



KEY ISSUES AFFECTING ACCESSIBILITY TO MEDIGAP INSURANCE

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EXECUTIVE SUMMARY

Although Medicare covers a large share of medical expenses for people age 65 and older, many of these elderly Americans are still exposed to substantial out-of-pocket costs. Long-term care and prescription drugs are generally not covered by Medicare, and beneficiaries must shoulder the program's premiums, copayments, and deductibles. Some choose to insure against Medicare's cost-sharing by purchasing a Medicare Supplemental Insurance Policy, also known as Medigap.

In 1993, 36 percent of all beneficiaries held individually purchased Medigap policies.¹ This study examines how changes in underwriting, premium rating practices, and increases in premium rates are affecting the accessibility and affordability of Medigap insurance.

Laws enacted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) have simplified consumers' ability to choose health insurance policies and established important consumer protection features. The OBRA-90 legislation authorized development of ten standardized Medigap plans (A through J) to address concerns about duplication of benefits, consumers' ability to compare policies, and policies that offered little value. However, insurers still have flexibility in determining whether they will allow individuals with certain health conditions to purchase a policy (through underwriting criteria) and in structuring premium rates. These underwriting and rating methods greatly influence beneficiaries' access to coverage and the premiums that companies can charge for policies.

Standardization of policy offerings has limited the ability of insurers to compete on the basis of most policy features, thereby creating more pressure for competition based on price. By inducing more insurers to deny policies to individuals with certain health conditions and to price policies to appeal to 65 year olds (but to increase rates as they grow older), this price competition could affect access to coverage.

This report addresses concerns about the ability of older people to access Medigap policies through two strategies: interviews with 22 insurers nationwide with large Medigap market shares, and insurance department filings of top-selling Medigap insurers in Arizona, Ohio, and Virginia. These states were chosen because they did not have regulations beyond those required by the OBRA-90 legislation that could limit market competition.

¹ Twenty-nine percent of beneficiaries have employer-provided supplemental benefits. These policies are not considered in this report.

A review of policies and discussions with insurers indicated that changes in market forces have affected consumers' ability to access Medigap policies in the following ways:

- individuals with certain health conditions have very limited choices;
- most premiums now increase automatically as consumers age;
- premium rates, in general, are rising;
- the large number of consumers who hold pre-standardized policies (sold before OBRA-90) face dramatic premium hikes, but may not be able to switch to newer policies; and
- the growth of Medicare managed care as an alternative to Medigap may cause sales to deteriorate and Medigap costs to rise.

CHANGES IN UNDERWRITING

Almost all Medigap insurers screen for health conditions before underwriting a policy, severely limiting access for some individuals. In particular, those with cancer, heart disease, Alzheimer's disease, Parkinson's disease, diabetes, stroke, and respiratory conditions may have difficulty purchasing a policy.

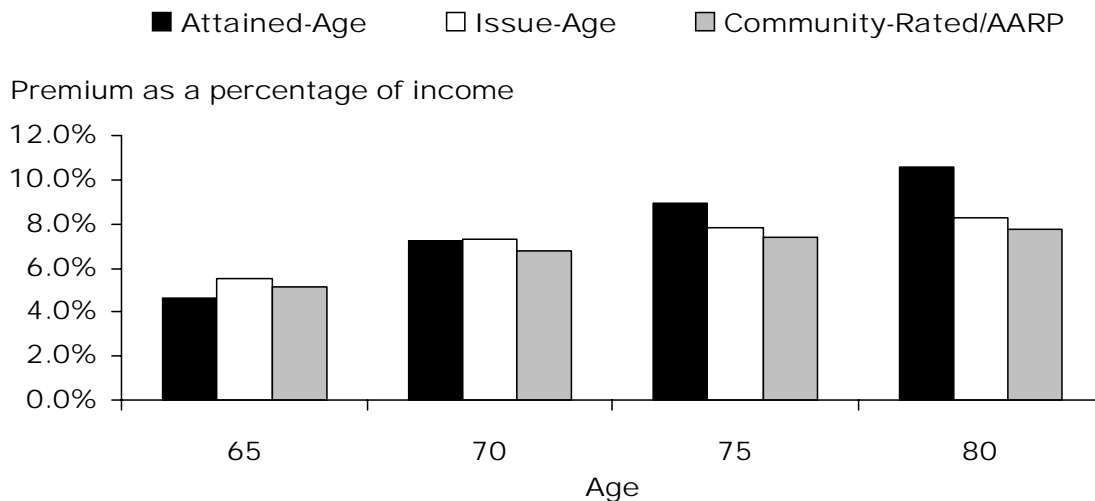
Other than plans sponsored by the American Association of Retired Persons (AARP) and some Blue Cross/Blue Shield companies, very few affordable policies are issued regardless of health conditions (guarantee-issue policies). As more Blue Cross/Blue Shield organizations underwrite their policies, AARP Prudential is becoming the last available source of Medigap insurance for older people with certain health conditions.

CHANGES IN RATING METHODS

The majority of insurers, in an apparent attempt to attract younger purchasers, now structure premiums to increase automatically as the policyholder ages (attained-age rating). A review in the three study states showed that attained-age policies have become the norm in the Medigap market. Nationwide, in 1996, 39 Blue Cross/Blue Shield companies (57 percent) sold policies on this basis. Fifteen of these companies (22 percent) used issue-age rating based on age at the time of purchase, and 14 (21 percent) used community rating, in which policies were not based on age. In many markets, only AARP offered community-rated policies.

Consumers may not understand that rates will increase as they grow older and have less ability to pay, and may choose the policy offering the lowest premium at their current age. On average, the attained-age premium for the most popular plan, Plan F, accounted for 4.6 of income at age 65, rising to 10.6 percent of income at age 80 (see Figure 1).

Figure 1: Premium for Plan F Purchased at Age 65 as a Percentage of Annual Income by Rating Method



Note: Within each state, premiums were weighted by 1994 premium volume for each company. A non-weighted average was used across all three study states. With the exception of AARP, all guarantee-issue policies were excluded.

Income reflects average income. Individual income was used for singles and one-half couple income was used for couples. Income data are cross-sectional and, therefore, may include declines in income attributable to lower earnings by earlier cohorts. However, longitudinal analyses also show that real income declines with age (Coleman and Dall, 1996).

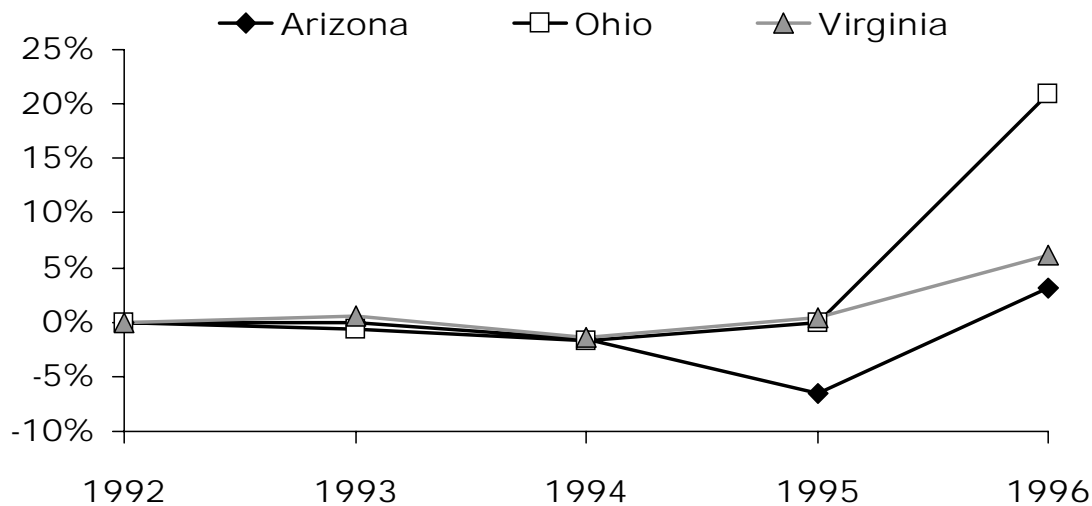
Source: The Lewin Group analyses of insurance department filings in Arizona, Ohio, and Virginia and the March 1996 *Current Population Survey*.

RISING PREMIUM RATES

A review of filings by the top-selling companies in three states revealed that premium rates increased substantially from 1995 to 1996, after remaining relatively flat compared to inflation from 1992 to 1995 (see Figure 2).

Interviews with large insurers nationwide suggested that while rates vary widely, almost half of Medigap insurers have implemented substantial increases over the past two years. Of the company representatives willing to project the increase in premium rates for the near future, nearly 70 percent cited double-digit annual increases.

Figure 2: Cumulative Average Increase in Premium Rates, Controlling for Increases in the Consumer Price Index for All Plans by State (Purchased at Age 65)



Note: Averages were weighted by plan premium volume.

Source: The Lewin Group analyses of insurance department filings in Arizona, Ohio, and Virginia.

AARP Prudential, the company with the largest market share and frequently the only community-rated, guarantee-issue option (available to everyone age 65 and older at the same premium regardless of health), increased its rates substantially in 1996 after holding them level for three years. These increases averaged 27 percent nationwide and 23 percent in the three states visited as part of this study.² AARP further increased rates by an average of 13 percent nationwide in 1997. Analyses also indicated a trend toward higher rates in 1996 beyond the effect of the AARP increases. Some insurers and regulators interviewed speculated that the AARP increases gave other companies the latitude to increase their rates.

A review of insurance department filings in three states revealed that, depending on the state and policy type, premiums in 1996 ranged from being affordable to the vast majority of consumers (annual premiums of \$402) to affordable to very few consumers (annual premiums of \$7,196). Premiums reviewed varied by plan type, consumer age, and state. Premiums for the same plan at the same age also varied substantially within states.

² These numbers reflect weighting plans by premium volume in 1994 within states, but using a simple average across states.

THE EFFECT OF STANDARDIZATION ON PRE-STANDARDIZED POLICIES

Consumers with pre-standardized policies (sold before the OBRA-90 regulations were implemented) may be forced to either pay dramatically rising premiums or choose one of the few standardized policies still available to them. Since insurers can no longer sell the pre-standardized policies to new purchasers, the average age of these policyholders is increasing, causing the average claim cost to rise. Interviews indicated that rates are rising dramatically for pre-standardized policies, and these increases affect a sizable portion of Medigap policyholders. In 1994, for example, 73 percent of AARP Prudential policyholders held pre-standardized policies.

THE EFFECT OF MEDICARE MANAGED CARE ON MEDIGAP INSURANCE

At the end of 1996, nearly 13 percent of Medicare beneficiaries were enrolled in a health maintenance organization (HMO). The Congressional Budget Office projects that this figure will grow to 20 percent by the year 2000 and to 35 percent by 2007. Three-quarters of the companies interviewed reported a decrease in sales that they attributed to the growth of Medicare managed care. Of these companies, three-quarters reported that drops had been substantial. The remaining one-quarter of companies generally believed that HMOs will strongly affect sales in the near future.

The Lewin Group's analyses of the Medicare *Current Beneficiary Survey* show that Medicare HMOs appeal most to younger, healthier individuals, and least to those with functional impairments. If primarily less healthy individuals are left with Medigap policies, their premiums may rise, encouraging even greater HMO enrollment among healthier Medicare beneficiaries. Recent Medigap premium increases were cited by insurance counselors as one reason beneficiaries switch to Medicare HMOs.

CONCLUSION

The trends described above will most directly affect older Medicare beneficiaries, especially those with health conditions. Their access to Medigap insurance may be threatened by the decreasing affordability of policies sold regardless of health status, especially those priced the same regardless of age. Community-rated, guarantee-issue policies may become the only option for older consumers and those with health conditions, yet the likelihood of companies offering these policies may dwindle.

The size of AARP's client pool and the number of new Medigap applications that AARP receives as a result of its unique market position may buffer against spiraling rate increases. Prudential representatives contend that, for the most part, recent increases were not caused by worse-than-expected claims.

Potential changes in AARP policies, such as discontinuing guarantee-issue policies or substantially increasing premiums, would most directly affect older, physically vulnerable

consumers. An 80 year old with health conditions in the three study states, for example, would pay from 41 to 70 percent more in premiums to get the same plan from a company other than AARP.

POLICY IMPLICATIONS AND CONSIDERATIONS

Consumer education and legislation could address the complex issues raised in this report in a number of ways. The Health Care Financing Administration (HCFA), for instance, could provide information and other outreach efforts to help consumers understand the implications of different rating methods.

On the legislative front, rating structures could be standardized through such measures as requiring that all policies be sold on an issue-age or community-rated basis. As of May 1997, six states have mandated community rating and two states have mandated issue-age rating. Legislation could also expand enrollment opportunities for those who wish to switch plans or switch back from Medicare HMOs to Medigap. Two states currently mandate continuous open enrollment, and three states mandate annual open-enrollment periods.

