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MEDIGAP INSURANCE

Plans Are Widely Available but Have Limited Benefits and May Have High Costs

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Millions of Medicare beneficiaries depend on private insurance to cover expenses not covered by Medicare, such as deductibles, copayments, coinsurance, and prescription drugs. To protect themselves against large out-of-pocket costs and help fill Medicare's coverage gaps, most beneficiaries purchase Medicare supplemental insurance (known as Medigap), contribute towards employer-sponsored retiree health benefits to supplement Medicare's coverage, or enroll in private Medicare+Choice plans as an alternative to the traditional fee-for-service Medicare plan. Since Medicare+Choice plans are not available in many parts of the country and many employers do not offer retiree health benefits, Medigap may be the only supplemental insurance option widely available to seniors. In particular, federal law guarantees beneficiaries the right to purchase a Medigap policy during the first 6 months after they are 65 and elect Medicare coverage for physician services, outpatient care, and certain other services.

The role of Medicare supplemental insurance is one of several issues that Congress has considered as part of its ongoing deliberations on Medicare reform, including proposed prescription drug coverage and other coverage alternatives for beneficiaries.[1] The Consolidated Appropriations Act for 2000 required us to report on Medigap insurance, including (1) enrollment levels; (2) availability across states and to individuals, especially those outside of their initial 6-month enrollment period; and (3) premiums and other out-of-pocket costs for health care expenses incurred by beneficiaries who purchase Medigap plans.[2] To provide information on these issues, we analyzed data collected on the National Association of Insurance Commissioners' (NAIC) 1999 Medicare Supplement Insurance Experience Exhibit and the Health Care Financing Administration's

[1]See also *Medicare: Cost Sharing Policies Problematic for Beneficiaries and Program* (GAO-01-713T, May 9, 2001).

[2]See Consolidated Appropriations Act for Fiscal Year 2000, P.L. 106-113, Appendix F, Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Section 553(a).

(HCFA)[3] 1998 Medicare Current Beneficiary Survey (MCBS). We also examined consumer guides for Medicare beneficiaries issued by most states and HCFA. In addition, we interviewed selected insurers, HCFA officials and state insurance regulators, and trade association representatives. Appendix I provides additional information on our methodology. We conducted our work from March 2001 through July 2001 in accordance with generally accepted government auditing standards.

Results in Brief

About 10.7 million Medicare beneficiaries—more than one-fourth of all beneficiaries—relied on Medigap policies in 1999 to cover some out-of-pocket costs and services not covered by Medicare. More than 60 percent purchased 1 of 10 standardized policy types, while the remainder had policies sold before federal law required the standardization of benefits in July 1992 or were in one of three states in which insurers are exempt from offering the federally standardized plans. Nearly two-thirds of those with a standardized Medigap policy purchased two mid-level policies that cover Medicare's cost-sharing requirements and selected other benefits but do not have any prescription drug coverage. Relatively few Medigap purchasers (8 percent of those purchasing a standardized Medigap policy) have bought the standardized plans that include prescription drug coverage. Low enrollment in these Medigap plans may be due to fewer plans with prescription drug benefits being marketed, higher premiums for these plans, and limits in coverage whereby beneficiaries are required to pay more than half of their drug costs while catastrophic prescription drug expenses are not covered.

Medigap policies are widely available to 65-year-old Medicare beneficiaries during the initial 6-month open-enrollment period guaranteed by federal law. In nearly every state, multiple insurers offer every Medigap policy, but the extent to which beneficiaries can select from among insurers offering different plan types and at different prices varies depending on where they live and other circumstances. All insurers that market Medigap must offer the standardized plan with the fewest benefits. Most insurers also offer other plans with additional standardized optional benefits, but comparatively few offer the three standardized plans that include prescription drug coverage. For example, in New York only a single

[3]On June 14, 2001, the Secretary of Health and Human Services announced that the name of HCFA had been changed to the Centers for Medicare and Medicaid Services (CMS). In this report, we will continue to refer to HCFA where our findings apply to information provided by the agency under that name.

insurer offers one of the three plans with prescription drug benefits, in Rhode Island only a single insurer offers any of the plans with prescription drug benefits, and in Delaware no insurer offers one of the plans with prescription drugs. In general, access may be more limited to beneficiaries who are not in the initial 6-month open-enrollment period or otherwise eligible for federal guarantees applying to certain other circumstances, such as when an employer terminates health benefits or their Medicare+Choice plan withdraws from their area. Depending on their health status, beneficiaries purchasing Medigap outside these periods or who want to switch to a plan with more benefits may find coverage alternatives limited or expensive.

Some Medigap policies can have relatively high premiums and may still leave Medicare beneficiaries with significant out-of-pocket costs for health care services. Overall, the average annual premium was more than $1,300 in 1999. Standardized plans with prescription drug coverage were more expensive—averaging more than $1,600 compared to about $1,150 for standardized plans without prescription drug coverage. Average premiums varied widely by state. For example, the average premium for standardized plans in California was 35 percent higher than the national average and more than twice as high as in New Hampshire, New Jersey, and Utah. Premiums also varied widely within the same state. For example, a Medicare beneficiary can find that premiums offered by different insurers for the same plan type often vary by two times and sometimes even more depending on several factors, including the premium rating methodology insurers use. In addition to their premium payments, Medigap purchasers continue to have significant out-of-pocket costs for health care services, averaging about $1,400 in 1998.

Background

Medicare is typically the primary source of health insurance coverage for seniors. Individuals who are eligible for Medicare automatically receive Hospital Insurance, known as part A, which helps pay for inpatient hospital care, skilled nursing facility services following a hospital stay, hospice care, and certain home health care services. Beneficiaries generally pay no premium for this coverage but are liable for required deductibles, coinsurance, and copayments. Medicare-eligible beneficiaries may elect to purchase Supplemental Medical Insurance, known as part B, which helps pay for selected physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for part B coverage, currently $50 per month. Beneficiaries are also responsible for part B deductibles, coinsurance, and copayments. See table 1 for a summary of Medicare's beneficiary cost-sharing requirements for 2001.

Table 1: Medicare Coverage and Beneficiary Cost Sharing for 2001

Part A coverage	Beneficiary cost-sharing requirements
Inpatient hospital	$792 deductible per admission[a] $198 copayment per day for days 61-90 $396 copayment per day for days 91-150 All costs beyond 150 days
Skilled nursing facility	No cost sharing for first 20 days $99 copayment or less for days 21-100 All costs beyond 100 days
Home health	No cost sharing 20 percent coinsurance for durable medical equipment
Hospice	$5 copayment for outpatient drugs 5 percent coinsurance for inpatient respite care
Blood	Cost of first 3 pints
Part B coverage[b]	
Physician and medical	$100 deductible per year 20 percent coinsurance for most services 50 percent coinsurance for mental health services
Clinical laboratory	No cost sharing
Home health	No cost sharing 20 percent coinsurance for durable medical equipment
Outpatient hospital	Cost sharing varies by service and may exceed 50 percent
Blood	Cost of first 3 pints 20 percent coinsurance for additional pints

[a]No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

[b]No cost sharing is required for certain preventive services—including specific screening tests for colon, cervical, and prostate cancer, and flu and pneumonia vaccines.

Source: HCFA, *Medicare & You 2001*.

To help pay for some of Medicare's cost-sharing requirements as well as some benefits not covered by Medicare parts A or B, most Medicare beneficiaries have some type of supplemental coverage. Privately purchased Medigap is an important source of this supplemental coverage. Other supplemental coverage options may include coverage through an employer, enrolling in a Medicare+Choice plan that typically offers lower cost-sharing requirements and additional benefits such as prescription drug coverage in exchange for a restricted choice of providers, or assistance from Medicaid, the federal-state health financing program for low-income individuals, including aged or disabled individuals.

