AHIP
Center for Policy and Research

July 2011

# Trends in Medigap Coverage and Enrollment, 2010-2011

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This report presents trends in enrollment in Medicare Supplement (Medigap) insurance coverage, using data on the numbers of policies in force as of December 2010 from the National Association of Insurance Commissioners (NAIC) and an America's Health Insurance Plans (AHIP) survey of newly purchased policies issued by Medigap carriers through the first quarter of 2011. The NAIC dataset contains information on most Medigap policies in force in the U.S.,[1] representing approximately 9.7 million covered lives as of December 2010, with policies from 250 carriers. Respondents to the AHIP survey of newly purchased policies included large nationwide carriers, single-state plans, and commercial carriers, representing about 52 percent of Medigap enrollment.

- The total enrollment in Medigap policies has been steady at around 10 million since 2004. In December 2010, enrollment in Medigap coverage increased by about 300,000 policies in force to 9.7 million, up from 9.4 million Medigap policies in force in December 2009.[2] Most Medicare beneficiaries obtain some form of supplemental coverage, either through Medigap, Medicaid, or employer-based retiree plans.

- In December 2010, most Medicare beneficiaries with standard Medigap plans purchased Plan F (47 percent). Plan C, the second most popular plan, had 16 percent of the Medigap standard plan market. Plans F and C currently cover 100 percent of the deductibles and coinsurance charged by Medicare.

- Plan F with a high deductible and newer standardized Medigap plans K, L, M, and N, which contain enrollee cost-sharing requirements (copayments, coinsurance or deductibles), made up 12 percent of new Medigap purchases in 2010, and 23 percent in the first quarter of 2011. Plan N, which includes cost sharing of up to $20 for physician office visits and up to $50 for certain emergency room visits, represented 15 percent of new Medigap policies purchased in early 2011 and is by far the most popular of the newer standardized plans.

[1] Some Medigap carriers may not report enrollment to the NAIC. However, we believe that the number of Medigap enrollees among these non-reporting carriers is relatively small and that the NAIC dataset includes most Medigap enrollment.
[2] AHIP Center for Policy and Research, Characteristics of Medigap Policies, December 2009. See: http://www.ahipresearch.org/pdfs/Medigap2009.pdf.

## BACKGROUND

Medigap is a key source of supplemental coverage for Medicare beneficiaries. Seniors purchase Medigap coverage to protect themselves from high out-of-pocket costs, to budget for medical expenses, and to avoid the confusion and inconvenience of handling complex bills from health care providers.

In 2011, the Medicare program has a $1,132 deductible per episode for inpatient hospital care (Part A) and 20 percent coinsurance for outpatient and physician care (Part B) after an annual deductible of $162.[3] The Medicare program does not have a limit on beneficiaries' potential out-of-pocket costs.

Most Medigap plans cover beneficiaries' Part A deductibles and Part B deductible and coinsurance. Some Medigap plans also cover certain benefits not covered by Medicare. In addition, under most Medigap policies, policyholders can assign their benefits directly to providers and thereby avoid the need to decipher bills and file claims. In some cases, Medigap provides "first-dollar" coverage (no cost sharing at the point of service), while other plans reduce, but do not eliminate, the cost sharing amounts beneficiaries would otherwise pay.

*Standardized Plans.* Medigap policies sold after July 1992 are required to conform to one of 14 uniform benefit packages Plans A through J, based on provisions in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).

In recent years, Congress has allowed new versions of the original standardized plans, authorized several new plans, and discontinued some of the original or modified plans.[4] The newer standardized plans require some cost sharing (deductibles, coinsurance, or copayments) to be paid by beneficiaries.

For example, Plan F is now authorized to be sold as a high-deductible plan. Plans K and L, which entered the market in 2006, do not cover the Medicare Part B deductible and only cover a portion of beneficiaries' Part B coinsurance. However, there is a limit on beneficiaries' annual out-of-pocket costs of $4,640 for Plan K and $2,320 (in 2011) for Plan L for Medicare eligible expenses.[5]

New Plans M and N entered the market in June of 2010. Plan M only covers half of the Part A deductible and does not cover the Part B deductible. Plan N provides coverage of all cost sharing, except for the Part B deductible and cost-sharing amounts of up to $20 for certain physician visits and $50 for certain emergency room visits (when the patient is not admitted to the hospital).