While these measures may increase access to Medigap in the short run, they could exacerbate the problem of the healthier elderly choosing Medicare HMOs over Medigap, thereby increasing Medigap premiums. An important step for public policy aimed at reforming insurance markets would be an explicit acknowledgment that changing the nature of competition in one aspect of the market may affect the nature of competition in another (i.e., standardizing features may alter rating practices). In addition, the experience of pre-standardized plans suggests that future legislation should avoid precluding new entrants into existing risk pools.

KEY ISSUES AFFECTING ACCESSIBILITY TO MEDIGAP INSURANCE

INTRODUCTION

Medigap insurance protects individuals with fee-for-service Medicare coverage against some or most out-of-pocket costs. Even with Medicare coverage, requirements that beneficiaries pay premiums, copayments, and deductibles, and a lack of coverage of other service needs—most notably long-term care and prescription drugs—often result in substantial out-of-pocket costs for many elderly and younger people with disabilities.

In 1994, Medicare beneficiaries averaged \$714 in out-of-pocket liabilities connected to Medicare copayments and deductibles (HCFA, 1996a). Because expenditures are related to need for care, out-of-pocket costs are distributed unevenly across Medicare beneficiaries. While approximately 63 percent of beneficiaries had Medicare cost-sharing liabilities of less than \$500, 1.8 percent had liabilities that exceeded \$5,000.

Many elderly choose to insure against these costs by purchasing a Medicare Supplemental Insurance policy, also known as Medigap. Medigap can cover costs associated with the Part A deductible (\$756 in 1997), Part B deductible (\$100 in 1997), coinsurance (20 percent for Part B services), and other related expenses, such as skilled nursing facility care and prescription drugs. In 1993, 36 percent of all beneficiaries held individually purchased Medigap policies to cover gaps in Medicare.

The Medigap market has changed substantially over the past five years. Federal legislation has altered the nature of competition among Medigap insurers by sharply limiting the packages of covered services that insurers can offer. In addition, Medigap increasingly competes with new mechanisms for financing care for the elderly, such as managed care.

These forces may alter how insurers market Medigap insurance and may affect Medigap premiums. Insurers must now compete on terms other than policy features. Changes regarding to whom insurers will sell a policy, how insurers structure rates, and increases in policy premiums may affect the ability of older people to purchase and retain Medigap policies.

This report addresses concerns about the ability of older people to obtain Medigap policies. We discuss how changes in rating practices, underwriting practices, and premium rates are affecting the accessibility and affordability of Medigap insurance.

OBRA-90

The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) established minimum federal standards that apply to all individually purchased Medigap policies.³ These standards have simplified consumers' ability to choose a policy and have incorporated important consumer protection features. They are enforced by individual states, which can adopt more stringent regulations in some areas (see Appendix B for a listing of states and adopted provisions beyond OBRA-90).

Standardized Medigap Plans

The OBRA-90 legislation authorized the National Association of Insurance Commissioners (NAIC) to develop up to ten standardized Medigap plans. Insurers selling Medigap can offer as many or as few of these plans as they choose, but they must all offer a basic Medigap plan, Plan A. Purchasers may retain policies that they held before standardization (pre-standardized policies). Congress chose standardized plans to make it easier for consumers to compare plan features and costs. A recent report examining the impact of this legislation concluded that it has achieved this goal (McCormack, Fox, Rice, and Graham, 1996).

The NAIC's ten plans are outlined in Table 1. All plans cover the so-called core benefits. These benefits include coverage of all Part A coinsurance for hospital stays longer than 60 days, plus coverage for 365 additional lifetime reserve days after Medicare benefits are exhausted, the 20 percent Part B coinsurance, and the Parts A and B blood deductible.

Plans differ on whether they cover deductibles for Medicare Part A (hospital insurance) and Part B (medical insurance), skilled nursing facility coinsurance, medical expenses incurred when traveling to another country, limited home health care, prescription drugs, and preventive care. In addition, Plans F, G, I, and J cover Part B charges in excess of the amount Medicare will allow. The need for this type of coverage has decreased in recent years as the vast majority of doctors have agreed to accept Medicare reimbursement rates, and the Health Care Financing Administration (HCFA) has put strict limitations on the amounts physicians can charge above Medicare rates. The comprehensiveness of the coverage offered by the different plans generally increases from A through J, with Plan A covering just core benefits, Plan F covering all Medicare-related copayments, and Plan J covering all options.

Consumers appear to have strong preferences for Plans C and F, which offer skilled nursing facility (SNF) coinsurance and cover Parts A and B deductibles and foreign travel (see Table 1). More than one-half of all Medigap purchasers in six states, representing one-quarter of Medicare beneficiaries, chose one of these two plans. Plans that cover certain

³ These standards do not apply to employer-provided supplemental policies.

Table 1: Benefits Covered by the Ten Standardized Medigap Plans

Benefit	Plan									
	A	B	C	D	E	F	G	H	I	J
Core benefits ^a	•	•	•	•	•	•	•	•	•	•
SNF ^b coinsurance			•	•	•	•	•	•	•	•
Part A deductible		•	•	•	•	•	•	•	•	•
Part B deductible			•			•				•
Part B excess charges						High ^c	Low ^c		High ^c	High ^c
Foreign travel			•	•	•	•	•	•	•	•
At-home recovery				•			•		•	•
Prescription drugs								Low ^d	Low ^d	High ^d
Preventive medical care					•					•
% of policies sold ^e	5.1	17.1	21.2	8.4	1.0	29.7	2.2	2.7	5.6	6.9

^a Core benefits include coverage of all Part A (hospital) coinsurance for stays longer than 60 days, the 20 percent Part B (medical) coinsurance, and the Parts A and B blood deductible.

^b SNF = skilled nursing facility.

^c Low excess charge coverage pays 80 percent of the difference between the physician's charge and the Medicare-allowable rate; high coverage pays 100 percent of the difference.

^d Low prescription drug coverage has a \$250 annual deductible, 50 percent coinsurance, and a maximum annual benefit of \$1,250; high coverage is similar, but has a \$3,000 maximum annual benefit.

^e From McCormack, Fox, Rice, and Graham, 1996 analyses of data from Florida, Missouri, New York, South Carolina, Texas, and Washington. These states represent 25 percent of all Medicare beneficiaries.

Source: NAIC, Medicare Supplement Insurance Minimum Standards Model Act (30 July 1991).

benefits, such as at-home recovery, prescription drugs, or preventive care (Plans D, G, H, I, and J), do not sell as well (McCormack, Fox, Rice, and Graham, 1996).

Other OBRA-90 Requirements

In addition to standardizing plans, the open-enrollment provision of OBRA-90 prohibits insurers from denying a policy to individuals within six months of enrolling in Part B of Medicare. Consumers must also receive a company's most favorable rate during this period. This provision does not apply to individuals under age 65 who are eligible for Medicare because of a disability.

The open-enrollment provision does not appear to have negatively affected the market or any insurer. A few insurers felt the provision actually helped them by inducing consumers to purchase a policy sooner.

OBRA-90 mandated that if insurers do not reach proscribed loss ratios, they must provide refunds to policyholders. Loss ratios are a measure of the return of premiums in the form of claims paid—the higher the loss ratio, the larger the share of premiums purchasers receive as benefits. OBRA-90 increased minimum loss ratios from 60 to 65 percent for policies sold to individuals. Loss ratio requirements for policies sold to groups remained at 75 percent.⁴ Refunds to purchasers resulting from this requirement began in 1995, three years after standardization.

In addition to these requirements, OBRA-90 included the following provisions:

- Severe penalties for insurers and agents who knowingly sell duplicate coverage
- A requirement that agent commissions during the first year of coverage are no more than twice the amount paid for policy renewals

Despite Standardization, Policies Can Still Differ

While standardization has significantly limited insurers' ability to differentiate their products, variation still occurs among policy offerings. Policy features can differ in two significant ways, both of which greatly influence premiums:

Underwriting Criteria

Medigap insurers can differentiate their policies by limiting to whom they will sell a policy. Some policies require that applicants meet certain health criteria, while others are available to anyone who applies (guarantee-issue). Theoretically, by screening out bad risks, insurers should be able to offer lower premiums for underwritten policies.

Rating Methods

Policies can also differ in terms of the structure of premium payments. Some insurers charge the same premiums for all policyholders regardless of current age or age at application (community rating); some base premiums on the age of the policyholder at the time of initial purchase (issue-age rating); and some base premiums on the current age of the policyholder (attained-age rating). Community- or issue-age rated policies offer consumers the advantage of paying premiums that will only increase to the extent that medical expenses increase. Attained-age policies should theoretically offer lower initial rates. However, these rates will increase as the insured ages, independent of increases caused by more claims.

⁴ Direct-mail sold group policies, such as AARP Prudential, are subject to individual loss ratios. However, some states have higher loss ratio requirements for these policies.

Some states place restrictions on insurers' ability to underwrite policies or on the rating method that they can use beyond OBRA-90 requirements (see Appendix B). For example, Florida does not allow insurers to use attained-age rating methodologies and New York requires all policies to be community-rated.

Trends Affecting the Accessibility of Medigap Insurance

Recent studies suggest that Medigap policies may be decreasingly affordable and accessible to consumers (Families USA, 1996; McCormack, Fox, Rice, and Graham, 1996). This research has raised concerns that recent increases in premiums and greater underwriting are affecting the ability of elderly persons to purchase policies. In addition, changes in rating practices may adversely affect the ability of policyholders to retain their policies or obtain adequate coverage when they need it.

A consensus emerged from interviews conducted as a part of this study that the OBRA-90 regulations have achieved the goal of limiting the ability of insurers to compete based on product differentiation.⁵ Companies now have to compete to a greater degree on the basis of price and targeting certain enrollees—specifically those younger and healthier. Because packages of covered services offered by different insurers are identical, consumers might be more likely to base purchase decisions on price. Representatives from several of the companies interviewed stated that competition has also become increasingly based on the level of service offered and company reputation. For example, a few companies believe that their ability to pay claims directly, thus avoiding the need for policyholders to file claims, gives them a competitive edge.

The market's emphasis on price competition could affect accessibility by inducing more insurers to use stricter underwriting criteria policies and attained-age rating methods. Insurers have a number of other options for reducing premiums, such as reducing agent commissions, relying on direct mail, or otherwise paying a greater share of premiums as benefits by reducing other administrative costs or profit margins. However, these options may adversely affect both sales and profits.

Access to Medigap policies may also be harmed if policies become less affordable. Medigap rates may be rising dramatically. Policies sponsored by the American Association of Retired Persons (AARP) and offered by Prudential, the largest Medigap insurer with a 20 percent market share, increased rates by an average of 27 percent in 1996. A recent

⁵ OBRA-90 regulations allow states to approve "innovative benefits." However, fewer than a half dozen states had approved innovative benefits as of early 1995 and these benefits were generally limited to Blue Cross/Blue Shield plans (McCormack, Fox, Rice, and Graham, 1996).

report by Families USA concluded that Medigap rates from 1995 to 1996 had increased substantially faster than the Medicare inflation rate and the cost of living.⁶

METHODOLOGY

For this study we have examined the accessibility of Medigap insurance using two strategies: interviews with Medigap insurers; and site visits to insurance departments and reviews of the filings of the top-selling Medigap insurers in three states (Arizona, Ohio, and Virginia). These states were chosen because they did not have regulations beyond those required by the OBRA-90 legislation that could limit market competition. The purpose of the site visits was to record the perceptions of state employees, who regulate and oversee the Medigap market, regarding changes in the accessibility of this product in recent years; and to document quantifiable evidence of changes in rates, as well as the pricing and underwriting structures used in policies. We examined filings each year from 1992 to 1996 for Plans A, C, F, and I.

We interviewed representatives from 22 insurers with large shares of the national Medigap market. Participating companies were evenly split between Blue Cross/Blue Shield insurers and non-Blue Cross/Blue Shield companies. Non-Blue Cross/Blue Shield companies generally offered policies nationwide or in several regions of the country. Interviews addressed the following issues:

- Market trends and company characteristics
- Pricing
- Rate changes
- Access issues, including underwriting
- Viability of the market
- Federal and state policy (i.e., OBRA-90)

Our discussions with insurers were not limited to issues concerning the three site visit states, but encompassed overall market issues. We provide details of our methodology in Appendix A.

⁶ These conclusions were based largely on the AARP increases and rate filings by Blue Cross/Blue Shields in 35 states.

CHANGES IN UNDERWRITING MEDIGAP INSURANCE

One mechanism for lowering premiums is denying policies to individuals with health conditions that are likely to lead to costly claims in the future. Our review found that other than AARP and some Blue Cross/Blue Shield policies, very few affordable guarantee-issue plans are available. In addition, nearly all companies, including AARP, underwrote plans with prescription medication coverage (Plans H through J).⁷ Based on the three-state review of filings and our interviews with insurers across the country, we identified only one company that offered a guarantee-issue plan covering prescription drugs. This Blue Cross/Blue Shield plan offered a guarantee-issued policy providing the lower level of prescription drug coverage (Plan H).