The Omnibus Budget Reconciliation Act (OBRA) of 1990[4] required that Medigap plans be standardized in as many as 10 different benefit packages offering varying levels of supplemental coverage. All policies sold since July 1992 (except in three exempted states) have conformed to 1 of these 10 standardized benefit packages, known as plans A through J. (See table 2.) In addition, beneficiaries may purchase Medicare Select, a type of Medigap policy that generally costs less in exchange for a limited choice of providers. A high-deductible option is also available for plans F and J. Policies sold prior to July 1992 are not required to comply with these 10 standard packages. Insurers in Massachusetts, Minnesota, and Wisconsin are exempt from offering these standardized plans because these states standardized their Medigap policies prior to the establishment of the federal standardized plans.

Table 2: Benefits Covered by Standardized Medigap Policies

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F[a]	Plan G	Plan H	Plan I	Plan J[a]
Coverage for: • Part A coinsurance • 365 additional hospital days during lifetime • Part B coinsurance • Blood products	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B balance billing[b]						X	X		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
Home health care				X			X		X	X
Prescription drugs								X[c]	X[c]	X[c]
Preventive medical care					X					X

[a]Plans F and J also have a high-deductible option that requires the beneficiary to pay $1,580 before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs ($250 per year for plan J) and foreign travel emergency ($250 per year for plans F and J) which are required in these plans with or without the high-deductible option.

[b]Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payment rate. Plan G pays 80 percent of balance billing; plans F, I, and J cover 100 percent of these charges.

[c]Plans H and I pay 50 percent of drug charges up to $1,250 per year and have a $250 annual deductible. Plan J pays 50 percent of drug charges up to $3,000 per year and has a $250 annual deductible.

Source: HCFA, *2001 Guide to Health Insurance for People With Medicare*.

[4]P.L. 101-508, section 4351, 104 Stat. 1388, 1388-127.

Medigap coverage is widely available to most beneficiaries. Federal law provides Medicare beneficiaries with guaranteed access to Medigap policies offered in their state of residence during an initial 6-month open-enrollment period, which begins on the first day of the month in which an individual is 65 or older and is enrolled in Medicare Part B. During this initial open-enrollment period, an insurer cannot deny Medigap coverage for any plan types they sell to eligible individuals, place conditions on the policies, or charge a higher price because of past or present health problems.[5] Additional federal Medigap protections include "guaranteed-issue" rights, which provide beneficiaries over age 65 access to plans A, B, C, or F in certain circumstances, such as when their employer terminates retiree health benefits or their Medicare+Choice plan leaves the program or stops serving their area.[6] Depending on laws in the state where applicants reside and their health status, insurers may choose to offer more than these four plans. Federal law also allows individuals who join a Medicare+Choice plan when they first become eligible for Medicare[7] and who leave the plan within 1 year of joining to purchase any of the 10 standardized Medigap plans sold in their respective states.[8]

[5]Policies sold during the open-enrollment period can exclude coverage for any preexisting conditions for up to 6 months. However, if the beneficiary had prior coverage and applied for Medigap within 63 days after this prior coverage ends, he or she receives credit to reduce or eliminate the length of the preexisting-condition exclusion period.

[6]Individuals must apply for a Medigap plan no later than 63 days after their prior health coverage ends for these guarantees to apply. During the guaranteed-issue periods no preexisting-condition exclusion period may be applied.

[7]This right to join any Medigap plan when a beneficiary leaves a Medicare+Choice plan within one year also exists for beneficiaries who have been involuntarily terminated by a prior Medicare+Choice plan, such as when a plan withdraws from their area.

[8]To be eligible for these federal access protections, beneficiaries must apply no later than 63 calendar days after their Medicare health plan coverage ends. In addition, federal protections allow individuals who dropped their Medigap plan to join a Medicare+Choice plan or buy a Medicare Select policy to return to their former Medigap policy if they leave the new plan within 1 year. In the event the original plan is not available, these individuals become eligible for plans A, B, C, or F.

Medigap Enrollment Exceeds 10 Million, Mostly Concentrated in Two Plans

In 1999, about 10.7 million Medicare beneficiaries—more than one-fourth of all beneficiaries—had a Medigap policy to help cover Medicare's cost-sharing requirements as well as some benefits not covered by Medicare parts A or B.[9] Of those having Medigap coverage in 1999, about 61 percent purchased 1 of the 10 standardized plans (A through J), while about 35 percent had supplemental plans that predate standardization. The remaining 4 percent had Medigap plans meeting state standards in the three states—Massachusetts, Minnesota, and Wisconsin—in which insurers are exempt from offering the federally standardized plans.

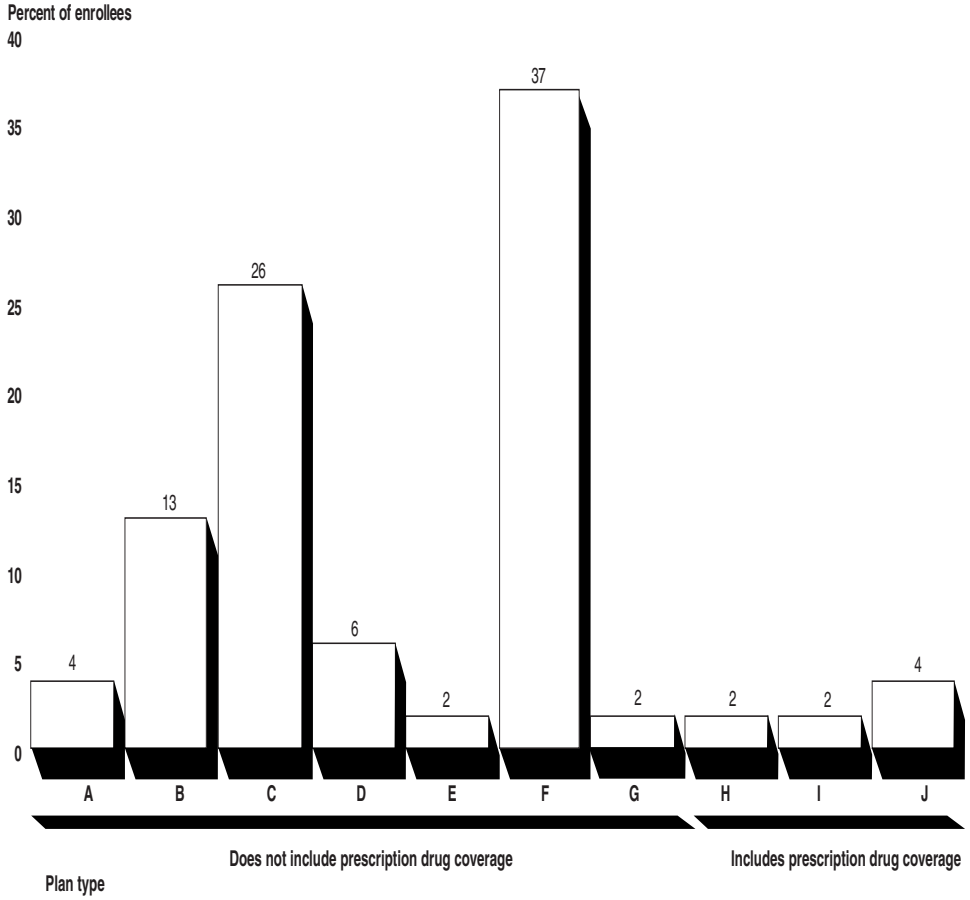
Among the 10 standardized plans, over 60 percent of purchasers were enrolled in two mid-level plans (C or F), which cover part A and part B cost-sharing requirements but do not cover prescription drugs. There are several reasons why these plans may be particularly popular among beneficiaries. For example, both plans cover the part B deductible, which insurers report is a popular benefit for purchasers.[10] They also represent two of the four plans that insurers are required to guarantee issue during special enrollment periods.[11] With the exception of plan B, in which 13 percent were enrolled, less than 7 percent of beneficiaries selected any one of the remaining seven plans. (See fig. 1.)

