VERMONT

DEPARTMENT OF FINANCIAL REGULATION

Act 99 Report: Medicare Supplement Open Enrollment Study

January 24, 2023

Submitted by: Kevin Gaffney, Commissioner, Department of Financial Regulation

Introduction

Act 99 (S.239) of 2022 required the Department of Financial Regulation (the Department) to convene a group of interested stakeholders to consider several issues related to enrollment in Medicare, Medicare supplement, and Medicare Advantage insurance and marketplaces. The group met four times between the Summer and Fall of 2022. The working group consisted of the following members:

1. Department of Financial Regulation
2. Department of Vermont Health Access
3. Health Care Advocate
4. Blue Cross Blue Shield of Vermont (BCBSVT)
5. MVP Health Care (MVP)
6. Vermont Association of Hospitals and Health Systems (VAHHS)
7. Community of Vermont Elders (COVE)
8. University of Vermont
9. Vermont Medical Society
10. Dialysis Patient Citizens
11. Amyotrophic Lateral Sclerosis (ALS) Association
12. Area Agencies on Aging

The Department consulted with Oliver Wyman and Risk and Regulatory Consulting (RRC) to provide analysis of issues requiring actuarial and analytical expertise.

This report is organized into five sections. The first section examines the coverage options available and explains the State's ability to regulate and impact the coverage options. The second section includes summary findings from Oliver Wyman related to the impacts of an annual open enrollment period, while also including how open enrollments in other states affect premiums and adverse selection. The third section addresses whether Vermont residents are receiving accurate information and sufficient assistance around coverage options and possible solutions. Section four provides information around the costs of coverage and the impact of those costs on lower income individuals, as well as the income eligibility thresholds of Medicare Savings Programs in Vermont and in other states. Section four also outlines reasons some Medicare beneficiaries do not have secondary coverage and options for increasing access to that coverage. Section five contains the conclusions of the working group's discussions and analysis.

Recommendations:

Based on the findings contained in this report the working group recommends the following:

- Increased support and resources for providing education to Vermonters eligible for Medicare.
- Proactive outreach from the State, targeted during open enrollment periods.
- Additional training for State Health Insurance Assistance Programs (SHIP) and consumer services staff around what coverage options are available and when.

- Mandating Medicare supplement rate reporting and maintaining an updated list of Medicare supplement premiums on the Department's website.
- Codification of BCBSVT as the insurer of last resort.

I. Coverage Options

Act 99 required the stakeholder group to consider coverage options available to older Vermonters, Vermonters under 65 years of age with end-stage renal disease (ESRD), and Vermonters under 65 years of age with disabilities. Specifically, the legislation asked the group to consider Medicare supplement and Medicare Advantage plans, the affordability of these options, and the extent to which the State can regulate or affect the plans offered to Medicare beneficiaries in Vermont, including the marketing and advertising of the plans.

Over 65

Vermonters over the age of 65 are eligible for various forms of health insurance coverage. The source of health insurance coverage can come from an employer, Medicare, Medicaid, or Tricare when an individual becomes eligible.

Original Medicare

Currently when an individual turns 65 they are eligible to sign up for Medicare three months before and three months after their 65th birthday.[1] Enrollment in Medicare happens either automatically when someone applies for Social Security benefits or when an individual applies. Medicare coverage is divided into two parts, Part A and Part B (Original Medicare). Part A, usually referred to as hospital insurance, covers the inpatient costs at hospitals, nursing facilities, hospice, and also home health care. In most instances Part A does not require beneficiaries to pay a premium, but care received under Part A does have a deductible that must be satisfied each time you are admitted for an inpatient hospital stay or to a skilled nursing facility. Medicare-eligible employees who receive insurance coverage through a group plan may elect to sign up for Part A coverage immediately after becoming eligible because in most instances there is no premium associated with the coverage.[2]

Part B, referred to as medical insurance, covers costs such as services from health care providers, outpatient care, durable medical equipment, and many preventive services. Enrollment in Part B requires beneficiaries to pay a monthly premium which is based on income. Beneficiaries who are not enrolled in an employer-sponsored health plan[3] must enroll in Medicare Part B when they are first eligible for Medicare, or they may be subject to a late enrollment penalty. Part B is also subject to an annual deductible and a coinsurance payment, which is 20% of the cost for each Part B Medicare-covered service after the deductible has been paid.

[1] Under 42 C.F.R. § 406.20(b), all individuals over the age of 65 are eligible for Medicare by reason of age, even if they were previously eligible by reason of disability.
[2] Beneficiaries do not usually pay premium for Part A if they paid Medicare taxes for a certain amount of time (usually 10 years).
[3] Beneficiaries employed at companies with less than 20 employees must enroll in Part B upon initial eligibility, while beneficiaries employed at companies with 20 or greater employees may defer Part B enrollment without a penalty.

Beneficiaries who remain employed after their initial Medicare open enrollment period may receive group insurance coverage through an employer. When the individual retires, terminates employment, or the coverage offered through the employer ends, there is an eight-month enrollment period to sign up for Part A and Part B.

Original Medicare is regulated at the federal level by the Centers for Medicare and Medicaid Services (CMS). All plan costs and deductibles are determined at the federal level and any advertising around Original Medicare is also regulated by CMS. Vermont has no ability to regulate or impact Original Medicare plan designs or advertising.

Prescription Drug Coverage

Medicare also offers prescription drug coverage called Part D. Medicare Part D coverage is provided through private insurers who contract with the federal government and can only be purchased by beneficiaries who enroll in Original Medicare. If beneficiaries enroll after the original eligibility period (either on the basis of age or upon losing employer-sponsored health coverage),[4] they are subject to a late enrollment penalty, unless a beneficiary has creditable coverage under their employer plan.

Medicare Advantage Plans, also known as Part C, may cover prescription drugs, sometimes referred to as MA-PD. Medicare supplement plans are not allowed to cover prescription drugs, so coverage must be separately purchased through a stand-alone Part D plan.

As with Original Medicare, Part D is regulated fully at the federal level, including plan designs and advertising. Vermont has no ability to regulate Part D plans.

Medicare Supplement

Medicare supplement insurance, also known as Medigap, is supplemental insurance coverage to Medicare Parts A and B. Medicare supplement insurance must be purchased separately from Original Medicare and helps cover the coinsurance and deductible costs for beneficiaries who choose to enroll in Part A and Part B.

All Medicare supplement plans are identified by the following letters (uncorrelated with Medicare Parts A,B, C, and D): A, B, C, D, F, G, K, L, M, and N.[5] The plan designs for each letter are uniform throughout all states and are determined at the Federal level.[6] States are the primary enforcer of rules around Medicare supplement and ensure the plan designs for each product sold are consistent with the federal requirements. This allows customers to compare the costs of each plan without having to also compare the benefits provided. Each plan has different cost sharing structures covering a portion of beneficiaries' out-of-pocket expenses, such as copayments, coinsurance, and deductibles, which are not covered under Original Medicare.[7]

The Insurance Division, within the Department, serves as the primary regulator of Medicare supplement plans. Under Insurance Division Regulation H-2009-04 all insurers are required to file all policies, forms, rates

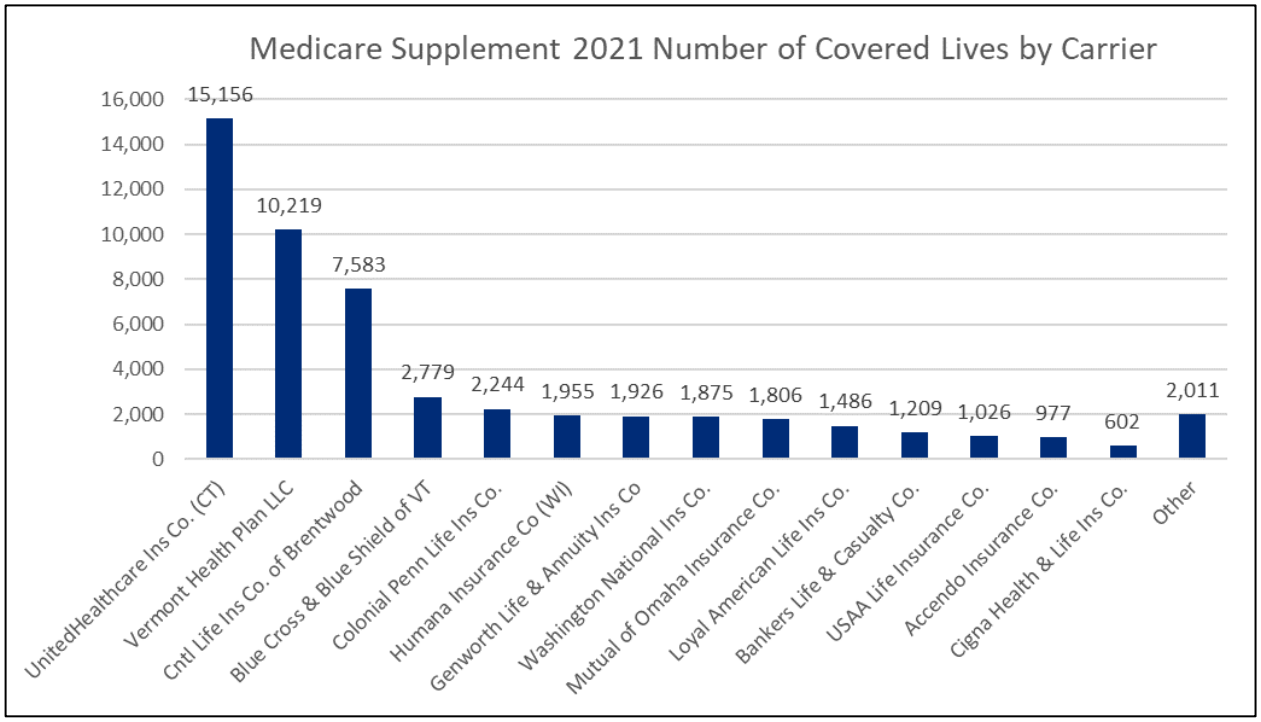
[4] The eligibility period for Part D is the same period as Medicare Part B.
[5] As of January 1, 2020, plans C and F are no longer available to new enrollees. *See* Department of Financial Regulation Rule H-2009-04 § 9.2 (Revised Aug. 15, 2019)*, available at* https://dfr.vermont.gov/reg-bul-ord/medicare-supplement-insurance-minimum-standards-regulations.
[6] Massachusetts, Minnesota, and Wisconsin have a different set of standardized plans under a federal waiver.
[7] See Appendix B.

(premium), and advertising occurring within the state. Vermont law[8] requires specific processes for reviewing rate increases that affect over 5,000 Vermonters or changes in loss ratio[9] of a rate which deviates an unreasonable amount from previously filed loss ratios. Companies are required to use a community rating methodology. This ensures that all beneficiaries at the plan level pay the same premium regardless of age or health conditions. Vermont law does allow companies to rate the disabled population separately from those eligible for Medicare due to age.[10]

As with Medicare, beneficiaries must enroll in a Medicare supplement plan during the same eligibility period as for Part A and Part B plans. There is also an enrollment period made available to beneficiaries who want to switch from a Medicare Advantage plan within 12 months of the original enrollment date. By enrolling during this time, beneficiaries can avoid paying penalties or medical underwriting. Medical underwriting is when "insurance companies try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits".[11] Currently, under Vermont law, companies have the flexibility, but are not required, to offer coverage outside of the eligibility period.[12] This allows beneficiaries who decide not to purchase the coverage initially to attempt to enroll in a plan at any time. However, outside the eligibility period, the insurer is not required to accept the application. States can expand the eligibility period for Medicare supplement plans. These expansions can take the form of a guaranteed, annual, or continuous open enrollment period, which will be discussed later in the report.

There are 14 insurers selling Medicare supplement insurance in Vermont. The marketplace has seen four new entrants in the last two years. A new entrant is a distinct insurance company offering standardized Medicare supplement products at a new rate. In addition to the 14 companies selling current products, there are also thirteen Medicare supplement companies maintaining "closed blocks," which represent products that are no longer for sale to new enrollees. Closed blocks have declining enrollment and may vary in size from a few hundred to fewer than five policyholders. Products may be available on a group basis, or exclusively through brokers, so not all products will be available to all consumers.

[8] 8 V.S.A. § 4062b.
[9] A loss ratio is the ratio of how much of the premium is used to pay claims divided by the total premium collected.
[10] 8 V.S.A. § 4080e; Insurers are required to automatically transfer disabled policyholders to the over-65 risk pool once the disabled policyholder becomes eligible for Medicare by reason of age. *See* Ins. Bulletin 208 (Feb. 10, 2020)*, available at* https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-insurance-bulletin-208-rating-disabled-medicare.pdf
[11] https://www.healthcare.gov/glossary/medical-underwriting/.
[12] In the Medicare supplement market, BCBSVT operates as the "insurer of last resort," offering Medicare supplement plans to Medicare beneficiaries outside of open enrollment.



[13]

As mentioned, all advertising is subject to state-level approval and must be filed with the Department before entering the market. The policies are reviewed to ensure that the benefits and contract language match the language as required under state and federal law. Advertising is reviewed for accuracy of statements as well as to eliminate any misleading or false information.

Medicare Advantage

Medicare Advantage (Part C) takes the place of both Original Medicare (Part A and B), and in many instances Part D. Medicare Advantage plans are administered by private insurance companies but are regulated at the Federal level by the Centers for Medicare and Medicaid Services (CMS).Medicare Advantage plans tend to resemble commercial health insurance plans in that they may have network restrictions, deductibles, and other utilization management features. Medicare Advantage plans also have more flexibility in the plan design and can offer ancillary benefits such as hearing aids, dental coverage, and other wellness benefits not covered under Original Medicare or Medicare supplement plans.

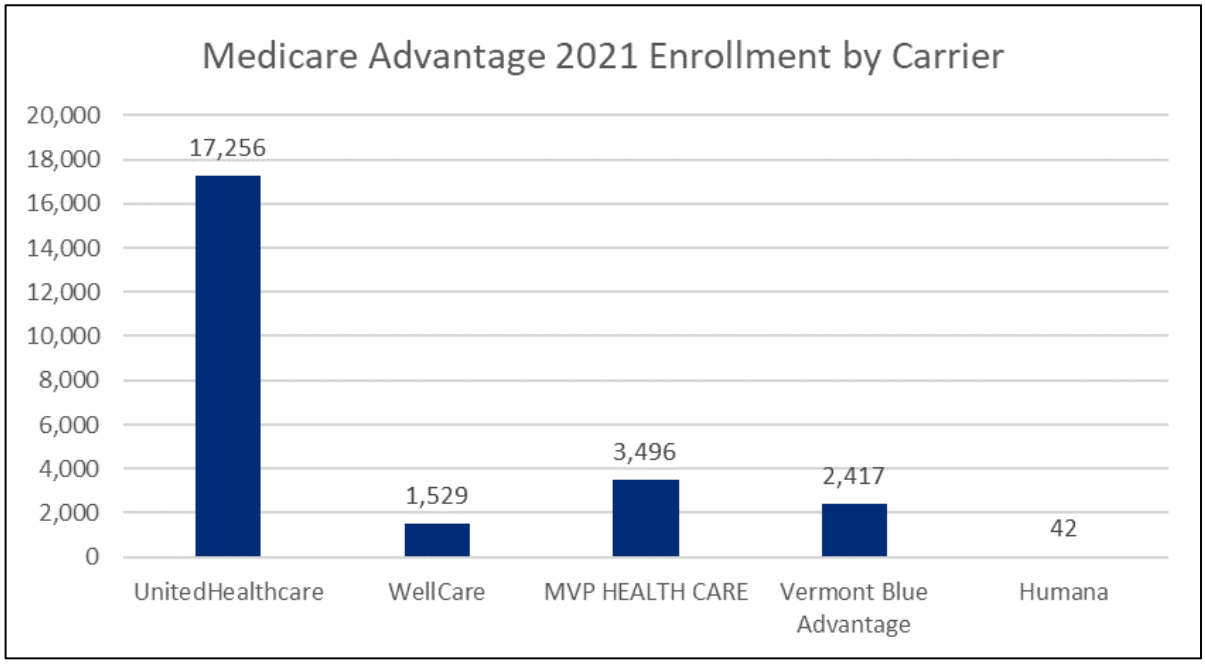
Unlike Medicare supplement plans, Medicare Advantage plans have an annual open enrollment period[14] during which beneficiaries are allowed to switch to another Medicare Advantage plan or switch back to Original Medicare. Beneficiaries who switched from a Medicare supplement plan to Medicare Advantage have twelve months from first enrolling in a Medicare Advantage plan to switch back to their original Medicare supplement plan. Individuals who were never enrolled or enroll in Medicare supplement outside of the twelve month period would likely be subject to underwriting when enrolling in Medicare supplement. Medicare Advantage plans are

[13] Oliver Wyman, Medicare Supplement Open Enrollment Periods, Recommendations to the General Assembly, December 14, 2022

[14] January 1 – March 31

available to beneficiaries who are eligible for Medicare due to age and disability, and as of 2021 to beneficiaries who are eligible for Medicare due to ESRD.

In Vermont there are four Medicare Advantage plans available. These plans are offered by UnitedHealthcare (UHC), WellCare, BCBSVT, and MVP. UHC makes up the largest segment of the market, covering almost 70% of Medicare Advantage enrollees.



[15]

Medicare Advantage plan administration, design, and advertising is regulated by the CMS. While states do not have the ability to regulate the marketing or advertising of Medicare Advantage plans, the brokers and agents who sell the MA plans do fall under states' jurisdiction.

Under 65 with ESRD and disabilities

Beneficiaries under age 65 who are disabled or have ESRD can become eligible for Medicare. The eligibility threshold, set in federal law, requires disabled beneficiaries or those with ESRD to receive Social Security Disability Insurance (SSDI) payments for 24 months before they are eligible to apply for Medicare. States can make Medicare supplement coverage available to those eligible for Medicare because of a disability or ESRD. Vermont law requires insurers to offer Medicare supplement plans to disabled Medicare beneficiaries but does not extend the same eligibility to beneficiaries who are eligible for Medicare due to ESRD.[16] The law also allows insurers to rate the plans offered to the disabled population separately from those eligible for Medicare due to age. As of 2021, beneficiaries with ESRD can enroll in Medicare Advantage plans.

[15] Oliver Wyman, Medicare Supplement Open Enrollment Periods, Recommendations to the General Assembly, December 14, 2022

[16] 8 V.S.A. § 4080e(c).

Affordability and Medical Debt

Medicare Advantage is an up-front lower cost option than Medicare supplement plans for many individuals and some Medicare Advantage plans have $0 premium. While Medicare supplement plans offer more coverage towards some potential out of pocket costs in the event of claims, the monthly premium for many lower income individuals is not an affordable option. As noted in the Oliver Wyman report[17] the total cost of care for a Medicare Advantage product for an individual at 400% of the federal poverty level averages 7.9% of income, and 11.5% for those enrolled in Medicare supplement plans. Under the Affordable Care Act coverage is considered unaffordable if the premium is greater than 9.12% of an individual's income.[18] According to the Oliver Wyman report, "an individual would need an income of $59,200, or 460% of the federal poverty level, for the total cost of a Medicare Supplement policy to be less than 10% of household income. "

With half of all Medicare beneficiaries with incomes below $26,200,[19] affordability of coverage is a primary concern. Many Medicare beneficiaries, due to disability or age, live on fixed incomes and unexpected costs incurred due to being uninsured or under insured can lead to medical debt. A report by the Kaiser Family Foundation found that 12% of individuals with incomes below 400% of the federal poverty level have significant medical debt.[20] Nationally, 6% percent of individuals between the ages of 65 and 79 have medical debt, compared to 12% of adults between the ages of 50 to 64.[21] The reduction in medical debt for those over age 65 is due largely to the fact that many individuals become eligible for insurance coverage through Medicare at age 65. The situation for individuals living with a disability is far worse, with 15% of those with a disability having medical debt of more than $250.[22] Having access to affordable coverage will help those with lower incomes become insured and potentially avoid medical debt.[23]

[17] See Appendix A.
[18] Rev. Proc. 2022-34; 2022-33 I.R.B. 143, https://www.irs.gov/pub/irs-drop/rp-22-34.pdf
[19] https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/#:~:text=Married%20individuals%20had%20higher%20median,%2C%20and%20%2415%2C350%2C%20respectively)
[20] Id.
[21] https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#Share%20of%20adults%20who%20have%20more%20than%20$250%20in%20medical%20debt,%20by%20demographic,%202019
[22] Id.
[23] In addition to personal medical debt, insufficient health care coverage also results in uncompensated care to health care providers, either through an individual's inability to pay or denied claims for services. For instance, a Medicare Advantage insurer at one Vermont hospital denied 60 claims for services versus no denials or low denials from all other insurers. Uncompensated care through unaffordability or denied claims contributes to less access to care and increases in other commercial premiums.

II. Annual or Continuous Open Enrollment

The working group analyzed the impact of an annual or continuous open enrollment on the Medicare supplement market in Vermont. The analysis considered an annual open enrollment[24] for existing Medicare supplement enrollees and the impact of allowing individuals without coverage to enroll after their initial eligibility period.