Consumers Have Few Options for Purchasing a Guarantee-Issue Policy

Other than AARP Prudential, only one non-Blue Cross/Blue Shield insurer in our review of filings in three states or our national interviews offered a guarantee-issue policy. In 1995, that insurer started offering an underwritten policy. The company can sell an underwritten policy to individuals meeting the screening criteria and a guarantee-issue policy to individuals failing the screen. This results in channeling “poor risks” into the guarantee-issue pool.

Not surprisingly, rates for this company’s guarantee-issue policies have risen dramatically. From 1992 to 1996, rates for this company increased an average of 52 percent in our three study states (compared to national average increases of less than 17 percent for all plans in all three states). Premiums increased more than 20 percent on average in 1996 alone.⁸ In Arizona, annual premiums for Plan I at age 80 were \$7,169 in 1996. Thus, these policies may not be affordable for large numbers of consumers.

Based on our national interviews, we found that in some markets the local Blue Cross/Blue Shield offered affordable guarantee-issue policies. However, of the 11 Blue Cross/Blue Shield insurers we interviewed, two-thirds underwrote some or all of their policies and one-fourth underwrote all policies, except where forbidden by open-enrollment requirements.

Similar to the non-Blue Cross/Blue Shield company discussed above, the Blue Cross/Blue Shield in Virginia makes a guarantee-issue policy available to individuals who have failed the screen for their underwritten policy. However, only Plans A and C are available on a guarantee-issue basis. A policy in the guarantee-issue risk pool cost 43 to 134 percent more than the same policy in the underwritten pool, despite the fact that the company

⁷ AARP underwrites only the prescription drug portion of these plans.

⁸ We weighted rate increases by premium volume for each plan type within each state. We used a non-weighted average across states.

subsidizes the guarantee-issue pool (i.e., targeted loss ratios are substantially above 100 percent).

All companies examined in the three study states underwrite plans that offer prescription drug coverage (Plans H and J). AARP's underwriting for these plans addresses use of only prescription drugs and does not directly address chronic health conditions.

The lack of guarantee-issue policies means that certain groups of consumers are likely to have limited choices for Medigap coverage if they have a health condition. Vulnerable groups include individuals beyond the open-enrollment period without a policy, those who wish to switch companies, and consumers who are unhappy with the care they receive from a Medicare HMO.

Medigap policyholders who want to increase their level of coverage may also have limited choices. The vast majority of companies interviewed underwrite applications by current policyholders for plans offering greater coverage. Thus, these consumers may be forced to keep their current level of coverage, switch to AARP, or face substantially higher premiums.

Underwriting Tools Screened for Diseases

We analyzed underwriting forms to assess which individuals were likely to be denied an underwritten policy. These materials were most likely to assess the following conditions: cancer, heart disease, Alzheimer's disease, Parkinson's disease, diabetes, stroke, or respiratory conditions (see Figure 3). The majority of insurers that underwrote policies included in this study disqualified applicants if they responded positively to any item.

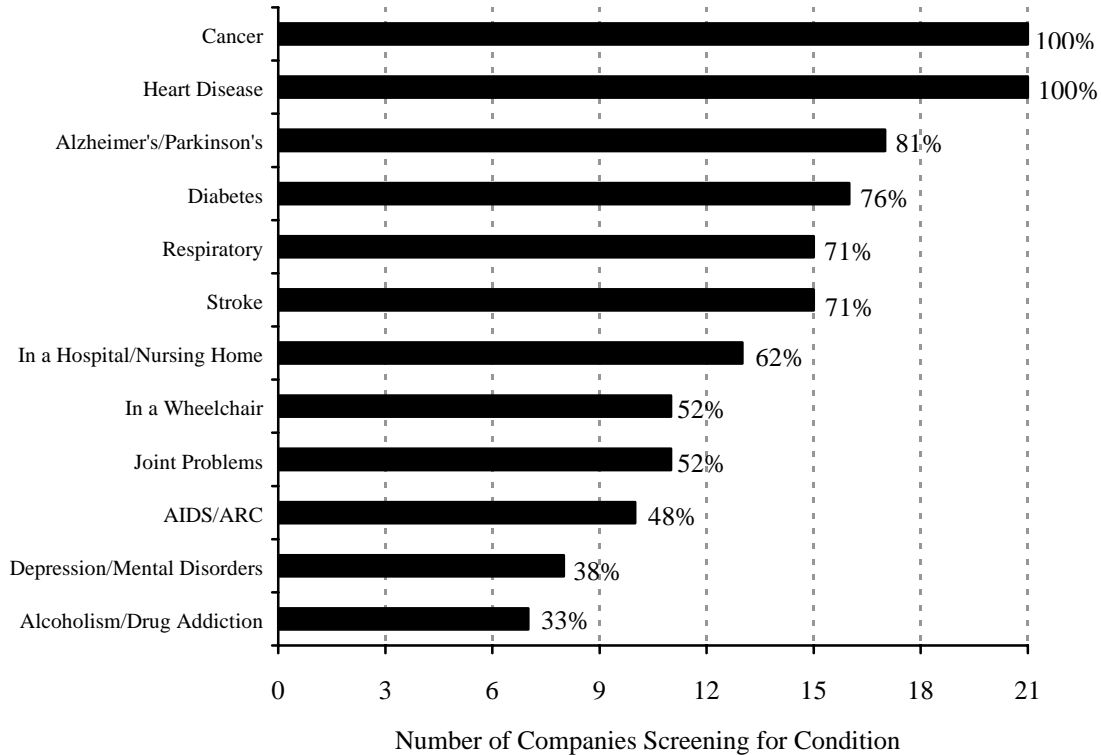
The Costs of Guarantee-Issue Policies versus Underwritten Policies

Overall, our analysis of insurance department filings found that guarantee-issue policies were not substantially more expensive than underwritten policies in the three study states in 1996. However, if we remove AARP policies from this comparison, guarantee-issue policies were 9 to 37 percent more expensive than underwritten policies for Plans A, C, and F at age 80.⁹

Guarantee-issue policies offered by other companies were substantially more expensive than comparable AARP policies. In the unlikely event that AARP were to withdraw its guarantee-issue policy, consumers with health conditions would have to pay substantially higher premiums to purchase another policy, especially at older ages. If the AARP policy were no longer available, an 80 year old requiring a guarantee-issue policy would pay

⁹ Comparisons based on premiums at age 80. Differences vary by policy and state.

Figure 3: Underwriting Items Used by 21 Companies



Note: Based on written questions in policy applications.

Source: The Lewin Group analysis of underwriting forms used by 21 Medigap insurers.

from 41 to 68 percent more in premiums to get the same plan from another company in the three study states.¹⁰ For example, premiums for an 80 year old with Plan F in Ohio would rise from \$94 to \$157 a month.

CHANGES IN RATING METHODS USED FOR MEDIGAP INSURANCE

In an effort to capture consumers they find more desirable, insurers appear to be using rating methods attractive to individuals just enrolling in Medicare. Our national interviews suggested that insurers concentrated their efforts on consumers turning age 65 for three main reasons: these individuals typically do not have a Medigap policy and need coverage; younger individuals may be more likely to purchase a policy because premiums are less expensive than at older ages (assuming they are sold on an issue- or attained-age basis); and this population tends to be healthier, which means a healthier overall risk pool. A healthier risk pool is more likely to be stable and less likely to experience a spiral of escalating claims and rising premiums. Because a larger portion of people newly eligible for Medicare

¹⁰ Comparisons based on the premium for the AARP policy and the least expensive attained-age policy for Plans A, C, and F.

shop for policies, adverse selection (individuals seeking to obtain or change insurance because they have health problems) is much less of a concern.

Many insurers are using attained-age rating to attract younger consumers.¹¹ All other things being equal, a policy sold to a 65 year old on an attained-age basis (for which premiums automatically increase as the individual gets older) should be less expensive than a policy sold on an issue-age (for which premiums are based on the age of the individual at the time of purchase) or community-rated basis (for which premiums are the same for all policy holders). Thus, younger Medicare beneficiaries judging policies only on the basis of current premiums may find an attained-age policy more attractive.

Insurers Try to Gain a Competitive Advantage by Selling Attained-Age Policies

Policies sold on an attained-age basis have become the norm in the Medigap market. Our review of policies in the three study states revealed that several companies have switched to attained-age structures (see Table 2).¹² In 1992, the majority of the largest selling companies in all three states sold policies on an issue-age or community-rated basis. In 1996, the majority of these same companies sold policies on an attained-age basis. Among Blue Cross/Blue Shields nationwide in 1996, 14 companies (21 percent) used community rating, 15 (22 percent) used issue-age rating, while 39 (57 percent) used attained-age rating.¹³ In all three states we examined, AARP was the only insurer with a substantial market share that offered a community-rated policy.¹⁴

Many companies included in the nationwide interviews that sell policies on an issue-age or community-rated basis contend that these rating practices make their policies less competitive and acknowledge that there is pressure to switch to an attained-age rating structure. In addition, our interviews suggest that a number of companies switched from

¹¹ Insurers are also using other techniques to capture this market. A few companies have filed rate decreases or have special rates for people age 65. In addition, several companies have tried to gain marketing advantages by reducing or eliminating preexisting-condition exclusions. The lack of such an exclusion was featured prominently in marketing materials. Although the elimination of preexisting-condition exclusions benefits applicants of all ages, the removal of these exclusions primarily benefits individuals just turning 65. If you already have a policy, OBRA requirements disallow a second preexisting-condition exclusion. Therefore, companies could not subject older individuals switching policies or companies to a preexisting-condition exclusion.

¹² Whether insurers should be allowed to switch rating practices on the same policy is an issue for many states because OBRA-90 provisions prohibit the sale of discontinued plan types for five years. It appears that states have the discretion to determine whether changes in rating practices could be considered the start of a new plan.

¹³ AARP Insurance Board materials prepared by AARP staff.

¹⁴ The Blue Cross/Blue Shield in Virginia used community rating, but only for the plans that serve people who failed the underwriting screen or persons with disabilities under age 65.

Table 2: Rating Practices by Number of Companies (1992 and 1996)

	1992	1996
<hr/> Arizona		
Community rating	1	1
Issue age	7	4
Attained age	5	8
<hr/> Ohio		
Community rating	1	1
Issue age	9	6
Attained age	5	8
<hr/> Virginia		
Community rating	1	1
Issue age	5	3
Attained age	5	7

Note: Some companies offer both underwritten and guarantee-issue policies. Therefore, the number of policies exceeds the number of companies.

Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

community- or issue-age rating to attained-age rating at the time of standardization to be more price-competitive.

Attained-Age Policies Result in Higher Premiums at the Oldest Ages

Representatives from the state senior counseling programs pointed out that many consumers may not understand the difference between purchasing an issue-age versus an attained-age product. Specifically, they may not be aware that if they purchase an attained-age policy, their premiums will be the highest when their ability to pay is likely to be less.

Table 3 compares the premiums an individual would pay at age 65 and age 80 for a policy purchased at age 65. While, on average, an attained-age policy would be less expensive than an issue-age or community-rated policy purchased at age 65, the attained-age policy would be substantially more expensive than either of the other two policies at age 80. At age 80, an attained-age policy would be 18 to 26 percent more expensive than an

Table 3: Average Annual Premiums for Issue-Age and Attained-Age Policies Purchased at Age 65 across Three States in 1996

	Plan A	Plan C	Plan F
Average price of issue-age policies purchased at age 65	\$613	\$1,067	\$1,177
Average price of AARP community-rated policies	\$574	\$1,047	\$1,102
Average price of attained-age policy at age 65	\$572	\$917	\$955
Price difference from issue-age policies (attained-issue)	-7%	-14%	-19%
Price difference from community-rated policy	0%	-12%	-13%
Average price of attained-age policy at age 80	\$823	\$1,406	\$1,443
Price difference from issue-age policies (attained-issue)	34%	32%	23%
Price difference from community-rated policy	43%	34%	31%

Note: With the exception of AARP, we excluded guarantee-issue policies. We used a non-weighted average across all three study states.

Source: The Lewin Group analyses of insurance department filings in Arizona, Ohio, and Virginia.

issue-age policy purchased at age 65, and 31 to 43 percent more expensive than an AARP Prudential community-rated and guarantee-issued product.¹⁵

Attained-age rating may present a particular hardship for older Medigap policyholders because income tends to be flat or decline with age. While the premium for an attained-age policy for the most popular plan, Plan F, on average accounted for 4.6 percent of an individual's income at age 65, the same policy rose to 10.6 percent of income at age 80 (see Figure 4).¹⁶ In comparison, the percentage of income spent on premiums for an issue-age policy originally purchased at age 65 rises from 5.5 percent at age 65 to 8.2 percent at age 80. The percentage of income spent on an AARP community-rated policy¹⁷ rises from 5.2 percent at age 65 to 7.7 percent at age 80.