[9]NAIC reports that Medigap enrollment has declined from about 14 million in 1994. In part, this decline may be related to increasing enrollment in Medicare health maintenance organizations (HMOs), including the development of Medicare+Choice options, which HCFA reports grew from about 2.3 million beneficiaries in 1994 to 6.3 million in 1999. HCFA reported that Medicare+Choice enrollment declined to about 5.7 million in 2001 as some Medicare+Choice plans have withdrawn from the program.

[10]Plans C, F, and J are the only Medigap plans that cover the Medicare Part B deductible, which was $100 per year in 2000.

[11]Only insurers that sell plans A, B, C, and F are required to guarantee issue them during special enrollment periods.

Figure 1: Percentage Enrolled in Standardized Medigap Plans by Plan Type, 1999



Note: Total does not equal 100 due to rounding.

Source: GAO Analysis of NAIC data.

Enrollment in the three plans with prescription drug coverage—H, I, and J—is relatively low (a total of 8 percent of standardized plan enrollment) for several reasons. Insurance representatives noted that the drug coverage included in these plans is limited while the premium costs are higher than plans without this coverage. For example, under the Medigap plan with the most comprehensive drug coverage (plan J), a beneficiary would have to incur $6,250 in prescription drug costs to receive the full $3,000 benefit because of the benefit's deductible and coinsurance requirements. Moreover, insurers often medically underwrite these plans—that is, screen for health status—for beneficiaries enrolling outside

of their open-enrollment period. Thus, individuals in poor health who want to purchase a plan with drug coverage may be denied or charged a higher premium. Further, insurers may be reluctant to market Medigap plans with prescription drug coverage because they would be required to offer them to any applicant regardless of health status during beneficiaries' initial 6-month open-enrollment period, according to NAIC officials. Finally, an insurance representative attributed low enrollment in these plans to beneficiaries who do not anticipate a need for a prescription drug benefit at the time they enroll.

Relatively few beneficiaries have purchased the Medicare Select and high-deductible plan options, which were created to increase the options available to beneficiaries.[12] About 9 percent of beneficiaries enrolled in standardized Medigap plans had a Medicare Select plan in 1999. With Medicare Select, beneficiaries buy 1 of the 10 standardized plans but are limited to choosing among hospitals and physicians in the plan's network except in emergencies.[13] In exchange for a limited choice of providers, premiums are typically lower, averaging $979 in 1999, or more than $200 less than the average Medigap premium for a standardized plan. Similarly, insurers report that few individuals choose the typically lower priced high-deductible option available for plans F and J. These options require beneficiaries to pay a $1,580 deductible before either plan covers any services.[14] An NAIC official noted that these options may have relatively low enrollment because beneficiaries may prefer first-dollar coverage and no restrictions on providers. In addition, an insurance representative noted that administrative difficulties and higher costs associated with operating these plans have discouraged some insurers from actively marketing these products, which likely contributes to the low enrollment. Beneficiaries do not have access to Medicare Select plans in all states—NAIC reports that 15 states do not have insurers within the state selling Medicare Select plans.

[12]Medicare Select plans were authorized by the Medigap Improvements Act of 1990 (P.L. 101-508, section 4358, 104 Stat. 1388, 1388-135) and were first made available in a limited number of states in 1992. Section 4032 of the Balanced Budget Act of 1997 (P.L. 105-33, 111 Stat. 355, 359) authorized the addition of high-deductible Medigap policies.

[13]Medicare Select options are also available in Minnesota and Wisconsin even though insurers are exempt from selling the standard Medigap plans in these states.

[14]In addition, beneficiaries purchasing the high-deductible option are responsible for the deductibles for prescription drugs ($250 per year for plan J) and emergency coverage during foreign travel ($250 per year for plans F and J) that are required in these plans with or without the high-deductible option.

Medigap Plans Are Widely Available in Most States, But Access May Be Limited for Certain Beneficiaries

While consumers typically have access to all 10 standardized Medigap plans during their 6-month open-enrollment periods, the extent to which they can choose from among multiple insurers offering these plans varies depending on where they live. Insurance companies marketing Medigap policies must offer plan A and frequently offer plans B, C, and F, but are less likely to offer the other six plans, particularly those plans with prescription drug coverage.[15] (See table 3.) Our review of state consumer guides and other information from states and insurers shows that during the 6-month open-enrollment period applicants typically have access to multiple Medigap insurers, with the most options available for plans A, B, C, and F.[16] For example, in 19 states, every Medigap insurer offered plan F to these beneficiaries. In contrast, fewer insurers offer Medigap plans with prescription drug benefits. Although in most states several insurers offer these plans, state consumer guides indicate that only one insurer offers plan J in New York and plans H, I, and J in Rhode Island. In addition, no insurers market plan H in Delaware or plans F, G, or I in Vermont.[17] Appendix II includes a summary of the number of insurers estimated to offer Medigap plans in each state.

[15]Insurers that sell plans A, B, C, and F are required to offer them to eligible beneficiaries during special enrollment periods.

[16]Most states publish a consumer guide for Medicare beneficiaries, which typically describes Medigap benefits and rights, as well as provides a list of insurers who offer Medigap plans. Some of these consumer guides note that not all insurers reported information on plans offered in the state. To supplement information provided in the consumer guides of certain states, we also called state insurance regulators and individual insurers.

[17]Vermont generally prohibits insurers from selling these plans because state law generally does not permit physicians to balance bill for charges higher than Medicare's agreed rates. Since plans F, G, and I vary from other standardized plan types only in that they cover Part B balanced billing, they do not provide additional value to beneficiaries in Vermont. See Vermont Statutes Annotated, Title 33, section 6502; Vermont Medicare Supplement Insurance Minimum Standards, CVR section 21-040-13 paragraph 9B.

Table 3: Insurers Offering Medigap Plans to 65-Year-Olds During Open Enrollment

	Plan type									
	A	B	C	D	E	F	G	H	I	J
Percent of insurers estimated to offer Medigap plans	100	67	92	52	26	89	41	19	24	18
Median number of insurers estimated to offer Medigap plans in each state	30	20	27	16	8	28	12	5	7	5

Source: GAO review of state consumer guides. For certain states, including those that did not have a consumer guide or whose consumer guides identified three or fewer Medigap insurers, we obtained additional information from HCFA, state insurance departments, and insurers.

While beneficiaries in most states have access to multiple insurers for most Medigap plans, a few insurers represent most Medigap enrollment. In all but one state, United HealthCare Insurance Company or a Blue Cross/Blue Shield plan represents the largest Medigap insurer. Nationally, about 64 percent of Medigap policies in 1999 were sold by either United HealthCare or a Blue Cross/Blue Shield plan. United HealthCare offers all 10 Medigap policies to AARP[18] members during their initial 6-month open-enrollment period in nearly all states and charges applicants in a geographic area the same premium regardless of their health status (a rating practice known as community rating). Outside of beneficiaries' 6-month open-enrollment period, United HealthCare also offers applicants without end-stage renal disease (i.e., permanent kidney failure) plans A through G without medically underwriting—that is, screening beneficiaries for health status—in states where it sells these policies. In an effort to minimize adverse selection and to remain competitive, United HealthCare medically underwrites applicants for the three plans with prescription drug coverage who are outside their initial open-enrollment period.