The Affordable Care Act of 2010 requires the NAIC to revise the standards for Plans C and F to include requirements for nominal cost sharing for Part B physicians' services beginning in 2015. Thus, Plans C and F, which are among the most popular Medigap plans, will no longer offer full "first-dollar" gap coverage for new purchasers after 2014.[6]

[3] Centers for Medicare and Medicaid Services. *Medicare premiums and coinsurance rates for 2011.* See: https://questions.medicare.gov/app/answers/detail/a_id/2305/~/medicare-premiums-and-coinsurance-rates-for-2011.

[4] Original Plans E, H, I, and J, and high-deductible Plan J are no longer available for new purchase.

[5] Centers for Medicare and Medicaid Services. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, 2011.* See: http://www.medicare.gov/publications/pubs/pdf/02110.pdf.

[6] Medicare now covers certain preventive services on a "first-dollar" (no beneficiary cost sharing at the point of service) basis.

*Waiver State Standard Plans*. Three states (Massachusetts, Minnesota, and Wisconsin) offer standard Medigap plans, but are exempt from the OBRA 1990 standard plan provisions. Individuals who purchase Medigap plans in one of these three states may keep their plans if they move to other states.

*Pre-Standardized Plans*. Medigap changes are usually phased in for new purchasers, and allow existing policyholders to retain their policies. Although OBRA 1990 prohibited the sale of new pre-standardized plans, some beneficiaries still have the pre-standardized policies.

## POLICIES IN FORCE, DECEMBER 2010

According to the NAIC data, roughly 92 percent of Medigap policies in force in December 2010 were standardized plans. The number of people with pre-standardized plans, which are no longer offered, accounts for only 8 percent of all policyholders (see Table 1).

Among people with Medigap standardized plans, Plan F continues to be the most popular, covering 47 percent of policyholders in 2010; Plan C had the second highest share, with 16 percent of the market, and Plan J had 10 percent of the Medigap standard plan market in 2010 (see Table 2). Traditionally, these most popular Medigap plans have covered all or most of Medicare's deductibles and coinsurance. The Appendix to this report shows enrollment in Medigap by state (including the District of Columbia, but not including the U.S. territories) and plan type in December 2010.

Table 1. Number of Individuals with Standardized and Pre-Standardized Medigap Plans, 2010

| | Policies | Percent |
|---|---|---|
| Standardized Plans | 8,910,110 | 92% |
| Pre-Standardized Plans | 769,422 | 8% |
| All Medigap Plans | 9,679,532 | 100% |

Source: AHIP Center for Policy and Research analysis of the National Association of Insurance Commissioners' (NAIC) *Medicare Supplement Insurance Experience Exhibit, For the Year Ended December 31, 2010.*

Table 2. Distribution of Individuals with Standardized Medigap Plans, by Type of Plan, December 2010

| Medigap Plan Type | 2010 |
|---|---|
| A | 2% |
| B | 5% |
| C | 16% |
| D | 4% |
| E | 2% |
| F | 47% |
| G | 4% |
| H | 1% |
| I | 2% |
| J | 10% |
| K | * |
| L | 0.5% |
| M | * |
| N | 2% |
| Waiver State Plans | 6% |
| Totals | 100% |

* Less than 0.5 percent.
Source: AHIP Center for Policy and Research. Analysis of the National Association of Insurance Commissioners' (NAIC) *Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2010*.
Notes: The data for standard policies include Medicare SELECT plans and those issued in three states (MA, MN, WI) that received waivers from the standard product provisions of OBRA 1990. Percentages may not sum to 100 percent due to rounding.

## CARRIERS OFFERING COVERAGE, DECEMBER 2010

In 2010, 10 percent of carriers covered individuals with standardized Medigap plans in 41 to 50 states, including the District of Columbia; 13 percent of carriers covered individuals in 26 to 40 states; 13 percent covered individuals in 11 to 25 states; and 20 percent of carriers covered individuals with standardized Medigap plans in 2 to 10 states. Over half (56 percent) of all Medigap carriers had policyholders in multiple states, and 44 percent had Medigap standardized policies in force in a single state only (see Table 3).

