiums charged to disabled beneficiaries under age 65 for plans A and C (that do not include prescription drug coverage) are as expensive as plans with prescription coverage for the population age 65 and older. The insurance bureau did not have much statistical data in this area. A regulator who reviewed the policy information filed by Medigap insurers had the impression that Michigan's open enrollment requirement did not cause their rates to differ too much from rates for similar policies in other states.

In Minnesota, Medicare disabled beneficiaries under age 65 are eligible for coverage through the state high-risk pool if they have been rejected by a private insurer and meet eligibility requirements. Risk pool rates are about 125 percent of standard Medigap market rates and, according to the regulator, are competitive with some private plans.

At the time this research was conducted, New Hampshire had not yet collected data on the impact of its open enrollment requirement on premiums, as the requirement had been in effect for less than a year.

The Oregon Insurance Division reports that with respect to the prohibition against charging beneficiaries under age 65 rates higher than rates charged to those age 65 and older, loss ratios in actuarial memoranda do not indicate that this requirement has caused a substantial change in rates for Medigap coverage.

Texas has not compiled information on differentials in premiums charged the population under age 65 in comparison to premiums charged to those ages 65 and over. Texas requires public filings if an insurer intends to increase Medigap rates; if an insurer has a separate rate for Medicare beneficiaries under age 65, it too must be filed.

A booklet with information on approved Medigap policies in Wisconsin, dated October 1997, lists comparative rates for Medicare beneficiaries under age 65 separately from those for other age categories. Wisconsin's guide indicates that insurers' practices vary. Some charge beneficiaries under age 65 a rate similar to that charged older Medicare beneficiaries, such as those above the age 80. Other insurers charge a rate closer to the age-65 rate or the rate charged Medicare beneficiaries between ages 65 and 79.

It was not possible to ascertain from the state survey whether the premiums reflected actual differences in claim costs or actuarial assumptions and insurer's pricing decisions. States do not generally have information that allows them to distinguish the underlying claims costs of beneficiaries under age 65 compared to those over age 65, or the interaction of the claims costs and rate regulations on premiums for those under and over age 65. Where regulations allow different rates for beneficiaries under age 65, it is not possible to determine the fairness of rates without access to information about the claims experience for the population under age 65 compared to those age 65 and older. Similarly, where community rating is required, without information on claims experience by

age, it is not possible to determine whether or how the costs of disabled Medicare beneficiaries under age 65 affect community rates.

Further research might shed additional light on the effects of the requirements in states providing access to Medigap coverage to disabled beneficiaries under age 65. However, even with more specific information, it could be difficult to identify or isolate the source of changes in rates. Some states' simultaneous implementation of several rating and access requirements (which may have independent effects) complicates efforts to determine effects of particular requirements, such as guarantee issue to Medicare beneficiaries under age 65. Regulators in New York and Massachusetts, both community rated states, indicated that, because access to coverage for beneficiaries under age 65 was implemented at the same time as other Medigap reforms, it is difficult to assign any rate effects to any one component of the policy requirements. Furthermore, changes in Medicare coverage and insurers' pricing decisions that occur in the same time frame as new state Medigap regulatory requirements also complicate the task of determining the factor(s) contributing to rate increases.

#### Impact on insurer participation in the market

Another potential market effect of requirements to make Medigap coverage available to Medicare beneficiaries under age 65 might be a decrease in the number of insurers in the Medigap market. This study did not uncover market disruption marked by a general exodus of insurers from the Medigap market in fifteen states surveyed.

Regulators in two states did indicate problems that were not market-wide but instead related to unique conditions affecting particular insurers. For example, in New Jersey, before the requirement was imposed on all Medigap insurers, one company was the only insurer offering Medigap to the Medicare population under age 65. This company had a history of some difficulty in this market and withdrew from the Medigap market for the under-age 65 population on March 31, 1995. According to the legislative findings and declarations that preceded New Jersey's statutory requirements expanding access to Medigap coverage, "[u]nsustainable losses, caused in part by the fact that this insurer was the only one providing such coverage, led to the insurer's withdrawal from the Medicare supplement[al] insurance market [for beneficiaries under age 65]."<sup>19</sup> The legislature enacted the requirement that all Medigap insurers provide coverage to the Medicare population under age 65 after the withdrawal of this insurer from the market.