PREMIUM RATES FROM 1992 TO 1996

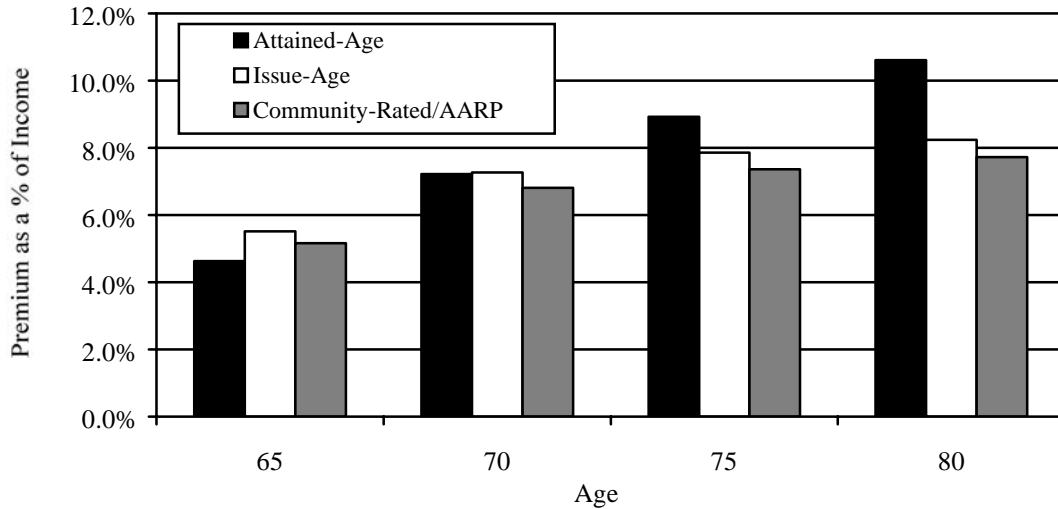
Our review of filings of the top-selling companies in three states revealed that premium rates do not appear to have risen beyond inflation from 1992 to 1995 (see Figure 5, Table

¹⁵ These estimates ignore premium increases caused by factors other than age, including increasing claims. However, these increases would affect all policies, regardless of rating practice. Increases in claims could differ based on underwriting practices.

¹⁶ Based on income figures derived from the March 1996 Current Population Survey. We averaged individual income for singles and one-half couple income for individuals in couples.

¹⁷ AARP policies are also guarantee-issue. The average mentioned for issue- and attained-age policies do not include guarantee-issue policies.

Figure 4: Premium for Plan F Purchased at Age 65 as a Percentage of Annual Income by Rating Method



Note: Within each state, premiums were weighted by 1994 premium volume for each company. A non-weighted average was used across all three study states. With the exception of AARP, all guarantee-issue policies were excluded.

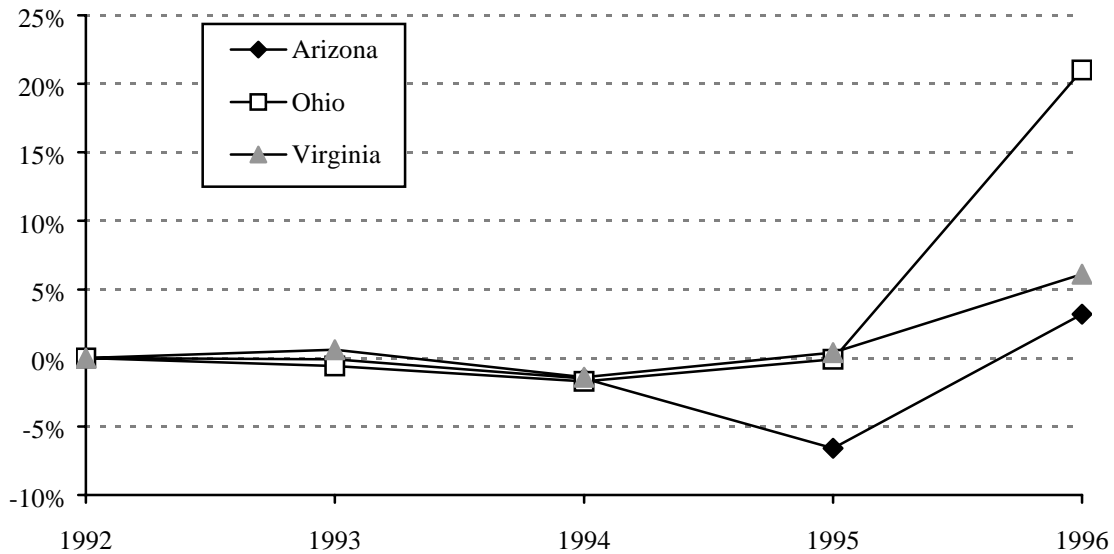
Income reflects average income. Individual income was used for singles and one-half couple income was used for couples. Income data are cross-sectional and, therefore, may include declines in income attributable to lower earnings by earlier cohorts. However, longitudinal analyses also show that real income declines with age (Coleman and Dall, 1996).

Source: The Lewin Group analyses of insurance department filings in Arizona, Ohio, and Virginia and the March 1996 *Current Population Survey*.

4, and Appendix C). However, the rates increased substantially from 1995 to 1996. Our finding broadens a similar Families USA finding by examining the experience of non-Blue Cross/Blue Shield companies other than AARP Prudential and including a longer time period.

Figure 5 shows cumulative rate increases from 1992 to 1996, controlling for growth in the Consumer Price Index (CPI). This chart demonstrates increases in policies purchased in 1992 relative to the growth in Social Security benefits (these benefits are linked to growth of the CPI). Rates increased roughly at the rate of inflation until 1996, when they increased substantially, particularly in Ohio. In that state, each of the four companies that accounted for the vast majority of the market increased their rates substantially. AARP, the largest seller in the state, increased its Ohio rates by almost 40 percent on some policies. Appendix C provides more detail on rate increases.

Figure 5: Cumulative Average Increase in Premium Rates, Controlling for Increases in the Consumer Price Index for All Plans by State (Purchased at Age 65)



Note: Averages were weighted by plan.

Source: The Lewin Group analyses of insurance department filings in Arizona, Ohio, and Virginia.

After holding rates flat for three years, AARP Prudential, the company with the largest share of the market and the only community-rated, guarantee-issue option for many consumers, increased its rates substantially in 1996. Representatives from AARP and Prudential contend that, for the most part, rate increases for AARP Prudential were not caused by worse-than-expected claims experience. According to both AARP and Prudential representatives, AARP Prudential subsidized rates for several years using a surplus that it had built up, and as a result, did not increase rates. After this surplus was exhausted, the company had to raise rates substantially to compensate for increases in expenses over the period.

Our analyses suggested a trend toward higher rates in 1996, beyond the effect of the AARP increases. Even after removing the effect of AARP Prudential rate increases, substantial rate increases remained in 1996 (see Table 4).

Rate increases in Arizona and Virginia were moderated by relatively small increases filed by the local Blue Cross/Blue Shields, both of which had large shares of the markets. Blue Cross/Blue Shield of Ohio had rate increases similar to AARP in 1996. Therefore,

Table 4: Percentage Rate Increase from Previous Years Including and Excluding AARP Prudential (Rates at Age 70)

	Increase Including Prudential AARP					Increase Excluding Prudential AARP				
	92-93	93-94	94-95	95-96	Cumulative 92-96	92-93	93-94	94-95	95-96	Cumulative 92-96
Plan A										
Arizona	2.0%	0.8%	1.2%	31.4%	36.8%	6.6%	2.6%	4.0%	13.5%	29.2%
Ohio	1.3%	0.4%	3.5%	32.5%	39.5%	4.7%	1.4%	12.2%	14.3%	36.2%
Virginia	4.9%	0.2%	2.1%	28.0%	37.4%	1.1%	0.5%	4.9%	12.2%	19.6%
Plan C										
Arizona	3.4%	5.3%	3.3%	18.0%	32.7%	5.2%	8.1%	5.1%	10.8%	32.3%
Ohio	4.8%	2.6%	7.6%	25.9%	45.8%	7.8%	4.3%	12.3%	18.7%	49.8%
Virginia	4.3%	4.4%	5.3%	18.3%	35.6%	2.7%	6.2%	7.5%	15.9%	36.1%
Plan F										
Arizona	3.7%	-1.2%	-1.7%	12.2%	12.9%	6.1%	-2.1%	-2.8%	7.8%	8.8%
Ohio	2.0%	0.9%	-0.5%	19.4%	22.4%	7.1%	3.2%	-1.6%	11.7%	21.5%
Virginia	3.7%	0.2%	3.9%	5.8%	14.3%	1.2%	0.3%	6.2%	3.9%	11.9%
Plan I										
Arizona	0.3%	0.7%	-0.4%	3.2%	3.7%	0.4%	0.8%	-0.6%	1.4%	2.1%
Ohio	0.1%	0.1%	0.0%	26.0%	26.3%	6.9%	6.6%	2.4%	14.5%	33.6%
Virginia	1.3%	0.2%	6.0%	1.5%	9.1%	0.1%	0.2%	7.0%	0.4%	7.7%
Total (Weighted by Plan)										
Arizona	3.0%	1.3%	0.3%	13.0%	18.3%	4.9%	1.9%	0.4%	7.8%	15.7%
Ohio	4.2%	2.3%	6.0%	24.8%	41.0%	7.6%	4.0%	9.6%	17.3%	43.9%
Virginia	3.1%	1.3%	4.9%	8.1%	18.5%	1.2%	1.9%	6.8%	6.1%	16.8%
Annual Percentage Increase in Total Medicare Spending										
	7.2%	13.2%	20.8%	9.6%	60.6%					

Note: We weighted “Total” across all plans by premium volume for each plan. Because of data availability, we used premium volume in 1994.

Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, Virginia, and HCFA, 1996a.

large increases by two non-Blue Cross/Blue Shield companies with large market shares had a more dramatic effect on average rates in Ohio than in the other two states.

Our national interviews suggested that while there is a wide variation in the experience of Medigap insurers, almost half have increased their rates substantially over the past two years. Of the companies interviewed, four reported no change in their rates in 1995 or

1996, six reported average annual increases of less than 10 percent over those two years, and nine companies reported average annual increases from 10 to 20 percent (three companies could not or would not report rates).

All company representatives interviewed thought that rates would go up in the future. Of the company representatives willing to project percentage increases, the majority (almost 70 percent) projected double-digit annual increases.

Despite these increases, three-fifths of company representatives interviewed argued that Medigap remains affordable. The remaining two-fifths argued that either Medigap was becoming unaffordable for most people or that only policies offering limited coverage, such as Plan A, were affordable for the vast majority of the population.

Worse-than-expected claims may be contributing to these increases. Half the companies indicated they had worse-than-expected claims experience. Only one-fifth of companies interviewed indicated that claims experience was better than expected. A majority of the companies interviewed thought that the following factors were contributing to rate increases:

- Increasing physicians' charges
- Increasing hospital outpatient charges
- Increasing frequency and severity of claims
- Increasing use of skilled nursing facilities

The best explanation of what has occurred in the Medigap market since 1992 may be that increases in Medigap premiums are reflecting increases in the cost of Medicare. From 1992 to 1995, Medigap premiums increased at a substantially slower rate than Medicare spending (see Table 4). Theoretically, because Medigap claims are related to Medicare spending, these growth rates should be roughly comparable. Medigap rate increases may have been low during the period immediately after standardization for a number of reasons, among them: insurers may have originally priced standardized policies high; insurers may not have had enough claims experience to justify substantial rate increases; or price competition may have induced insurers to accept higher loss ratios.

In 1996, insurers across the board reversed the pattern of the preceding years and substantially increased premiums. Several individuals interviewed suggested that some insurers increased rates in 1996, in part, because the AARP increases reduced pressure for

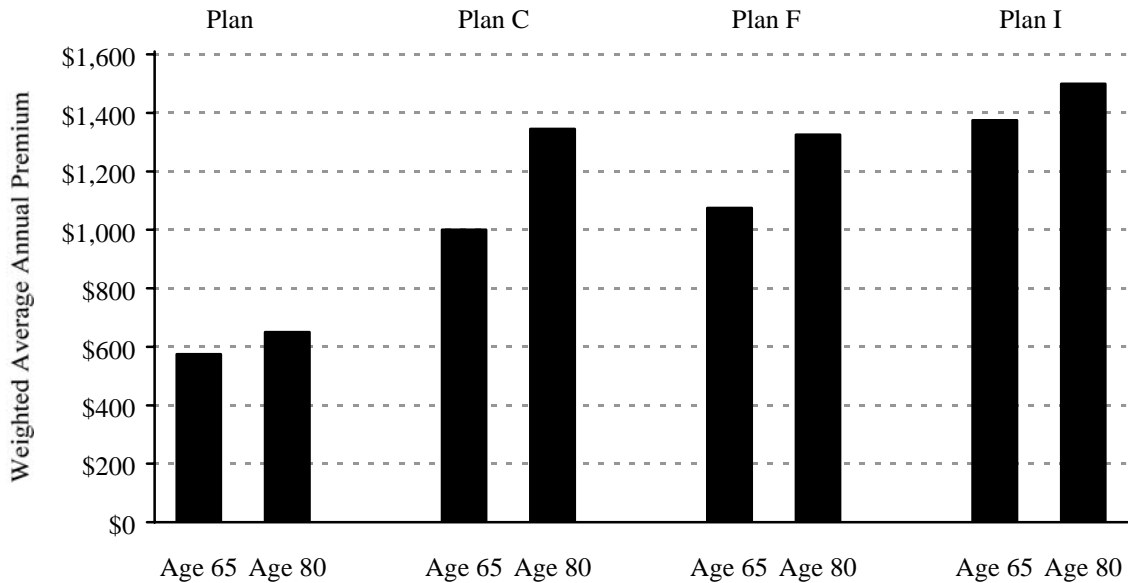
them to keep their rates low. This suggests that some insurers “shadow priced” AARP policies. Thus, the AARP increase may have had a ripple effect on the rest of the market.