Table 3. Distribution of Medigap Carriers with Standardized Medigap Policies in Force, by Market Size, 2010

| Number of States | 2010 |
|---|---|
| 41 to 51 States | 10% |
| 26 to 40 States | 13% |
| 11 to 25 States | 13% |
| 2 to 10 States | 20% |
| 1 State | 44% |
| Total | 100% |

Source: AHIP Center for Policy and Research. Analysis of the National Association of Insurance Commissioners' (NAIC) *Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2010.*
Notes: Data in this table depicting the number of states is based on companies with standardized Medigap policies in force; it does not include companies with only pre-standard policies in force. The data for standardized policies include Medicare SELECT plans, and those issued in three states (MA, MN, WI) that received waivers from the standard product provisions of OBRA 1990. The number of carriers with standardized Medigap policies in force reporting to the NAIC for 2010 was 250. For this report the District of Columbia is counted as a "state."

Medicare SELECT plans are identical to standardized Medigap plans but require policyholders to use provider networks to receive the full insurance benefits. For this reason, Medicare SELECT plans generally cost less than other Medigap plans. Table 4 shows the number of carriers with Medicare SELECT policies in force, and the number of Medicare beneficiaries having a Medicare SELECT policy in 2010. Carriers with Medicare SELECT policies in force are located across the country in 45 states.

Table 4. Number of Carriers with Medicare Select Policies in Force and Number of Individuals with Medicare Select Plans, 2010

| | |
|---|---|
| Number of Carriers with Medicare SELECT Policies in Force | 106 |
| Number of Individuals with Medicare SELECT Policies | 865,460 |

Source: AHIP Center for Policy and Research. Analysis of the National Association of Insurance Commissioners' (NAIC) *Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2010.*

Table 5. Percent of Carriers with Standardized Medigap Policies in Force, by Plan Type, 2010

| Standard Plan Type | 2010 |
|---|---|
| A | 84% |
| B | 62% |
| C | 79% |
| D | 44% |
| E | 31% |
| F | 81% |
| G | 48% |
| H | 26% |
| I | 26% |
| J | 29% |
| K | 14% |
| L | 13% |
| M | 4% |
| N | 28% |
| Waiver State Plans | 28% |

Source: AHIP Center for Policy and Research analysis of the National Association of Insurance Commissioners' (NAIC) *Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2010*.
Notes: The data for standardized policies include Medicare SELECT plans, and those issued in three states (MA, MN, WI) that received waivers from the standard product provisions of OBRA 1990. The number of carriers with standardized Medigap policies in force for 2010 was 250. All plans offering new coverage must offer Plan A.

Table 6. Percent of Newly Purchased Medigap Policies with Cost-Sharing Features Sold/Issued in Standardized Categories, 2007 to First Quarter 2011

| | 2007 | 2008 | 2009 | 2010 | First Quarter 2011 |
|---|---|---|---|---|---|
| Plan F (High-Deductible) | 1% | 1% | 3% | 3% | 4% |
| Plan K | 1% | 1% | 2% | 1% | 2% |
| Plan L | 1% | 3% | 2% | 1% | 1% |
| Plan M | ** | ** | ** | * | * |
| Plan N | ** | ** | ** | 6% | 15% |
| Total New Medigap Cost-Sharing Policies Issued/Sold | 3% | 5% | 7% | 12% | 23% |

Source: AHIP Center for Policy and Research.
* Less than 0.5 percent.
** Plans authorized for sale beginning June 2010.

Table 5 displays the percentage of reporting carriers with standardized Medigap policies in force by each product type. In 2010, the percentages of carriers offering the newer Plans K and L, which were authorized beginning in 2006, are 14 percent and 13 percent, respectively. In June 2010, new Plans M and N were authorized for sale. Only 4 percent of carriers offered plan M in 2010. However, nearly 30 percent of reporting carriers offered new Plan N in its first year of availability.

## TRENDS IN NEWLY PURCHASED POLICIES

In the summer of 2011, AHIP conducted a survey of Medigap carriers at the request of the NAIC. The results of that survey indicate that the newer standardized plans requiring some enrollee cost sharing are becoming a larger share of new policies purchased. In particular, new Plan N with predictable cost sharing amounts (instead of high deductibles or unpredictable coinsurance amounts), has rapidly become the most popular new plan, representing 6 percent of new policies sold in 2010, and 15 percent in the first quarter of 2011 (see Table 6).