In New Jersey's relatively new program for disabled Medicare beneficiaries under age 50,<sup>20</sup> the contracting insurer must file an annual report with the Commissioner of Insurance indicating net earned premiums, claims paid, administrative expenses, as well as any net loss. A forthcoming report on the under-50 plan had not been released at the time of this survey.

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<sup>19</sup> NJ Stat. 17B:26A-12.

<sup>20</sup> Disabled Medicare beneficiaries ages 50 through 64 have access to coverage in the marketplace rather than through the publicly-run program for those under age 50.

In Wisconsin, one company with a high percentage of enrollees with prescription drug coverage began to experience rapidly increasing losses shortly after the state mandated open enrollment for disabled Medicare beneficiaries under age 65. For this business, it was not simply the drug portion of the claims experience that increased; the base policy and Medicare Part A claims experience also were significantly greater than for plans without the drug rider. Although the Medicare population under age 65 contributed to the rapid increase in the Wisconsin claims experience, this insurer was also experiencing high claims nationally on its standardized plans that included prescription drug benefits. As a result, the insurer ceased writing all Medigap plans with prescription drug benefits in 1996. The Department of Insurance permitted this company and another company with similar experience to close their blocks of business that included the drug rider. These insurers were permitted to offer new policies with lower rates, subject to a requirement to use the combined experience of the old and new blocks of business to determine future premium changes for non-prescription drug benefits. According to a Wisconsin regulator, no company has tried to apply different rate increase factors to the Medicare populations under age 65 and age 65 and over.

A number of Medigap insurers in New York left the market after rating and guaranteed issue requirements went into effect in April 1993. The simultaneous implementation of several new requirements makes it impossible to isolate the effect of the guaranteed issue requirement from the others.

### **Summary and Conclusions**

At the end of 1997, fourteen states had taken some action to give the disabled Medicare population under age 65 guaranteed access to Medigap coverage to supplement Medicare. And, in at least one other state, such policies are available in the absence of any legal requirement to do so. State requirements for making Medigap insurance available to disabled Medicare beneficiaries under age 65 are generally the same as those for beneficiaries age 65 and over. However, in some states, insurers are only required to offer the disabled Medicare beneficiaries under age 65 one or two plans and are subject to separate rating restrictions for this population.

The research found nine additional states that provide Medicare beneficiaries under age 65 with access (in some cases limited) to some form of supplemental coverage through their state high-risk pools rather than through the Medigap market. Additional research is necessary to learn more about these arrangements.

Little systematic information about experience in states with Medigap market requirements is publicly available. As a result, it is not possible to draw any firm conclusions about the impact of the measures on either disabled Medicare beneficiaries under age 65, or on the Medigap insurance market.

Regulators generally do not have data on the number of policies sold to this population. Therefore, it is difficult to determine how many Medicare beneficiaries have been helped by these Medigap requirements. In the uninsured population generally, cost is the most common reason for not having

insurance<sup>21</sup>. Since the proportion of disabled Medicare beneficiaries under age 65 with low incomes is higher than among the Medicare population age 65 and older, and since this population faces higher premiums than do many older Medicare beneficiaries in many states, cost may be even more of a barrier to coverage for Medicare beneficiaries under age 65 than for aged beneficiaries.

Disabled Medicare beneficiaries under age 65 who do not have end stage renal disease are eligible, under federal law, to enroll in Medicare + Choice plans. Because many of these plans have no or low premiums and include benefits not covered in Medicare's fee-for-service program, managed care plans may present a less costly alternative to Medigap coverage. It is important that educational efforts inform all Medicare beneficiaries of the coverage options available to them. Estimates indicate that about 4 percent of Medicare beneficiaries under age 65 were in Medicare managed care plans in 1997.<sup>22</sup>

In 1997, faced with a federal proposal to require offering Medicare disabled beneficiaries under age 65 access to Medigap coverage, some insurers raised concerns about the cost increases and market disruption that this might cause. For the most part, regulators in the states with enhanced Medigap market requirements indicated that insurers' rate filings were not citing the requirements for this population as a problem. Information comparing claims costs for Medicare beneficiaries under age 65 and for those age 65 and older could shed further light on this concern. However, such information is not publicly available. Because other requirements were often implemented at the same time, even if information on claims costs were available, it would be difficult to separate the costs attributable to enrollment of disabled beneficiaries under age 65 from those attributable to other requirements. For example, a state's simultaneous implementation of rating and access requirements, which may have independent effects, complicates efforts to determine effects of particular components of the requirements, such as the guaranteed issue requirement.