The first analysis considered the adoption of an annual open enrollment which would allow individuals who had not purchased Medicare supplement during the initial eligibility period to purchase coverage. The analysis found that allowing individuals to enroll outside of the initial eligibility period would increase rates in the aged pool by approximately 1% and increase rates in the disabled pool by 11%. Since many individuals who want to enroll in Medicare supplement have already done so (or elected an alternative coverage option), the population choosing to enroll outside of the initial eligibility period would likely have higher morbidity and lead to adverse selection against the Medicare supplement market. While the impact on the aged pool would likely be small, the existing disabled policyholder would see a larger rate increase, further driving the concern around the affordability of Medicare supplement. The analysis shows that in 2020 only 7.2% of disabled were enrolled in Medicare supplement plans, with plan affordability being the likely cause of the low enrollment. With a larger share of under 65 beneficiaries having lower incomes,[25] it is more likely that this population would sign up for Medicare supplement as health care needs increased.

The second analysis looked at how an annual open enrollment period available to existing Medicare supplement policyholders would impact affordability and access. The analysis found that an annual open enrollment period for existing beneficiaries would narrow the differences in premium as members with higher premiums moved to less expensive coverage. Over time the morbidity of the population would be more equally spread across plans, leading to similar prices across the market. Increasing access to Medicare supplement through an annual open enrollment for existing members is unlikely to increase affordability or access to affordable care. This held true for both the disabled and aged pools.

The working group also considered whether annual or continuous open enrollment periods in other states have led to higher rate increase or adverse selection. The analysis found that higher Medicare Advantage penetration rates in other states were the main driver of cost increases in the Medicare supplement market, and annual or open enrollment periods did not have an impact on costs or enrollment in the Medicare supplement market.

Affordability of premium payments is the main barrier for individuals who consider purchasing Medicare supplement insurance.[26] The availability of an annual open enrollment period is unlikely to widely increase enrollment in Medicare supplement as long as it remains more costly than Medicare Advantage. Having robust

[24] While the legislation asked the working group to consider an annual or continuous open enrollment, the analysis focused on an annual open enrollment analogous to what is currently available in the Medicare Advantage and Original Medicare space.

[25] https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities

[26] See survey results further detailed in Section 4.

health insurance is the way consumers can avoid medical debt and increase access to care, yet most consumers make decisions about coverage primarily based on premium cost.[27]

There are also current annual options for Medicare-eligible individuals to enroll in health insurance coverage, either through the Medicare Advantage annual open enrollment period or Blue Cross Blue Shield of Vermont's (BCBSVT) Medicare supplement plan. Due to the potential negative impact on premiums for the under 65 disabled population and the limited additional enrollment in the over 65 population the working group does not recommend creating an open enrollment period.

BCBSVT Plan Insurer of Last Resort

BCBSVT currently functions as the insurer of last resort. While no statutory mandate exists, BCBSVT currently offers a guaranteed issue plan to any Vermonter who wants to enroll in the Medicare supplement market at any time. BCBSVT is a nonprofit hospital service corporation formed under Title 8 V.S.A. § 4513 and as such "is not a private business operating freely within the competitive market."[28] Rather it is a quasi-public entity which is operated solely for the benefit of its subscribers.[29] Historically, BCBSVT had served as the safety net insurer for the small group health insurance market in Vermont and has continued this role in the Medicare supplement market.[30] BCBSVT supported, and the working group agreed, that a statutory change should be made to codify BCBSVT to serve as the insurer of last resort for the Medicare supplement market.

III. Advertising and Information

The stakeholder group considered whether Vermont residents are receiving accurate information about Medicare supplement and Medicare Advantage plan options and if sufficient assistance is available to support Vermonters in selecting products.

As mentioned in the first section, Medicare supplement advertising is regulated by the Department of Financial Regulation. The Department ensures accurate information is being included in the advertising and does not approve advertising with misleading statements. While complaints around advertising of Medicare supplement are uncommon, many individuals call the Department asking questions around rates for different plans.

Throughout the working group meetings, several stakeholders shared anecdotes of beneficiaries being aggressively solicited to join Medicare Advantage products or being switched to a Medicare Advantage plan without realizing what they were buying. The reports mainly focused on the pervasive advertising for Medicare

[27] Id.
[28] In re Vermont Health Service Corp. (1984) 144 Vt. 617, 482 A.2d 294
[29] Id.
[30] See repealed Title 8 V.S.A. § 4080c.

Advantage plans, including some in the form of television advertising, but several group members also commented on the aggressive sales techniques used for Medicare Advantage.

These accounts are supported by the recent report on Medicare Advantage marketing released by the United States Senate Committee on Finance. The report cited a recent CMS statistic showing the number of complaints the agency received around Medicare Advantage marketing went from 15,497 complaints in 2020 to 39,617 in 2021.[31] The Committee reviewed materials submitted by 14 states and other stakeholders, including State Health Insurance Assistance Programs (SHIPS). The report found that, like CMS, states were seeing an increase in complaints related to the marketing of Medicare Advantage plans. Consumers identified receiving mail advertisements, robo-calls, and telemarketing calls, with a large increase in third party print and television advertisements, with both misleading content and aggressive sales tactics. The report found evidence of beneficiaries having their coverage changed without consent and high-pressure sales activity targeting both older beneficiaries and beneficiaries who are cognitively impaired.

In January of 2022 CMS issued a proposed rule, which was finalized in May of 2022, acknowledging more oversight of third-party marketing organizations (TPMOs) was needed to protect Medicare beneficiaries from misleading and confusing advertisements.[32] The new rule clearly defines TPMOs, requires new disclaimers in advertising by TPMOs, and creates an obligation for Medicare Advantage and Part D plans to oversee TPMOs providing services on behalf of the plans.

In anticipation of the rule, the Department of Financial Regulation issued a comment letter expressing concerns that the new rule did not go far enough in the regulation of TPMOs.[33] The Department requested that CMS consider expanding the ability of state regulators to oversee the marketing of Medicare Advantage and Part D plans. The Department also supported a comment letter from the National Association of Insurance Commissioners (NAIC)[34] containing similar messaging.

Currently the Department of Financial Regulation Consumer Services staff as well as the State Health Insurance Assistance programs (SHIPs) and the Vermont Health Care Advocate are the primary resources for Vermonters who have questions about Medicare, Medicare supplement, and Medicare Advantage. SHIP services are a national program that offer unbiased assistance to Medicare beneficiaries with a mission "to empower, educate, and assist Medicare-eligible individuals through objective outreach, counseling, and training." The SHIP program is funded through federal grants and managed by the Office of Healthcare Information and Counseling (OHIC) under the Administration of Community Living (ACL). Vermont's SHIP Program is administered through the area agencies on aging.

During the working group discussion, SHIP participants indicated further resources for staff to increase education and outreach to the public would be important for handling the growing amount of consumer questions and complaints. Currently there are six Medicare counselors for the entire state's SHIP program in the area agencies on aging. The Department of Financial Regulation is currently a primary resource for consumers in Vermont on

[31] MA Marketing Finance Report November 2022 footnote 1
[32] 42 C.F.R. Parts 417, 422, and 423
[33] *See* Department of Financial Regulation, CMS-4192-P Comment (Mar. 7, 2022)*, available at* https://www.regulations.gov/comment/CMS-2022-0012-4088.
[34] The National Association of Insurance Commissioners is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories.

the issues discussed above. The Department has one staff member primarily dedicated to health insurance complaints. Medicare-related questions and complaints have grown in number over the years, from 35 to 47 total complaints in 2021 alone, an increase of more than 25%.

The Department has historically maintained a list of Medicare supplement premiums classified by plan issuer and type. Currently issuers are not required to report supplement plan premium information to the Department, which can lead to incomplete or inaccurate information and an inability for the Department to get a complete picture of the market in real time. The working group recognized that improving the information available on the Department's website was an important resource for consumers.

Survey Results

To determine whether Vermont residents are receiving accurate information, the working group created a survey which was distributed by the Department and stakeholders. The goal of the survey was to gain insight into consumer experiences with purchasing and utilizing Medicare supplement, Medicare Advantage, or with choosing to go without coverage secondary to Medicare. While the survey provides greater understanding through anecdotal evidence, it is not a scientific survey due to the small sample size relative to the population of Medicare beneficiaries in Vermont.

The Department received and tallied 468 responses electronically and on paper over a two-month period. The survey participants were split into three groups: (1) Beneficiaries with Original Medicare and Medicare supplement, (2) beneficiaries with Medicare Advantage, and (3) beneficiaries with Original Medicare and no supplemental coverage. The survey did not consider Medicare Part D, which is prescription drug coverage that often pairs with Medicare supplement coverage and is built into many Medicare Advantage plan designs.

Each group was asked questions related to reasons they selected a coverage type and their experience with the coverage. The questions varied and were designed to capture specifics related to Act 99, including questions which the group found valuable to the working group's topics of discussion.

The survey results showed that individuals with Medicare supplement were generally more satisfied with their coverage than those enrolled in Medicare Advantage. However, the unaffordability of the Medicare supplement benefits led many to purchase Medicare Advantage products. Some respondents indicated that supplemental benefits such as hearing aids, dental, and vision coverage were attractive options, yet still did not necessarily provide sufficient coverage.

The survey revealed some evidence of adverse selection[35] against the Medicare supplement market with the increased access to zero-dollar premium Medicare Advantage plans. For instance, this comment is indicative of the adverse selection already at play in the supplemental-to-Medicare insurance markets:

> "I would have preferred a Medigap (Medicare Supplement) plan, but it was far too expensive, especially with adding prescription coverage. My zero-dollar

[35] In the context of health insurance, "adverse selection" occurs when an insurer (or a market as a whole) contains a disproportionate share of unhealthy individuals.

premium Advantage plan does very well for me now, but I worry a lot about not being able to switch to a Medigap plan if my needs increase."

Beneficiaries who decided not to enroll in Medicare supplement were asked why they decided not to. Notably, the largest reported barrier to purchasing Medicare supplement coverage was the affordability of the premiums, with 60% of responses citing this factor. Twenty-seven percent of respondents did not think they would need the product, and only 13% reported being confused by the choices.

Detailed survey results are available in Appendix C.

IV. Coverage Costs and Medicare Savings Programs

Medicare Part B Premium Cost

To enroll in Medicare Part B, Medicare beneficiaries must pay a monthly premium. Medicare Part B covers "physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A."[36] Each year CMS releases the Part B premium and deductible amounts. The standard monthly premium for Medicare Part B in 2023 will be $164.90, a decrease of $5.20 from 2022. Medicare Part B premiums increase based on an individual's adjusted gross income starting at $97,000 and increasing up to $560.50 for beneficiaries with an adjusted gross income greater or equal to $500,000.

Medicare Part D premiums vary from plan to plan. Beneficiaries enrolled in Medicare Advantage have drug coverage rolled into the Medicare Advantage Premium, with an average annual member premium of $283.[37] Medicare supplement plans are not allowed to cover prescription drugs, so beneficiaries must buy Part D coverage separately at an average premium of $676 annually.[38] On top of the Medicare Part D premium CMS adds an income-based monthly adjustment amount. For beneficiaries earning less than $97,000 the premium is $0.00 and increases on a sliding scale to $76.40 for beneficiaries earning $500,000 or more.

While the premiums for Original Medicare are adjusted based on income, the out-of-pocket costs associated with coverage are not. There are a variety of programs to help Vermonters pay costs associated with Medicare Part A and B, and Part D.

To help pay the cost of Medicare, some low-income beneficiaries may be eligible for a Medicare Savings program (MSP). MSPs are administered by each state's Medicaid agencies. MSPs help pay Medicare premiums, and may also pay deductibles, coinsurance, and copays, depending on eligibility. There are three Medicare Savings Programs utilized in Vermont: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare

[36] Centers for Medicare and Medicaid Service, Fact Sheet, 2023 Medicare Parts A & B Premiums and Deductibles 2023 Medicare Part D Income-Related Monthly Adjustment Amounts (Sep. 27, 2022) *available at* https://www.cms.gov/newsroom/fact-sheets/2023-medicare-parts-b-premiums-and-deductibles-2023-medicare-part-d-income-related-monthly.

[37] Premiums for Medigap and MA are member-weighted average premiums in the Vermont market, based on 2021 CMS Landscape files and 2021 Medicare Supplement Experience Exhibits.

[38] Id.

Beneficiaries (SLMB), and Qualified Individuals (QI-1). As of 2022, the MSPs covers 26,064 Vermonters, with 1,370 beneficiaries enrolled in an MSP and a supplemental policy.

QMB pays for Medicare Part A and Part B premiums and cost sharing and does not pay for anything that Medicare will not cover. To be eligible for QMB, beneficiaries must have income at or below 100% of the Federal Poverty Level (FPL).

SLMB pays for the Medicare Part B premium only. To be eligible for SMLB, beneficiaries must have income at or below 120% of FPL and above 100%. QI-1 also pays for the Medicare Part B premium. The eligibility threshold for QI-1 is having income between 120% and 135% of FPL.

Vermonters can have QMB and SLMB and still have full Medicaid. Individuals are not eligible for QI-1 if they have Medicaid.

Program	Income Limit (FPL)	Asset Limit	Benefits*
QMB	100%	None	Pays Medicare Part A and B premiums; deductibles; co-insurance
SLMB	120%	None	Pays Medicare Part B premium only
QI-1	135%	None	Pays Medicare Part B premium only

Beneficiaries who are eligible for the Medicare Savings Programs are deemed eligible for the Low-Income Subsidy (LIS) program, which is administered by the Social Security Administration. LIS pays Part D premiums, eliminates prescription drug deductibles and coverage gaps, offers low copayments, and provides a continuous special enrollment period for Medicare drug coverage.

In 2022, most states had the same income eligibility thresholds as Vermont, with four states and DC having higher income standards. Ten states (VT included) and the District of Columbia (D.C.) have no resource or asset test.

State	QMB	SLMB	QI-1	Asset Test?
Massachusetts*	130% FPL	150% FPL	165% FPL	Yes
Maine*	150% FPL	170% FPL	185% FPL	Yes
Indiana	150% FPL	170% FPL	185% FPL	Yes
Connecticut	211% FPL	231% FPL	246% FPL	No
DC**	300%	N/A	N/A	No

The working group considered the impact of raising the income eligibility thresholds for MSPs. Specifically, the working group considered and analyzed the potential fiscal and population impacts of the current Connecticut (CT) income eligibility thresholds were they to be implemented in Vermont. Expanding to CT MSP income limits could make an estimated 31,234 Vermonters newly eligible for the programs. The State would need to provide additional general funding of approximately $44 million.

Program	Gross Impact Estimate	Contributions from State General Fund	Federal Contributions
QMB	$91,620,909.32	$38,554,078.64	$53,066,830.68
SLMB	$13,080,028.40	$5,446,155.95	$7,633,872.45
QI-1	$4,455,939.60	None	$4,455,939.60
Total Cost	**$109,156,877.32**	**$44,000,234.59**	**$65,156,642.73**

Lower income Individuals who are not eligible for Medicaid or a Medicare Savings Program may be more likely to select or enroll in a Medicare Advantage product with a low or $0 premium. As noted above, Medicare Advantage plans may have more restrictive networks and higher cost sharing requirements, potentially limiting lower income individuals' ability to access care.

V. Conclusions

Affordability was clearly a primary theme throughout the working group discussions and survey response results. Individuals who did not purchase supplemental coverage to Original Medicare cited the cost of the supplemental products as the primary factor in their decision. Medicare Advantage continues to be a growing part of the way Medicare-eligible Vermonters are meeting their health insurance needs, due to the affordability of these product premiums in contrast to the higher costs of Medicare supplement plans. While Medicare Advantage is an attractive and lower cost coverage option in most cases, the advertising in this space can be confusing, and individuals may be choosing a plan based not on their actual needs but on misleading statements. Medicare supplement plans, while more expensive, tend to provide individuals who can afford them with more expansive provider options and less cost sharing exposure.

While the group analyzed the impact of increasing the Medicare Savings Program income thresholds, the cost of such an expansion was viewed as prohibitive to making a recommendation to adjust Vermont's current income eligibility requirements. Further consideration and study should be given to alternative income eligibility limits.

Due to affordability being the main driver of beneficiaries' choice of whether to purchase a Medicare supplement plan, an annual or continuous open enrollment period is unlikely to increase enrollment in the market. While an open enrollment period may not increase participation in the Medicare supplement market, it is also unlikely to increase premiums for the over 65 population, but could have a detrimental impact for the under 65 rate. When looking at other states with open enrollment periods, the analysis showed increased penetration of Medicare Advantage plans as the main driver of cost increases in the Medicare supplement market, and not the open enrollment policies. Education and outreach would likely have the greatest impact to help beneficiaries understand which coverage options can best address and meet their health care needs, as well as up to date information on the Department's website.

Concern around access to coverage is ameliorated by the fact that individuals currently have access to Medicare Advantage plans on an annual basis, as well as BCBSVT's guaranteed issue Medicare supplement plan. Maintaining access to that plan was universally agreed upon and will ensure a guaranteed issue product, though at a higher cost.

Appendix A

MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIODS

Recommendations to the General Assembly under S. 239

January 6, 2023

Kurt Giesa, FSA, MAAA

Contents

1. Executive Summary

This report contains seven sections. The first is this executive summary. The second discusses federal minimums regarding open enrollment periods (OEPs) for individuals eligible for Medicare, how states have adopted legislation that goes beyond the federal minimums, and how Vermont regulates its Medicare supplement market. The third section goes into some detail regarding the make-up of the Medicare market in Vermont and options available to Vermonters eligible for Medicare. In the fourth section, we examine the potential impact of allowing guaranteed issue access to Medicare supplement coverage. In the fifth and sixth sections we present our findings and describe the data we relied upon in performing this work, respectively. In the seventh section, we provide a discussion of qualifications and limitations.

Background, Purpose, and Scope

Oliver Wyman has undertaken this work on behalf of the Vermont Department of Financial Regulation (DFR) in response to S. 239 (Act 99) requiring that DFR present "findings and recommendations regarding Medicare supplemental coverage and Medicare Advantage plans, including any recommendations for changes to Vermont law, to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance." See Appendix A for the full text of the legislation.

As background, Medicare is a federal health insurance program providing health insurance coverage to most individuals aged 65 and older (aged individuals), certain younger individuals with disabilities (disabled individuals), and individuals with end-stage renal disease (ESRD individuals). Fee-for-service Medicare (FFS) covers inpatient hospital services (Part A), outpatient hospital, professional services, and supplies (Part B), and prescription drugs (Part D).

Most individuals do not pay a monthly premium for Part A. Part A coverage includes various patient cost sharing amounts. Examples of Part A cost sharing include a $1,600 deductible (2023) and co-payments for hospital stays extending beyond 60 days.[1]

For Part B coverage, individuals pay an income-based premium. For individuals with incomes up to $97,000, the monthly Part B premium is $164.90 (2023). Monthly premiums for individuals with incomes greater than $97,000 are higher, increasing to $560.50 for individuals with incomes of $500,000 or more. In addition to the Part B premium, Part B services are subject to an annual deductible of $226 (2023), and 20% coinsurance for most services.[2]

Unlike Parts A and B, Medicare Part D coverage is provided by private insurance companies offering Part D plans (PDPs), so premiums and cost sharing vary. The national average monthly PDP premium across the 16 national PDPs in 2023 is projected to be $43, and most PDP enrollees will have a $505 annual deductible.[3] The lowest-cost PDP available in Vermont is Aetna's SilverScript SmartSaver plan with a monthly premium of $6.80, and copays ranging from $2.00 for preferred generic drugs to 25% for drugs in the specialty tier. Beginning in 2025, PDP plans will limit patient cost sharing to $2,000.[4]

Individuals with Medicare FFS coverage often purchase supplemental coverage from private insurance companies to help cover the patient cost sharing amounts and to prevent what could be very large out-of-

[1] https://www.medicare.gov/basics/costs/medicare-costs
[2] Ibid.
[3] https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-medicare-drug-plans-in-2023/
[4] Ibid.

pocket expenses. Medicare supplement plans are labeled with letters, for example Plan A. Companies can make Plan A through Plan N available.[5] Every company offering a Plan A or Plan B, for example is offering the exact same covered benefits as all the other issuers in the market. The difference among the plans, for example between Plan A and Plan B, is the extent to which they supplement Medicare coverage. All plans provide coverage of Part B coinsurance, for example, but Plans K and L only cover 50% and 75% of Part B coinsurance, respectively. Plan A is the least rich plan and Plans F and N are the richest plans. The average monthly premium in Vermont for a Medicare supplement policy in 2021 was roughly $190.[6]

Individuals with FFS Medicare can receive covered services from any facility or provider accepting Medicare patients.