1996 Premiums Varied Substantially Among Policies and States

Our review of insurance department filings revealed that depending on the state and policy type, premiums in 1996 ranged from being affordable to the vast majority of consumers (annual premiums of \$402), to affordable only for very few consumers (annual premiums of \$7,196). Premiums reviewed vary by plan type, consumer age, and state. Premiums for the same plan at the same age also vary substantially within states.

Premiums for policies generally increase with plan type and age of the policyholder. At age 65, annual premiums in the three states we studied ranged from \$571 for Plan A to \$1,379 for Plan I. At age 80, average premiums ranged from \$661 to \$1,490 for Plan I (see Figure 6 and Table 5). Prices for the most popular plans, C and F, appear to be about the same. Plans C and F differ only in the coverage of Part B excess charges, or balanced billing. These plans are probably similarly priced because charges in excess of what Medicare will pay have declined. In 1994, 95 percent of physician-allowed charges were assigned (HCFA, 1996b).

Figure 6: Average Annual Premium by Age and Plan Type across Three States in 1996



Note: Average premium price within each state is weighted by premium volume in 1994. Average across states is a non-weighted average.

Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

Table 5: Annual Premiums in Three States in 1996

	Premium at Age 65		Premium at Age 80		Weighted Average Premium	
	Minimum	Maximum	Minimum	Maximum	Age 65	Age 80
Plan A						
Arizona	\$557	\$785	\$648	\$1,166	\$634	\$743
Ohio	\$402	\$876	\$510	\$1,441	\$574	\$683
Virginia	\$456	\$710	\$525	\$978	\$505	\$555
Average	\$472	\$790	\$561	\$1,195	\$571	\$661
Plan C						
Arizona	\$936	\$1,317	\$1,113	\$2,007	\$1,071	\$1,457
Ohio	\$728	\$1,183	\$1,077	\$1,949	\$1,020	\$1,431
Virginia	\$813	\$951	\$951	\$1,566	\$883	\$1,135
Average	\$826	\$1,150	\$1,047	\$1,840	\$992	\$1,341
Plan F						
Arizona	\$1,014	\$1,474	\$1,212	\$2,352	\$1,167	\$1,436
Ohio	\$772	\$1,177	\$1,125	\$1,886	\$1,101	\$1,273
Virginia	\$912	\$1,027	\$969	\$1,687	\$966	\$1,268
Average	\$899	\$1,226	\$1,102	\$1,975	\$1,078	\$1,325
Plan I						
Arizona	\$1,359	\$4,100	\$1,359	\$7,169	\$1,527	\$1,672
Ohio	\$1,416	\$3,426	\$1,416	\$5,675	\$1,414	\$1,429
Virginia	\$1,170	\$2,460	\$1,170	\$4,301	\$1,196	\$1,368
Average	\$1,315	\$3,329	\$1,315	\$5,715	\$1,379	\$1,490

Note: Average premium price weighted by premium volume in 1994. Average across states is a non-weighted average.

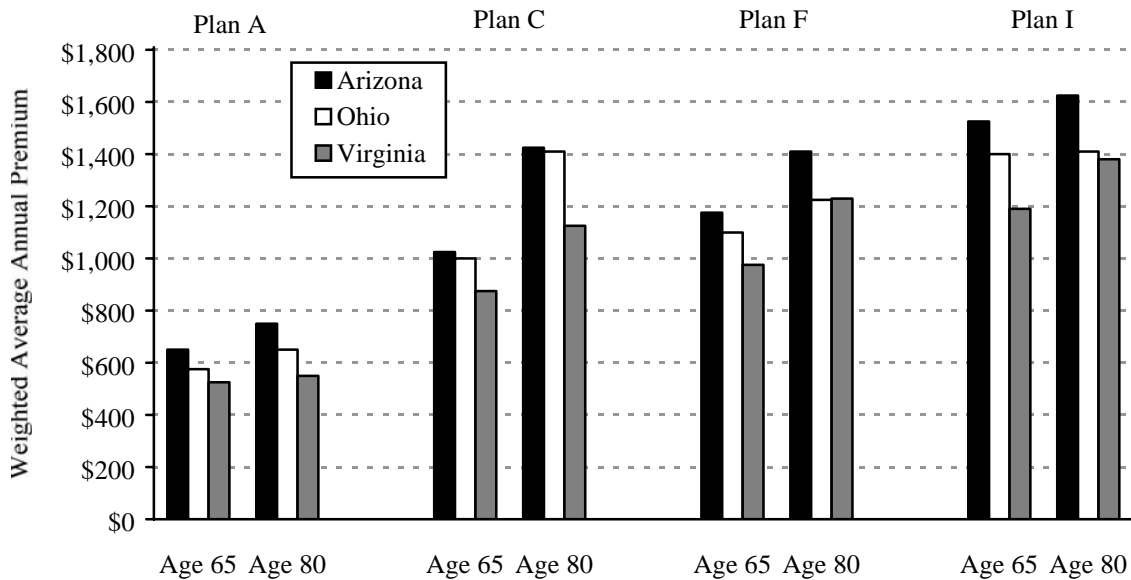
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

Prices also vary substantially across states (see Table 5 and Figure 7). For example, the average annual premium for Plan A in Arizona was one-third higher than the average premium in Virginia.¹⁸ These differences are probably due to the mix of insurers offering plans in each state and the dominant role of the Blue Cross/Blue Shield plan in Virginia, which offers lower premiums.¹⁹

¹⁸ Premiums weighted by premium volume in 1994.

¹⁹ In Virginia, Blue Cross/Blue Shield premiums are lower than any other policy reviewed with one exception. AARP Prudential policies, which are community rated, are less expensive than the Blue policies, which are issue-age rated.

Figure 7: Average Annual Premium by Age and Plan Type in Three States in 1996



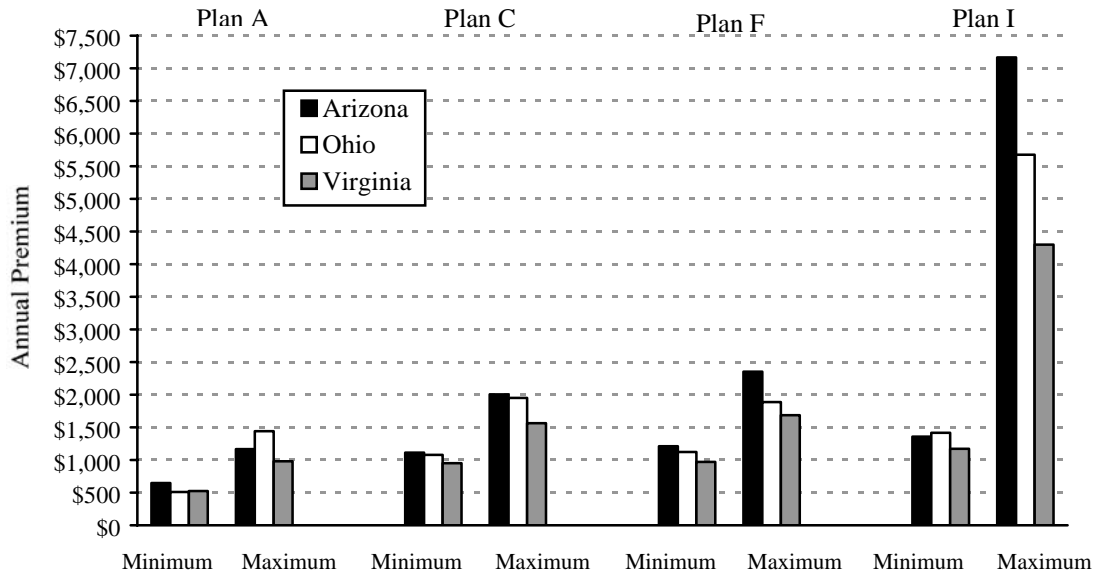
Note: Average premium price within each state is weighted by premium volume in 1994.

Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

Our review of policy offerings in three states revealed substantial variation in premiums across companies (see Table 5 and Figure 8). The difference between the premium for the least expensive policy and the most expensive policy for each plan within each state ranged from 13 percent to 428 percent.²⁰ Across plans and states, the difference between the most expensive and least expensive policy was an average of 75 percent at age 65 and 151 percent at age 80. Differences in premiums generally reflected differences in rating methods. The least expensive policy at age 65 generally used an attained-age rating method, while the most expensive was generally issue-age rated. The least expensive policy at age 80 was generally community rated, while the most expensive was attained-age rated.

²⁰ We made comparisons between policies for the same plan within the same state.

Figure 8: Minimum and Maximum Premiums by Plan Type in Three States in 1996



Note: Premiums are for individuals at age 80.

Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

THE EFFECT OF STANDARDIZATION ON PRE-STANDARDIZED POLICIES

OBRA-90 standardization and refund requirements have had implications for the experience of pre-standardized policies. Specifically, OBRA-90 required that:

- no new pre-standardized policies could be sold
- refunds must be given to consumers (three years after the implementation of standardization) when loss ratios on standardized policies are not met

As a result, companies must treat experience of the standardized policies independently from the experience of pre-standardized policies.

The lack of new entrants into these pre-standardized risk pools means that the experience of the pool could be expected to deteriorate as the pool ages. Our review of filings and discussions with state insurance department representatives revealed that some companies chose to subsidize pre-standardized products, while others did not. The refund requirement means that, starting in 1995, companies could no longer subsidize the experience of pre-standardized policies with premiums from standardized policies.

Our interviews indicated that rates are increasing dramatically for pre-standardized risk pools, probably as a result of the closing of pre-standardized blocks of business and the lack of subsidization. A sizable portion of policyholders still have pre-standardized products. For example, in 1994, 73 percent of AARP Prudential policyholders held pre-standardized policies.

Individuals holding pre-standardized plans are older and, as a result, more likely to have health conditions. If rates for their policies increase to the point where they are not affordable, these individuals may be forced to choose between an AARP plan or a Medicare HMO.

THE EFFECT OF MEDICARE HMOs ON MEDIGAP INSURANCE

The growth of the Medicare HMO market may have implications for the Medigap market. The majority of the representatives from our national sample of insurers contended that the growth of Medicare managed care as an alternative to Medicare fee-for-service is causing the traditional Medigap market to shrink. Several of these insurers also expressed concern that this trend may cause Medigap premiums to rise in the future. Medicare managed care appears to appeal more to younger, healthier individuals than less healthy individuals. The Lewin Group’s analysis of the Medicare *Current Beneficiary Survey* demonstrates that individuals with functional impairments are less likely to enroll in an HMO (see Table 6). Healthier individuals may be less concerned with access to particular providers and more attracted to the benefits of managed care, such as low or no monthly premiums and additional benefits (i.e., prescription drug and eyeglass coverage). Less healthy individuals may be more interested in the ability to decide upon providers that traditional Medigap offers. Medigap premiums may rise if the pool of individuals with a policy becomes less healthy. This, in turn, may cause greater HMO enrollment among healthier Medicare beneficiaries.

Table 6: Medicare HMO Enrollment Rates by Age and Disability Status

	Activity of Daily Living (ADL) Impairments		
	Total	None	One or More
All Ages	7.5%	8.0%	4.6%
Under Age 65	2.9%	2.8%	3.5%
Age 65-74	8.4%	8.7%	4.2%
Age 75-84	8.1%	8.6%	5.4%
Age 85 and over	6.3%	7.6%	4.6%

Note: The sample sizes for those with one or more activity of daily living (ADL) impairments result in estimates with high standard errors. Estimates include institutionalized persons.

Source: The 1993 Medicare *Current Beneficiary Survey Cost and Use File*.

Companies included in this study reported declining market share in areas with heavy managed care penetration. Three-quarters of the companies interviewed reported deterioration in sales they attributed to Medicare HMOs. Of these companies, three-fourths report that drops have been substantial. The remaining one-quarter of companies generally believe that managed care will strongly affect sales in the near future.