Medicare beneficiaries who are not in their open-enrollment period or do not otherwise qualify for one of the special enrollment periods, such as when an employer eliminates supplemental coverage or a Medicare+Choice plan stops serving an area, are not guaranteed access under federal law to any Medigap plans. Depending on their health, these individuals may find coverage alternatives to be reduced or more

[18]Formerly known as the American Association of Retired Persons, the association has changed its name to AARP. While access to the AARP Medigap plans through United HealthCare requires the beneficiary to be a member of AARP, this membership is widely available to nearly all Medicare beneficiaries (except disabled beneficiaries younger than AARP's membership age of 50) for a nominal annual fee.

expensive. Outside of the initial or special open-enrollment periods, access to any Medigap plan could depend on the individual's health, the insurer's willingness to offer coverage, and states' laws.[19] Further, beneficiaries whose employer terminates their health coverage or whose Medicare+Choice plan withdraws from the program are only guaranteed access to Medigap plans A, B, C, and F, which do not offer prescription drug coverage.

Medicare beneficiaries can change Medigap policies, but may be subject to insurers' screening them for health conditions prior to allowing a change to a Medigap policy with more generous benefits outside open-enrollment/guaranteed-issue periods. If a person has a Medigap policy for at least 6 months and decides to switch plans, the new policy generally must cover all preexisting conditions. However, if the new policy has benefits not included in the first policy, the company may make a beneficiary wait 6 months before covering that benefit or, depending on the health condition of the applicant, may charge a higher premium or deny the requested change. According to an insurer representative, virtually all Medigap insurers will screen the health condition of applicants who want to switch to plans H, I, or J to avoid the potential for receiving a disproportionate share of applicants in poor health.

Beneficiaries With Medigap Policies May Still Incur Significant Out-of-Pocket Costs

Beneficiaries purchasing Medigap plans may still incur significant out-of-pocket costs for health care expenses in addition to their premiums. In 1999, the average annual Medigap premium was more than $1,300, although a number of factors, such as where a beneficiary lives and insurer rating practices, may contribute to significant variation in the premiums charged by insurers. Despite their supplemental coverage, Medicare beneficiaries with Medigap coverage paid more out-of-pocket for health care services (excluding long-term care facility care) than any other group of beneficiaries even though their self-reported health status was generally similar to other beneficiaries.

[19]In addition to federal protections, HCFA's *2000 Guide to Health Insurance for People with Medicare* reports that 21 states also provide other safeguards for beneficiaries purchasing Medigap policies. For example, Arkansas and Florida do not allow insurers to set premiums for standardized plans using an "attained-age" methodology, whereby insurers increase premium prices as individuals age. New York requires community rating of premiums and provides all Medicare beneficiaries with open enrollment at all times for all 10 standardized Medigap plans.

Medigap Policies Can Have High Cost

Medigap plans can be relatively expensive, with an average annual premium of more than $1,300 in 1999. Premiums varied widely based on the level of coverage purchased. Among the 10 standardized plans, plan A, which provides the fewest benefits, was the least expensive with average premiums paid of nearly $900 per year. The most popular plans—C and F—had average premiums paid of about $1,200. (See table 4.) The plans with prescription drug coverage—H, I, and J—had average premiums paid more than $450 higher than those plans without such coverage ($1,602 compared to $1,144).

Table 4: Annual Premiums Per Covered Life, 1999

Medigap plan	Average annual premium per covered life
A	$877
B	1,093
C	1,158
D	1,032
E	1,067
F	1,217
G	981
H	1,379
I	1,698
J	1,672
Standardized plans A through J	1,185
Plans in states in which insurers are exempt from plan standards[a]	1,368
Pre-standard (policies originally sold before July 1992)	1,525
Average	1,311

[a]Massachusetts, Minnesota, and Wisconsin have alternative standardized plans in effect and insurers in these states are exempt from offering the federal standardized Medigap plans.

Note: Data reported by insurers to the NAIC do not include plan type for policies representing less than 8 percent of Medigap policy covered lives, with an average paid premium of $1,275. These plans are excluded from the data reported in the table.

Source: GAO analysis of data collected by the NAIC from the 1999 Medicare Supplement Insurance Experience Exhibit.

In addition, Medigap policies are becoming more expensive. One recent study reports that premiums for the three Medigap plans offering prescription drug coverage have increased the most rapidly—by 17 to 34

percent from 1999 to 2000. Medigap plans without prescription drug coverage rose by 4 to 10 percent from 1999 to 2000.[20]

Additional factors, such as where Medicare beneficiaries live or specific demographic or behavioral characteristics, also may influence variation in Medigap premiums. For example, premiums often vary widely across states, which may in large part reflect geographic differences in use and costs of health care services as well as state policies that affect how insurers can set premium rates. Additionally, premiums for the same policy can vary significantly within the same state. The method used by insurers to determine premium rates can dramatically impact the price a beneficiary pays for coverage over the life of the policy. Finally, depending on the state or insurer, other factors such as smoking status and gender may also affect the premiums consumers are charged.

Premiums vary widely among states. For example, based on data reported by the insurers to NAIC, average premiums per covered life for standardized Medigap plans in California were $1,600 in 1999—more than one-third higher than the national average of $1,185 and more than twice as high as Utah's average of $706. (See app. III for average premiums per covered life for standardized plans by state.) This variation is also evident for specific plan types. For example, average annual premiums per covered life for plan J were $646 in New Hampshire and $2,802 in New York, and for plan C were $751 in New Jersey and $1,656 in California. In six states (i.e., Alabama, California, Florida, Illinois, Louisiana, and Texas), the average premium per covered life exceeded the national average for all 10 standard plan types while in six states (i.e., Hawaii, Montana, New Hampshire, New Jersey, Utah, and Vermont), the average premium per covered life always fell below the national average.

Beneficiaries in the same state may also face widely varying premiums for a given plan type offered by different insurers. For example, our review of state consumer guides showed that in Texas, a 65-year-old consumer could pay an annual premium from $300 to as much as $1,683 for plan A, depending on the insurer. Similarly, in Ohio, plan F annual premiums for a 65-year-old ranged from $996 to $1,944 and in Illinois, plan J premiums ranged from $2,247 to $3,502. Table 5 provides premium ranges for a 65-year-old in five states with large Medicare populations.

[20]Weiss Ratings, "Prescription Drug Costs Boost Medigap Premiums Dramatically," March 26, 2001, http://www.weissratings.com/NewsReleases/Ins_Medigap/20010326Medigap.htm.

Table 5: Range of Annual Premium Prices for Selected Plans for a 65-Year-Old in Five States with Large Medicare Populations

	Plan A	Plan C	Plan F	Plan J
Illinois	$467 to $1,202	$802 to $1,633	$854 to $1,861	$2,247 to $3,502
New York	$864 to $1,560	$1,408 to $2,385	$1,617 to $2,800	n/a[a]
Ohio	$612 to $1,284	$924 to $2,064	$996 to $1,944	$2,028 to $3,156
Pennsylvania	$500 to $1,373	$761 to $1,964	$802 to $1,649	$2,312 to $2,976
Texas	$300 to $1,683	$664 to $2,125	$880 to $2,171	$2,059 to $5,658

[a]Only one insurer reported offering plan J in New York's consumer guide, with a premium of $3,552.