## COMMENTARY

As this report was being completed, Congress and the Administration were negotiating possible budget cuts as part of a political deal to increase the nation's debt limit. Although the discussions have not been held in public, Medicare cuts involving restrictions on Medigap coverage have been mentioned among budget proposals being considered.[7] The Congressional Budget Office (CBO) routinely publishes lists of possible budget cuts in its periodic Budget Options report, and the CBO options for restricting Medigap coverage have been directly cited in the deficit debate.[8] Unlike previous changes to Medigap policies, which have been phased in only for new purchasers, the CBO options imply that existing

[7] Washington Post. *Five Questions on the Debt-Ceiling Debate.* 15 July 2011. http://www.washingtonpost.com/politics/five-questions-on-the-debt-ceiling-debate/2011/07/14/gIQAcLKeGI_story.html; Appleby, Julie. *FAQ Seniors May See Changes in Medigap Policies.* Kaiser Health News. 15 July 2011. http://www.kaiserhealthnews.org/Stories/2011/July/15/medigap-medicare-supplemental-faq.aspx.
[8] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options. March 2011*. See: http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf.

Medigap policies would also be subject to restrictions.

However, the effectiveness of adding additional cost-sharing requirements on Medicare beneficiaries by restricting Medigap coverage is unclear. A review of the issues, which includes the most recent research and provides some policy suggestions, was published in the *Journal of Economic Perspectives* in March of 2011.[9]

The key issues are whether Medigap policies raise Medicare costs by spurring possible overutilization of certain health services (mostly physician office visits and certain diagnostic tests)[10] and whether proposed restrictions on Medigap coverage could have unintended consequences, including additional hospitalizations and higher health costs, especially among enrollees with chronic health care conditions and/or with low incomes.

There are three main questions in the debate over restrictions on Medigap coverage:

1. Are observed differences between the Medicare spending of Medigap policyholders and those with no supplement coverage due to an "insurance effect" (more coverage causes more spending) or a "self-selection" effect (people who know they use more health care services seek more insurance coverage)?

2. Is Medigap coverage moving away from first-dollar coverage already, such that additional restrictions would have a smaller-than-expected impact?

3. Could some types of restrictions on Medigap coverage cause enrollees to defer or skip medically necessary care, increasing their risk of adverse health consequences and expensive hospitalizations?

For years, CBO has noted the observation that Medicare enrollees with no supplemental coverage have Medicare costs that are about 25 percent less than those with Medigap coverage. This 25 percent estimate, in turn, is based on observed differences in Medicare spending between survey respondents with and without Medigap coverage, first from the National Health Interview Survey in the 1990s,[11] and similar estimates recently computed from the Medicare Current Beneficiary Surveys in the mid-2000s in a report commissioned by the Medicare Payment Advisory Commission (MedPAC).[12] The MedPAC report found that virtually all of the differences in Medicare spending among Medigap purchasers and beneficiaries with no supplemental coverage were attributable to Part B (physician and outpatient) services.

However, AHIP researchers have pointed to the higher-than-average observed levels of major and chronic illnesses as an indication that sicker beneficiaries choose Medigap coverage in the first place.[13] Thus, if a self-selection effect accounts for a

[9] Baicker, Katherine, Goldman, Dana, "Patient Cost-Sharing and Healthcare Spending Growth," (Spring 2011), Journal of Economic Perspectives, Vol. 25 / No.2, pages 47–68, last accessed on 5/25/11 at: http://www.aeaweb.org/articles.php?doi=10.1257/jep.25.2.47.

[10] Medigap only covers services deemed "medically necessary" by Medicare.

[11] Christensen, S., and J. Shinogle. (1997). Effects of supplemental coverage on use of services by Medicare enrollees. *Health Care Financing Review* 19, no. 1 (Fall): 5–17.

[12] Direct Research LLC, Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly. See: http://www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf.

[13] Lemieux, J., Chovan, T., and Heath, K. (2008). Medigap coverage and Medicare spending: A second look, *Health Affairs* 27, *(continued)*

substantial portion of the difference in spending between Medigap purchasers and Medicare beneficiaries with no supplemental coverage, the actual reduction in Medicare spending that would accompany any Medigap restrictions could be much smaller than the current estimates would imply.

MedPAC's June 2009 report to Congress, notes this ambiguity:

> *"The issue of how much Medicare spending is induced by supplemental coverage is contentious. Researchers agree that beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage. However, they disagree about what proportion of this difference is due to the pure effect of insurance (called moral hazard or insurance effect) compared with the tendency of sicker individuals to seek insurance coverage (adverse selection).[14]"*

Second, the new AHIP survey indicates that new purchasers of Medigap coverage are already moving to policies that do not have first-dollar coverage, especially Plan N. Among newer standardized Medigap plans, Plan N is the first to show a substantial uptake in its first months of availability. If the shift to Plan N accelerates in 2011 and 2012, it is possible that any additional restrictions on Medigap coverage would have smaller-than-expected impacts on Medicare spending. Likewise, if the new Plan F and C policies with nominal cost sharing, which are scheduled to enter the market in 2015, are equally popular, many more beneficiaries would voluntarily move from first-dollar coverage. Thus, any additional restrictions on Medigap plans could have a smaller impact.