In addition to Parts A, B, and D, there is Medicare Part C. Medicare Part C allows private plans to contract with Medicare to provide medical benefits under a Medicare Advantage (MA) plan and prescription drug coverage under an MA-PD plan. To be eligible for MA coverage, an individual must have coverage under Parts A and B of Medicare, which means having paid their Part B premium. MA plans cover all the same services covered under Medicare Parts A and B and may offer additional benefits such as vision and dental coverage. MA enrollees generally must use health care providers who participate in the plan's network. Patient cost sharing under an MA varies by plan but tends to be much richer than coverage under FFS Medicare. Where FFS Medicare provides no limit on patient cost sharing, MA plans must limit patient cost sharing to no more than $8,300 (2023). [7] In many markets, including Vermont, MA plans are available with zero-dollar premiums. Some plans offer non-emergency coverage out of network, but typically at a higher cost.

Key Findings

Overview of Open Enrollment Provisions

- Medicare supplement markets are regulated at the state level subject to federal minimums. Consistent with federal minimum requirements, Vermont provides a one-time, six-month OEP for individuals over the age of 65, when they first become eligible for Part B coverage. Vermont goes beyond the federal minimum and extends that open enrollment period to individuals under the age of 65 who qualify for Medicare through disability, but not ESRD. During the six-month OEP, Medicare supplement issuers must issue a policy to any qualified individual seeking coverage, and they may not consider the individual's health status, pre-existing conditions, claims, or treatments received in determining their premium. Additionally, the policies are guaranteed renewable as long as the enrollee pays the premium.
- Individuals who fail to enroll in a Medicare supplement policy during their initial open enrollment period, or who enroll in an MA plan when first eligible and leave that plan after more than a year to enroll in a Medicare supplement policy, may be underwritten and denied coverage. The presence of cancer or a history of heart disease are examples of reasons why an individual could be denied coverage.
- Vermont requires Medicare supplement issuers to community rate, so premiums may not vary by age, gender, claims experience, health history, the presence or absence of medical conditions, or for any other

[5] As of January 1, 2020, Medigap plans sold to people new to Medicare can no longer cover the Part B deductible. Because of this, Plans C and F are no longer available to people new to Medicare on or after January 1, 2020, but Plan F remains the most popular plan due to the enrollment of people first eligible for Medicare before January 1, 2020.

[6] Oliver Wyman calculations using the 2021 Medicare Supplement Experience Exhibits.

[7] https://www.federalregister.gov/documents/2022/04/14/2022-07642/medicare-program-maximum-out-of-pocket-moop-limits-and-service-category-cost-sharing-standards

reason other than geography, but Vermont does allow two community rated pools – one for individuals under the age of 65, and one for individuals ages 65 or older.

- With respect to MA coverage, individuals who are eligible for Parts A and B of Medicare are eligible for an annual open enrollment period, known as the annual election period (AEP), from October 15 through December 7, during which beneficiaries may enroll in an MA plan or can make changes to their MA coverage, so individuals who do not enroll in a Medicare supplement plan when first eligible, may still access relatively comprehensive coverage through an MA plan. MA plans are prohibited from basing premiums on an individual's health status, expected claims, age, gender, expected need for treatment, or for any other reason.

Cost of Coverage and the Growth of MA Plans

- Coverage under an MA plan is more affordable than coverage under a Medicare supplement plan. We estimate that for the typical enrollee in 2021, MA coverage, including the Part B premium, patient cost sharing for deductibles and copays, and premiums for the MA plan, would be roughly $4,100. This compares to $5,900 for coverage under a Medicare supplement plan. Coverage under a Medicare supplement plan does allow the insured to access any provider accepting Medicare. We reviewed the coverage of hospitals in Vermont among MA plans and found that coverage was extensive.

- MA enrollment has been growing rapidly. In 2017, 9% of Medicare eligible individuals in Vermont were enrolled in an MA plan. In 2022, that increased to 27%.

The Role of BCBSVT in the Market

- While not required in statute or regulation, Blue Cross Blue Shield of Vermont (BCBSVT) plays the role of Medicare supplement issuer of last resort. If an individual who failed to enroll in a Medicare supplement plan during their initial OEP seeks coverage under a Medicare supplement plan, BCBSVT will provide a policy. Again, while not required in statute, this extends to ESRD individuals. We also note that BCBSVT does community rate but uses only a single pool where every other issuer in Vermont develops two sets of premiums, one for the aged enrollees and another for disabled enrollees under age 65.

Considerations in Providing an Annual or More Frequent OEP

- Some states provide an OEP to their Medicare supplement enrollees through a mechanism referred to as a "birthday rule." Once a year, typically around their birthday, individuals have the right to switch issuers and select a Medicare supplement plan, generally with benefits equal to or less than their current plan. Individuals who do change plans usually do so to obtain a lower premium.

- Because this birthday rule mechanism allows issuers to underwrite and deny coverage to individuals in poor health who did not enroll when first eligible to enter the Medicare supplement market, it has a minimal impact on the morbidity of the overall market. Our examination of the markets where states have adopted this approach, such as Oregon, Washington, California, and Missouri, leads us to believe that this approach has not led to significant, adverse effects in those states' markets. Premiums remain reasonable, and choice remains adequate.

- Vermont's market has the complicating factors of BCBSVT serving as the issuer of last resort and community rating across the disabled and the aged pools. If BCBSVT enrollees are given access to a birthday rule OEP, we expect the aged enrollees will leave BCBSVT for lower premiums offered by other issuers. As a result of this movement, premiums for disabled individuals would increase substantially.

- If Vermont were to adopt an OEP, we would expect significant disruption in the marketplace initially across all issuers as issuers change premiums in response to the likely movement of members among plans.

Impact of Allowing Individuals without Medicare Supplement Coverage Guaranteed Access to Coverage

- We examined the impact on the market of allowing individuals without existing Medicare supplement coverage access to coverage through an annual guaranteed issue option. Assuming 10% of the aged and disabled/ESRD population without coverage entered the market, we estimate premiums for the aged would increase by 1% and premiums for the disabled population would increase by 11%. Overall premiums would increase by 4%.

2. Regulating Medicare Supplement and Medicare Advantage Plans

Federal Minimum Standards for Medicare Supplement Open Enrollment Periods

The Omnibus Budget Reconciliation Act of 1990 established federal minimum requirements related to Medicare supplement policies.[8] First, beneficiaries who are age 65 and over are granted a six-month OEP from when they are first enroll with Part B coverage. During this six-month period, all Medicare supplement issuers must make available any policy the issuer makes available to new enrollees, at a rate that does not discriminate based on the individual's health status, pre-existing conditions, claims, or treatments received. Additionally, the policies are guaranteed renewable provided the enrollee continues to pay the premium. The federal regulations also restrict the use of pre-existing condition exclusions. For standardized Medicare supplement plans, pre-existing condition exclusions cannot exceed six months and may only be imposed in a replacement policy to the extent the exclusion has not been satisfied under the policy that is being replaced.

Finally, for individuals meeting the qualifying conditions listed below, there is a mandated 63-day guarantee issue period during which all issuers must make available to the individual any policy an issuer makes available to new enrollees at a rate that does not discriminate based on the individual's health status, pre-existing conditions, claims, or treatments received. The following qualify an individual for this guaranteed issue period:

- The loss of employer-sponsored coverage supplementing Medicare coverage
- The loss of coverage under a Medicare Advantage or other such plan whose certification is terminated or who move to an area where the plan is not available
- The involuntarily loss of Medigap coverage due to the insolvency of the insurer or in certain other, limited circumstances such as material misrepresentations
- Those enrolling in a Medicare Advantage or other such plan who disenroll within the first 12 months

It is important for Medicare beneficiaries to understand that their initial plan choice during the six-month open enrollment period is bound with both the benefit plan and the issuer. Other than the exceptions discussed above, the federal standards only mandate that the beneficiary's exact plan be guaranteed renewable. For example, if a beneficiary initially enrolls in Plan F offered by issuer X but wants to switch to Plan F offered by issuer Y, they may be subject to underwriting for the new policy.

Open Enrollment Periods for Medicare Advantage Plans

The federal government regulates open enrollment periods for MA plans. For individuals who are eligible for Parts A and B of Medicare, there is an annual open enrollment period known as the annual election period (AEP), from October 15 through December 7. During this time, beneficiaries can make changes to their MA coverage. Note that prior to January 1, 2021, individuals with ESRD were prohibited from enrolling in MA

[8] https://www.congress.gov/101/statute/STATUTE-104/STATUTE-104-Pg1388.pdf

plans, but the 21st Century Cures Act allowed Medicare-eligible individuals with ESRD to enroll in MA plans beginning January 1, 2021.[9]

During the AEP, beneficiaries can make any of the following changes:

- Switch from original Medicare to an available MA plan in their service area
- Switch from an MA plan to original Medicare
    - The beneficiary will also need to enroll in a Part D only plan, if they do not otherwise have coverage
- Switch from one MA plan to another MA plan in their service area
- Switch from one Part D only plan to another Part D plan in their state
- Newly enroll in a Part D only plan if they did not enroll when they were first eligible

Where federal regulations only require an OEP for individuals over the age of 65 for Medicare supplement issuers, the AEP is available to both qualifying individuals under age 65 and those aged 65 and over.

If a beneficiary does not make a change during the AEP, their coverage for the next calendar year will match the current year's coverage.

A final opportunity exists for beneficiaries to change coverage to or from an MA plan. The Medicare Advantage Open Enrollment Period (MAOEP) runs from January 1 to March 31 of the coverage year. The MAOEP allows beneficiaries to make one change, either from original Medicare to an MA plan, from an MA plan to original Medicare, or from one MA plan to another plan that better suits the beneficiary's needs. The MAOEP is intended to be used only as a back-up option, and CMS encourages beneficiaries to review their coverage options during AEP. Also, the MAOEP does not allow beneficiaries to switch between Part D only plans during this time.

Vermont's Medicare Supplement OEP Regulations

Vermont expands upon the federal standards described above by extending the OEP to individuals who are under the age of 65 and eligible for Medicare due to disability. Vermont excludes from the OEP individuals who are under age 65 and eligible for Medicare by reason of ESRD. Additionally, Vermont requires community rating, so that the premium an individual pays may not reflect age, gender, health status, pre-existing conditions, claims, or treatments received. But Vermont does allow for two community rated pools, one for individuals qualifying for Medicare through disability and one for aged individuals.[10] This means that the premiums for disabled beneficiaries under age 65 can be, and are, higher than those for beneficiaries over age 65.[11]

Outside of these OEPs, Medicare supplement issuers in Vermont are allowed to underwrite applicants and may deny coverage to individuals they deem to represent too high a risk, for example if the applicant has or had cancer, a stroke, a heart attack, or diabetes. Underwriting allows issuers to offer coverage at lower premiums for those who present lower risk but can also make it difficult for higher risk individuals to obtain Medicare supplement coverage from issuers other than BCBSVT.

In its role as issuer of last resort, BCBSVT offers Medicare supplement coverage to any Medicare beneficiary who is outside of the initial six-month open enrollment period without underwriting, but premium rates for

[9] https://www.cms.gov/newsroom/fact-sheets/2021-medicare-advantage-and-part-d-advance-notice-part-ii-fact-sheet
[10] 8 V.S.A. § 4080e at https://legislature.vermont.gov/statutes/fullchapter/08/107
[11] https://dfr.vermont.gov/document/medicare-supplemental-rates

the plans offered by BCBSVT reflect the claims of the individuals it insures, leading to higher premiums than other market participants charge. Additionally, unlike all other issuers in Vermont, BCBSVT does not vary premium rates between the aged and disabled individuals it covers. The approach BCBSVT takes results in premium rates for individuals over 65 subsidizing premium rates for those under age 65.

Medicare Supplement OEPs in Other States

States' approaches to regulating their Medicare supplement markets vary. Below, we provide a high-level summary of Medicare supplement regulations in the New England states, where the Medicare supplement regulatory environments tend to be relatively liberal.

Connecticut

Connecticut requires that Medicare supplement issuers "base the premium rates charged on a community rate," and that the rate "not be based on age, gender, previous claims history or the medical condition of the person covered by such policy or certificate." Connecticut also requires that coverage "not be denied on the basis of age, gender, previous claim history or the medical condition of the person covered by such policy or certificate." Connecticut does allow a six-month pre-existing conditions exclusion consistent with federal minimum standards.[12]

Connecticut further requires that, to the extent an issuer offers Medicare supplement Plans A, B, and D to aged Medicare beneficiaries, they offer the same plans to persons eligible for Medicare through disability. As a result, some issuers in Connecticut set premiums for Plans A, B, and C much higher than they would be if these Plans were not guarantee issue to individuals qualifying for coverage through disability, or do not offer Plans B and C at all.[13]

Finally, Connecticut includes continuous guarantee issue provisions, which gives Connecticut beneficiaries the option to switch plans at any time, regardless of health.

Maine

Maine extends the six-month open enrollment period for guaranteed issue to beneficiaries under age 65. Each issuer in Maine is required to offer Plan A on a guaranteed issue basis, without pre-existing condition exclusions, or any other probationary period, for one month of the issuer's choosing each year.[14]

Under Maine's continuity rights, issuers must allow an individual who has or had a Medicare supplement policy to change issuers or policies to a plan with the same or lesser benefits currently being offered by the issuer, without underwriting, provided any gap in coverage between the new plan and the plan being replaced is less than 90 days. This right also applies to beneficiaries who switch from a Medicare supplement plan to a Medicare Advantage plan and want to return to Medicare supplement within three years.

Massachusetts

Massachusetts regulations require that "no issuer … deny or condition the issuance of any Medicare Supplement Insurance Policy … for sale in Massachusetts, nor discriminate in the pricing of such a plan, to any

[12] https://www.cga.ct.gov/current/pub/chap_700c.htm#sec_38a-495c

[13] https://portal.ct.gov/-/media/AgingandDisability/AgingServices/CHOICES/CHOICES-MediGap-Rate-and-Benefit-Chart--7522---English.pdf

[14] https://legislature.maine.gov/legis/statutes/24-A/title24-Asec5012.html

eligible person because of the age, health status, claims experience, receipt of health care, medical condition, or genetic information of the eligible person."

In addition, the regulations require that "no Medicare Supplement Insurance Policy … contain any waiting period, or pre-existing condition limitation or exclusion"

Massachusetts extends the six-month open enrollment period for guaranteed issue to beneficiaries under age 65. Additionally, the rates for these beneficiaries are subject to the same community rating requirements as those for beneficiaries over age 65.

Finally, in addition to the open enrollment periods required under federal law, all issuers in Massachusetts, must conduct an annual open enrollment period from February 1 through March 31 during which issuers must allow enrollment into all their Medicare supplement products "currently available." The annual open enrollment period allows people to enroll in a Medicare supplement plan who missed their initial six-month enrollment window or people to switch to a different plan. Issuers must notify policyholders of the existence of the open enrollment period by January 1.[15]

New Hampshire

Consistent with federal law, New Hampshire's Medicare supplement market includes a six-month open enrollment period for aged individuals when they are first eligible for coverage. New Hampshire extends this provision to Medicare beneficiaries under the age of 65 and to those with ESRD. Unlike Vermont, New Hampshire does not require community rating. Rates in New Hampshire for a given plan offered by a given company vary age and gender, and some companies provide discounts to couples living together. Note that premiums for individuals under age 65 in New Hampshire are considerably higher than for most individuals over age 65.[16]

In 2020, the New Hampshire legislature considered adopting a "birthday rule" approach to providing an annual open enrollment period. [17] However, where most states that have adopted the birthday rule only allow insured individuals guaranteed access to their current plan or a plan with fewer benefits, New Hampshire's law would have given individuals access to any plan an issuer offers. The legislation also prohibited issuers from charging the under-age 65 enrollees more than the enrollees over the age of 65. The legislation passed through the Senate but failed in the House.

Rhode Island

As discussed above, federal minimum standards do not require that Medicare supplement issuers provide an open enrollment period to individuals under the age of 65, and unlike Vermont, Rhode Island does not impose this requirement on its issuers. However, coverage for Plan A is available through at least Blue Cross and Blue Shield of Rhode Island, but premiums are roughly 175% of Plan A premiums for individuals ages 65 to 67.[18] Again, unlike Vermont, Rhode Island allows issuers to vary premiums by age.

Other States with Notable OEP Allowances

New York

[15] https://www.mass.gov/files/documents/2017/10/23/211-71.pdf
[16] https://www.nh.gov/insurance/consumers/documents/2023-medicare-suppguide.pdf
[17] https://legiscan.com/NH/text/SB646/id/2095588
[18] https://oha.ri.gov/media/1186/download?language=en

New York has perhaps the most liberal Medicare supplement regulations.[19] State law and regulation require any insurer writing Medicare supplement insurance to accept a Medicare enrollee's application for coverage at any time throughout the year. They need not have an existing Medicare supplement policy. Insurers may not deny the applicant a Medicare supplement policy or make any premium rate distinctions because of health status, claims experience, medical condition or whether the applicant is receiving health care services. This applies to both the over- and the under-age-65 population. Premiums may not vary with age or health status. Issuers in New York are allowed to include a pre-existing conditions exclusion provision consistent with federal minimum standards.

Delaware

Delaware extends the six-month open enrollment period for guaranteed issue to beneficiaries under age 65.

Delaware law requires that any Medicare supplement insurer make all the plans the issuer offers available to both people over age 65 and people under age 65 and eligible for Medicare due to disability or ESRD. However, insurers are explicitly prohibited from cross-subsidization in rating. That is, Delaware prohibits subsidizing the risk of providing coverage for disabled Medicare beneficiaries by increasing premiums for the over age 65 population. Additionally, Delaware requires that insurers have separate rating pools for under-age-65 enrollees who are eligible due to ESRD and those under age 65 enrollees who are eligible due to disability. The resulting annual premium for ESRD enrollees, rated on their own pool's experience, can be over $10,000 annually, and in many cases are well in excess of $20,000.[20]

The Birthday Rule

Several states have regulations giving beneficiaries opportunities to switch Medicare supplement plans and issuers without medical underwriting. A common allowance is referred to as a "birthday rule," which is in regulation in the eight states listed in Table 2.1. These birthday rule states allow beneficiaries with an existing Medicare supplement policy to switch to another Medicare supplement issuer's plan within a certain time relative to their birthday or birth month. The allowance period varies between 30 and roughly 60 days.

In most cases, the new Medicare supplement plan must be at the same or lower level of benefits as the plan the beneficiary is switching from. The exceptions are Washington that allows insureds with Plan A to only move to another issuer's Plan A but otherwise makes any plan available, and Missouri which allows individuals to only select the same plan offered by the new issuer.

Only Illinois restricts the insured from switching issuers. We note that Illinois is also the only state with an existing issuer of last resort. As we discuss later in this report, we think this is significant, as Illinois's insurer of last resort would have served as a portal to non-underwritten coverage for those individuals who failed to enroll when first eligible for coverage, thereby increasing the morbidity of the pool as a whole.

Only Washington requires community rating, and only Washington has a continuous OEP allowing an insured to switch issuers and policies at any time, provided they have had coverage for the prior 90 days.

[19] https://govt.westlaw.com/nycrr/Document/I7642340bac6811de925e8b6c0f928f1d?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

[20] https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/03/MedicareSup_Guide.pdf

Table 2.1
Select States' Open Enrollment Provisions

State	Open enrollment provisions effective	Type	Plans available	Can Switch Issuers?	Community Rating 2021 and prior	Guaranteed issue plans available to under 65	Issuer of last resort
California	2010	Birthday rule	Same or lower	Yes	No	Yes	No
Idaho	2022	Birthday rule	Same or lower	Yes	No	Yes	No
Illinois	2022	Birthday rule (limited to ages 65 to 75)	Same or lower	No	No	Yes	Yes
Oregon	2013	Birthday rule	Same or lower	Yes	No	Yes	No
Louisiana	2022	Birthday rule	Same or lower	No	No	Yes	No
Missouri	2013	Anniversary rule	Same level	Yes	No	Yes	No
Nevada	2022	Birthday rule	Same or lower	Yes	No	No	No
Washington	2004	Continuous	Plan A to Plan A, otherwise open	Yes	Yes	No	No

We have examined the operation of the Medicare supplement markets in the states that have had a birthday rule in place for several years – California, Oregon, Missouri, and Washington. In Table 2.2 we provide some statistics on the Medicare supplement markets in these states as well as in Vermont and in the rest of the nation.

Table 2.2
Characteristics of the Medicare Supplement Markets with a Birthday Rule – 2021

State	Market concentration (HHI)	Plan F annual claims per person	5% Sample Member Cost Sharing	Selection (Plan F claims/5% cost sharing)	MA Penetration
CA	4,553	$2,110	$1,442	**1.46**	44%
OR	1,483	2,286	1,358	**1.68**	46%
MO	1,261	2,347	1,612	**1.46**	37%
WA	1,857	2,080	1,431	**1.45**	34%
VT	1,522	1,798	1,448	**1.24**	12%
All Other		2,178	1,502	**1.45**	37%

To measure market concentration, we use the Herfindahl-Hirschman Index (HHI) – the sum of the square of the market share of each of the firms competing in the market. An HHI of between 1,500 and 2,500 is considered moderately concentrated. An HHI of more than 2,500 is considered highly concentrated.[21] The median HHI across all 50 states is 1,861. California's market is highly concentrated, and Washington's is moderately concentrated, though Washington's HHI is less than the nationwide median. We believe this shows that a birthday rule does not necessarily result in the loss of market participants or restricted choice.