Source: State consumer guides prepared by state insurance departments for premiums typically offered in 2000 or 2001.

Some of the variation seen in table 5 is attributable to differences in the premium rating methodology used by different insurers. Insurers who "community rate" policies charge all applicants the same premium, regardless of their age. Those who use an "issue-age-rated" methodology base premiums on an applicant's age when first purchasing the policy, and although the premium can increase for inflation, any such increase should not be attributable to the aging of the individual. In addition to increases for inflation, an "attained-age-rated" policy's premium also increases as a beneficiary ages. Although attained-age policies are generally cheaper when initially purchased, they may become more expensive than issue-age rated policies at older ages. For example, a Pennsylvania insurer that sells both attained-age and issue-age policies for plan C charges a 65-year-old male $869 for an attained-age policy or $1,347 for an issue-age policy. But over time, under the attained-age rated policy, this individual would have premium increases both due to inflation and the higher cost the insurer anticipates as the policyholder ages. However, under the issue-age-rated policy, rate increases would only reflect inflation because the higher anticipated costs resulting from aging have already been included in the premium rate. By age 80, excluding increases attributable to inflation, the attained-age policy would cost $1,580 but the issue-age policy would remain at $1,347. Individuals who did not anticipate premium increases over time for attained-age policies may find it increasingly difficult to afford continued coverage and consequently may let their Medigap coverage lapse. Or, as their premiums increase and if an individual is still in good health, individuals may switch to plans sold by insurers that charge the same premium regardless of age, thus creating the potential for these insurers to have a disproportionate share of older beneficiaries. For individuals not in their open-enrollment period or otherwise eligible for a guaranteed-issue product, insurers may also adjust premium prices based on the health status of individuals.

Because the consumer guides show that insurers offer the same Medigap plan type for a wide range in premiums, some plans with higher premiums are unlikely to have high enrollment. Nonetheless, insurers may have an incentive to continue offering higher cost plans despite low enrollment because states prohibit insurers that stop marketing a plan type from reentering the market and selling that particular plan for a 5-year period. Insurers that may not want to completely exit a market may continue to offer a plan type with a premium higher than the market rate, thereby discouraging enrollment but ensuring their continued presence in the market. However, federal law requiring Medigap plans to pay at least 65 percent of premiums earned for beneficiaries' medical expenses for individually purchased policies limits insurers' ability to charge rates excessively higher than the market rates.[21]

Gaps in Coverage Leave Medigap Purchasers With Significant Out-of-Pocket Costs

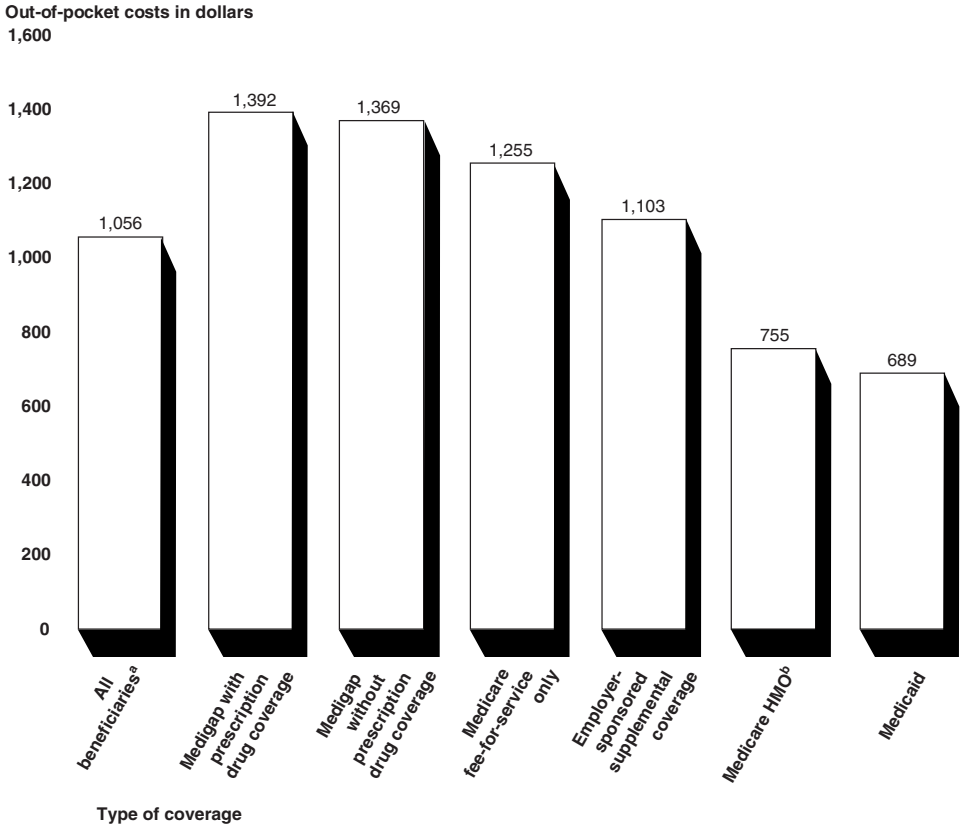
Despite purchasing Medigap policies to help cover Medicare cost-sharing requirements and other costs for health care services that the beneficiary would have to pay directly out of pocket, Medigap purchasers still pay higher out-of-pocket costs than do other Medicare beneficiaries. Our analysis of the 1998 MCBS showed that out-of-pocket costs for health care services, excluding long-term facility care costs,[22] averaged $1,392 for those purchasing individual Medigap policies with prescription drug coverage and $1,369 for those purchasing individual Medigap policies without prescription drug coverage—significantly higher than the $1,056 average for all Medicare beneficiaries. (See fig. 2.) Furthermore, Medigap purchasers had higher total expenditures for health care services ($7,631, not including the cost of the insurance) than Medicare beneficiaries without supplemental coverage from any source ($4,716) in 1998. These higher expenditures for individuals with Medigap may be due in large part to higher utilization rates for individuals with supplemental coverage. In addition, Medigap's supplemental coverage of prescription drugs is less

[21]On average, nearly 80 percent of the Medigap premiums are spent for medical expenses. In 1999, the 15 largest Medigap insurers spent between 64 and 88 percent of premiums on medical expenses.

[22]We excluded long-term care facility costs because these costs represent a major cost for some Medicare beneficiaries, but are not typically covered by Medicare or Medigap. Since Medicaid or beneficiaries pay most of these costs, including these costs would disproportionately increase out-of-pocket expenditures for some categories of Medicare beneficiaries. Long-term care facilities include licensed nursing homes, retirement homes, domiciliary or personal care facilities, mental health or mental retardation facilities, continuing care facilities, assisted living facilities, and rehabilitation facilities.

comprehensive than typically provided through employer-sponsored supplemental coverage and therefore may leave beneficiaries with higher out-of-pocket costs. Differences in health status do not appear to account for higher out-of-pocket costs and expenditures for those with Medigap. We found that Medicare beneficiaries with Medigap coverage reported a health status similar to those without supplemental coverage.

Figure 2: Out-of-Pocket Costs (Excluding Long-Term Facility Care Costs) for Medicare Beneficiaries, 1998



[a]In addition to the subcategories of Medicare beneficiaries included in the figure, about 6 percent of beneficiaries receive supplemental health care services through other public plans or private HMOs.

[b]Medicare HMOs contract with the Medicare program to provide services to beneficiaries as an alternative to the traditional fee-for-service Medicare program.

Source: GAO analysis of 1998 Medicare Current Beneficiary Survey.