Finally, two new studies indicate that while certain outpatient visits may be reduced by higher cost sharing, the negative health consequences for patients with chronic illnesses or low incomes (or both) can lead to an increase in the number of expensive hospitalizations.

In a study of changes in copayments among elderly enrollees in the California public employees' retiree system, Chandra et. al. found that a $10 increase in physician copayments was associated with a 17 percent decrease in physician visits, but also a 6 percent increase in hospitalizations. The associated $10.53 savings in Medicare-paid physician services was offset by a $5.58 increase in Medicare-paid hospital costs.[15]

In a study comparing utilization of elderly patients subject to increased copayments with those whose copayments were not increased, Trivedi et. al. estimated that the increase in physician copayments was associated with a 20 percent reduction in outpatient visits, but a 13 percent increase in hospital days. Since the cost of a hospital day exceeds that of an office visit, Trivedi estimated that the additional

no. 2 (March/April): 469–477. See: http://content.healthaffairs.org/content/27/2/469.abstract . The AHIP report suggested that high risk scores for serious and chronic illness among Medigap purchasers suggested a substantial selection effect. The report also suggested that prior studies did not sufficiently account for military or VA health users among beneficiaries coded as having no supplemental coverage, although the subsequent MedPAC report doubted the importance of the this effect.

[14] MedPAC, June 2009 Report to Congress, Improving Incentives in the Medicare Program. See: http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

[15] Chandra, Amitabh, Gruber, and McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," (March 2010), American Economic Review, 100:1, 193–213, last accessed on 4/11/11, at http://www.aeaweb.org/articles.php?doi=10.1257/aer.100.1.193.

hospital costs would likely outweigh the savings from fewer physician visits.[16]

For these reasons, policymakers considering restricting Medigap coverage should weigh the potential disruption to Medicare beneficiaries against the possibility that actual Medicare savings could be much less than currently predicted. At the least, new estimates of Medigap restrictions should factor in the possibility of adverse health consequences and possible offsetting cost increases. It would also seem prudent to see whether the modified Plans C and F (with nominal cost sharing) and new Plan N gain substantial shares of the market in coming years before mandating additional changes to Medigap coverage.

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[16] Trivedi, Amal N., Moloo, Husein, M.P.H., et. al., "Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly," (January 2010), The New England Journal of Medicine, last accessed on 4/4/2011 at http://www.nejm.org/doi/full/10.1056/NEJMsa0904533.

# APPENDIX – DECEMBER 2010 MEDIGAP ENROLLMENT, BY PLAN TYPE AND STATE, AS REPORTED TO THE NAIC

| | AK | AL | AR | AZ | CA | CO | CT | DC | DE | Total Covered Lives (All States) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan A | 276 | 1,280 | 842 | 2,927 | 9,581 | 1,579 | 2,720 | 174 | 680 | 192,177 |
| B | 94 | 138,219 | 781 | 1,510 | 4,178 | 1,556 | 4,433 | 110 | 1,130 | 451,013 |
| C | 698 | 35,359 | 3,162 | 13,929 | 21,964 | 5,126 | 17,902 | 676 | 2,666 | 1,386,307 |
| D | 119 | 1,249 | 1,020 | 1,709 | 4,436 | 1,608 | 3,423 | 62 | 3,851 | 332,547 |
| E | 70 | 503 | 219 | 1,048 | 2,225 | 786 | 1,790 | 68 | 2,307 | 151,271 |
| F | 4,323 | 20,343 | 31,165 | 109,405 | 145,696 | 66,915 | 48,935 | 2,937 | 8,861 | 4,200,028 |
| G | 114 | 3,117 | 2,232 | 5,016 | 8,506 | 4,552 | 3,350 | 146 | 1,345 | 331,828 |
| H | 21 | 128 | 27 | 740 | 1,882 | 318 | 931 | 23 | 183 | 66,899 |
| I | 430 | 313 | 271 | 1,762 | 7,512 | 1,856 | 2,302 | 233 | 2,017 | 148,616 |
| J | 1,523 | 1,869 | 6,246 | 14,077 | 85,337 | 13,726 | 31,208 | 1,899 | 6,124 | 865,464 |
| K | 46 | 197 | 245 | 681 | 1,773 | 433 | 423 | 46 | 392 | 29,466 |
| L | 40 | 171 | 236 | 630 | 1,672 | 462 | 451 | 53 | 274 | 39,917 |
| M | - | 1 | 1 | 3 | 3 | 2 | - | - | 1 | 265 |
| N | 33 | 1,369 | 1,511 | 2,705 | 1,968 | 896 | 706 | 51 | 459 | 148,192 |
| Waiver | - | - | - | - | - | - | - | - | - | 547,310 |
| Pre-Standard | 433 | 2,051 | 106,094 | 7,374 | 28,253 | 5,465 | 36,049 | 663 | 2,994 | 769,127 |
| Total Covered Lives (State) | 8,220 | 206,169 | 154,052 | 163,516 | 324,986 | 105,280 | 154,623 | 7,141 | 33,284 | 9,660,427 |