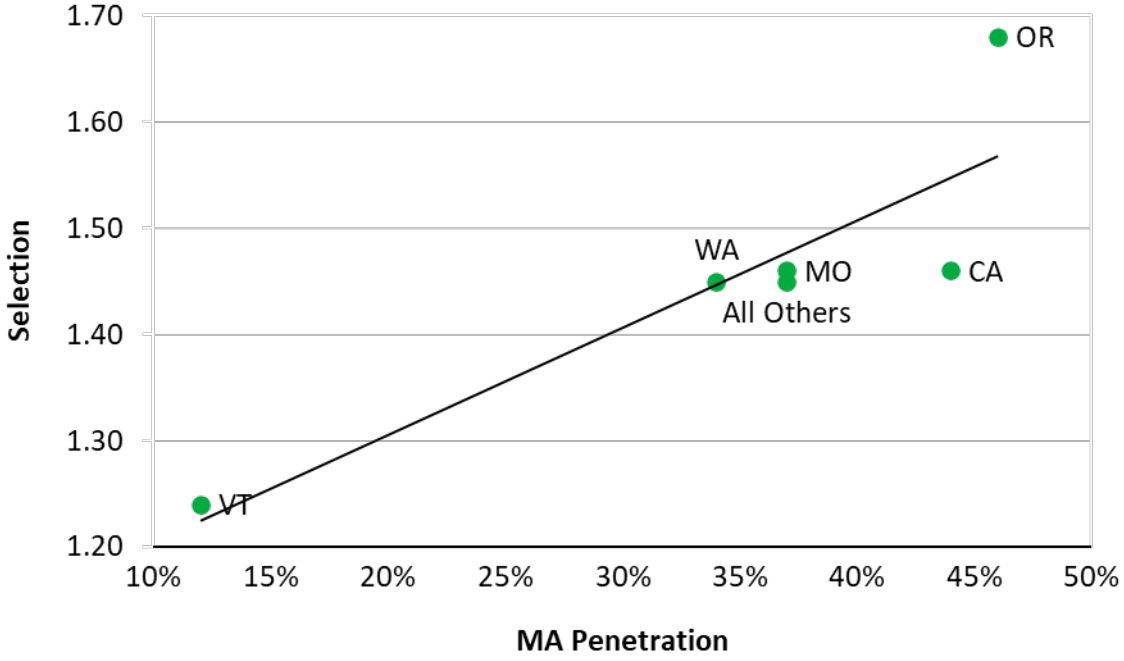
To test the effect of a birthday rule on premiums and adverse selection, we compared the annual claims under a Medicare supplement Plan F to the Medicare member cost sharing from the 5% sample. Plan F covers essentially all Medicare cost sharing amounts, so the ratio of Plan F claims per member to total member cost sharing provides a measure of selection.[22] We note that Washington's experience with continuous open enrollment, does not appear to have resulted in selection beyond what we see in other states with an annual open enrollment period.

Compared to Vermont's market, it appears as though selection may be greater in those states that have a birthday rule as the ratio of Plan F claims to the 5% sample claims is lower in Vermont than in the other states. However, in addition to looking at selection from the standpoint of the ratio of Plan F claims to 5% sample claims, we examined the impact of MA penetration on the ratio of Plan F claims to 5% sample claims. We show the result in Figure 2.1, below.

[21] https://www.justice.gov/atr/herfindahl-hirschman-index

[22] In addition to indicating a measure of selection, the ratio of Plan F claims to member cost sharing is also measuring induced demand – the extent to which an insured uses more services because insurance is covering a material portion of the cost of those services.

Figure 2.1 – Selection (Plan F Claims / Medicare 5% Sample Cost Sharing) vs MA Penetration – 2019



While not conclusive, increasing MA penetration in these states is positively correlated with increased selection.

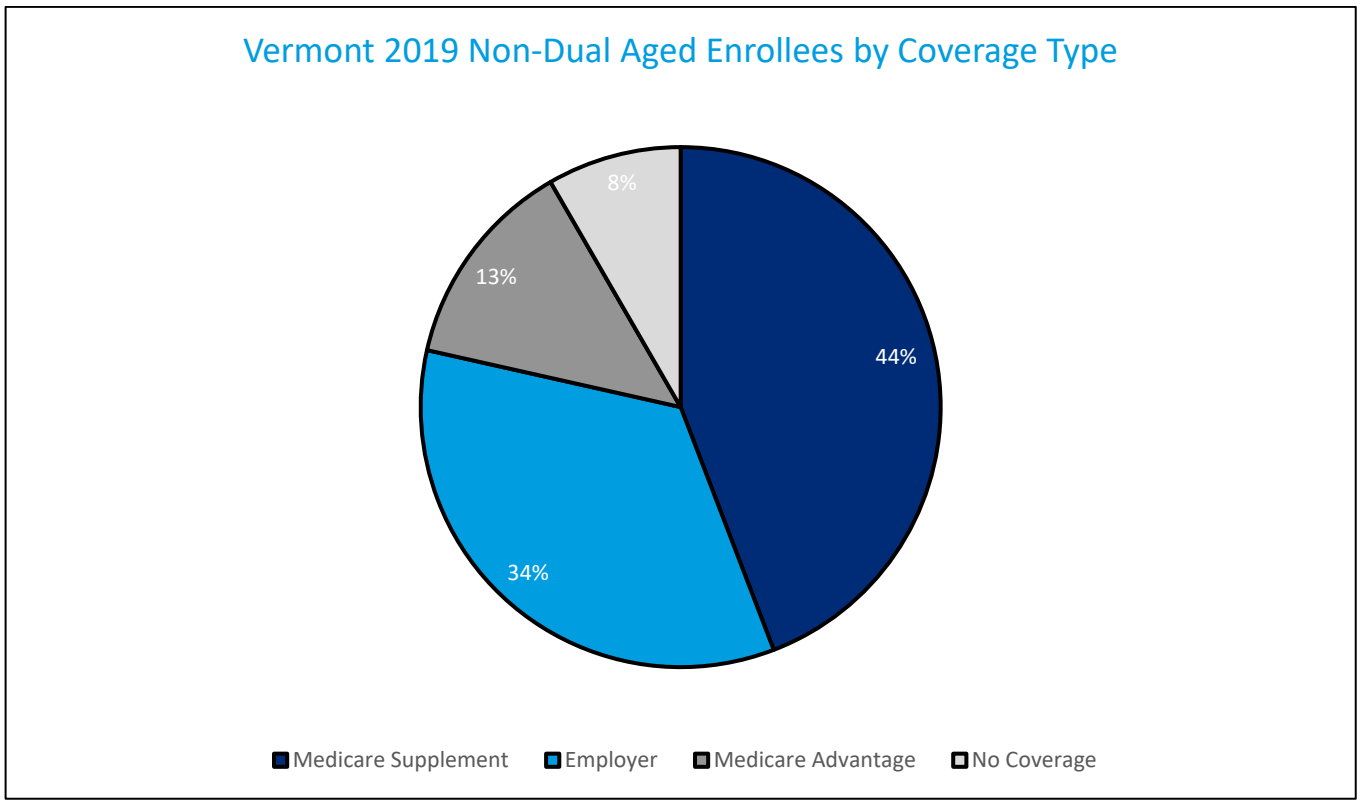
Based on this review, we find that the birthday rule type of open enrollment periods in California, Oregon, Missouri, and Washington, states that implemented a birthday rule sufficiently long ago that we consider the market to be in equilibrium, does not appear to have reduced competition or resulted in significant adverse selection.

3. Medicare Coverage in Vermont

Demographics of the Medicare Covered Population in Vermont

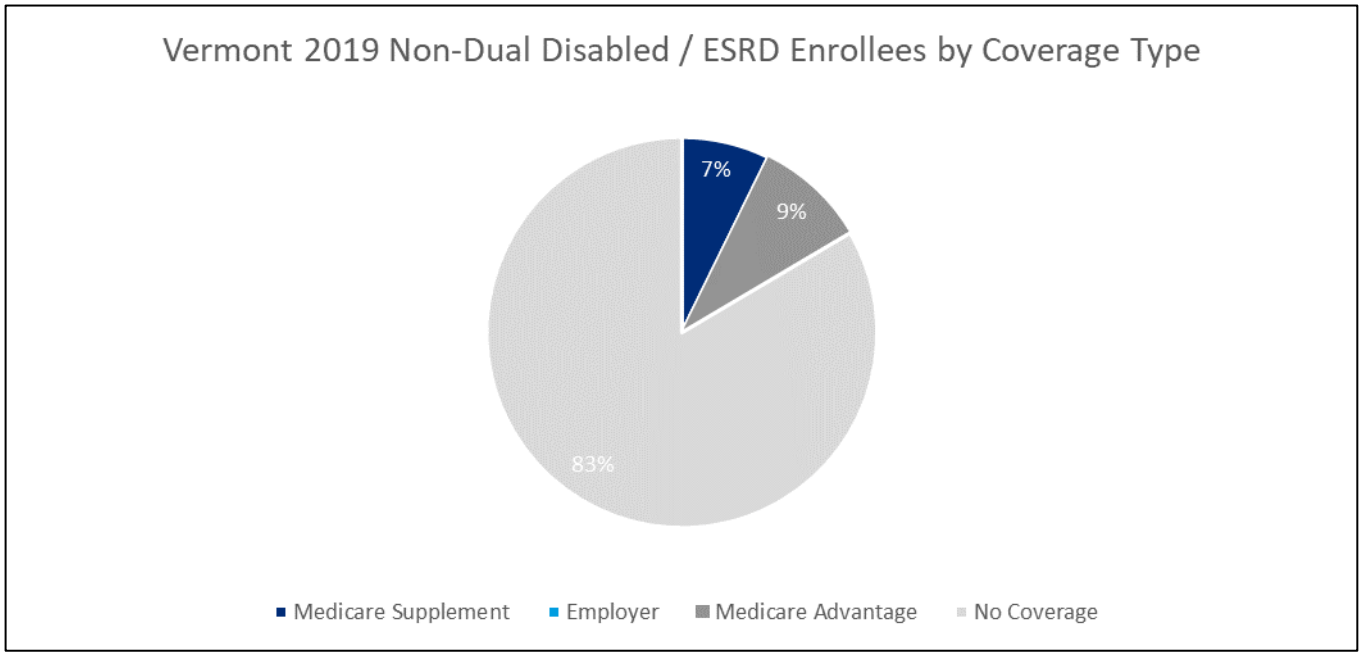
The Medicare market can be split between those who are enrolled in traditional, fee-for-service (FFS) Medicare (Parts A and B), and those enrolled in the MA program (Part C). Those who are enrolled in FFS may be enrolled in an employer sponsored insurance (ESI) plan providing supplemental coverage, may elect to purchase a Medicare supplement policy, may be dually eligible for both Medicare and Medicaid (duals), or may have no coverage. In Figures 3.1 and 3.2, we show the distribution of coverage for the non-dual, Medicare members in Vermont, separately for the aged population and the disabled (below age 65) population. The no coverage cohort represents members who are enrolled in traditional FFS Medicare, without any supplemental coverage through Medicare Advantage, Medicare supplement, or ESI.

Figure 3.1



The aged, non-duals represent about 107,000 people in Vermont, the majority of whom are enrolled in some type of supplemental coverage, primarily Medicare supplement and ESI coverage. We note that the MA market has been growing rapidly, as we show and discuss below.

Figure 3.2



For Vermont's roughly 9,900 non-dual, disabled/ESRD Medicare enrollees, significantly more people are in the no coverage group, with about 83%, or roughly 8,300, having no additional coverage beyond traditional Medicare.

Figure 3.3, displays the distribution of non-dual Medicare enrollees by reason for eligibility, split between FFS, Medicare Advantage, and in total (combined FFS and MA). The FFS and MA markets have similar distributions, however we see fewer disabled enrollees in Medicare Advantage compared to FFS. We note that ESRD did not qualify as a reason for eligibility under the Medicare Advantage program until 2021.

Figure 3.3

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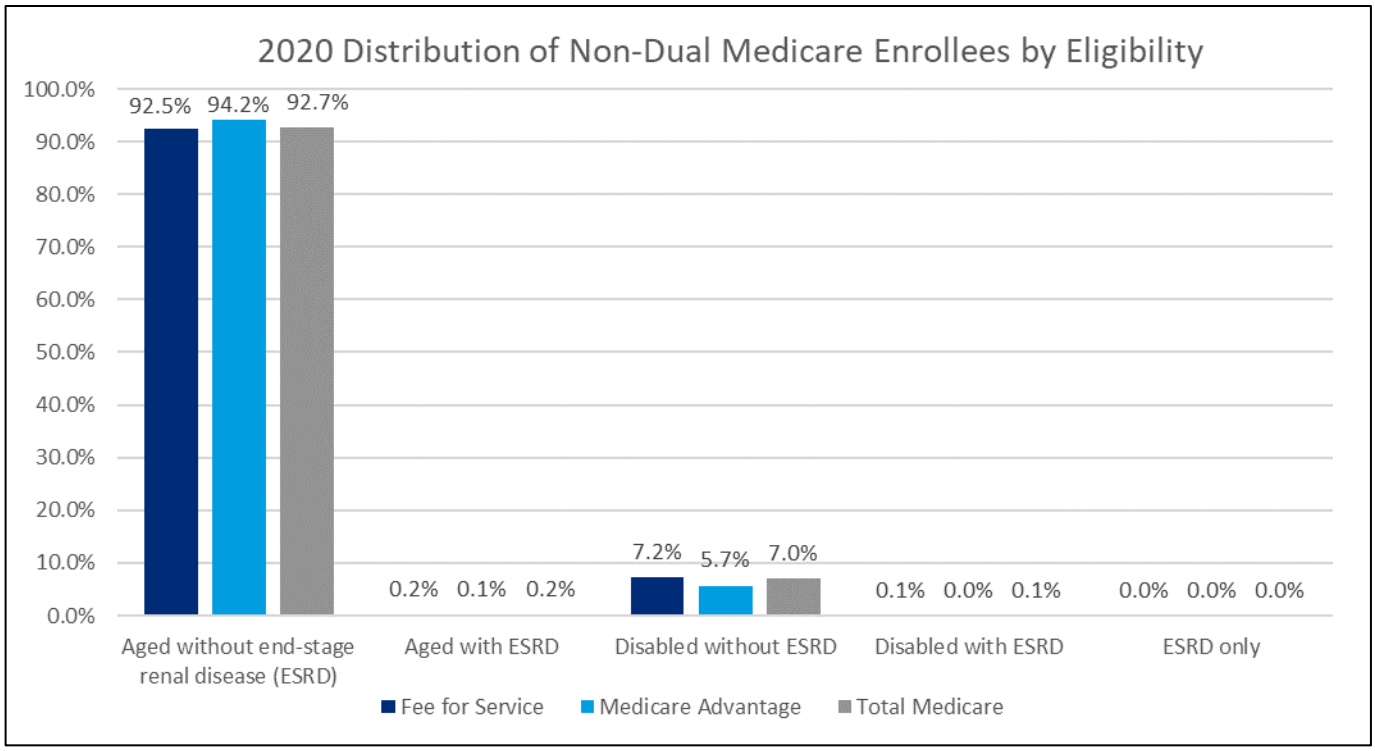
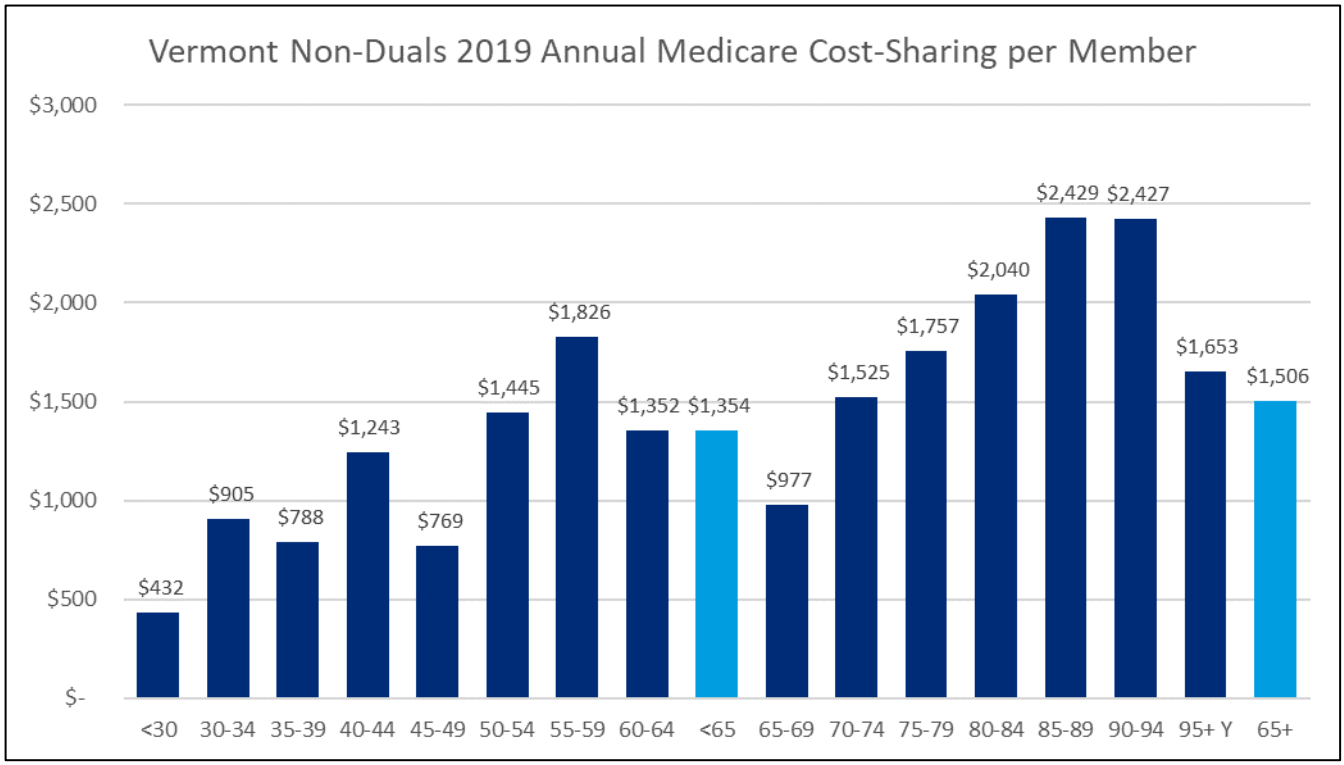


In Figure 3.4, we show the annual Medicare patient cost sharing per member for Vermont non-duals in FFS Medicare grouped into age buckets using data from the 2019 Medicare 5% sample. These are the amounts that the patient is responsible for through the Part B deductible, the Part B coinsurance, and other cost sharing amounts. In general, and as we show in Figure 3.4, the FFS non-dual individuals under age 65 have a lower cost-sharing liability than the over age 65 individuals. Nationwide data (not shown) follows a similar pattern with the cost-sharing liability for the under age 65 population being lower than for the over age 65 population. However, this differs from the Medicare supplement market, where we typically see higher claims and premiums for the disabled population. This is likely an effect of self-selection where the sickest, highest risk disabled members enroll in coverage under a Medicare supplement policy, while the healthier, less costly disabled individuals choose to forego supplemental coverage, likely due to the cost of coverage.

Figure 3.4



The Cost of Medicare Coverage and Access to Care in Vermont

The Cost of Coverage

In Table 3.1, we compare the total annual cost of coverage for an MA plan with prescription drug coverage to the cost of traditional Medicare with both a Part D (drug) plan and a Medicare supplement policy. In the table, premiums for the Medicare supplement and the MA plan are member-weighted average premiums in the Vermont market. Out-of-pocket expenses represent the expected costs a member incurs through deductibles, copays, and coinsurance.[23].

[23] Premiums are based Oliver Wyman calculations using the 2021 CMS Landscape files and the 2021 Medicare Supplement Experience Exhibits. Out of pocket expenses for medical and drug are Oliver Wyman estimates using CMS's 2021 Out of Pocket Cost (OOPC) model and 2021 plan-specific Plan Benefit Package (PBP) data for the MA plan and the Medicare 5% sample for Medicare supplement.