Supplemental coverage can offset the effects of cost-sharing requirements intended to encourage prudent use of services and thus control costs. Providing "first-dollar coverage" by eliminating beneficiaries' major cost

requirements for health care services, including deductibles and coinsurance for physicians and hospitals, in the absence of other utilization control methods can result in increased utilization of discretionary services and higher total expenditures. One study found that Medicare beneficiaries with Medigap insurance had 28 percent more outpatient visits and inpatient hospital days relative to beneficiaries who did not have supplemental insurance, but were otherwise similar in terms of age, gender, income, education, and health status.[23] Service use among beneficiaries with employer-sponsored supplemental insurance (which often reduces, but does not eliminate, cost sharing and is typically managed through other utilization control methods) was approximately 17 percent higher than the service use of beneficiaries with Medicare fee-for-service coverage only.

Medigap covers some health care expenses for policyholders but also leaves substantial out-of-pocket costs in some areas, particularly for prescription drugs. Our analysis of the 1998 MCBS shows that Medigap paid about 13 percent of the $7,631 in average total health care expenditures (including Medicare payments) for beneficiaries with Medigap. Even with Medigap, beneficiaries still paid about 18 percent of their total costs directly out of pocket, with prescription drugs being the largest out-of-pocket cost. (See table 6.)

[23]Sandra Christensen and Judy Shinogle, "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review*, Fall 1997. Other studies have also found higher out-of-pocket costs or utilization by Medicare beneficiaries with Medigap. See John A. Poisal and Lauren Murray, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," *Health Affairs*, March/April 2001 (Vol. 20, No. 2, pp. 74-85) and David Gross and Normandy Brangan, "Out-of-Pocket Spending on Health Care By Medicare Beneficiaries Age 65 and Older: 1999 Projections," AARP Public Policy Institute, December 1999.

Table 6: Expenditures by Payer for Beneficiaries With an Individually Purchased Medigap Policy, 1998[a]

Type of service	Medicare	Medigap	Out-of-pocket	Other payers[b]	Total costs
Inpatient hospital care	$2,447 (89%)	$194 (7%)	$60 (2%)	$46 (2%)	$2,747
Physicians, laboratories, and other medical providers	$1,396 (61%)	$422 (18%)	$353 (15%)	$129 (6%)	$2,300
Outpatient hospital care	$443 (51%)	$261 (30%)	$109 (13%)	$58 (7%)	$871
Prescription drugs					
• Medigap policyholders with prescription drug coverage	—[c]	$239 27%)	$548 (61%)	$105 (12%)	$893
• Medigap policyholders without prescription drug coverage	—[c]	—[c]	$618 (82%)	$129 (17%)	$757
Other services[d]	$589 (65%)	$37 (4%)	$259 (28%)	$27 (3%)	$912
Total	**$4,876 (64%)**	**$996 (13%)**	**$1,376 (18%)**	**$383 (5%)**	**$7,631**

[a]Percentages may not add to 100 due to rounding.

[b]Other payers may include uncollected liabilities or health care received through the Department of Veterans Affairs, other public health plans, or private HMOs.

[c]Expenditures were negligible (less than $10).

[d]Other services include dental, home health, hospice, and short-term skilled nursing facility care, but exclude long-term facility care services.

Source: GAO analysis of 1998 Medicare Current Beneficiary Survey.

Among Medigap policyholders with prescription drug coverage, Medigap covered 27 percent ($239) of prescription drug costs, leaving the beneficiary to incur 61 percent ($548) of the costs out of pocket.[24] For Medigap policyholders without drug coverage, beneficiaries incurred 82

[24]Moreover, Medigap policyholders with prescription drug coverage had on average about $136 higher total prescription drug costs, but spent 11 percent (or $70) less out of pocket on prescription drugs, than those without prescription drug coverage. In addition, they paid 22 percent ($285) more in premiums for their Medigap policy than policyholders without prescription drug coverage.

percent ($618) of prescription drug costs.[25] Out-of-pocket costs for prescription drugs were higher for Medigap policyholders than any other group of Medicare beneficiaries, including those with employer-sponsored supplemental coverage ($301). Higher out-of-pockets costs for prescription drugs may be attributable to differences in supplemental coverage. Medigap policyholders with prescription drug coverage have high cost-sharing requirements (a $250 deductible and 50-percent coinsurance with a maximum annual benefit of $1,250 or $3,000 depending on the plan selected) in contrast to most employer-sponsored supplemental plans that provide relatively comprehensive prescription drug coverage. Employer-sponsored supplemental plans typically require small copayments of $8 to $20 or coinsurance of 20 to 25 percent, and provide incentives for enrollees to use selected, less costly drugs, such as generic brands or those for which the plan has negotiated a discount. Further, few employer-sponsored health plans have separate deductibles or maximum annual benefits for prescription drugs.

Concluding Observations

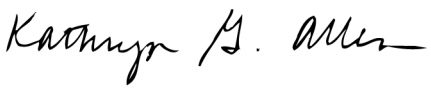
As Congress continues to examine potential changes to the Medicare program, it is important to consider the role that Medigap supplemental coverage has on beneficiaries' use of services and expenditures. Medicare beneficiaries who purchase Medigap plans have coverage for essentially all major Medicare cost-sharing requirements, including coinsurance and deductibles. But offering this "first-dollar" coverage may undermine incentives for prudent use of Medicare services, especially with regard to discretionary services, which could ultimately increase costs for beneficiaries and the entire Medicare program. While the lack of coverage for outpatient prescription drugs through Medicare has led to various proposals to expand Medicare benefits, relatively few beneficiaries purchase standardized Medigap plans offering these benefits. Low enrollment in these plans may be due to fewer plans being marketed with these benefits, their relatively high cost, and the limited nature of their prescription drug benefit, which still requires beneficiaries to pay more than half of their prescription drug costs while receiving a maximum of $3,000 in benefits. As a result, Medigap beneficiaries with prescription drug coverage continue to incur substantial out-of-pocket costs for prescription drugs and other health care services.

[25]The remainder represents uncollected liabilities and payments from other sources, such as private HMOs, state prescription drug programs, or public programs, such as coverage through the Department of Veterans Affairs.

We did not seek agency comments on this report because it does not focus on agency activities. However, we shared a draft of this report with experts in Medigap insurance at CMS and NAIC for their technical review. We incorporated their technical comments as appropriate.

We will send copies of this report to the Administrator of CMS and other interested congressional committees and members and agency officials. We will also make copies available to others on request.

Please call me at (202) 512-7118 or John Dicken, Assistant Director, at (202) 512-7043 if you have any questions. Rashmi Agarwal, Susan Anthony, and Carmen-Rivera Lowitt also made major contributions to this report.



Kathryn G. Allen
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Appendix I: Methodology

To assess issues related to Medigap plan enrollment and premiums incurred by beneficiaries who purchase Medigap plans, we analyzed data collected on the National Association of Insurance Commisioners' (NAIC) 1999 Medicare Supplement Insurance Experience exhibit. We also analyzed the 1998 Medicare Current Beneficiary Survey (MCBS) to examine out-of-pocket costs paid by Medicare beneficiaries with Medigap policies. To assess the availability of Medigap plans across states and to individuals who are not in their open-enrollment periods we examined consumer guides for Medicare beneficiaries published by many states and by the Health Care Financing Administration (HCFA). (Appendix II further discusses our review of these consumer guides and the number of insurers offering standardized Medigap plans.) Additionally, we interviewed researchers and representatives from insurers, HCFA, NAIC, and several state insurance regulators. We conducted our work from March 2001 through July 2001 in accordance with generally accepted government auditing standards.