| | FL | GA | HI | IA | ID | IL | IN | KS | KY | Total Covered Lives (All States) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan A | 15,471 | 2,979 | 173 | 1,027 | 677 | 7,144 | 5,304 | 1,840 | 2,132 | 192,177 |
| B | 63,255 | 5,680 | 57 | 362 | 367 | 7,688 | 5,305 | 821 | 10,839 | 451,013 |
| C | 107,226 | 28,498 | 594 | 5,043 | 2,826 | 31,978 | 22,514 | 21,461 | 32,524 | 1,386,307 |
| D | 82,462 | 5,440 | 41 | 1,161 | 280 | 47,238 | 8,414 | 2,993 | 3,829 | 332,547 |
| E | 21,636 | 15,119 | 32 | 5,161 | 159 | 3,888 | 6,233 | 1,350 | 7,263 | 151,271 |
| F | 165,568 | 132,714 | 1,856 | 192,005 | 39,422 | 418,013 | 170,219 | 146,444 | 77,439 | 4,200,028 |
| G | 14,832 | 10,833 | 66 | 2,090 | 3,493 | 12,125 | 22,111 | 3,966 | 7,229 | 331,828 |
| H | 1,672 | 186 | 15 | 150 | 12 | 419 | 1,168 | 183 | 4,082 | 66,899 |
| I | 9,418 | 2,435 | 95 | 457 | 263 | 2,590 | 3,170 | 1,143 | 1,520 | 148,616 |
| J | 105,162 | 17,421 | 928 | 21,849 | 4,864 | 22,265 | 18,107 | 5,755 | 6,555 | 865,464 |
| K | 2,148 | 875 | 33 | 89 | 273 | 970 | 625 | 602 | 319 | 29,466 |
| L | 2,355 | 751 | 24 | 402 | 134 | 824 | 1,076 | 398 | 505 | 39,917 |
| M | 49 | 5 | - | 2 | 1 | 12 | 2 | 2 | 3 | 265 |
| N | 5,359 | 3,402 | 20 | 3,097 | 726 | 11,076 | 11,447 | 2,114 | 4,346 | 148,192 |
| Waiver | 2 | 10 | - | - | - | 3,150 | - | - | - | 547,310 |
| Pre-Standard | 46,541 | 14,315 | 287 | 20,990 | 1,434 | 40,217 | 17,754 | 8,169 | 11,233 | 769,127 |
| Total Covered Lives (State) | 643,156 | 240,663 | 4,221 | 253,885 | 54,931 | 609,597 | 293,449 | 197,241 | 169,818 | 9,660,427 |