Table 3.1 – Total Annual Cost of Coverage in 2021 – Medicare Supplement with Part D versus MA-PD

Medicare Advantage		**Medicare Supplement**	
Part B Premium	**$1,782**	**Part B Premium**	**$1,782**
Member Premium (Part C and D)	$283	Member Premium (Med Supp)	$2,249
Member Premium (PDP) – Included above	$0	Member Premium (PDP)	$676
Out of Pocket Expenses – Medical	$1,012	Out of Pocket Expenses – Medical	$129
Out of Pocket Expenses – Drug	$1,026	Out of Pocket Expenses – Drug	$1,082
Total Beneficiary Costs	**$4,103**	**Total Beneficiary Costs**	**$5,919**
Total Beneficiary Cost as a Percent of Income at 400% FPL ($51,520) [24]	**7.9%**	**Total Beneficiary Costs as a Percent of Income at 400% FPL ($51,520)**	**11.5%**

Table 3.1 shows that Medicare coverage with a supplemental policy is considerably more expensive than MA coverage and would consume 11.5% of the average covered individual's income at 400% of the federal poverty level. In comparison, MA coverage could be obtained for 7.9% of income at 400% of the federal poverty level. An individual would need an income of $59,200, or 460% of the federal poverty level, for total costs under an average Medicare supplement policy to be less than 10% of household income.

Access to Care

Individuals with a Medicare supplement plan have access to any provider accepting Medicare patients. MA plans can restrict the provider network an enrollee may use to a subset of providers accepting Medicare. To evaluate the breadth of MA networks in Vermont, we reviewed the provider directories of the major MA plans operating in the state. UnitedHealth is the largest issuer of MA coverage in Vermont. Both their PPO and HMO network plans include all hospitals in Vermont except Northeastern Vermont Regional Hospital.[25] The next two

[24] 2021 poverty guidelines: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines

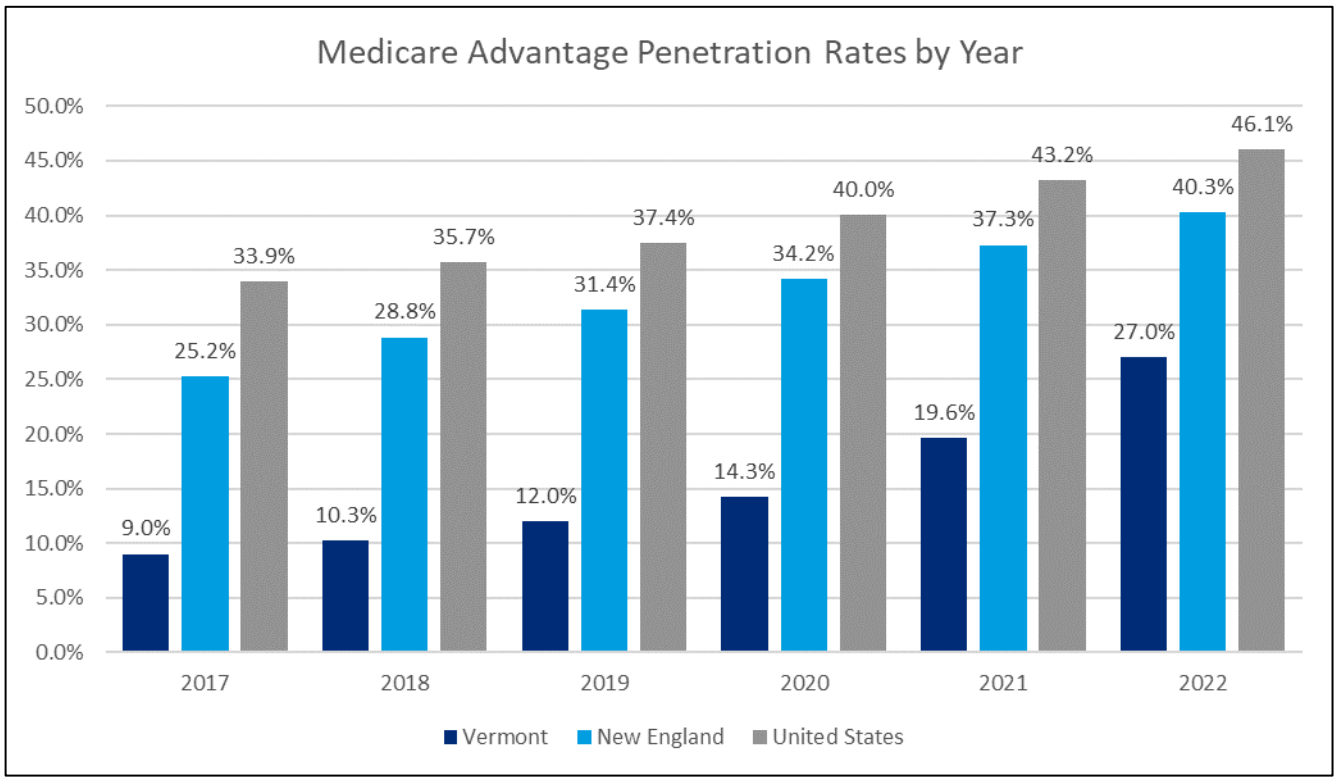
[25] https://connect.werally.com/county-plan-selection/uhc.mnr/zip?clientPortalCode=AARP1&backBtn=false

largest plans, MVP Health Care and VT Blue Advantage, include all hospitals in Vermont as in-network providers.[26,27]

Growth in Medicare Advantage

In Figure 3.5, we show MA penetration rates (MA enrollees divided by total individuals eligible for Medicare) over the last five years in Vermont, the New England states, and nationwide. The MA market is growing rapidly, particulary in Vermont, where the Medicare Advantage penetration rate has tripled over the last 5 years, growing from 9% in 2017 to 27% in 2022.

Figure 3.5



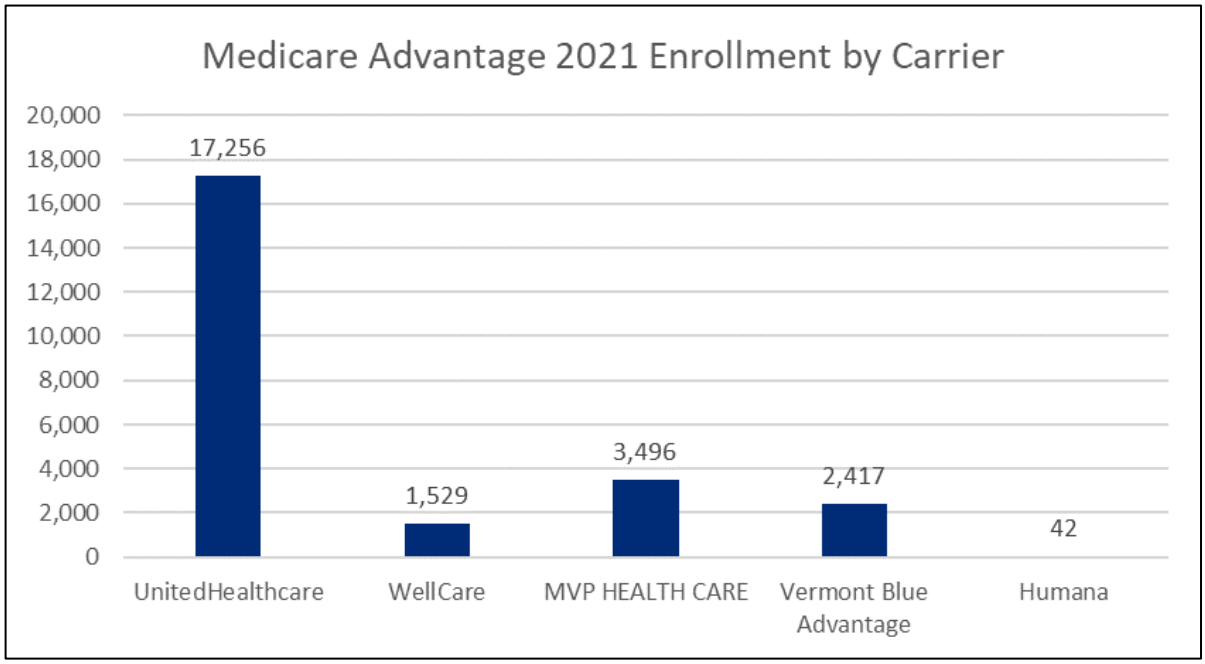
Medicare Advantage Marketplace – Participants and Premiums

The Medicare Advantage market in Vermont has five issuers: UnitedHealthcare, WellCare, MVP Healthcare, Vermont Blue Advantage, and Humana, offering various plans, including HMO and PPO MA-PD plans. Figures 3.6 and 3.7 show enrollment for the MA market participants and premiums the issuers make available, respectively.

[26]MVP: https://mvp.healthsparq.com/healthsparq/public/#/one/insurerCode=MVP_I&brandCode=MVP

[27] VT Blue Adv.: https://vba-providers.bluerelay.com/

Figure 3.6



There was a total of almost 24,750 MA enrollees in Vermont in 2021. Of these, about 17,250 were enrolled with UnitedHealthcare, making up almost 70% of the total MA market. MVP Health Care had the second highest enrollment making up about 14% of the MA market. This market is considered “highly concentrated” with a Herfindahl-Hirschman Index (HHI) of 5,198 points. Markets in which the HHI is greater than 2,500 points are considered highly concentrated.

Figure 3.7

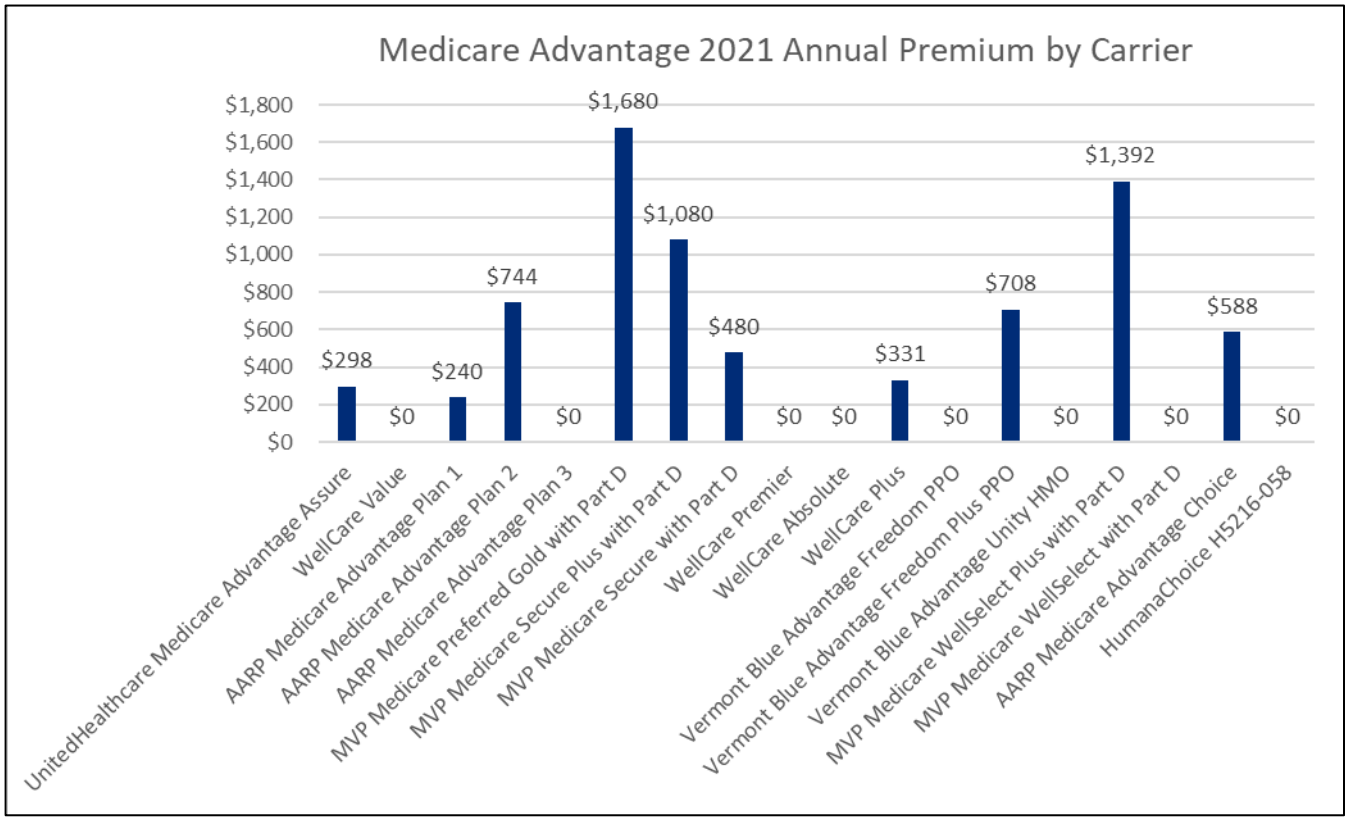


Figure 3.7 shows annual premiums by issuer for plans with enrollment in 2021 (including multiple plans for each issuer). In the MA market, plans with $0 premiums are common and we see eight of the 18 plans available in Vermont in 2021 had a $0 premium. Most of the other plans offer low premiums and likely will move towards $0 premiums to compete in the market. Over 40% of Vermont's MA enrollees are enrolled in a $0 premium plan, with less than 2% of enrollees in a plan with annual premium greater than $1,000. Many MA plans also offer supplemental benefits such as hearing, vision, or dental, included at no additional cost, but subject to the MA plan's network restrictions.

Medicare Supplement Marketplace – Participants and Premiums

Vermont's Medicare Supplement market has 14 issuers with more than 500 lives offering standardized Medicare supplement plans. Figure 3.8 shows enrollment by plan in Vermont's Medicare supplement market in 2021. Plan F has the most enrollment, with about one-third of the total 52,850 covered Medicare supplement lives. Plan F is the plan with the most comprehensive benefits, covering essentially all of a beneficiary's Medicare out-of-pocket costs. However, this plan, along with Plan C, may not be offered to enrollees who became eligible for Medicare on or after January 1, 2020. Of the plans available to newly eligible Medicare members, Plan N and Plan G are now the plans with the most benefits.

Figure 3.8

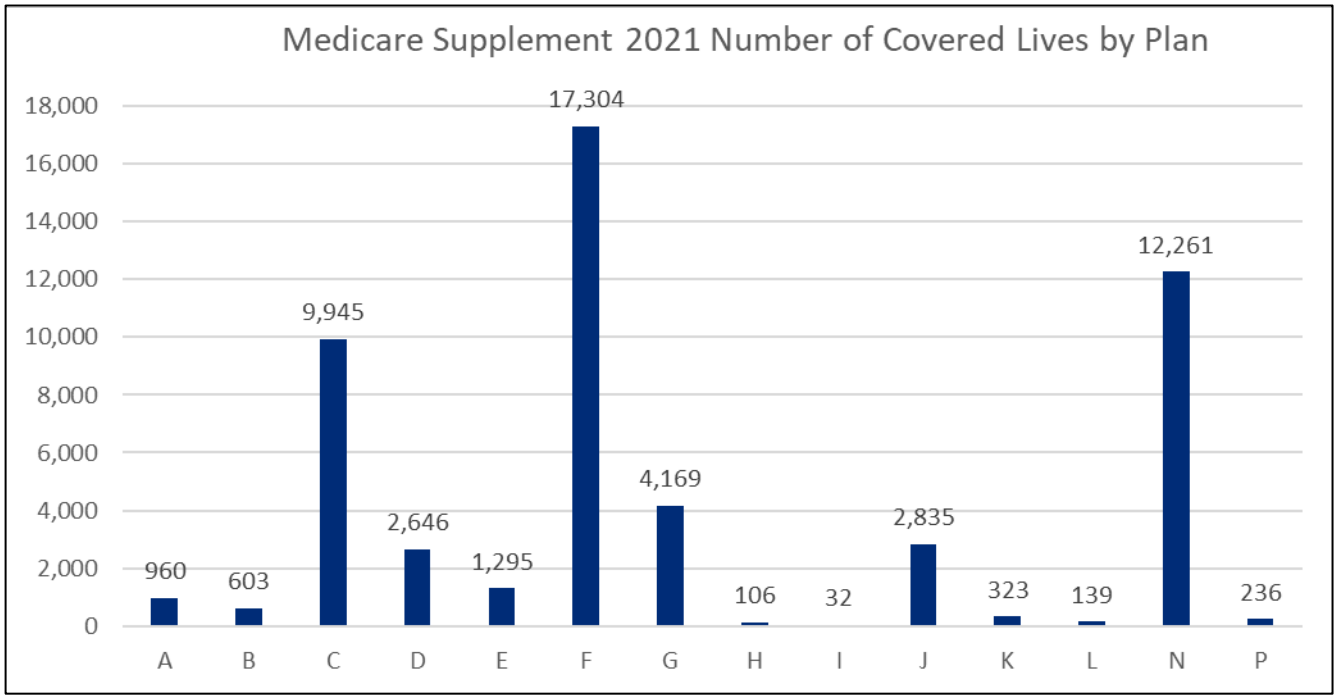


Figure 3.9 shows the annual premium by Medicare supplement Plan in 2021 in Vermont using data from the Medicare Supplement Experience Exhibits. Plans K and L have the lowest annual premiums, while Plan F offers the most coverage. Note that a high deductible option is available at lower premiums for Plan F. When compared to the Medicare Advantage premiums discussed above, where $0 premiums are common, Medicare supplement plan premiums are significantly more expensive.

Figure 3.9

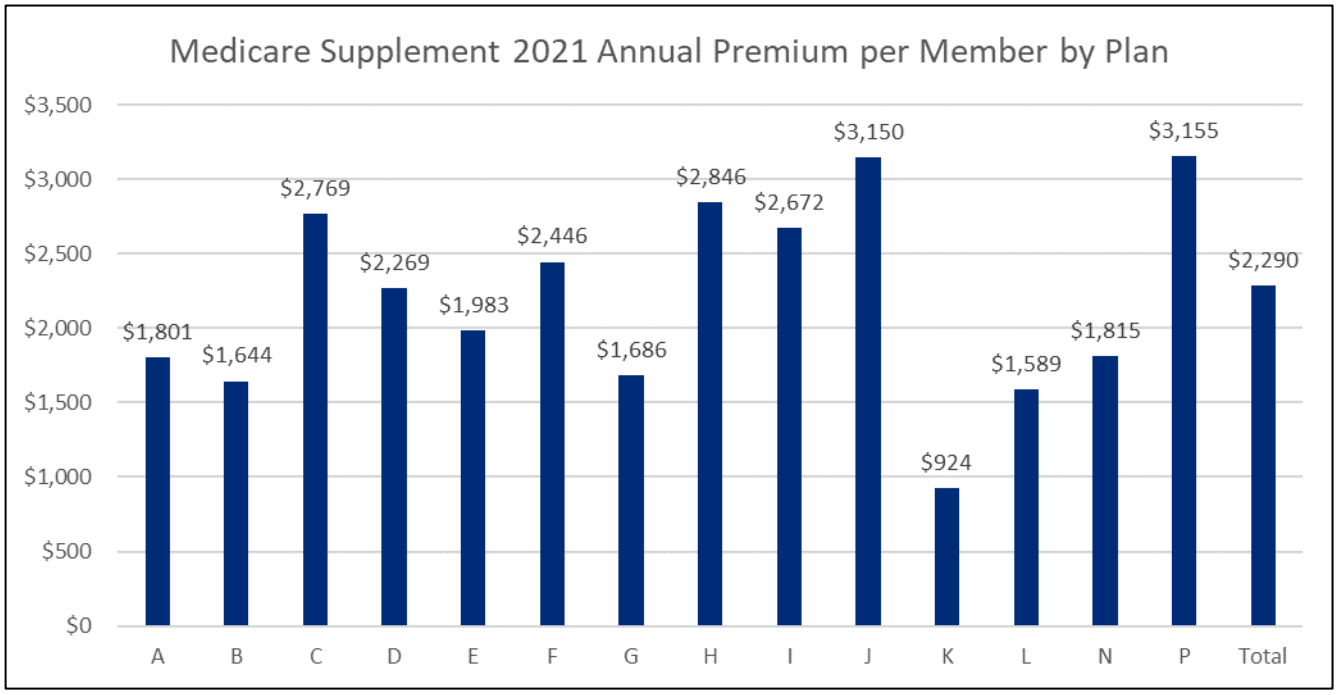
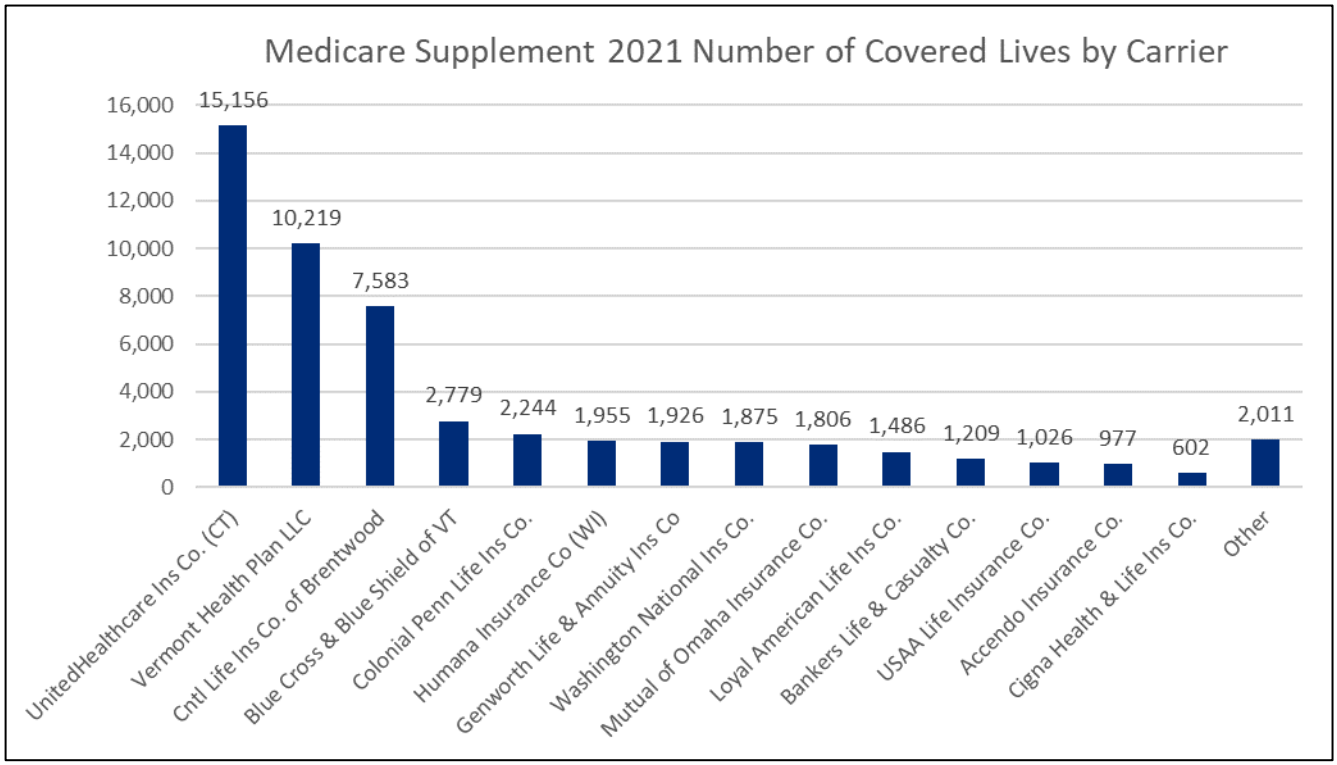


Figure 3.10 shows Medicare Supplement enrollment by issuer. The "Other" group represents carriers with fewer than 500 enrollees (16 carriers in 2021). While we see there are many carriers offering plans, the top three issuers have over 62% of the lives covered under a Medicare supplement policy in Vermont. With an HHI of 1,522, the Medicare supplement market in Vermont is at the low end of what is considered a "moderately concentrated market".