Apart from isolated cases of particular insurers' experiencing difficulties, regulators did not report widespread market disruption. In some states, the requirements are quite new, and it may be too soon to know the effect of giving Medicare beneficiaries under age 65 access to the Medigap market. Based on the limited cases in which regulators reported that an insurer had experienced difficulties, the circumstances giving rise to such situations can be complex. The root of such problems may lie in other forces in the Medigap market rather than in access to Medigap coverage given to younger disabled beneficiaries. The origins of these situations and whether and how to address them are topics for further study.

In order to explore how to effectively provide disabled Medicare beneficiaries under age 65 with access to supplemental coverage, further research is needed. Possible questions for additional research are:

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<sup>21</sup> "Getting Behind the Numbers on Access to Care," Harvard School of Public Health, Kaiser Family Foundation, National Opinion Research Center, October 22, 1996.

<sup>22</sup> AARP Public Policy Institute, *Barriers to Care and Out of Pocket Health Spending for Medicare Beneficiaries Under Age 65*, Washington, DC 1999 (forthcoming).

- What role do state high-risk pools play in providing access to coverage for Medicare beneficiaries? What information do state high-risk pools have about the numbers of disabled Medicare enrollees under age 65 and their claim costs?
- What are the characteristics of disabled Medicare beneficiaries under age 65 with supplemental coverage through the Medigap market or state high-risk pools? How do they compare to Medicare beneficiaries with either employer-sponsored coverage, Medicaid, or no other form of supplemental coverage?
- What role does Medicare managed care play for this population? Are there differences in the characteristics of disabled beneficiaries under age 65 in managed care and those in fee-for-service Medicare with supplemental insurance?
- What barriers (financial and other) do disabled Medicare beneficiaries under age 65 face in accessing supplemental coverage or managed care plans that are available to them?

Answers to these questions could be helpful in future policy deliberations at the state and federal level. National data can shed light on some of the general characteristics of this population and their cost to Medicare. However, in order to evaluate the success of state requirements providing access to Medigap coverage to disabled Medicare beneficiaries under age 65, better state-level data are needed. Information on the numbers of disabled Medicare beneficiaries under age 65 holding Medigap coverage, and their Medigap claim costs are known only to the insurers enrolling them; the impact of the requirements cannot be assessed objectively without access to this information. To inform discussions on how to ensure that Medicare beneficiaries under age 65 have access to supplemental coverage, more information about actual experience under requirements must be collected. Since the information is private, insurers would either have to voluntarily agree to provide the needed information to some neutral organization, or the states or federal government would have to require insurers to report such information.

## Appendix A-Descriptions of State Measures Expanding Medigap Market

This appendix provides an overview of the market requirements in the fifteen states surveyed about expanded access to Medigap insurance to disabled Medicare beneficiaries under age 65.

### Connecticut

Connecticut requires all insurers selling Medigap policies to make at least one plan available on a continuous basis to persons eligible for Medicare by reason of disability. Insurers chose to offer Medigap Plan A, the least generous standardized plan. As of October 1, 1998, insurers offering Plans B and C to Medicare beneficiaries age 65 are also required to offer these plans to Medicare beneficiaries under age 65.

The state requires community rating and prohibits rating based upon age, gender, claims history, medical condition, or geography for plans A-G. The rating requirement means that Medigap policyholders, under and over age 65, who buy the same policy from an insurer are “pooled together” and charged the same rate. Plans H to J can be medically underwritten for both rating and issuance;<sup>23</sup> insurers may consider health status in deciding whether or not to offer an individual the plan and what premium to charge. To help consumers compare prices, Connecticut makes a rate chart available for the standard plans. These requirements have been in place since January 1, 1994, (except for the expanded access to Plans B and C, which was enacted in 1998). Hence, in Connecticut, as of October 1998, Medicare beneficiaries under age 65 are guaranteed access to three Medigap plans (if insurers otherwise offer A-C), and they must be charged the same rate as other Medicare beneficiaries offered the same policy.