*(Continued)*

# APPENDIX – DECEMBER 2010 MEDIGAP ENROLLMENT, BY PLAN TYPE AND STATE, AS REPORTED TO THE NAIC *(Continued)*

| | LA | MA | MD | ME | MI | MN | MO | MS | MT | Total Covered Lives (All States) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan A | 691 | 153 | 5,282 | 1,641 | 15,368 | 2,556 | 3,703 | 1,136 | 1,039 | 192,177 |
| B | 4,233 | 69 | 7,013 | 2,894 | 1,464 | 3,918 | 4,255 | 1,792 | 616 | 451,013 |
| C | 5,589 | 1,588 | 28,877 | 19,690 | 185,307 | 275 | 21,520 | 6,234 | 7,890 | 1,386,307 |
| D | 1,153 | 87 | 6,326 | 1,204 | 4,410 | 24 | 14,714 | 2,427 | 698 | 332,547 |
| E | 393 | 116 | 1,065 | 1,964 | 1,904 | 41 | 3,540 | 507 | 219 | 151,271 |
| F | 82,767 | 1,139 | 75,958 | 31,746 | 76,687 | 1,006 | 156,444 | 86,717 | 30,669 | 4,200,028 |
| G | 7,388 | 100 | 4,249 | 2,173 | 16,350 | 25 | 10,924 | 5,905 | 2,207 | 331,828 |
| H | 162 | 34 | 1,212 | 60 | 387 | 72 | 986 | 137 | 71 | 66,899 |
| I | 1,034 | 223 | 1,203 | 3,179 | 1,892 | 306 | 3,643 | 472 | 582 | 148,616 |
| J | 1,987 | 543 | 16,438 | 7,919 | 11,964 | 3,265 | 21,384 | 8,249 | 4,493 | 865,464 |
| K | 542 | . | 608 | 101 | 968 | 39 | 513 | 204 | 91 | 29,466 |
| L | 520 | - | 630 | 237 | 1,064 | 43 | 620 | 197 | 150 | 39,917 |
| M | 1 | . | 3 | 1 | 26 | - | 7 | 3 | 1 | 265 |
| N | 2,918 | - | 2,910 | 601 | 7,242 | - | 6,051 | 4,810 | 411 | 148,192 |
| Waiver | - | 203,722 | - | - | - | 147,039 | - | - | - | 547,310 |
| Pre-Standard | 7,517 | 2,902 | 13,163 | 1,309 | 31,843 | 7,347 | 20,371 | 5,375 | 2,706 | 769,127 |
| Total Covered Lives (State) | 116,895 | 210,676 | 164,937 | 74,719 | 356,876 | 165,956 | 268,675 | 124,165 | 51,843 | 9,660,427 |

| | NC | ND | NE | NH | NJ | NM | NV | NY | OH | Total Covered Lives (All States) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan A | 3,495 | 222 | 786 | 1,387 | 12,106 | 1,019 | 1,339 | 22,341 | 5,074 | 192,177 |
| B | 5,925 | 150 | 1,261 | 1,070 | 5,189 | 1,166 | 904 | 53,067 | 6,558 | 451,013 |
| C | 24,487 | 1,480 | 5,908 | 5,326 | 105,639 | 3,055 | 2,777 | 52,736 | 96,778 | 1,386,307 |
| D | 6,236 | 302 | 1,181 | 789 | 4,376 | 693 | 896 | 3,461 | 22,124 | 332,547 |
| E | 3,414 | 70 | 160 | 2,288 | 995 | 185 | 394 | 10,891 | 6,158 | 151,271 |
| F | 218,042 | 49,949 | 89,053 | 23,385 | 68,457 | 22,649 | 27,376 | 142,998 | 124,763 | 4,200,028 |
| G | 15,577 | 330 | 5,207 | 2,496 | 14,488 | 1,286 | 2,669 | 11,976 | 21,447 | 331,828 |
| H | 1,104 | 41 | 192 | 479 | 5,424 | 110 | 688 | 7,539 | 1,800 | 66,899 |
| I | 4,127 | 123 | 442 | 670 | 15,974 | 1,380 | 981 | 14,394 | 5,854 | 148,616 |
| J | 51,400 | 1,572 | 10,819 | 21,289 | 64,863 | 6,054 | 6,193 | 11,204 | 24,566 | 865,464 |
| K | 670 | 9 | 62 | 124 | 1,105 | 144 | 293 | 1,612 | 874 | 29,466 |
| L | 901 | 23 | 103 | 668 | 1,246 | 198 | 350 | 1,889 | 9,255 | 39,917 |
| M | 6 | - | 9 | 1 | 2 | 7 | 1 | 35 | 3 | 265 |
| N | 9,310 | 159 | 1,403 | 780 | 3,197 | 398 | 619 | 3,132 | 7,764 | 148,192 |
| Waiver | - | 5 | - | - | - | - | - | - | - | 547,310 |
| Pre-Standard | 19,759 | 987 | 14,241 | 5,411 | 38,918 | 2,492 | 1,814 | 19,270 | 24,158 | 769,127 |
| Total Covered Lives (State) | 364,453 | 55,422 | 130,827 | 66,163 | 341,979 | 40,836 | 47,294 | 356,545 | 357,176 | 9,660,427 |