These companies did not generally think that these sales declines had adversely affected experience. In addition, Medicare managed care penetration in Ohio and Virginia does not appear to be substantial enough to explain rate increases in those states. However, a representative from AARP Prudential noted that they have seen indications that claims are increasing at a faster rate in areas with heavy managed care penetration than in areas with a low presence. Because of its large and broad market share, AARP is the company in the best position to track deteriorating Medigap experience related to managed care.

Medigap Insurers Respond to the Growth of Medicare Managed Care

As noted above, Medigap insurers are aware of the potential threat that Medicare managed care poses to their market. Our interviews suggested that these insurers have responded to this challenge in one of three ways.

Some companies have taken little or no action to try to compensate for competition from managed care. Many of these companies have seen their market share decrease, sometimes dramatically.

Other companies have actively targeted populations that may find managed care less attractive, especially wealthier individuals and those living in more rural areas. These companies are conceding a certain share of the market to Medicare HMOs and positioning themselves to procure the share of the market that remains in fee-for-service.

Still other companies have or are developing their own Medicare HMO entities and are coordinating their marketing and enrollment of products. For example, some companies are allowing individuals who shift from one of their Medigap products to their HMO product to avoid underwriting if they choose to return to Medigap. This may make HMOs more attractive to consumers by easing concerns about what would happen if they enrolled and were unhappy with the care the HMO provided.

Most insurers interviewed agreed that traditional Medigap insurance would account for a smaller share of the market as Medicare Risk grew. The Congressional Budget Office projects that the percentage of individuals enrolled in HMOs will grow from nearly 13 percent in 1996 to 20 percent by the year 2000 and to 35 percent by 2007. Recent

substantial increases in Medigap premiums have encouraged many Medicare beneficiaries to reconsider HMOs.

While it appears that Medigap will still play a role in an environment dominated by managed care, Medigap policies may be a more attractive alternative to HMOs for a certain segment of the market, notably: wealthier individuals; individuals living in more rural areas with few or no Medicare HMO choices; more mobile individuals (i.e., “snowbirds”) who would be deterred by the limited coverage area offered by HMOs; and individuals who place greater value on the ability to choose a provider (i.e., those with strong ties to their physicians).

Most insurers interviewed indicated that Medicare Select, the form of Medicare Supplemental Insurance that is analogous to a preferred provider arrangement, currently plays a small role and, for the most part, did not see it playing a large market role in the future. They argued that Medicare Select only offers limited potential for savings and these small savings are more than outweighed by the limitations placed on choice of hospital.

CONCLUSION: FUTURE ACCESS TO MEDIGAP MAY BE THREATENED

Our national interviews and reviews of filings in three states led us to conclude that while all consumers generally have at least one feasible option for Medigap insurance, current trends may threaten future access. Changes in rating and underwriting practices and the growing popularity of Medicare HMOs may create a deteriorating cycle of adverse selection that undercuts the ability of any insurer to offer a product that is affordable for all Medicare beneficiaries.

Of primary concern is the experience of a community-rated guarantee-issue policy in a market that is almost exclusively underwritten and attained-age rated. The experience of a community-rated guarantee issue policy that is the sole such policy in a market may deteriorate because this type of policy is likely to be most attractive to older consumers and consumers with health conditions that other companies will not underwrite. This type of policy may also be the only option available to someone with a health condition who was not pleased with the care provided by a Medicare HMO.

Increasing average age and worsening health of policyholders could increase claims. This could cause premium prices to climb. Increasing premiums could make community-rated guarantee issue policies less of an attractive option to younger and healthier consumers. This could lead to a deterioration of the risk pool and spiraling prices.

Recent rate increases by AARP, the often sole community-rated and guarantee-issue policies in many markets, do not, for the most part, appear to be a result of this type of a

rate spiral. The size of AARP's pool of business and the number of new entrants it receives because of its unique position in the market may act as a buffer against a rate spiral. In 1994, AARP Prudential policies accounted for 20 percent of all Medigap premiums (NAIC, 1995). However, as AARP's community-rated guarantee-issue policy becomes the only such policy in more markets and more people switch to Medicare managed care, the possibility that experience will deteriorate and premiums will rise increases. The fact that AARP is noticing deterioration of its risk pools in markets with heavy managed care penetration raises some cause for concern.

QUESTIONS FOR FURTHER RESEARCH

This study identified populations that may have difficulty accessing a Medigap policy. Future research may wish to further explore the extent to which this is occurring.

- This research only peripherally addressed the experience of pre-standardized blocks of business. Additional research may want to examine the effect of the lack of new business on premium rates for pre-standardized products. In addition, this research might want to examine the choices of individuals holding these policies.
- Other research might examine the implications of creating separate risk pools for people who cannot pass underwriting screens. These practices may make Medigap unaffordable for people with disabilities or other conditions. Thus, it is important to examine the experience of these pools in relation to the income of these populations.
- A number of states have placed restrictions on insurers' ability to use attained-age rating methods (six states mandate community rating and two mandate issue-age rating). Research could examine the effect these requirements have had on the market within these states.
- Finally, this research did not examine the ability of Medicare beneficiaries under age 65 with disabilities to access Medigap policies. Future research could explore the Medigap choices and affordability of products for these individuals.

POLICY IMPLICATIONS AND CONSIDERATIONS

This study identified potential threats to the ability of consumers to access and retain a Medigap policy, including: the growing predominance of rating practices that place greater burdens on older consumers, the limited selection of policies for individuals with health conditions, and possible rate spirals among policies that are available to individuals with health conditions. There are a number of ways in which education and legislation may address these issues:

- The federal government or states could increase efforts to educate consumers about the implications of different rating methods and underwriting. Legislation could mandate that all Medigap applicants be given materials that provide information about different practices.
- Legislation could standardize rating structures, such as requiring that all policies be sold on an issue-age or community-rated basis. Prohibiting attained-age rating would facilitate the ability of consumers to base decisions on the true price of a policy and avoid automatic premium increases as they age. While this action would further restrict consumer choice, it would improve consumers' abilities to make choices based on actual price differences, not differences that are the result of different rating practices.

The Clinton Administration's 1998 budget contains provisions that would require community rating. Six states have already taken this step. In addition to facilitating consumers' ability to make true price comparisons, this action would make policies more affordable for older consumers, while increasing premiums for younger consumers. Mandatory community rating may accelerate selection bias related to Medicare HMOs, because, theoretically, Medigap would become less appealing for younger consumers and more attractive to older consumers. Mandatory issue-age rating, a step taken by Florida and Georgia, would be less likely to lead to adverse selection away from Medigap into Medicare HMOs than mandatory community rating. However, mandatory issue-age rating would do little to improve the affordability of Medigap policies among the oldest Medicare beneficiaries.

- The President's 1998 budget also contains a provision to expand open-enrollment requirements. Specifically, the President's proposal mandates an annual open-enrollment period, an action already implemented by California, Maine, and Massachusetts. Two states, Connecticut and New York, have gone further than this by mandating continuous open-enrollment. This action would greatly increase Medigap choices among individuals with pre-standardized policies and individuals dissatisfied with Medicare HMOs. As a result, AARP's policy offering would not be the only choice for many "bad risks" and may be less likely to experience a cycle of deteriorating experience and escalating premiums.

Requiring an annual open-enrollment period could also accelerate adverse selection problems for the Medigap market. If individuals can get Medigap insurance when they are ill, they may wait until a condition arises before they buy a policy. Individuals would have greater ability to rely on Medicare Risk when they

are healthy and enroll in Medigap only when they require care and want greater choice of providers and services.

Proposals under consideration also extend open-enrollment requirements. Instead of an annual open-enrollment period, these proposals mandate that individuals who disenroll from a Medigap policy to join a Medicare HMO must be allowed to switch back to their Medigap policy within one year without any penalties for their health status. Theoretically, such a bill could lead to higher premiums by inducing more younger seniors to “try out” Medicare managed care and allowing individuals who develop health problems to self-select back to fee-for-service. However, the one-year time limit should limit adverse selection to individuals who have a health crisis within the first year of enrolling in a Medicare HMO.

- Congressional legislation also proposes extending the mandatory initial six-month open-enrollment requirement to individuals under 65 who become eligible for Medicare because of a disability. This could substantially increase the ability of these individuals to access Medigap insurance. However, because these individuals are likely to have greater claims, premiums may not be affordable for substantial numbers of these consumers.²¹ One way to overcome this would be to subsidize the premiums for these younger consumers. However, this would result in somewhat higher premiums for other Medigap policyholders.
- The experience of the Medigap market may have important lessons for policies aimed at reforming insurance markets. Changing the nature of competition in one aspect of the market may affect the nature of competition in other aspects of the market. By limiting competition along plan type, OBRA-90 regulations unintentionally encouraged insurers to compete on price, causing some to switch to attained-age rating to gain a competitive edge.

Future policies could try to avoid precluding new entrants into existing risk pools (truncating risk pools). By not allowing new entrants into pre-standardized blocks of business, the OBRA-90 legislation created conditions under which deteriorating claims experiences and rate spirals could be expected. The refund requirements, which were designed to ensure that companies met loss ratios, inadvertently prevented companies from compensating with premiums from new business.

²¹ In 1995, per enrollee expenditures for Part A services among under-65 Medicare beneficiaries were very similar to those ages 65 and over. However, Part B expenditures per enrollee were roughly 25 percent higher for those qualifying for Medicaid based on a disability. Because the majority of Medigap liability results from Part B services, this would result in higher premium among those qualifying for Medicare due to a disability (Committee on House Ways and Means, 1996).

APPENDIX A METHODOLOGY

This study consisted of two components: 1) site visits to insurance departments and reviews of the filings of the top selling companies in three states; and 2) interviews with 22 insurers with large Medigap market shares nationally.

A. Site Visits

The purpose of the site visits was to obtain: (1) the perceptions of people regulating and overseeing the Medigap market of changes in the accessibility of this product in recent years; and (2) quantifiable evidence of changes in rates and pricing and underwriting structures used in policies. Each state site visit lasted two to three days.

We selected three states (Arizona, Ohio, and Virginia) that were likely to reflect the effect of market forces on access to Medigap insurance. We did not include states that had regulations that limit the ability of insurers to price and sell policies beyond the requirements of OBRA-90. These regulations include:

- disallowing the use of attained-age policies,
- extending the six-month open-enrollment period
- mandating the availability of policies to people with disabilities under age 65

We also did not include states that had standardized plans different from those proscribed in the OBRA regulations (i.e., Wisconsin, Minnesota, and Massachusetts).²²

We strove to obtain a diverse set of states. Thus, we selected states in different regions of the country and with different levels of Medicare managed care penetration (see Appendix B). We also based state selection on our ability to access Medigap filings.

We reviewed the filings for the previous five years for the 15 companies with the largest market share in each state.²³ With the exception of AARP Prudential, we removed companies from this pool if they did not sell individual standardized policy filings. We gathered data on rating and underwriting practices from companies that changed their rating structures (i.e., switched from issue to attained age rating), but did not include them in

²² States that had standardized plans before OBRA-90 were exempted from these regulations. For example, Minnesota and Wisconsin sell policies on a “core-plus-rider” format. All purchasers receive core benefits and can choose from a list of riders.

²³ According to the National Association of Insurance Commissioners (NAIC) loss ratio reports for each state, which include premiums paid.

analyses of premium increases. We did this to remove changes in price attributable to changes in rating practices.

We reviewed the filings for four of the standardized Plans: A, C, F, and I. We chose Plans C and F because they were the policies consumers are most likely to choose (McCormack, Fox, Rice, and Graham). We chose Plan A because it is the most affordable policy and OBRA-90 requires that all companies offering standardized Medigap policies offer it. We chose Plan I because we wanted to include one plan that had prescription drug benefits and our preliminary review of filings from Virginia revealed that more insurers offered Plan I than the other plans covering prescription drugs.

We gathered information for 1992 through 1996. We obtained the following information from each of the filings:

- requested and granted rate increases
- whether the policy was underwritten
- the rating method used (attained versus issue age)
- total lives, premiums and claims

We compensated for missing data using the following sources: (1) state insurance department consumer guides; (2) calls to the companies; and (3) imputations based on available data (i.e., inferring that rates were increased the same for all ages based on filings for other years or states that indicated this was the company's practice). We removed a company from the analysis only as a last resort.

During these site visits, we conducted interviews with the following individuals in each state:

- the individual responsible for reviewing policy filings and ensuring compliance with Medigap regulations
- a representative from the division that oversees Medigap complaints
- a representative from the state senior insurance counseling program

B. Insurer Interviews

We interviewed representatives from the major Medigap insurers to enhance the information gathered from the state interviews and review of filings. We targeted the top 50 insurers nationwide with the largest market share in 1994 according to the NAIC loss ratio report.²⁴ Twenty-two companies agreed to participate in our survey. Participating companies were evenly split between Blue Cross/Blue Shield insurers and non-Blue Cross/Blue Shield companies.