Figure 3.10



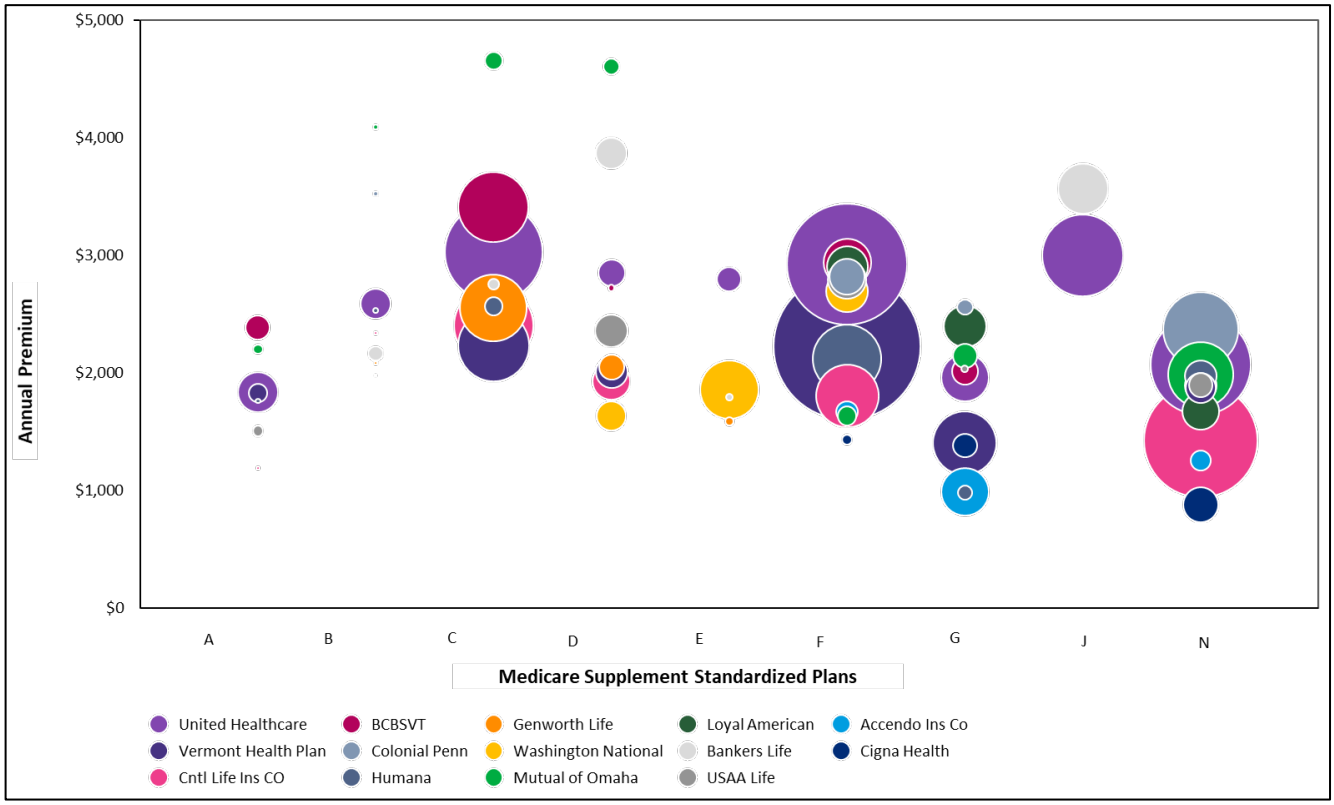
In Figure 3.11, we show 2021 Medicare supplement annual premiums and enrollment by carrier and standardized plan. Each circle represents a carrier's plan. The y-axis is the annual premium, the x-axis the standardized plan, and the size of the bubble represents enrollment. Much of the enrollment is in Plans F, N, and C. These are also the plans with the smallest variance in premiums among the carriers. UnitedHealthcare, Vermont Health Plan, and Continental Life have a significant share of enrollment in the market.

Currently, healthy individuals who can pass underwriting are able to move among Medicare supplement issuers and plans in response to changes in premiums, and they do move. This leaves the less healthy individuals behind, and over time, it is common to see claims and therefore premiums diverge as we show in Figure 3.11.

If Vermont were to implement an annual OEP giving enrollees with existing Medicare supplement coverage the ability to move to another issuer's plans, we would expect to see the range of premiums narrow as issuers try to entice and anticipate the movement of members, and members covered by issuers with higher premiums move to issuers with lower premiums. For example, as we show in Figure 3.11 for Plans C, Mutual of Omaha enrollees are paying roughly $4,700 per year for coverage. Under an OEP, they could move to a Plan C offered by Vermont Health at a cost of roughly $2,200.

Figure 3.11 – Annual Premiums in 2021 for Medicare Supplement Plans by Issuer (Bubble Size ~

Covered Lives)



We expect the process of finding market equilibrium would take some time, and as the process occurs, we believe there could be considerable market disruption. It is possible that an issuer like Mutual of Omaha, for example, with relatively high premiums in the market, will have to drive for higher rate increases as the healthiest individuals it currently covers move to lower-cost issuers and the less healthy remain behind. The number of people affected may be small, Mutual of Omaha insures roughly 1,800 people, but the effect of this migration on premiums to those remaining insured could be sizable.

BCBSVT's Role in the Market

Figure 3.12 shows 2022 annual premiums for the Medicare supplement market for aged enrollees, split between BCBSVT and the other issuers in the market, and then in total for each of the standardized plans that BCBSVT offers. Because BCBSVT is the issuer of last resort, it is subject to adverse selection, and we see higher premiums than the rest of the market for the aged population. BCBSVT sets premiums to reflect the morbidity of the individuals it insures, and the high premiums BCBSVT has in the market reflect adverse selection among the aged population. In addition, unlike the rest of the market, BCBSVT does not vary its premiums based on whether an individual is over or under age 65. Finally, while not a statutory requirement, BCBSVT accepts ESRD individuals who tend to have very high claims. In most of the market, the under age 65 population pays much

higher premiums due to selection than the over age 65 population. BCBSVT is essentially using higher premiums from the aged population to charge lower premiums for the disabled and ESRD populations.

If Vermont allowed an annual OEP, we expect that a large majority of the aged enrollees would leave BCBSVT for other issuers. Aged enrollees with BCBSVT would, over time, move to the market average premium, with premiums roughly 20% to 50% lower, and the aged with other issuers would see premiums increase by 1% to 5%, depending on the plan.

Figure 3.12 – 2022 Annual Premiums for Products Offered by BCBSVT and Rest of Market - Aged

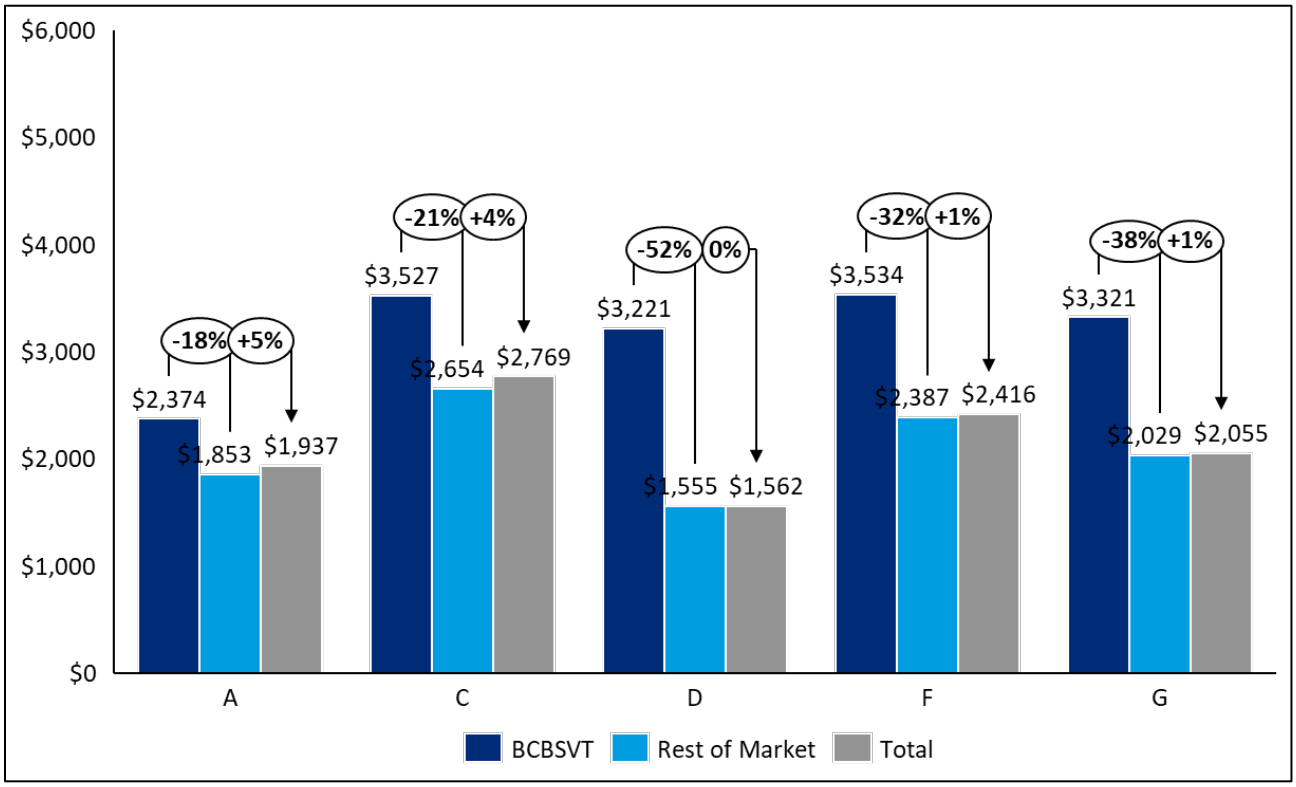
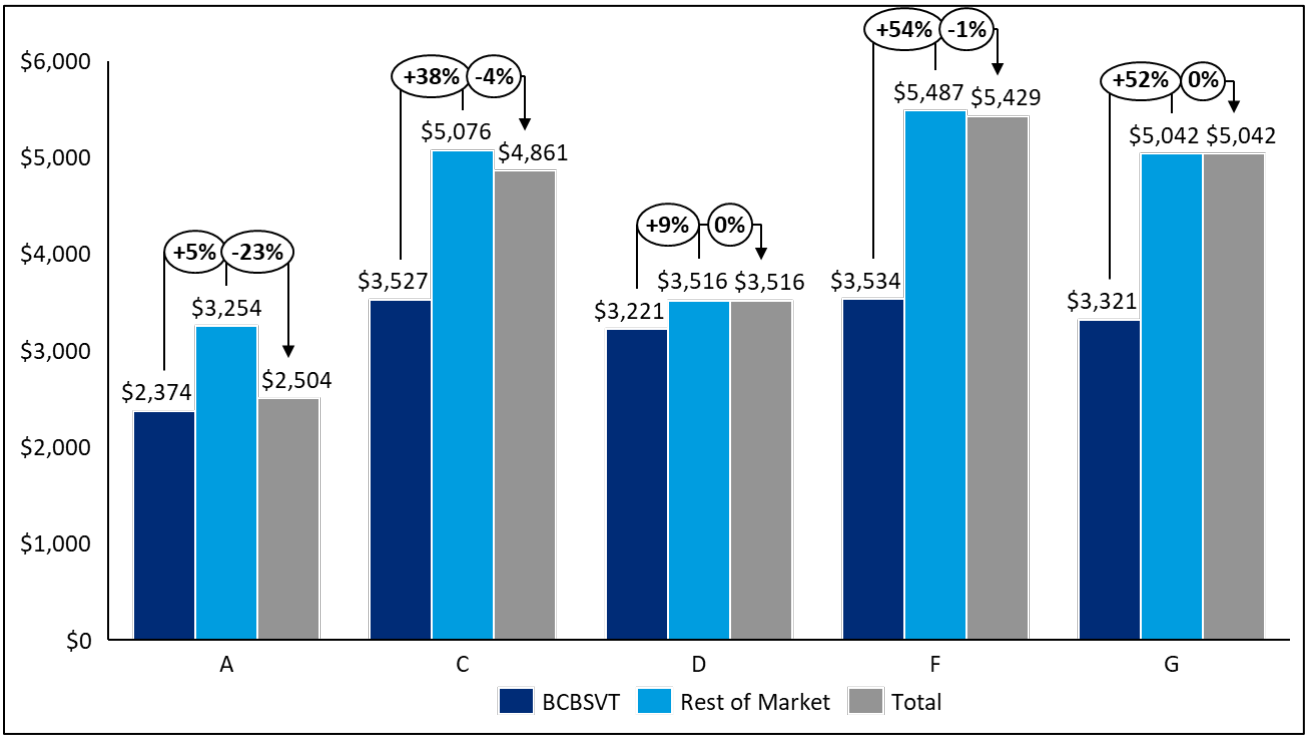


Figure 3.13 shows the disabled/ESRD population premiums. For the disabled/ESRD population, premiums for BCBSVT are lower than the rest of the market due to the subsidies flowing from the aged BCBSVT enrollees to the disabled/ESRD enrollees from community rating across the aged and disabled pools. BCBSVT would be unable to maintain this community rating across pools as the aged would leave for other issuers offering lower premiums, and BCBSVT would have to recognize the higher cost of covering the disabled/ESRD population. We anticipate BCBSVT disabled/ESRD enrollees would see premiums increase by 5% to 54%.

Figure 3.13 – 2022 Annual Premiums for Products Offered by BCBSVT and Rest of Market – Disabled/ESRD



4. Modeling Open Enrollment for those without Coverage

In addition to examining the impact on the market of an OEP for those with existing Medicare supplement coverage, we have modeled the impact of allowing those without existing Medicare supplement coverage guaranteed access to such coverage. Specifically, we used data from 2019 Medicare supplement rate filings in Vermont, the 2019 Medicare 5% sample for Vermont, and the NAIC's Medicare Supplement Experience Exhibits for 2019. Using these sources, we developed estimates of the number of aged and disabled/ESRD enrollees with Medicare supplement coverage and those without coverage.

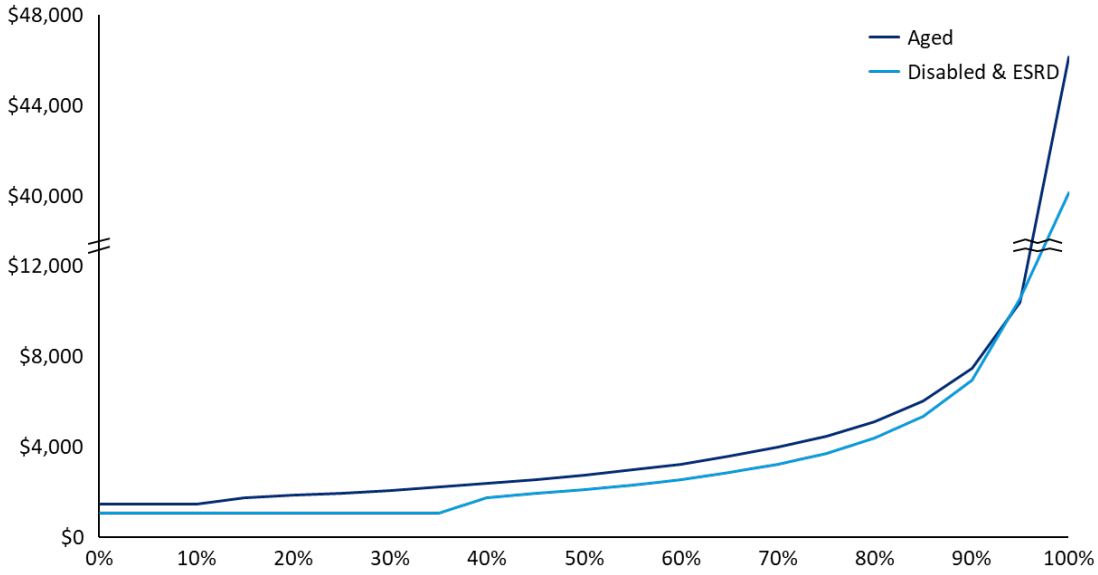
In Table 4.1, we show these estimates. We estimate that in 2019, 47,987 have Medicare supplement coverage and of those, 721 are non-dual, non-aged, and eligible for Medicare through ESRD or disability. We estimate that average Medicare supplement claims per month across both populations is $1,764. We showed in Figure 3.4 that claims for the disabled/ESRD population are lower, on average, than claims for aged individuals. However, very few of the disabled/ESRD population enroll in coverage, presumably due to the cost high of coverage and limited incomes, and those that do enroll in a Medicare supplement plan have much higher claims than those who do not enroll. We estimate that those disabled/ESRD individuals who do enroll in coverage have average claims of $3,992 per year, compared to $1,111 for those who do not enroll. In Table 4.1 we increase the estimated claims of those without coverage by a factor of 1.15 to recognize the additional utilization expected when the cost of care is covered through a Medicare supplement policy and not paid out-of-pocket. This yields an estimate of Medicare supplement claims of $1,278 PMPM for the disabled/ESRD population currently without coverage.

Table 4.1
Make-up of the Vermont Medicare Supplement Market by Coverage -- 2019

	Aged	Disabled/ESRD	Total
Medicare Supplement			
Enrollees	47,266	721	47,987
Claims PMPY	$1,730	$3,992	$1,764
No Coverage	8,928	8,262	17,190
Cost Sharing PMPY	$878	$1,111	$990
Induced Demand	1.15	1.15	1.15
Est. Medicare Supplement Claims PMPY	$1,009	$1,278	$1,138

In addition to making estimates of average claims PMPY for those currently with and without Medicare supplement coverage, we developed estimates of the impact of adverse selection on claims. In Figure 4.1, we show annual patient cost sharing in Vermont for the non-dual, FFS, aged and disabled/ESRD populations. The hundredth percentile in Figure 4.1 represents the claimant in the data with the highest claims. For both the aged and the disabled/ESRD populations, patient cost sharing is heavily skewed with 5% of members representing 35% of claims for the aged population and 50% of claims for the disabled/ESRD population. This skewness opens the market up to significant adverse selection.