Medicare Supplement Insurance Experience Exhibit

We relied on data collected on the NAIC's 1999 Medicare Supplement Insurance Experience Exhibit for information on Medigap enrollment by plan type and premiums per covered life by plan type and across states. Under federal and state statutes, insurers selling Medigap plans annually file reports, known as the Medicare Supplement Insurance Experience Exhibit, with the NAIC. NAIC then distributes the exhibit information to the states. These exhibits are used as preliminary indicators, in conjunction with other information, as to whether insurers meet federal requirements that at least a minimum percentage of premiums earned are spent on beneficiaries' medical expenses, referred to as loss ratios. Additionally, insurers report information on various aspects of Medigap plans including plan type, premiums earned, the number of covered lives, as well as other plan characteristic information and a contact for the insurer. We relied on NAIC data containing filings as of December 31, 1999, for the 50 states and the District of Columbia. These data represent policies in force as of 1999, including pre-standardized policies, standardized policies, and policies for individuals living in three states in which insurers are exempt from the federal standardized policies (i.e., Massachusetts, Minnesota, and Wisconsin).

An initial analysis of the 1999 data set revealed that several insurers failed to include or did not designate a valid plan type on their filings. As part of our data cleaning, we reclassified some of these filings to include or correct the plan type based on information reported in other sections of the insurance exhibit. We also called 37 insurers that covered more than

5,000 lives and had not included a valid plan type on their filing.[1] During these calls, we asked for plan type information as well as verified whether the insurer sold a Medicare Select plan that included incentives for beneficiaries to use a network of health care providers, and corrected the data in the database. After the data-cleaning process, approximately 8 percent of the 10.7 million[2] covered lives still had an unknown plan type[3] and less than 1 percent had missing information about whether the plan was sold as a Medicare Select policy.

NAIC does not formally audit the data that insurers report, but it does conduct quality checks before making the data publicly available. We did not test the accuracy of the data beyond the data-cleaning steps mentioned above. During our phone calls to insurers, we found that some insurers failed to report separate filings for the various Medigap plan types they sell and instead reported aggregate information across multiple plan types. Since plan type information was unavailable for these plans, information for these insurers was excluded from our estimates of enrollment and premium estimates for standardized plans.

Medicare Current Beneficiary Survey (MCBS)

We relied on HCFA's 1998 MCBS for information on expenditures for health care services by payer for Medicare beneficiaries. Specifically, we examined (1) the out-of-pocket costs incurred by beneficiaries with a Medigap plan in comparison to other beneficiaries[4] and (2) the out-of-pocket costs for beneficiaries with a Medigap plan as a share of total

[1]We were unable to call two insurers because the NAIC data did not provide sufficient contact information for the insurer.

[2]The 10.7 million covered lives that we calculated exclude the following: (1) information not available to us from 2 insurers representing 5,744 covered lives and (2) all filings that reported information on covered lives but not premiums, or reported premiums but not covered lives. These filings lacking either covered lives or premium information represent 10,847 lives (including a single insurer with 10,651 lives enrolled in plan A in Kentucky) and $61 million in premiums earned. We excluded these filings to prevent them from distorting estimated premiums per covered life by plan type across states.

[3]We also found that a plan type only applicable in states exempt from the federal standards was being reported in states other than the three exempt states. Some of these filings may have reflected beneficiaries moving from exempt states to other states. The insurer may have misreported the plan type or reported the state of residence instead of the state of issue. We placed these policies into the unknown plan type category since the insurer may have misreported for that filing.

[4]The MCBS does not contain information on expenditures for beneficiaries by Medigap plan type.

expenditures for health care services, including payments by Medicare and other payers. The MCBS is a multipurpose survey of a representative sample of the Medicare population. The 1998 MCBS collected information on a sample of 13,024 beneficiaries, representing about a 72-percent response rate. Because the MCBS is based on a sample, any estimates derived from the survey are subject to sampling errors. A sampling error indicates how closely the results from a particular sample would be reproduced if a complete count of the population were taken with the same measurement methods. To minimize the chances of citing differences that could be attributable to sampling errors, we highlight only those differences that are statistically significant at the 95-percent confidence level.

We analyzed the MCBS' cost-and-use file representing persons enrolled in Medicare as of January 1, 1997, and 1998. The cost-and-use file contains a combination of survey-reported data from the MCBS and Medicare claims and other data from HCFA administrative files. The survey also collects information on services not covered by Medicare, including prescription drugs and long-term facility care. HCFA notes that there may be some underreporting of services and costs by beneficiaries.[5] To compensate in part for survey respondents who may not know how much an event of care costs or how the event was paid for, HCFA used Medicare administrative data to adjust or supplement survey responses for some information, including cost information. We did not verify the accuracy of the information in the computerized file.

Because some Medicare beneficiaries may have supplemental coverage from several sources, we prioritized the source of insurance individuals reported to avoid double counting. That is, if individuals reported having coverage during 1998 from two or more kinds of supplemental coverage, we assigned them to one type to estimate enrollment and costs without including the same individuals in multiple categories. We initially separated beneficiaries enrolled in a health maintenance organization (HMO) contracting with the Medicare program (a Medicare HMO) from beneficiaries in the traditional fee-for-service Medicare program. Then, we used the following hierarchy of supplemental insurance categories: (1) employer-sponsored, (2) individually purchased (that is, a Medigap policy) with prescription drug coverage, (3) individually purchased without

[5]In particular, HCFA notes that prescription drug and ancillary service cost information for persons in long-term care facilities may not be complete.

prescription drug coverage, (4) private HMO, (5) Medicaid, and (6) other public health plans (including coverage through the Department of Veterans Affairs and state-sponsored drug plans). Finally, those without any supplemental coverage were categorized as having Medicare fee-for-service only. For example, a beneficiary with Medicare HMO coverage sponsored by an employer would be included within the Medicare HMO category. Table 7 shows the number and percent of beneficiaries in each insurance category.

Table 7: Number and Percent of Beneficiaries by Insurance Category, 1998

Insurance category	Number of beneficiaries (in millions)	Percent of beneficiaries
Medicare HMO	7.1	18
Employer-sponsored	12.8	32
Medigap with prescription drug coverage	2.9	7
Medigap without prescription drug coverage	6.2	15
Private HMO	1.7	4
Medicaid	5.5	14
Other public	0.6	1
Fee-for-service Medicare only	3.3	8
Total	**40.0**	

Note: Percents may not add to 100 due to rounding.

Source: GAO analysis of 1998 MCBS.

Appendix II: Insurers Offering Standardized Medigap Plans During Open-Enrollment Periods

Table 8 shows the extent to which health insurers offer the 10 standardized Medigap policies to 65-year-olds during the initial open-enrollment period. The table lists information for 47 states and the District of Columbia where insurers sell these plans. Three states—Massachusetts, Minnesota, and Wisconsin—are not included in the table because insurers in these states are exempt from federal Medigap standardized requirements.

To determine the extent to which Medigap standardized plans are available in each state, we primarily relied on state consumer guides and information available from the Health Care Financing Administration's (HCFA) web site. For states that did not have available information in consumer guides or Internet sites, we obtained information from their state insurance departments and insurers. We also contacted state insurance departments and insurers to verify state consumer guide information for states reporting three or fewer insurers offering any plan type to ensure that we did not understate the availability of Medigap plans in these states. Information from consumer guides and HCFA data may not contain comprehensive data on insurers operating in a state at a given point in time because (1) in some states, insurers voluntarily submit data to insurance departments and do not always report on the Medigap policies they offer and (2) data may not reflect recent changes such as companies that stop selling a product or new insurers that the states certify to sell Medigap plans. Also, in some states, such as Michigan, some insurers may be licensed to sell Medigap in the state but are not actively marketing the plan to new enrollees. We did not independently confirm information reported by state insurance departments and insurers.