We did not include two companies because they stopped selling Medigap insurance before standardization. Blue Cross/Blue Shield insurers were more likely to refuse to participate than non-Blue Cross/Blue Shield companies. Three-fifths of the Blue Cross/Blue Shields either out-right refused to participate or did not return phone calls,²⁵ compared to less than one-half of non-Blue Cross/Blue Shield companies. The most common reasons given for refusal to participate (when a reason was given) were concerns about supplying information to competing companies and lack of staff time.

Interviews addressed the following issues: (1) market trends and company characteristics; (2) pricing; (3) rate changes; (4) access issues including underwriting; (5) viability of the market; and (6) federal and state policy (i.e., OBRA-90).

We sent letters describing the study and a copy of the protocol to a contact person in each company, typically within the underwriting department. Interviews lasted from 30 to 75 minutes.

We also conducted an interview with a representative from AARP. We did this because: (1) AARP Prudential represents the largest block of business in the market; (2) the AARP policy is one of the few offering a guarantee-issue, community-rated product; and (3) AARP recently had filed large rate increases.

²⁴ We substituted one company because they were no longer selling new policies. In its place, we chose the company with the next largest market share that was not a Blue Cross/Blue Shield.

²⁵ We called once a week over a period of several months.

**Appendix B: Medicare Risk Penetration and Regulations Exceeding OBRA-90
Requirements by State**

State	1996 Medicare Risk Penetration	Mandatory Community Rating	Mandatory Issue-Age Rating	Continuous Open Enrollment	Annual Open Enrollment
Alabama	3.9%				
Alaska	0.4%				
Arizona	33.6%				
Arkansas	1.4%				
California	37.2%				X
Colorado	25.8%				
Connecticut	5.1%	X		X	
Delaware	6.3%				
D.C.	9.3%				
Florida	21.5%		X		
Georgia	1.2%		X		
Hawaii	32.3%				
Idaho	2.5%				
Illinois	8.0%				
Indiana	2.8%				
Iowa	3.2%				
Kansas	4.3%				
Kentucky	3.3%				
Louisiana	8.9%				
Maine	0.1%	X			X
Maryland	8.5%				
Massachusetts	16.3%	X			X
Michigan	1.5%				
Minnesota	17.4%	X			
Mississippi	0.4%				
Missouri	8.0%				
Montana	0.3%				
Nebraska	3.1%				
Nevada	28.2%				
New Hampshire	1.4%				
New Jersey	8.8%				
New Mexico	16.9%				
New York	12.2%	X		X	
North Carolina	0.7%				
North Dakota	0.8%				
Ohio	6.2%				
Oklahoma	5.6%				
Oregon	35.5%				
Pennsylvania	16.6%				
Rhode Island	11.0%				
South Carolina	0.7%				
South Dakota	0.1%				
Tennessee	0.9%				
Texas	10.5%				
Utah	11.5%				
Vermont	1.5%				
Virginia	2.8%				
Washington	21.5%	X			
West Virginia	7.6%				
Wisconsin	2.6%				
Wyoming	2.7%				
All States	12.6%	6	2	2	3

Source: HCFA December 1996 Medicare risk data and unpublished National Association of Insurance Commissioners research conducted in May 1997.

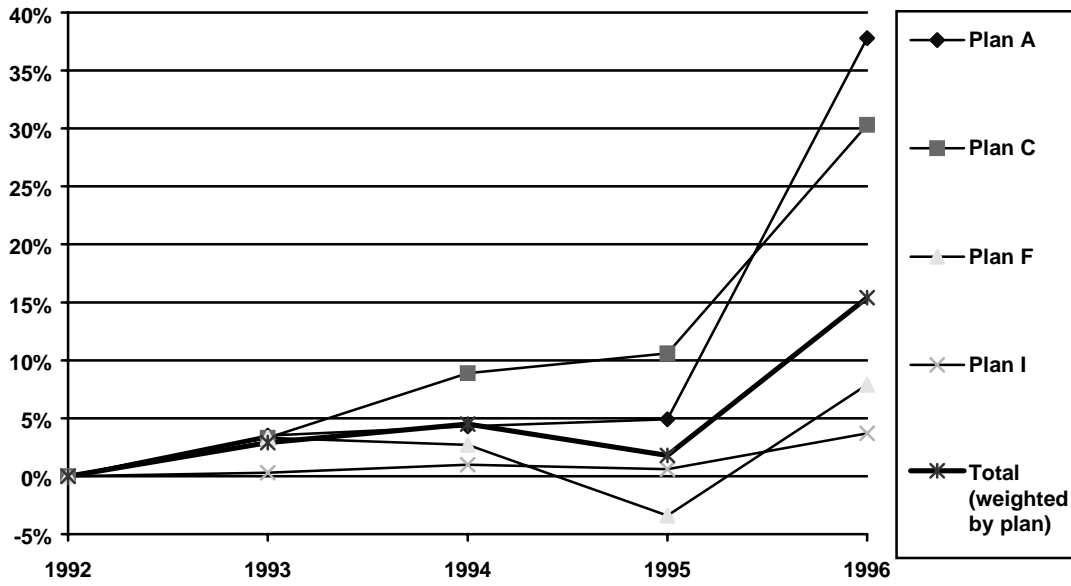
Appendix C
Premiums and Rate Increases by Plan Type in the Three Study States (Age 65)

	Plan A	Plan C	Plan F	Plan I	Total (weighted by plan)
Arizona					
Average Increase 92-93	3.5%	3.3%	3.5%	0.3%	3.0%
Average Increase 93-94	0.8%	5.3%	-1.2%	0.7%	1.2%
Average Increase 94-95	0.5%	2.6%	-2.0%	-0.4%	-0.2%
Average Increase 95-96	31.4%	18.0%	12.2%	3.2%	13.7%
Average Annual Increase 1992-96	8.4%	8.4%	3.0%	0.9%	4.7%
Largest Increase 92-93	11.5%	11.7%	10.0%	10.0%	11.7%
Largest Increase 93-94	10.1%	19.0%	19.0%	16.0%	19.0%
Largest Increase 94-95	12.5%	11.0%	0.8%	15.0%	15.0%
Largest Increase 95-96	39.4%	31.6%	18.8%	50.0%	50.0%
Largest Increase 1992-96	13.1%	12.1%	5.9%	17.7%	17.7%
Ohio					
Average Increase 92-93	-0.2%	3.3%	1.4%	0.1%	2.4%
Average Increase 93-94	0.4%	2.7%	0.9%	0.1%	1.9%
Average Increase 94-95	2.5%	7.1%	-0.5%	0.1%	4.2%
Average Increase 95-96	32.4%	25.7%	19.1%	26.0%	23.9%
Average Annual Increase 1992-96	8.0%	9.3%	5.0%	6.0%	7.7%
Largest Increase 92-93	10.0%	11.7%	10.1%	10.0%	11.7%
Largest Increase 93-94	10.0%	10.0%	10.0%	15.0%	15.0%
Largest Increase 94-95	27.4%	23.0%	7.0%	16.6%	27.4%
Largest Increase 95-96	39.7%	37.5%	22.5%	58.3%	58.3%
Largest Increase 1992-96	15.7%	13.4%	6.5%	20.6%	20.6%
Virginia					
Average Increase 92-93	4.9%	5.7%	3.7%	1.3%	3.6%
Average Increase 93-94	0.2%	3.2%	0.2%	0.2%	1.0%
Average Increase 94-95	2.3%	4.9%	2.9%	6.4%	4.4%
Average Increase 95-96	27.2%	18.1%	5.8%	1.5%	8.5%
Average Annual Increase 1992-96	8.1%	7.8%	3.1%	2.3%	4.3%
Largest Increase 92-93	10.0%	11.7%	10.0%	10.0%	11.7%
Largest Increase 93-94	15.8%	14.1%	10.0%	15.0%	15.8%
Largest Increase 94-95	35.0%	19.6%	11.0%	10.5%	35.0%
Largest Increase 95-96	40.0%	27.4%	22.0%	35.0%	40.0%
Largest Increase 1992-96	17.3%	14.6%	6.5%	14.4%	17.3%
Average of all Three States					
Average Increase 92-93	2.7%	4.1%	2.9%	0.6%	3.0%
Average Increase 93-94	0.5%	3.7%	0.0%	0.3%	1.4%
Average Increase 94-95	1.8%	4.9%	0.2%	2.0%	2.8%
Average Increase 95-96	30.3%	20.6%	12.4%	10.2%	15.4%
Average Annual Increase 1992-96	8.2%	8.5%	3.7%	3.1%	5.6%
Largest Increase 92-93	11.5%	11.7%	10.1%	10.0%	11.7%
Largest Increase 93-94	15.8%	19.0%	19.0%	16.0%	19.0%
Largest Increase 94-95	35.0%	23.0%	11.0%	16.6%	35.0%
Largest Increase 95-96	40.0%	37.5%	22.5%	58.3%	58.3%
Largest Increase 1992-96	17.3%	14.6%	6.5%	20.6%	20.6%

Note: We weighted "Total" across all plans by premium volume for each plan. Because of data availability, we used premium volume in 1994. Averages across states used non-weighted averages and did not consider differences in premium volume across states.

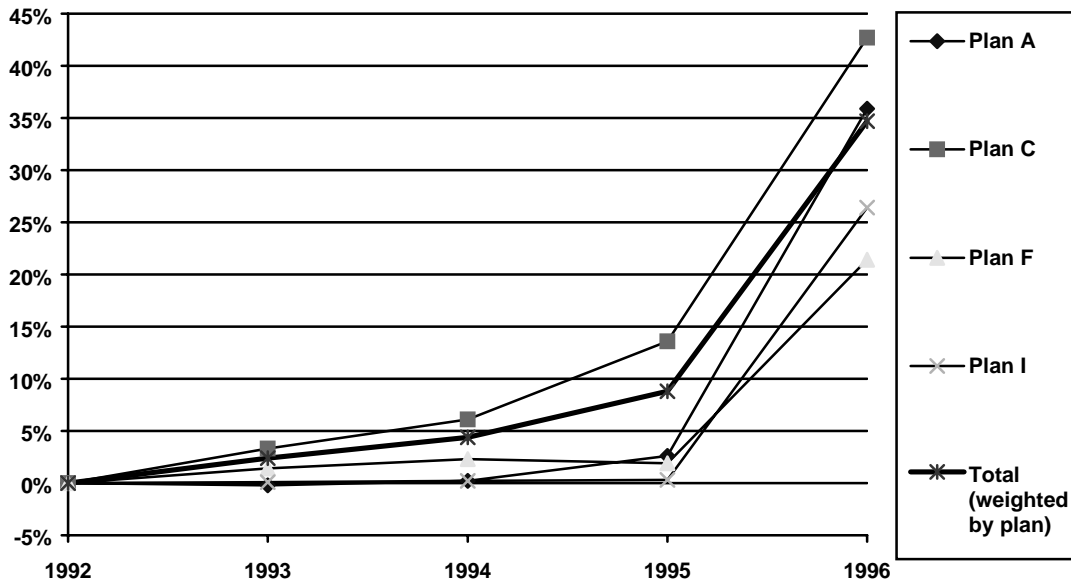
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

Figure C-1: Cumulative Average Increase by Plan Type in Arizona (1992-1996) (age 65)



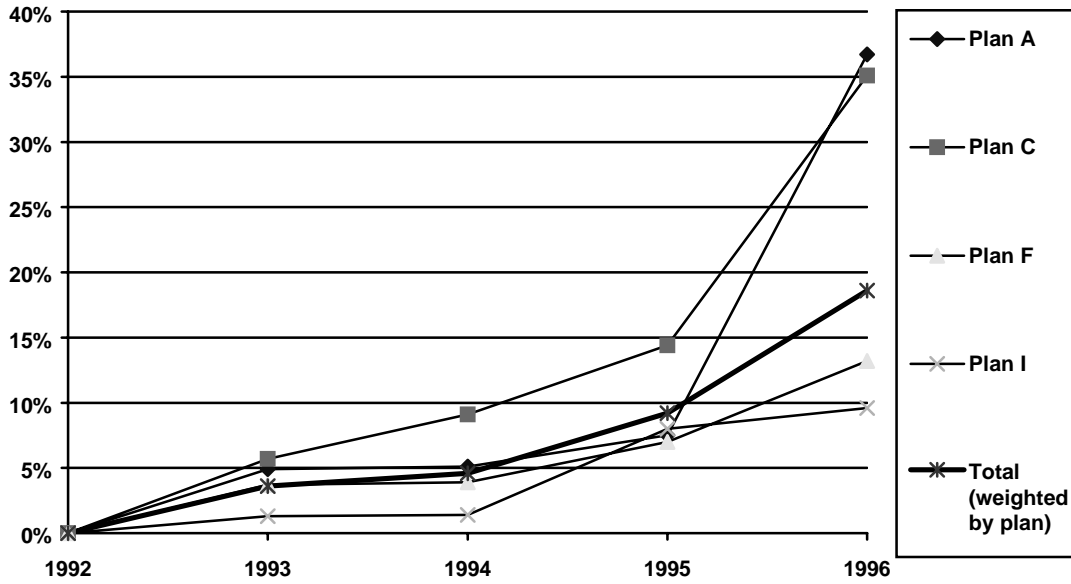
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia

