March 16, 2022

RE: AHIP Comments on S.239 – An act relating to enrollment in Medicare supplemental insurance policies

To Chairwoman Cummings and Members of the Senate Committee on Finance,

America's Health Insurance Plans (AHIP) appreciates the opportunity to offer our comments on S.239, legislation that would establish annual open enrollment requirements for Medicare Supplement insurance.

AHIP opposes S.239 because it would increase seniors' Medicare Supplement plan premiums and would destabilize the Medicare Supplement market in Vermont.

Medicare Supplement (Medigap) insurance helps protect people eligible for Medicare from high out-of-pocket costs not covered by traditional Medicare. Medicare Supplement also provides seniors the flexibility to budget for those costs and avoid multiple complex bills from their doctors and hospitals. It offers coverage, at varying levels, for the significant out-of-pocket costs that are not covered by Medicare, such as deductibles, coinsurance, and copayments. Medigap coverage allows seniors and younger Medicare enrollees with disabilities – many of whom are on fixed incomes – to budget for medical costs and avoid the confusion and inconvenience of handling complex medical bills. **Among enrollees, 85% say that losing their Medicare Supplement coverage would cause them worry about losing financial security.**[1]

Today in Vermont, one is generally eligible to purchase any Medicare Supplement policy offered in their state during an initial six-month open enrollment period when they are first enrolled in Medicare Part B. During the Medicare open enrollment period, the enrollee has guaranteed-issue rights (cannot be turned down for coverage because of pre-existing conditions or health problems) and cannot be charged higher premiums based on health nor require medical underwriting, though some variation is allowed for enrollees under the age of 65.

If an enrollee later decides to change a Medicare Supplement policy outside of an open enrollment period and is not covered by limited exceptions (such as a plan bankruptcy), insurers can require medical underwriting or take health status into consideration when reviewing the application; premiums with the new plan can be higher or the application can be rejected altogether. These plan requirements help guard against adverse selection and enhance risk pool stability. The end result is effective plan offerings at reasonable premium rates.

Requiring an annual open enrollment would incentivize eligible seniors to delay plan enrollment until they need coverage for a health condition or treatment. As a result, seniors would see a significant increase in premiums for these plans.

A fundamental principle of insurance involves the pooling of risks. To ensure stable premiums, a pool of individuals must include healthy people as well as those who are less healthy. If a pool only attracts those with a higher risk of health care needs (adverse selection), average costs increase and consumers face higher premiums.

[1] According to a survey carried out by Global Strategy Group on behalf of AHIP in January 2021 (https://www.ahip.org/new-research-shows-seniors-are-satisfied-withmedigap-coverage/)

When insurers are required to provide insurance regardless of health status (guaranteed issue), it ensures the pool will attract predominantly less healthy individuals. With guaranteed issue requirements, less healthy people will purchase coverage immediately because they cannot be denied coverage regardless of health condition. Conversely, it also allows healthy people to delay purchasing coverage because they know they will be able to get insurance when their health care needs demand it. Allowing healthy individuals to delay obtaining coverage essentially penalizes the less healthy, who enroll when first eligible, through higher premiums. These principles hold for annual open enrollment periods and continuous open enrollment periods.

Allowing permanent and continuous open enrollment period would likely result in Medicare Supplement carriers leaving the market in Vermont.

Insurers would have no incentive to remain in the market as the adverse selection would make pricing difficult and risk pool stabilization challenging. This is particularly true for Medicare Supplement plans, for which risk pools and actuarial calculations are made for the life of the product, rather than on an annual basis (as is done for individual commercial market and Medicare Advantage plans). Insurers who happen to attract a disproportionate number of unhealthy risks would essentially be penalized for remaining in the market.

Like Medicare Supplement, traditional Medicare recognizes the importance of a limited open enrollment period and requires a beneficiary to enroll during the designated open (or special) enrollment period. If the requirement is not met, the enrollee faces a penalty. For Medicare Part A, the late enrollment penalty increases premiums by 10% for twice the number of years the beneficiary did not enroll after their initial eligibility.[2] For Medicare Part B, monthly premiums increase up to 10% for each 12-month period the beneficiary did not enroll after eligibility.[3] The federal government views the limited guaranteed issue period as a necessary requirement to address adverse selection, encouraging people not to wait until they need coverage to obtain it and ensuring that premiums remain as stable as possible for the entire senior population.

By:_____

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America's Health Insurance Plans

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

[2] https://www.medicare.gov/your-medicare-costs/part-a-costs/part-a-late-enrollment-penalty
[3] https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-late-enrollment-penalty