### Kansas

Kansas requires insurers to offer a six-month “open enrollment period” for Medicare beneficiaries under age 65<sup>24</sup>, beginning on the first day of the beneficiary’s first month of Medicare Part B enrollment. During this period, insurers must offer eligible individuals *any* of the policies that they offer in the Medigap market.

Insurers may not deny coverage or discriminate in the pricing of a policy based on health status or claims experience during the open enrollment period. This has the effect of ensuring that if they purchase a policy during the initial six months following enrollment in Part B, all new enrollees are charged the same rate, regardless of health status or the basis of their Medicare eligibility.

Under a transition rule, disabled Medicare beneficiaries who became eligible for Medicare prior to April 28, 1996 (the effective date of the regulation) may be charged rates capped at 150 percent of the rate charged those who are 80 years old. However, those Medicare beneficiaries under age 65 who became eligible for Medicare after April 28, 1996 may not be charged rates in excess of those charged to the beneficiaries age 65 or older.<sup>25</sup> Kansas does not have any other rating requirements for Medigap

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<sup>23</sup> Conn. Gen. Stat. 38(a)-495(c).

<sup>24</sup> K.A.R. 40-4-35(f)

<sup>25</sup> *Id.* at (g).

policies. Insurers can use any rating method. The majority use “attained age” rating, according to a regulator with the Department of Insurance.

### Maine

Maine requires Medigap insurers to offer a six-month guaranteed issue open enrollment period upon a beneficiary’s initial Medicare enrollment, regardless of the age of the Medicare beneficiary. Insurers also must offer Medicare beneficiaries under age 65 the same coverage options they offer older Medicare beneficiaries. In addition, insurers must hold an annual open enrollment period of at least one month in length for Plan A for all Medicare beneficiaries, including those under age 65.<sup>26</sup> Insurers may not impose preexisting condition exclusions on a beneficiary switching to a comparable policy if s (he) had coverage under a prior policy equivalent to the length of such an exclusion. Since January 1993, premiums have been subject to a community rating requirement. Policies for all age groups must be “pooled together”; therefore, premiums cannot vary based on an individual’s health status or age.

### Massachusetts

Massachusetts mandates a six-month open enrollment period for Medicare beneficiaries beginning when they are first enrolled for benefits under Part B.<sup>27</sup> Those Medicare beneficiaries under age 65 who qualify for Medicare because they have end-stage renal disease (ESRD) are excluded from the open enrollment requirement. Medigap policies are community rated in this state. In addition, there is a mandatory annual two-month open enrollment period for all Medigap policies. Massachusetts is one of the states that is exempt from federal standardization requirements.

The open enrollment requirement and the ESRD exclusion may be traced to past insurer policies. Blue Cross and Blue Shield of Massachusetts was subject to such a requirement prior to the reform; this reform extended to all insurers the requirements that had previously applied to this insurer. Hence, in Massachusetts, only those Medicare beneficiaries under the age of 65 who do not have ESRD benefit from an open enrollment period. Non-ESRD Medicare beneficiaries’ access to Medigap coverage in Massachusetts, therefore, is similar to that of Medicare beneficiaries age 65 and older in the state.

### Michigan

Michigan requires every insurer to offer those individuals insured by them under a non-Medicare health insurance conversion to Medicare Supplement coverage (Plan A or C) without restriction policy if the individuals would otherwise lose individual or group health coverage as a result of Medicare entitlement.<sup>28</sup> Individuals must request coverage within 90 days before or after eligibility or within

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<sup>26</sup> 24-A M.R.S. 5010-A and 5012.

<sup>27</sup> Mass. Ann. Laws ch. 176K, Sec. 5. This requirement was enacted on January 14, 1994, and effective January 1, 1995. According to a regulator with the Massachusetts Department of Insurance, this requirement also extends to individuals who move out of an HMO service area, become a Massachusetts resident, or lose employer-based Medigap coverage, under certain specified circumstances.

<sup>28</sup> M.S.A. 24.13831, Sec. 3831(1).