Table 8: Number of Insurers Offering Standardized Medigap Policies by Plan Type and by State to 65-Year-Olds in Their Initial Open-Enrollment Period

	Plan type									
	A	B	C	D	E	F	G	H	I	J
Alabama	19	15	18	9	5	17	8	4	5	5
Alaska	15	8	12	9	4	15	8	3	5	5
Arizona	31	16	29	17	6	29	12	6	6	5
Arkansas	47	35	45	24	13	46	22	7	12	6
California	18	13	17	10	4	18	8	5	6	4
Colorado	41	27	35	17	10	39	19	6	8	7
Connecticut	15	10	12	11	4	15	6	5	5	4
Delaware	17	17	17	13	5	16	5	0	4	2
District of Columbia	9	6	8	6	3	9	4	2	3	2
Florida	38	27	30	17	13	34	19	7	13	5
Georgia	28	21	26	16	5	28	9	3	6	4
Hawaii	25	14	20	12	9	21	14	8	8	9
Idaho[a]	15	8	10	6	6	11	7	7	9	10
Illinois	41	25	35	21	9	40	14	4	8	7
Indiana	44	28	41	25	10	44	20	8	8	7
Iowa	37	24	33	21	10	37	16	5	8	7
Kansas	45	29	40	17	8	40	15	6	10	7
Kentucky	38	32	36	24	12	37	15	9	8	9
Louisiana	21	16	20	14	6	21	13	3	3	4
Maine	13	10	11	9	6	13	7	4	5	3
Maryland	23	15	16	10	8	21	12	4	5	5
Michigan	98	30	98	25	11	38	15	9	11	8
Mississippi	10	7	10	7	4	9	7	2	2	2
Missouri	43	28	39	23	9	42	20	9	10	6
Montana	24	13	24	11	7	24	13	5	6	6
Nebraska	35	26	34	20	7	35	15	7	7	6
New Hampshire	17	10	16	9	6	17	10	4	5	4
New Jersey	7	5	7	5	3	7	4	2	3	2
New Mexico	62	48	59	32	18	56	27	10	20	10
Nevada	26	20	24	15	7	24	11	5	7	5
New York	16	16	13	7	4	10	7	8	4	1
North Carolina	27	20	25	15	6	25	12	2	6	4
North Dakota	36	23	35	23	8	36	16	6	7	6
Ohio	35	25	33	20	11	33	16	7	11	5
Oklahoma	42	28	39	23	11	41	18	9	11	9
Oregon	27	16	25	13	6	26	12	5	10	7
Pennsylvania	46	46	44	24	14	11	7	17	6	7
Rhode Island	10	7	9	5	2	9	6	1	1	1
South Carolina	29	20	27	16	5	29	12	3	3	3

	Plan type									
	A	B	C	D	E	F	G	H	I	J
South Dakota	26	16	25	11	6	25	11	4	5	5
Tennessee	50	35	48	25	12	50	23	11	12	11
Texas	46	32	42	28	10	46	19	9	9	8
Utah	30	24	30	20	10	31	17	6	8	7
Vermont	16	11	15	10	8	0	0	7	0	4
Virginia	34	26	31	19	8	33	11	5	8	7
Washington	30	15	26	11	10	27	9	4	11	5
West Virginia	34	21	32	15	9	34	14	3	8	5
Wyoming	36	22	36	18	8	35	15	7	11	7
Median	**30**	**20**	**27**	**16**	**8**	**28**	**12**	**5**	**7**	**5**

[a]For Idaho, the state insurance department confirmed the number of insurers offering plans H, I, and J. Other carriers may also offer plans A through G, but this information was not readily available.

Note: This table does not include Massachusetts, Minnesota, and Wisconsin because insurers in these states are exempt from the standardized plans. Our review of information from these states' insurance departments indicates that multiple insurers also offer Medigap policies in these states.

Source: GAO review of most recently available state consumer guides, generally representing policies offered in 2000 or 2001. For certain states, including those that did not have a consumer guide or whose consumer guides identified three or fewer Medigap insurers, we obtained additional information from HCFA, state insurance departments, and insurers.

Appendix III: Average Annual Premiums by State

Table 9 presents information from the National Association of Insurance Commissioners' (NAIC) 1999 Medicare Supplement Insurance Experience Exhibit on premiums per covered life for standardized Medigap plans among the states and the District of Columbia offering the federally standardized Medigap plans. Nationally, the average premium per covered life in 1999 for the standardized plans was $1,185, and ranged from $706 in Utah to $1,600 in California.

Table 9: Average Annual Premiums Per Covered Life by State, 1999

State	Premiums per covered life for standardized plans A-J (dollars)	Percent difference from national average for standardized plans A-J
California	1,600	35.0
New York	1,509	27.3
Florida	1,507	27.2
Texas	1,404	18.5
Rhode Island	1,376	16.1
Louisiana	1,369	15.5
Connecticut	1,351	14.0
Ohio	1,351	13.9
Nevada	1,334	12.6
District of Columbia	1,329	12.1
Arizona	1,301	9.7
Mississippi	1,295	9.2
Michigan	1,291	8.9
Illinois	1,289	8.7
Colorado	1,269	7.0
Georgia	1,265	6.7
West Virginia	1,260	6.3
Missouri	1,258	6.1
Oklahoma	1,248	5.3
Tennessee	1,243	4.9
Washington	1,243	4.8
Kansas	1,241	4.7
Idaho	1,234	4.1
Indiana	1,233	4.0
Virginia	1,212	2.2
North Carolina	1,201	1.3
Alaska	1,201	1.3
South Carolina	1,185	0.0
U.S. average	**1,185**	**0.0**
Maine	1,166	-1.6
Oregon	1,163	-1.9
Alabama	1,162	-2.0

State	Premiums per covered life for standardized plans A-J (dollars)	Percent difference from national average for standardized plans A-J
Nebraska	1,161	-2.1
Kentucky	1,149	-3.1
New Mexico	1,145	-3.4
Wyoming	1,136	-4.2
Maryland	1,129	-4.7
Iowa	1,125	-5.1
South Dakota	1,121	-5.5
Arkansas	1,104	-6.9
North Dakota	1,090	-8.1
Hawaii	1,079	-9.0
Delaware	1,060	-10.6
Vermont	960	-19.0
Pennsylvania	891	-24.8
New Hampshire	762	-35.7
New Jersey	729	-38.5
Utah	706	-40.4

Notes: Percent difference may be different for the same premium amount in different states due to rounding. Excludes data for Montana because of problems with data reported by a large insurer in the state. Insurers in Massachusetts, Minnesota, and Wisconsin are exempt from offering the standardized plans because these states standardized their plans prior to the establishment of the federal standardized plans. The average premium per covered life was $1,922 in Massachusetts, $1,377 in Minnesota, and $1,264 in Wisconsin.

Source: GAO analysis of data collected on NAIC's 1999 Medicare Supplement Insurance Experience Exhibit.

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Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings (GAO/HEHS-00-183, Sept. 7, 2000)

Medigap: Premiums for Standardized Plans That Cover Prescription Drugs (GAO/HEHS-00-70R, Mar. 1, 2000)

Prescription Drugs: Increasing Medicare Beneficiary Access and Related Implications (GAO/T-HEHS/AIMD-00-100, Feb. 16, 2000)

Medigap Insurance: Compliance With Federal Standards Has Increased (GAO/HEHS-98-66, Mar. 6, 1998)

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