Figure C-2: Cumulative Average Increase by Plan Type in Ohio (1992-1996) (age 65)



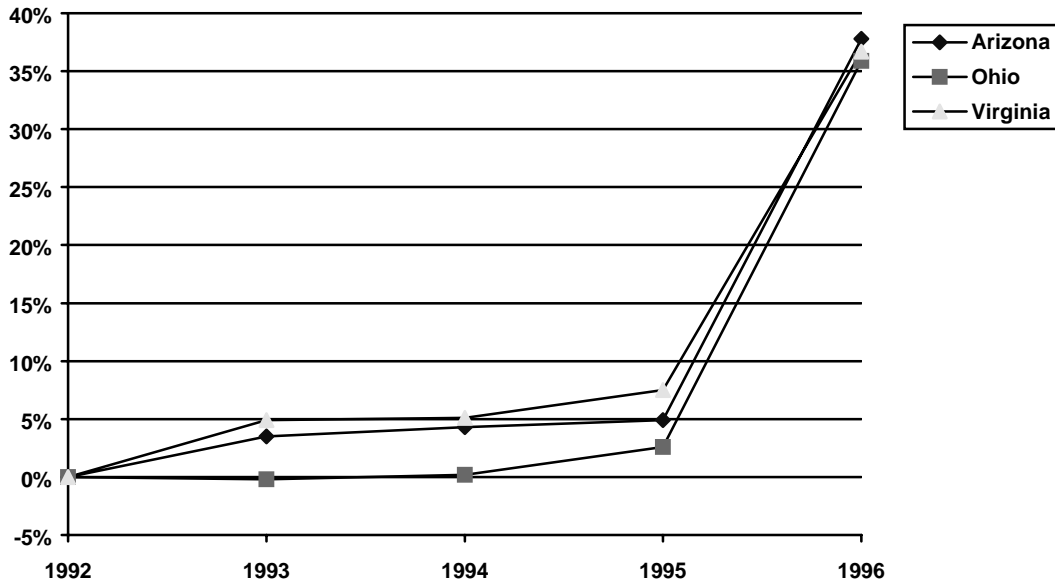
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia

Figure C-3: Cumulative Average Increase by Plan Type in Virginia (1992-1996) (age 65)



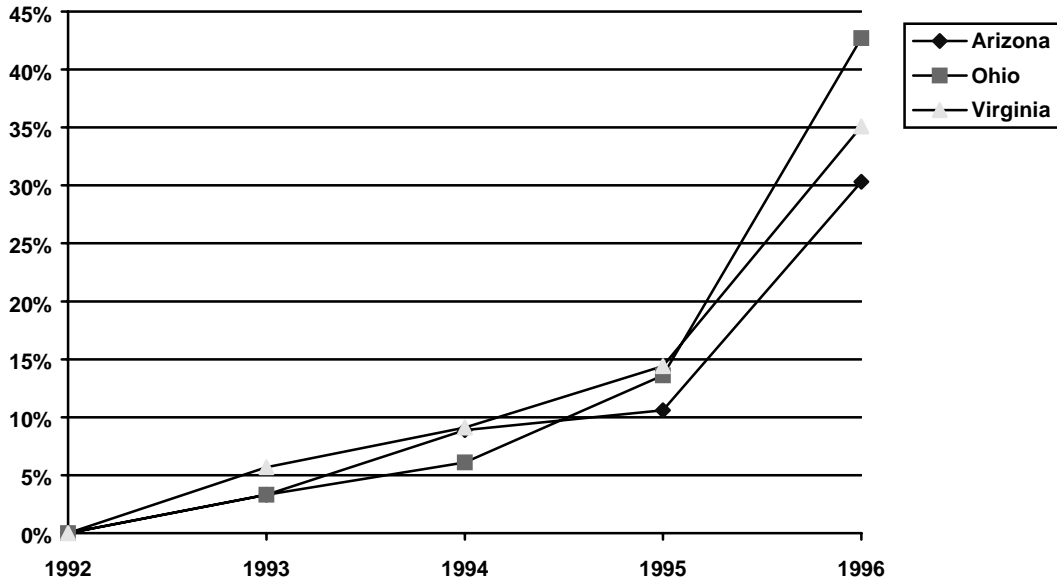
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia

Figure C-4: Cumulative Average Increase for Plan A by State (1992-1996) (age 65)



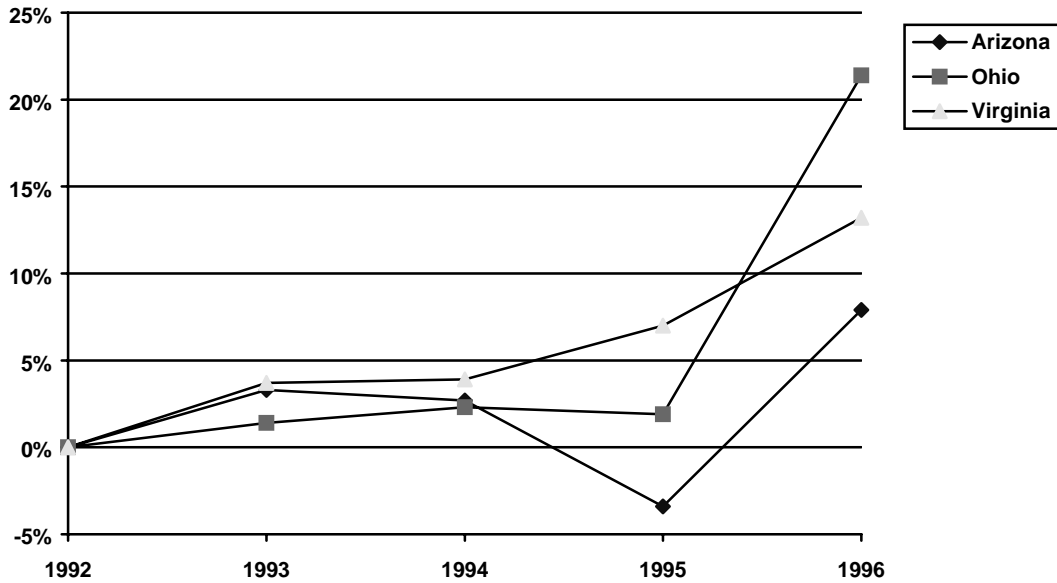
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia

Figure C-5: Cumulative Average Increase for Plan C by State (1992-1996) (age 65)



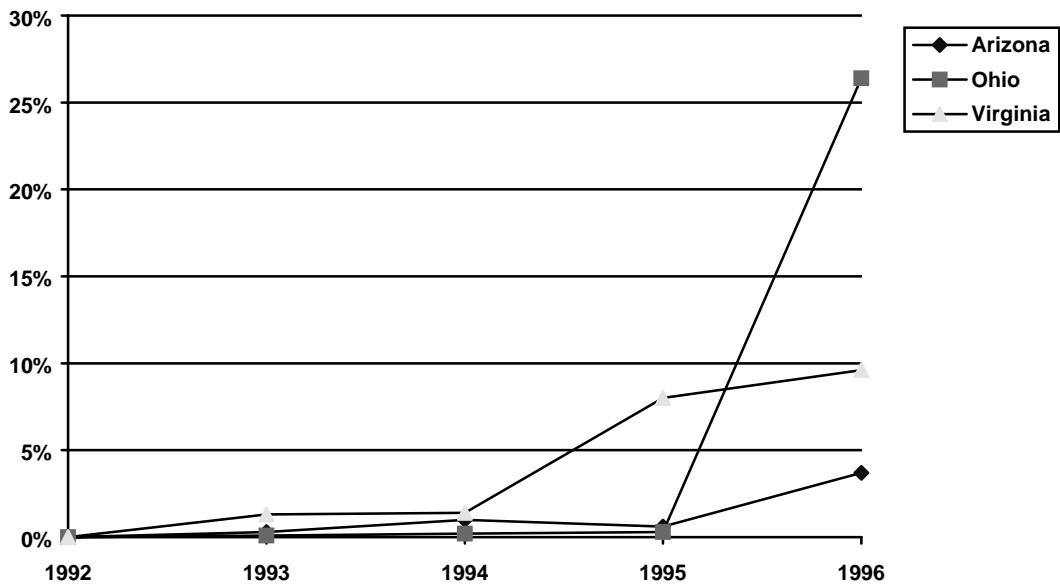
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia

Figure C-6: Cumulative Average Increase for Plan F by State (1992-1996) (age 65)



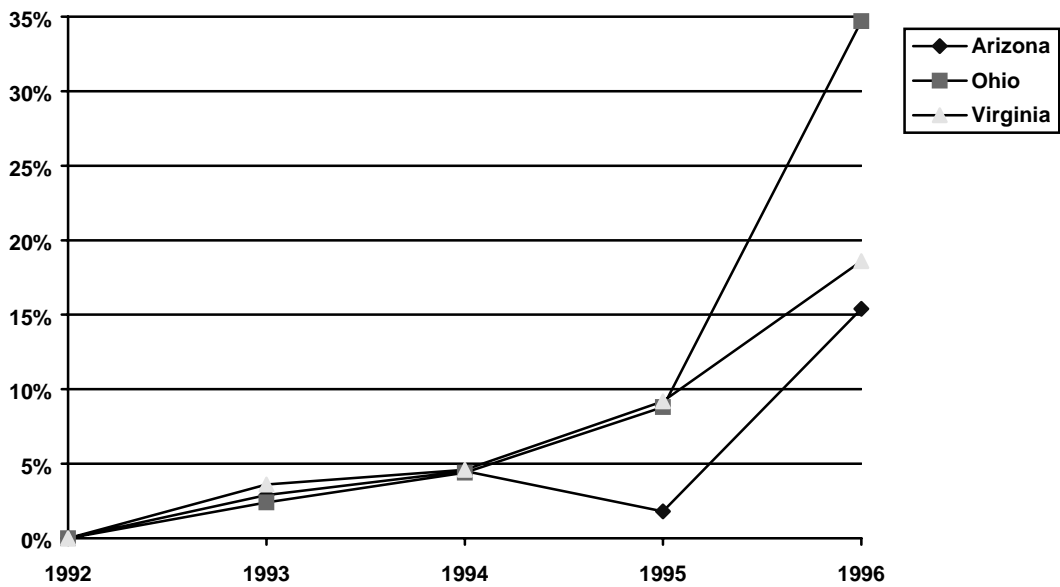
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

Figure C-7: Cumulative Average Increase for Plan I by State (1992-1996) (age 65)



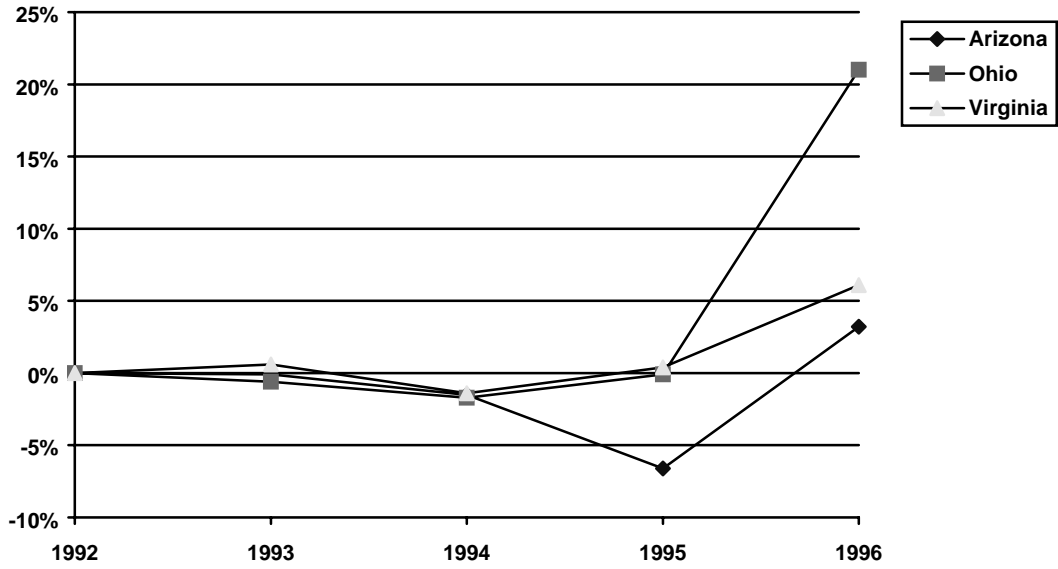
Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia

Figure C-8: Cumulative Average Increase for All Plans (weighted by plan) by State (1992-1996) (age 65)



Source: The Lewin Group analysis of insurance department filings in Arizona, Ohio, and Virginia.

Figure C-9: Cumulative Average Increase Controlling for Increases in the CPI for All Plans (weighted by plan) by State (1992-1996) (age 65)



Source: The Lewin Group analysis of filings in Arizona, Ohio, and Virginia.

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