180 days of losing group coverage. Medicare beneficiaries 60 years of age or older who lose group coverage must apply 90 days before or after Medicare entitlement.

Since the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires renewal of coverage irrespective of Medicare entitlement, insurers are not permitted to discontinue a policyholder's coverage due to Medicare entitlement. As a result, the conversion requirement for individual policies is no longer as relevant.

According to a regulator with the Michigan Insurance Bureau, different rates are permissible for the group under age 65. Insurers file proposed rates for Medigap policies using either their own experience or the maximum rates approved by the Insurance Bureau. The Michigan Insurance Bureau has a maximum Medigap rate that is based on HCFA claims experience for Medicare. Michigan Medigap insurers' rates generally vary by age, and may reflect either issue-age or attained-age rating methods.

The rates for Medigap policies offered by Blue Cross and Blue Shield of Michigan are established differently. In Michigan, Blue Cross and Blue Shield must guarantee issue all the policies they offer year round, including Medicare Supplement coverage, pursuant to a separate statutory requirement.<sup>29</sup> Hence, for Medicare beneficiaries under age 65 who do not have prior private health insurance coverage, this guarantee issue requirement is the most relevant, as it guarantees access to a Medigap product. Michigan Blue Cross and Blue Shield also must community-rate its policies; thus, the average age in this pool, which may be fairly old, determines the price of plans. According to a regulator with the Michigan Insurance Bureau, the requirement for community rating is based upon the Michigan Attorney General's interpretation of the Michigan Non-profit Health Care Corporation Act.<sup>30</sup>

### Minnesota

Since November 1991, Minnesota has required a six-month open enrollment period without the imposition of a pre-existing condition exclusion for those enrolled in Part B. The open enrollment period begins on the first day of the first month the individual enrolls in Medicare Part B. Individuals enrolled in Medicare based upon disability who are involuntarily disenrolled due to loss of disability status are eligible for another six-month enrollment period upon re-enrollment in Medicare.<sup>31</sup>

Minnesota, under an exemption for states that had standardized Medigap coverage before the enactment of the federal requirements for standard plans, is exempt from the federal standardization requirements. Insurers must offer their "Basic plan" and "Extended basic plan" during the open enrollment period. Minnesota has required insurers to community rate Medigap coverage since November 1991; an insurer's rates can be adjusted, based on benefit design. Geography, smoking status, and state-approved "healthy lifestyle behaviors" are allowable rating factors; gender is not an allowable rating factor. Hence, in Minnesota, Medicare beneficiaries under age 65 have rights

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<sup>29</sup> M.S.A.; M.C.L. 550.1401

<sup>30</sup> M.C.L. 550.1101 to 550.1704.

<sup>31</sup> Minn. Stat. 62A.31, Subd. 1h.

regarding the access and affordability of Medigap coverage similar to Medicare beneficiaries age 65 and over, provided they enroll during the specified open enrollment period.

#### New Hampshire

New Hampshire requires an open enrollment period for the under age 65 Medicare disabled population during the six-month period beginning with the first day of the month in which an individual is enrolled under Medicare Part B.<sup>32</sup> All Medigap plans offered by an insurer must be available during open enrollment. All rating methods are allowed. The New Hampshire Insurance Department reviews rate filings; policies in which the under-65 rate exceeds the highest rate otherwise charged to the over-65 population are reviewed according to Department guidelines.

#### New Jersey

New Jersey has divided its Medigap market for those under age 65 into two parts, for those age 50 to 64 and those under age 50, with different regulatory requirements applicable to each group.

All insurers that market Medigap policies to the population age 65 and older must also offer at least Plan C to Medicare beneficiaries between the ages of 50 and 65 who are enrolled in Medicare due to disability.<sup>33</sup> Premiums for these policies may not exceed the lowest rate charged by the insurer for the same type of policies issued to persons age 65 or older.<sup>34</sup> Insurers must offer a 6-month open enrollment period beginning on the date of first enrollment in Medicare Part B and may only impose a 3-month preexisting condition exclusion for treatment or diagnoses received during the six-month period prior to the effective date.<sup>35</sup> Insurers that only issue group Medigap policies for groups whose membership is not dependent upon health status, claims experience, or receipt of health care are not subject to this requirement for business outside the group. (Such groups also may not institute an age requirement for participation on or after June 1, 1995). These issuance requirements have been in effect since August 16, 1995.