Figure 4.1 – Annual Claims by Decile for Medicare Covered Individuals – 2019[28]



We used the distributions in Figure 4.1 to model the market assuming 10% of individuals without coverage enter the market in response to a guaranteed issue, open enrollment period. Using the distributions in Figure 4.1, we estimate that claims for the 10% of the aged population enrolling are 3.01 times the average of the aged who are currently without coverage, and 3.78 times the average for the disabled/ESRD population. We show the result of merging 10% of the individuals without coverage into the existing market in Table 4.2. We show aged premiums would increase by 1% and disabled/ESRD premiums would increase by 11%. Total premiums would increase by 4%. Note that these answers depend heavily on the assumption that 10% of individuals without coverage enroll when provided with the opportunity. Note, too, that we have not considered the potential impact of individuals leaving their MA plans to enter this market. At the same time, these estimates are based on 2019 data and in 2019, MA enrollment in Vermont was modest.

Table 4.2 – Impact on the Market if 10% of Those with No Coverage Enroll -- 2019

	Aged	Disabled /ESRD	Total
Medicare Supplement Enrollees	48,159	1,547	49,706
Est Medicare Supplement Claims PMPY	$1,754	$4,439	$1,838
Change in Medicare Supplement Claims PMPY	1%	11%	4%

[28] Source: Oliver Wyman calculations using the 2019 5% sample for Vermont enrollees

5. Findings

Vermont is studying a broader OEP for Medicare beneficiaries who are already enrolled in a Medicare supplement plan. Generally, in most states, an OEP does not materially change the make-up of the overall market. Those currently insured can move among issuers looking for lower cost coverage, but no new individuals gain access to the market. However, with BCBSVT serving as the issuer of last resort in the state, BCBSVT could become a "back-door" to guaranteed issue coverage at a community rate. A given individual who failed to enroll in a Medicare supplement plan when first eligible and who otherwise could not gain access to Medicare supplement coverage due to pre-existing conditions, could take advantage of BCBSVT's role as issuer of last resort to gain access to the market and then move to another issuer during the OEP. This would allow an insured to use the open enrollment period to avoid higher premiums BCBSVT needs to charge as the insurer of last resort and pass that burden on to other issuers operating in the market and the individuals they insure.

We expect the long-term impact of allowing an open enrollment period will be rate compression, where the range of issuers' rates for a given plan narrows over time.

Further, we expect the largest issuers to be able to deliver services with the lowest administrative expenses and therefore offer the lowest prices and attract the most members. However, our review of market concentration in the states that have had open enrollment periods in place for several years shows only California with a highly concentrated market. Washington's market is moderately concentrated, and the other markets we examined fall below moderately concentrated.

More movement among Medicare supplement insureds may have cost implications for issuers, as more movement may make it difficult for issuers to recoup higher initial year costs. Issuers may need to lower broker compensation schedules or increase premiums to compensate for the administrative costs associated with this additional movement.

Specific to Vermont, OEPs and BCBSVT's current practice of not varying premiums between its aged and disabled/ESRD populations could result in a marked increase in the premiums for disabled individuals currently insured by BCBSVT and a marked decrease in the rates paid by the aged insureds with BCBSVT.

Based on our review of available data related to states that have implemented a birthday rule, we did not find evidence that an open enrollment period would increase market wide costs market wide in a meaningful way, nor would it significantly reduce competition or choice. However, we note there are only a few data points available on which to base this conclusion. It is possible that the small increase in premiums that most consumers would experience if BCBSVT enrollees moved to other issuers would result in a further increase Medicare Advantage penetration which would, in turn, lead to additional adverse selection and higher costs in the Medicare supplement market.

Finally, our modeling an open enrollment period that allows individuals without current coverage to enter the market shows an increase of 1% for the aged population and 11% for the disabled/ESRD population, assuming 10% of those without coverage choose to enter the market.

6. Data

The analyses and findings we developed in this report are based on several data sources.

The Medicare Supplement Experience Exhibits (MSEEs) from the NAIC Life, Health, and P&C Blanks for calendar years 2019 to 2021 were used to show how the Medicare Supplement market looks historically in Vermont and surrounding states. The MSEEs report covered lives, earned premium, and incurred claims at a plan level for each carrier in the state.

The MA market overview in Vermont was based on the CMS Landscape files, the Medicare Advantage penetration reports, and contract-plan-state-county enrollment files, which are publicly available through CMS.

We used the Medicare FFS Limited Data Set to evaluate the demographics and claims costs for the Medicare-eligible population. The beneficiary-level file from the 2020 Medicare FFS 100% Sample Limited Data Set includes a record for every Medicare-eligible person in Vermont. This data was used to determine how the population is distributed across age, gender, coverage type, and eligibility reason. The 100% Sample does not include complete claims data for all members. Additionally, the 2020 claims data is not representative of the population in a normal year due the COVID-19 Public Health Emergency that began in 2020. Therefore, we also utilized the 2019 Medicare FFS 5% Sample Limited Data Set. This data set was utilized to evaluate overall claims costs and the member's liability across several categories, including age, gender, coverage type, and eligibility reason.

The 2019 American Community Survey (ACS) data was utilized to estimate the proportion of Medicare-eligible members that have supplemental coverage through an employer-sponsored insurance plan (ESI).

Additionally, we relied on the 2022 rate filings for the Medicare Supplement carriers in Vermont. The carriers report the final premium rates by benefit plan and eligibility group and historical enrollment and claims experience by eligibility group.

7. Qualifications and Considerations

Qualifications – I, Kurt Giesa, am a Partner in the firm of Oliver Wyman Actuarial Consulting, Inc., and am responsible for this work. I am member of the American Academy of Actuaries and a fellow of the Society of Actuaries. I meet the American Academy of Actuaries' qualification standards for performing this work. This work has been performed in conformance with the applicable Actuarial Standards of Practice (ASOPs) promulgated by the that body, specifically ASOP No. 41, Actuarial Communications and ASOP No. 23, Data Quality.

Usage and Responsibility of Client – Oliver Wyman prepared this report for the sole use of the Vermont Department of Financial Regulation for the stated purpose. Oliver Wyman's consent to any distribution of this report to parties other than the client named herein does not constitute advice by Oliver Wyman to any such third parties. Any distribution to third parties shall be solely for informational purposes and, in the case of regulators and officers of the State who are formally participating in the regulatory process, for purposes of fulfilling related regulatory, administrative, and official functions. Oliver Wyman assumes no liability related to third party use of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein. This report should not replace the due diligence on behalf of any such third party.

Data Verification – For our analysis, we relied on publicly available data and information without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. Our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions might therefore be unreliable.

Unanticipated Changes – We based our conclusions on the estimation of the outcome of many contingent events. We developed our estimates from historical experience, with adjustments for anticipated changes. Unless otherwise stated, our estimates make no provision for the emergence of new types of risks not sufficiently represented in the historical data on which we relied or which are not yet quantifiable.

Internal / External Changes – The sources of uncertainty affecting our estimates are numerous and include factors internal and external to the client named herein. Internal factors include items such as changes in the legal, social, or regulatory environment, and the potential for emerging diseases. Uncontrollable factors such as general economic conditions also contribute to the variability.

Uncertainty Inherent in Actuarial Work – While this analysis complies with applicable ASOPs, users of this analysis should recognize that our work involves estimates of future events that are subject to economic and statistical variations from expected values. We have not anticipated any extraordinary changes to the regulatory, legal, social, or economic environment or the emergence of new diseases or catastrophes that might affect our results. For these reasons, we provide no assurance that the emergence of actual experience will correspond to the projections in this analysis.

Appendix A. Legislative Text of S.239

(S.239)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4080e is amended to read:

§ 4080e. MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES; COMMUNITY RATING; DISABILITY

* * *

(d) The Department of Financial Regulation shall collaborate with health insurers, advocates for older Vermonters and for other Medicare-eligible adults, and the Office of the Health Care Advocate to educate the public about the benefits and limitations of Medicare supplemental insurance policies and Medicare Advantage plans, including information to help the public understand issues relating to coverage, costs, and provider networks.

Sec. 2. MEDICARE SUPPLEMENTAL COVERAGE; MEDICARE ADVANTAGE PLANS; DEPARTMENT OF FINANCIAL REGULATION; REPORT

(a) The Department of Financial Regulation shall convene a group of interested stakeholders, including Vermonters eligible for Medicare by reason of age, disability status, or end stage renal disease and representatives of health care providers, the Community of Vermont Elders, the area agencies on aging, the Office of the Health Care Advocate, and the Department of Vermont Health Access, to consider issues relating to Medicare Advantage plans and to the availability of, enrollment in, and use of supplemental coverage by individuals enrolled in Medicare. A majority of the stakeholders shall not have a financial stake in any Medicare supplemental coverage or Medicare Advantage product.

(b) The stakeholder group shall examine:

(1) the options available to older Vermonters, Vermonters under 65 years of age with end stage renal disease, and Vermonters under 65 years of age whose disabilities make them eligible for Medicare, through Medicare supplement and Medicare Advantage plans, the affordability of these options, and the extent to which the State may regulate or otherwise affect the options offered to Medicare beneficiaries in Vermont, including the marketing and advertising of these products;

(2) the effects of annual or continuous open enrollment periods for Medicare supplemental coverage available in other states, including whether they have led to adverse selection or higher rate increases, or both; other options for enabling Vermont residents to enroll in Medicare supplemental coverage after their initial open enrollment period ends without experiencing higher premiums or financial penalties; and the extent to which an open enrollment change for Medicare supplemental coverage would be likely to increase access to affordable coverage for eligible individuals and to reduce medical debt;

(3) whether Vermont residents are receiving accurate information about Medicare supplemental coverage and Medicare Advantage plan options and sufficient assistance with selecting products that are in their best interests and, if not, how to best remedy the situation;

(4) the costs of Medicare Part B premiums, Medicare Part D plans, Medicare supplement plans, and Medicare Advantage plans; the effect of those costs on access to health care for Vermonters with low income who are not eligible for Medicaid or for a Medicare Savings Program; the income eligibility thresholds for Medicare Savings Programs in Vermont and in other states; and whether Vermont should consider revising the income eligibility thresholds for its Medicare Savings Programs;

(5) the reasons that some Medicare beneficiaries do not have secondary coverage and the policy options available to increase their access; and

(6) any other issues that the Department deems appropriate relating to the availability of, enrollment in, and use of supplemental coverage by individuals enrolled in Medicare or in a Medicare Advantage plan.

(c) On or before January 15, 2023, the Department of Financial Regulation shall provide its findings and recommendations regarding Medicare supplemental coverage and Medicare Advantage plans, including any recommendations for changes to Vermont law, to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

Sec. 3. EFFECTIVE DATE

This act shall take effect on passage.

Date Governor signed bill: April 27, 2022

Appendix B

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare First Eligible before 2020	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ Copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [2019][2]					[$5560][2]	[$2780][2]				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [$2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Appendix C

Medicare Survey Review

October 27, 2022

Survey Overview

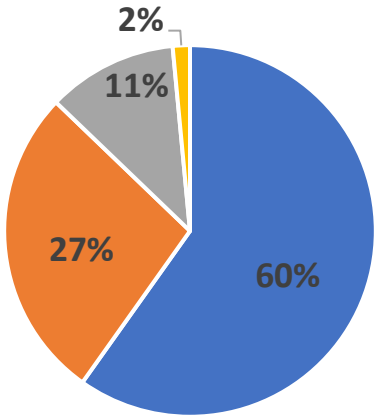
- VT DFR conducted a survey of Medicare eligible consumers in July / August 2022
- Goal of survey – Gain insight into consumer experience on Medicare Supplement or Medicare Advantage plans
- 468 responses were received including digital and paper responses

Presentation Overview

- Review of Survey Respondents
- Medicare Supplement Specific Questions
  - Insurer, Plan, Monthly Premium, Other Detailed Questions
- Medicare Advantage Specific Questions
  - Insurer , Advertising, Other Detailed Questions
- Original Medicare Specific Questions
- Coverage Length Comparison
- Open Ended Feedback

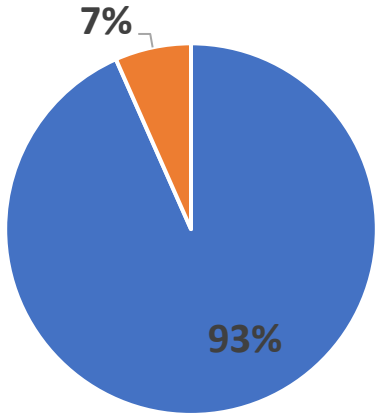
Survey Respondents by Medicare Coverage

Q. Do you have health insurance in addition to Medicare?



Legend	Medicare Coverage	Respondent Count
	Medicare Supplement	280
	Medicare Advantage	128
	Original Medicare	53
	Unknown	7

Q. Are you currently enrolled in Medicare?
(I am over 65 and on Medicare / I am under 65 and on Medicare due to disability



Legend	Age	Respondent Count
	Over 65	437
	Under 65	31

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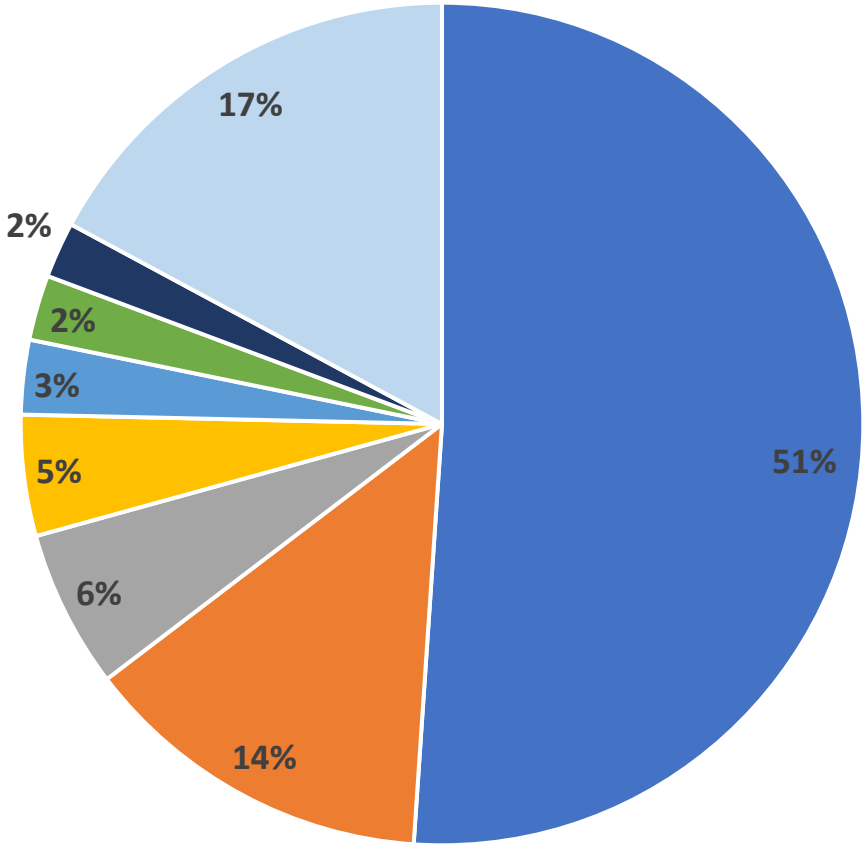
Medicare Supplement (n=280)*

* n= represents the number of survey respondents for each question

Med Sup– Insurance Company



Legend	Insurance Company	Respondent Count
	BCBSVT	143
	United Healthcare	38
	Aetna	17
	Cigna	13
	Humana	8
	Accendo	7
	USAA	6
	Other*	48

**Includes insurers with < 5 respondents or insurer not provided*

Q. Which insurance company did you purchase your plan from?

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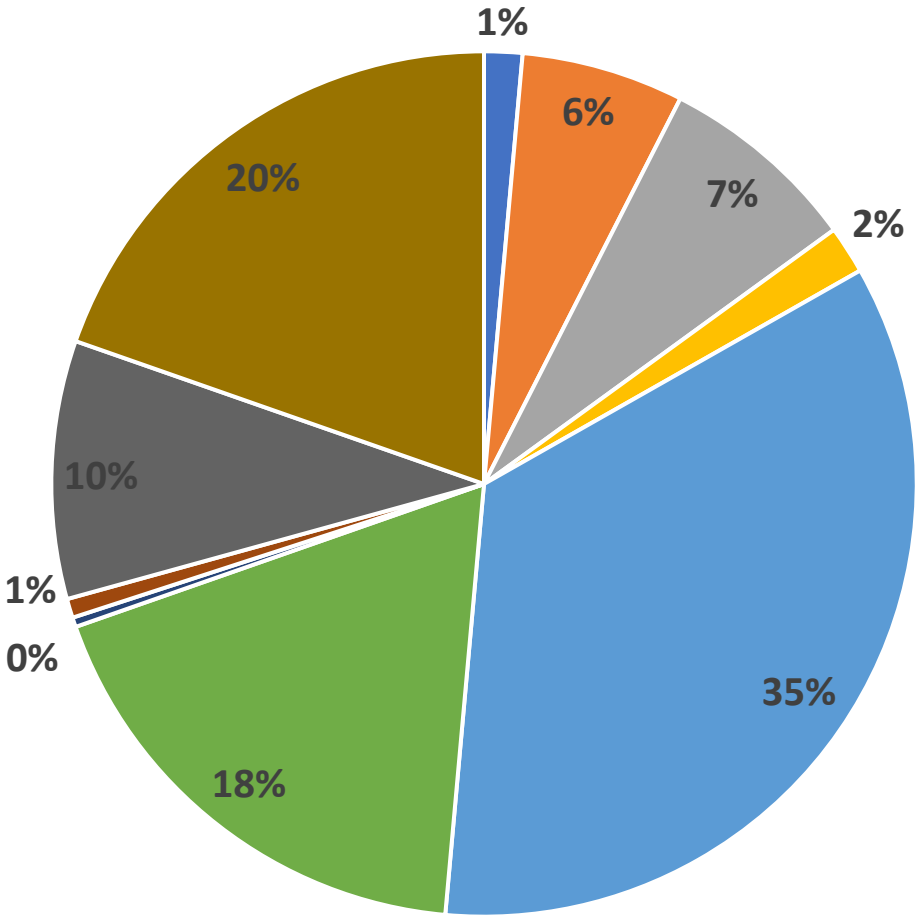
Med Sup – Plan



Legend	Plan	Respondent Count
	Plan A	4
	Plan B	17
	Plan C	21
	Plan D	5
	Plan F	97
	Plan G	51
	Plan J	1
	Plan K	2
	Plan N	27
	Unknown*	55

**Includes 52 respondents who responded, "I don't know" and 3 who did not provide a response*

Q. Which Medicare Supplement ("Medigap") plan do you have?

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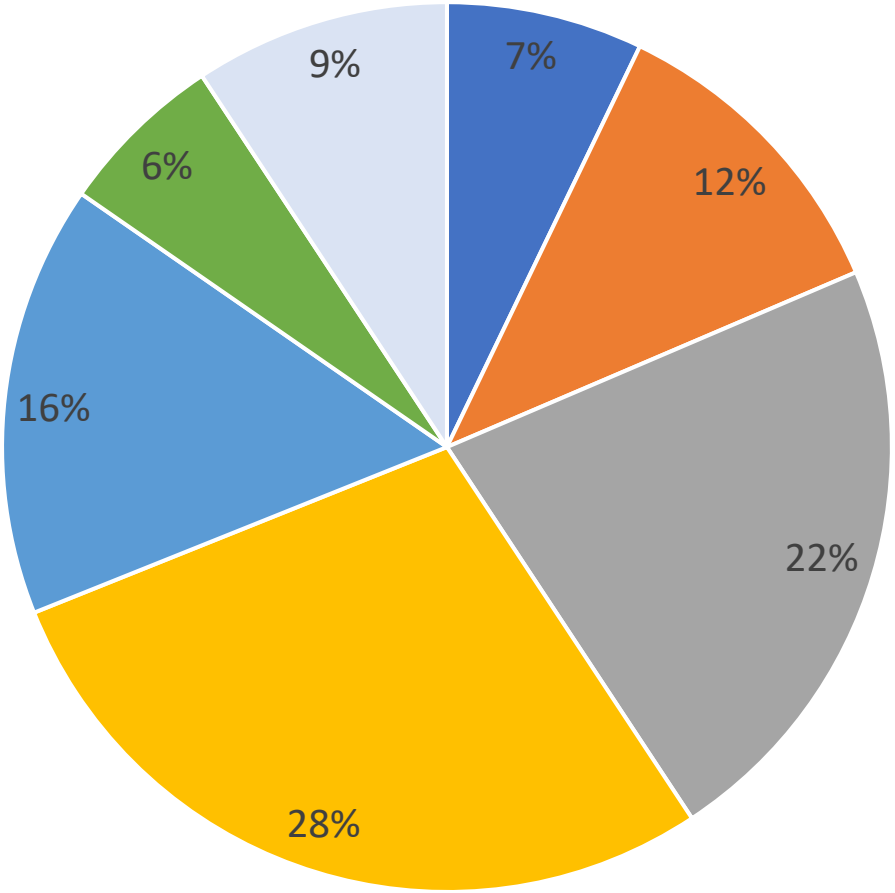
Med Sup – Monthly Premium



Legend	Premium Band	Respondent Count
	<$100	20
	$100-$150	32
	$150-$175	62
	$175-$200	79
	$200-$300	44
	$300+	17
	Unknown*	26