New Jersey has a separate program for Medicare beneficiaries under the age of 50.<sup>36</sup> A governing board administers it, and coverage is provided by an insurer that contracts with the state. In effect, it operates similarly to a high-risk pool and has been in effect since January 1997. Through this program, Medicare beneficiaries under age 50 must be given an opportunity to enroll in Plan C during the six-month period they are first enrolled in Medicare Part B. The pricing can not be dependent upon health status. The insurer can only impose a three-month preexisting condition exclusion for treatment or diagnoses received during the six-month period prior to the effective date. As with coverage for

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<sup>32</sup> NH Admin. Code 1905.08.

<sup>33</sup> N.J.A.C. 11:4-23B.1(a) (effective date of underlying statute Aug. 16, 1995)

<sup>34</sup> Id. Sec.4.

<sup>35</sup> Id. Sec. 3. However, persons with prior coverage without a lapse who had been treated or diagnosed for a condition under that policy or who satisfied a three month preexisting condition limitation under that policy or contract shall not be subject to such a limitation.

<sup>36</sup> . N.J.A.C. 11:4-23A.3.

beneficiaries age 50 to 65, the rates for those under age 50 cannot exceed the lowest rate the contracting insurer charges for Medicare Supplement Plan C policies to beneficiaries age 65 or older. There is a system under which any losses experienced by the contracting insurer may be apportioned among other insurers and HMOs doing business in New Jersey. Information on the size of the enrollment for this program was not available at the time of this survey but is expected to be available in an upcoming report on the program.

#### New York

New York requires insurers to guarantee issue all Medigap plans they offer to all Medicare beneficiaries, regardless of age. An insurer must accept applicants throughout the year for any Medigap plan offered.<sup>37</sup> Insurers selling Medigap must offer at least Plans A and B.<sup>38</sup> State law requires insurers to give credit for prior coverage against any pre-existing condition limitation that might have been imposed, as long as there was no more than a 60-day lapse in coverage.<sup>39</sup> Premiums must be community rated,<sup>40</sup> and the only permissible variation is for geographic location. Thus, in New York, all Medicare beneficiaries are treated similarly with respect to Medigap coverage and are guaranteed access to, at a minimum, Medigap Plans A or B at the same rate as other Medicare beneficiaries, regardless of their age or Medicare eligibility status. These guaranteed issue and rating requirements have been in effect since April 1, 1993.

#### Oklahoma

Oklahoma requires an open enrollment period during the six-month period disabled individuals under age 65 are first enrolled in Medicare Part B. In addition, insurers must make at least one of the plans offered by the issuer available to Medicare beneficiaries who qualify by reason of disability; some insurers offer more policies to this population.<sup>41</sup> This requirement went into effect on July 1, 1994. The department has not collected or analyzed data regarding the impact of this requirement upon the overall price of Medigap coverage or upon the number of Medicare beneficiaries under the age of 65 with Medigap coverage.

Oklahoma imposes no rating restrictions on Medigap policies. However, it facilitates dissemination of comparative rating information by publishing a Shopper's Guide for Medicare Supplement insurance that includes insurers' rates.

#### Oregon

Oregon requires guaranteed issue of any of the Medigap plans offered by an issuer during an open enrollment period of the initial six months of enrollment in Medicare Part B, regardless of a

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<sup>37</sup> Id. 11NYCRR 52.22(k).

<sup>38</sup> Id. 52.22(d)(7).

<sup>39</sup> Id. at 52.22(b)(3)(i),(ii). The BBA allows a gap of 63 days for the 65-and-over Medicare population; federal law did not address crediting prior coverage for those enrolling in Medicare under the age of 65.

<sup>40</sup> Id. 52.22(k).