**Includes respondents who responded with a combined premium with spouse/partner or did not know*

Q. About how much do you pay per month for this insurance coverage?

Med Sup–Other Detail*

Did you enroll during initial enrollment period? (n = 280)

Have you needed significant health care while on Medicare? (n = 279)

Would you enroll in a different plan if you had an annual enrollment period that allowed you to switch plans? (n = 271)

Are you satisfied with your coverage? (n = 278)

* Percentages exclude those who did not provide a response

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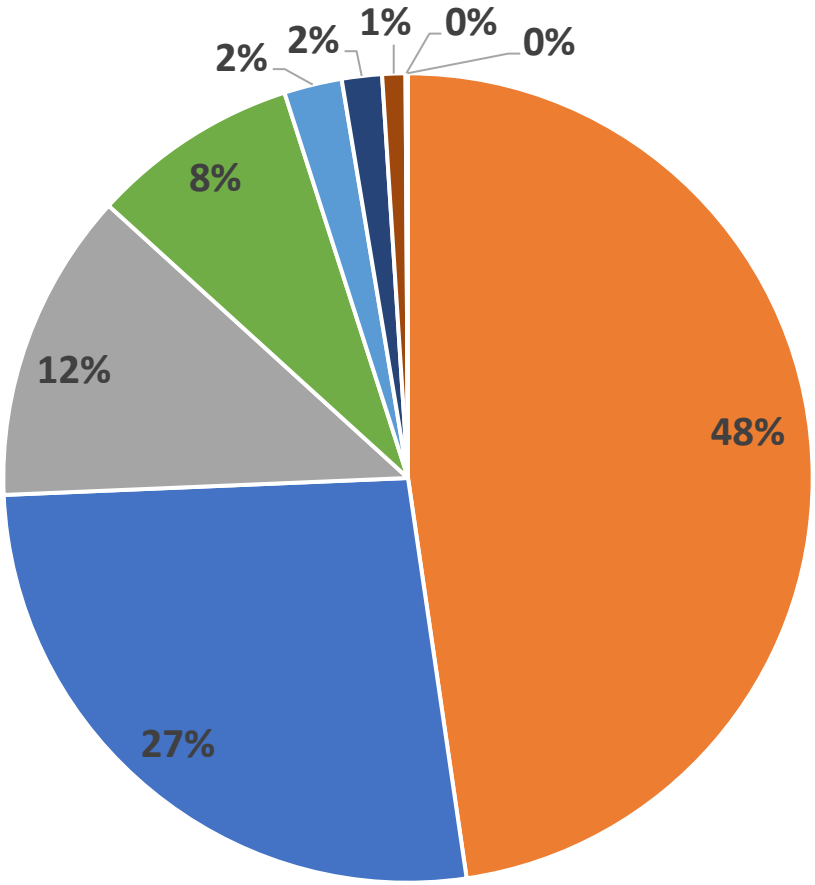
Medicare Advantage (n=128)

Med Adv– Actual Part C Enrollment

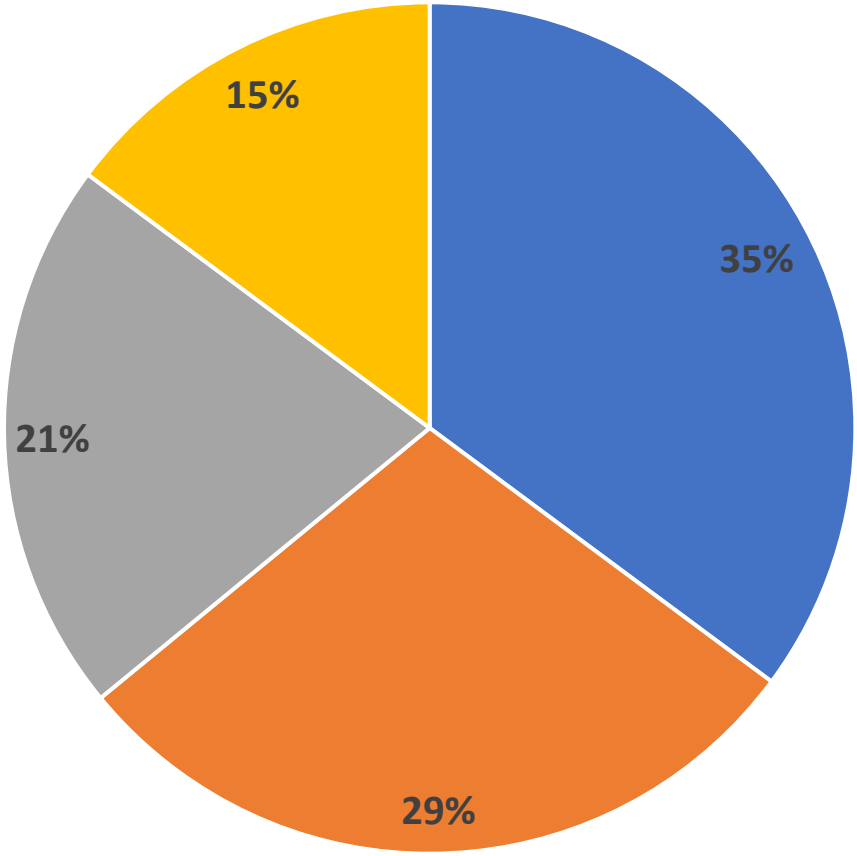
(as of Sep 2022)



Legend	Insurance Company	Monthly Enrollment
	United Healthcare	20,107
	BCBSVT	11,237
	MVP	5,235
	Wellcare	3,506
	Aetna	975
	Cigna	676
	Humana	390
	Highmark	27
	Anthem	14
	Total	42,167

Source: CMS Monthly Reporting by Plan https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County

Med Adv– Insurance Company

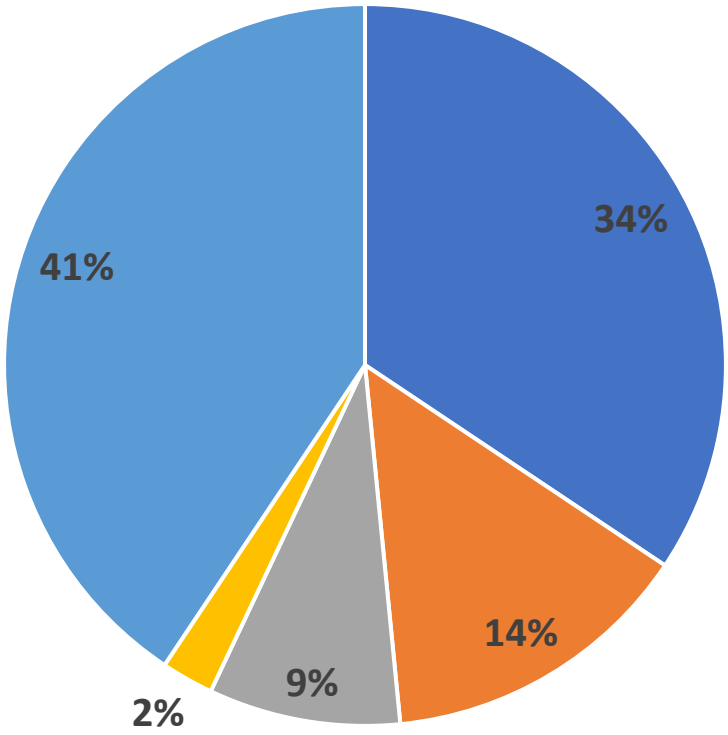


Legend	Insurance Company	Respondent Count
	BCBSVT	45
	United Healthcare	37
	MVP	27
	Other*	19

**Includes insurers with < 5 respondents or insurer not provided*

Q. Which insurance company did you purchase from?

Med Adv– Advertising



Legend	Advertising	Respondent Count
	Mail Advertisement	44
	Phone call	18
	TV Advertising	11
	Approached at Home	3
	Not Provided	52

Q. Which kinds of advertising impacted your choice?

Med Adv–Other Detail*

Was the plan sold by an insurance broker? (n = 127)

Did advertising have an impact on your decision to enroll or switch to a different plan? (n = 115)

Have you ever switched plans after being enrolled for more than a year? (n = 112)

- 37% (11 / 30) switched for better coverage/benefits
- 11% (4 / 30) switched to a lower price plan
- 11% (4 / 30) switched because former employer changing plan
- 11% (3 / 30) switched due to relocation/provider not covered

* Percentages exclude those who did not provide a response

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Med Adv–Other Detail*

Have you had issues finding providers to accept your plan? (n = 123)

- 30% (7 / 23) of people with issues tried to resolve this

Does your plan cover dental or hearing aids? (n = 121)

- 76% (55 / 72) of people have accessed these benefits

Has coverage for a provider out of network been denied? (n = 117)

Are you satisfied with your coverage? (n = 124)

* Percentages exclude those who did not provide a response

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Original Medicare (n=53)

Original Medicare–Other Detail*

Did you consider a Medicare Supplement plan during initial enrollment? (n = 53)

Have you needed significant health care while on Medicare? (n = 53)

Have you had difficulty paying for care? (n = 51)

* Percentages exclude those who did not provide a response

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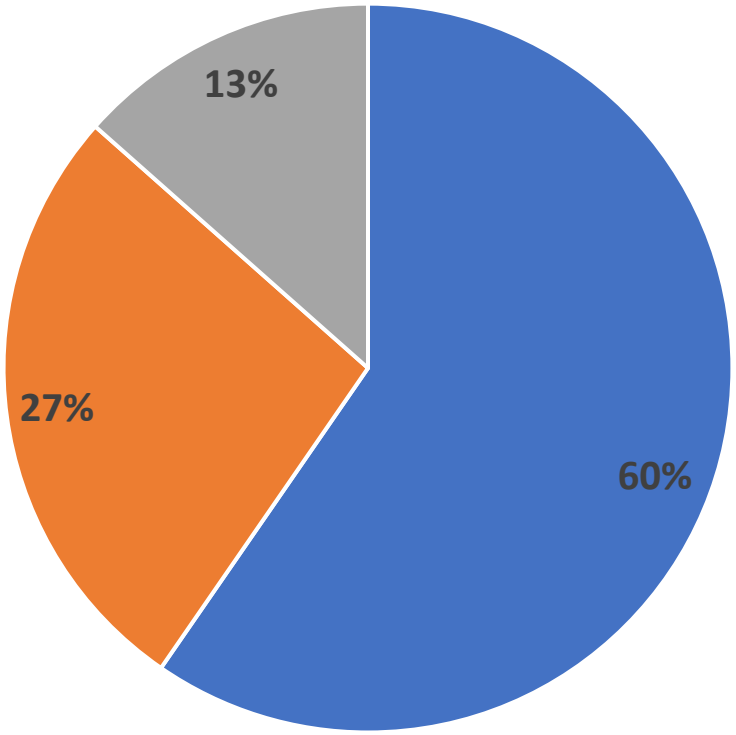
Original Medicare – Supplement Coverage

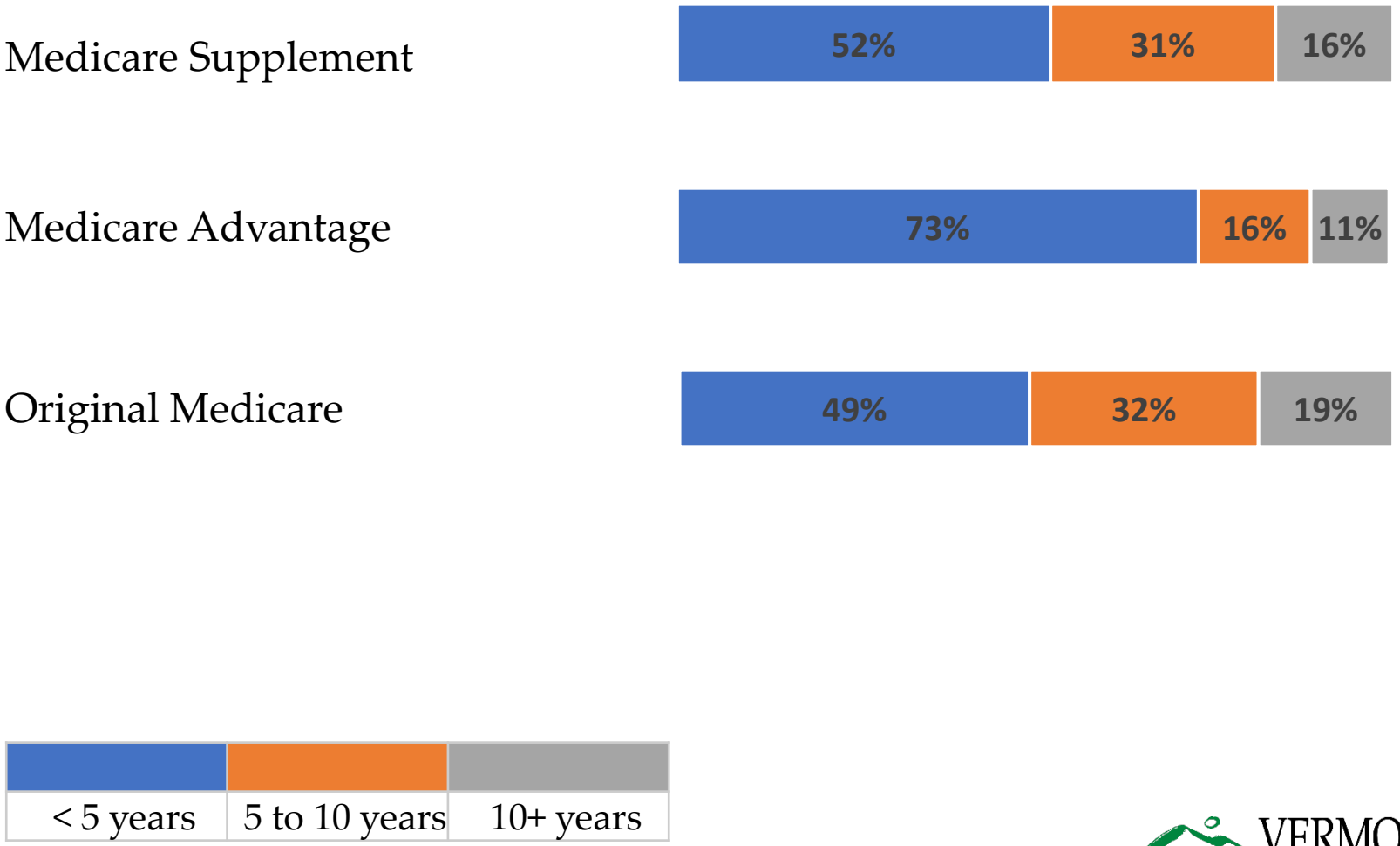


Legend	Switched	Respondent Count
	Could not afford the premiums	31
	Did not think I needed this product	14
	Was confused by the choices	7

Q. Why did you decide not to enroll (in a Med Sup plan when you first became eligible)?

Coverage Length Comparison

How long have you had this insurance coverage?



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Open Ended Feedback

Open Ended Question - Summary

- 304 respondents provided feedback to an open-ended question
- Major themes:
  - Desire for expanded benefit coverage (primarily dental, vision, hearing, acupuncture and the Shingles vaccine)
  - Concerns about affordability now and in the future
  - Concerns about value (i.e., premiums not appropriate given the benefit coverage)
  - Desire for additional open enrollment periods
  - Confusion about different types of coverage, feeling misled by advertising, and struggling with a complicated system
  - Concerns about limited provider access

Q. Is there anything else you would like to tell us about your experience on Medicare?

Open Ended Question – Med Sup / Med Adv

- Medicare Supplement Themes
  - No coverage for shingles shot, hearing aids, dental, and vision benefits
  - Premiums are too high
  - Signing up is complicated / not aware of penalties for late signups
  - For those also with a Part D plan: drug costs / cost sharing are too high

- Medicare Advantage Themes
  - Coverage for hearing aids, dental, and vision does not go very far
  - Not able to switch back to a Med Sup plan easily
  - Cost sharing amounts are too high
  - Limited provider options (specifically mental health providers); high costs to see out of network providers

Q. Is there anything else you would like to tell us about your experience on Medicare?

Open Ended Question - Quotes

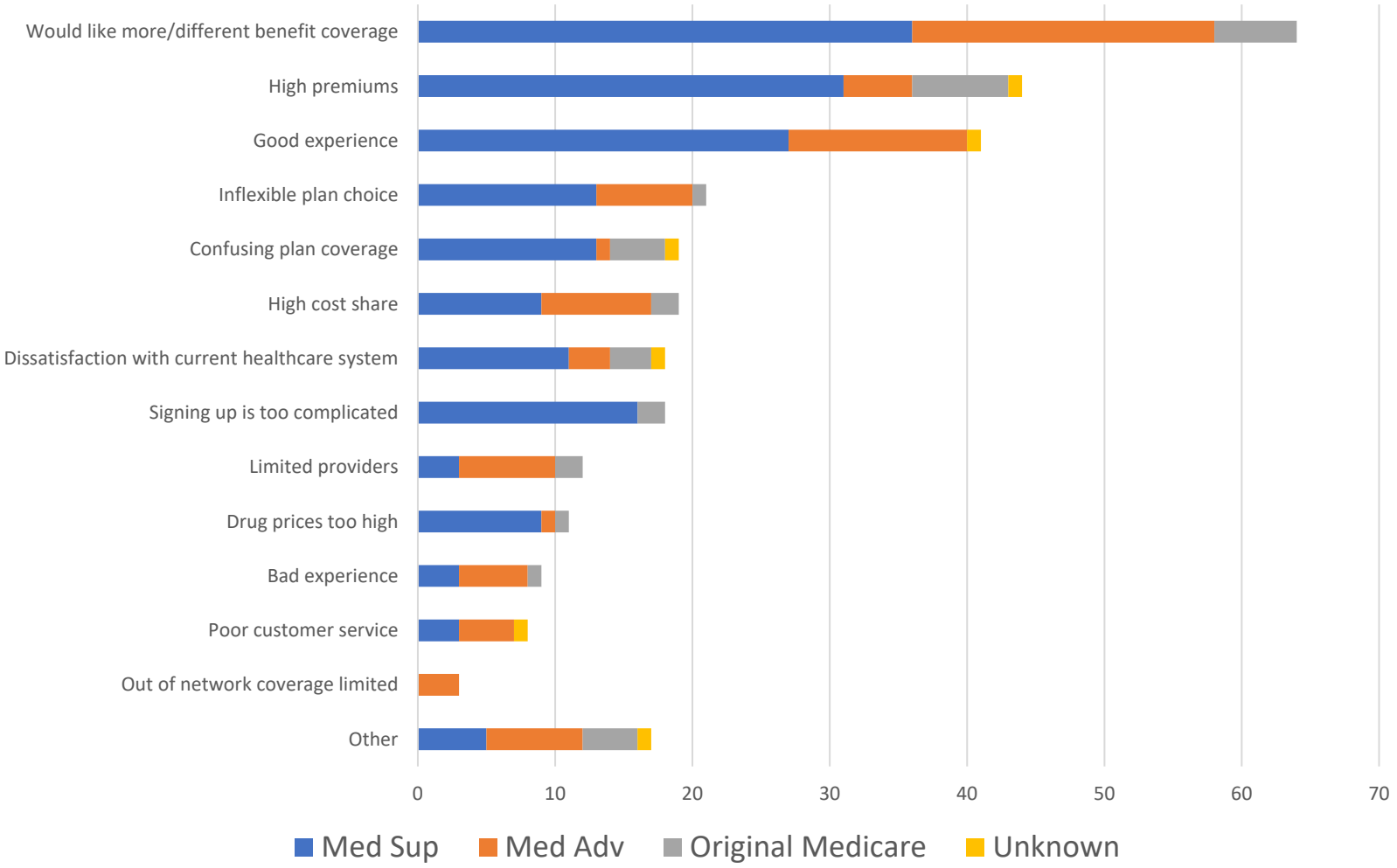
“While I am satisfied with my coverage, to get this good coverage the cost of this [carrier] Plan F Medicare Supplement Plan is outrageous for people on fixed incomes: $2697.48 for one and over $5000 for my husband and myself per year. This already high premium has been rising for the past several years. It can and does increase sometimes during the current plan period completely at the insurance company's discretion with no option to change plans during this current period.”

“I wish there were more affordable health insurance options for individuals on disability; SSDI income is simply not enough to survive on as it is. It honestly doesn't make sense to me that disabled people can't continue Medicaid coverage (and maintain care relationships with trusted medical providers who often aren't covered by Medicare).”

“I would have preferred a Medigap plan, but it was far too expensive, especially with adding prescription coverage. My 0 premium Advantage plan does very well for me now. I worry a lot about not being able to switch to a Medigap plan if my needs increase.”

“Eyes, ears and teeth/mouths are part of the human body. Therefore, vision, hearing and dental care must be included in Medicare and Medigap coverage…”

Open Ended Question– Grouped Responses*



*Judgment was applied in grouping of the comments. A single category was assigned although comments could fall into multiple categories

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