<sup>41</sup> OAC 365:10-5-129.

beneficiary's age. This requirement applies to disabled Medicare beneficiaries who enrolled in Part B on or after Sept. 1, 1993. Medigap rates for the population under age 65 can be no greater than the rate for 65-year olds. For rating purposes, the pool of persons eligible by reason of disability is pooled with persons qualifying by reason of age. After individuals reach age 65, insurers offering attained age policies cannot differentiate rates on the basis of the reason an individual was initially eligible for Part B.<sup>42</sup> These requirements have been in effect since the fall of 1993. Thus, in Oregon, disabled Medicare beneficiaries are guaranteed access to Medigap during an open enrollment period. Those disabled beneficiaries age 65 and older with attained age policies must be charged the same rate as other Medicare beneficiaries with such policies, and those under age 65 must be charged no more than the rate for Medicare beneficiaries age 65.

#### Pennsylvania

Pennsylvania requires a six-month open enrollment period beginning the first day of the first month a beneficiary is first enrolled in Medicare Part B; this includes the Medicare disabled population under age 65. Insurers must make all of the Medigap policies they offer available during this time to all persons without regard to age.<sup>43</sup> The open enrollment requirement for Medigap was changed in November 1994 to include the disabled population. During the open enrollment period, insurers must provide Medicare beneficiaries under age 65 access to the "best available rate," e.g. the rate which is generally charged to beneficiaries age 65, for the plan the beneficiary selects. Hence, in Pennsylvania, Medicare beneficiaries under age 65 who enroll during the open enrollment period are treated the same as those over 65 in terms of policy availability and pricing requirements.

#### Texas

For Medicare beneficiaries under the age of 65, Medigap insurers must make at least Plan A available within the first six months they are enrolled in Part B. Insurers must make all Medigap policies that they offer available during such a period to all applicants 65 and over. Insurers may not raise policy premiums solely because a policy is issued under these open enrollment requirements. During this six-month period, rating of such policies may not be based upon health status or claims experience.<sup>44</sup> The open enrollment requirement for beneficiaries under age 65 applies to those who enroll in Part B on or after January 1, 1997 and who apply for a Medigap policy during the six-month period after they first enrolled, or for those who enroll during the period of eligibility that would apply if the person first enrolled upon turning age 65. (A transition enrollment period held the first six months of 1997 was available to those enrolled in Part B between March 1, 1992 and January 1, 1997.).

#### Vermont

Vermont does not mandate open enrollment for disabled Medicare beneficiaries under age 65, although there are a limited number of insurers that do offer Medigap coverage to this population. Vermont publishes data relating to premiums charged to Medicare beneficiaries under age 65 and age 65 and older. Therefore, the variation in premiums charged these beneficiaries is known.

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<sup>42</sup> OAR 836-052-0138.

<sup>43</sup> 31 Pa. Code 89.778.

<sup>44</sup> 28 TAC 3.3324.

According to a regulator with the Vermont Department of Banking, Securities and Health Care Administration, Vermont implemented a new rating requirement on January 1, 1998; insurers must community rate Medigap policies. There is a two-year transition period. Rates can vary 40 percent from the community rate during 1998 and 20 percent during 1999. Community rating will be fully implemented by the year 2000. Allowable rating factors during the transition period do not include health status but can include age. Medicare beneficiaries under age of 65 will be pooled with those ages 65 and older for rating purposes. Hence, Medicare beneficiaries under age 65 with a Medigap policy will be charged a rate increasingly similar to that charged to beneficiaries age of 65 or older. Upon completion of the transition to community rating, the rates charged the populations over and under age 65 will be the same.

### Wisconsin

Since September 1994, Wisconsin has required an open enrollment period for all individuals when they are first eligible for Part B.<sup>45</sup> While the state is exempt from federal standardization requirements, it requires insurers to make state-defined standard riders available to everyone. According to a regulator, there are no restrictions on rating for Medigap policies, except that insurers must charge a single rate for the population under age 65, even for age-attained policies. This means that all those under the age of 65 covered by a single policy will not be charged different rates based on their individual health status or age. In Wisconsin, the majority of Medigap policies are sold on an age-attained basis. Some are rated according to an issue-age methodology; the AARP plan sold by UnitedHealthcare is community rated. When Medicare beneficiaries turn 65, their policies are pooled with other policies for the Medicare population age 65 and older. Hence, in Wisconsin, after Medicare beneficiaries reach the age of 65, there can be no differentiation in rates based upon the reason a person was first eligible for Medicare.

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<sup>45</sup> Wisc. Adm. Code Ins. 3.39(4m).