*(Continued)*

# APPENDIX – DECEMBER 2010 MEDIGAP ENROLLMENT, BY PLAN TYPE AND STATE, AS REPORTED TO THE NAIC *(Continued)*

| | OK | OR | PA | RI | SC | SD | TN | TX | UT | Total Covered Lives (All States) |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan A | 3,205 | 1,774 | 8,023 | 351 | 2,371 | 479 | 2,014 | 12,477 | 891 | 192,177 |
| B | 2,185 | 643 | 63,360 | 272 | 4,908 | 234 | 4,305 | 7,097 | 731 | 451,013 |
| C | 6,626 | 6,186 | 283,366 | 26,042 | 9,402 | 1,140 | 19,696 | 38,601 | 4,836 | 1,386,307 |
| D | 4,903 | 1,278 | 22,528 | 147 | 22,347 | 108 | 7,417 | 17,781 | 2,068 | 332,547 |
| E | 1,114 | 528 | 27,071 | 110 | 847 | 329 | 4,060 | 3,224 | 736 | 151,271 |
| F | 97,697 | 68,090 | 56,081 | 4,960 | 92,523 | 57,314 | 84,467 | 315,988 | 21,461 | 4,200,028 |
| G | 5,267 | 2,607 | 9,525 | 153 | 10,038 | 928 | 6,475 | 46,930 | 2,610 | 331,828 |
| H | 311 | 121 | 25,924 | 19 | 421 | 17 | 380 | 4,343 | 678 | 66,899 |
| I | 930 | 1,291 | 18,895 | 197 | 1,498 | 159 | 1,104 | 9,728 | 675 | 148,616 |
| J | 9,001 | 6,833 | 32,602 | 1,318 | 15,387 | 2,152 | 8,576 | 62,569 | 4,794 | 865,464 |
| K | 1,214 | 335 | 1,334 | 23 | 420 | 24 | 495 | 3,947 | 92 | 29,466 |
| L | 1,953 | 273 | 1,725 | 262 | 518 | 112 | 449 | 4,378 | 173 | 39,917 |
| M | 3 | 7 | 5 | 1 | 2 | 2 | - | 43 | - | 265 |
| N | 3,117 | 3,077 | 8,442 | 187 | 3,516 | 346 | 4,542 | 14,246 | 697 | 148,192 |
| Waiver | - | - | - | 1 | 1 | - | - | - | - | 547,310 |
| Pre-Standard | 8,175 | 6,476 | 48,439 | 368 | 7,566 | 4,519 | 24,081 | 26,520 | 2,846 | 769,127 |
| Total Covered Lives (State) | 145,701 | 99,519 | 607,320 | 34,411 | 171,765 | 67,863 | 168,061 | 567,872 | 43,288 | 9,660,427 |

| | VA | VT | WA | WI | WV | WY | Total Covered Lives (All States) |
|---|---|---|---|---|---|---|---|
| Plan A | 3,628 | 1,309 | 9,045 | 8,545 | 1,331 | 590 | 192,177 |
| B | 6,251 | 1,454 | 1,573 | 8,081 | 1,667 | 323 | 451,013 |
| C | 16,608 | 13,553 | 19,741 | 408 | 8,153 | 2,647 | 1,386,307 |
| D | 3,606 | 7,030 | 1,463 | 39 | 976 | 420 | 332,547 |
| E | 3,675 | 2,641 | 1,970 | 52 | 632 | 121 | 151,271 |
| F | 148,919 | 1,002 | 102,885 | 636 | 35,337 | 20,603 | 4,200,028 |
| G | 6,550 | 137 | 7,794 | 36 | 2,106 | 752 | 331,828 |
| H | 1,318 | 333 | 188 | 13 | 146 | 49 | 66,899 |
| I | 9,475 | 35 | 7,918 | 83 | 1,997 | 365 | 148,616 |
| J | 37,230 | 6,783 | 28,270 | 2,907 | 5,315 | 2,610 | 865,464 |
| K | 347 | 94 | 2,726 | . | 225 | 61 | 29,466 |
| L | 531 | 63 | 556 | - | 256 | 116 | 39,917 |
| M | 5 | 1 | 2 | . | 1 | - | 265 |
| N | 3,482 | 368 | 1,391 | - | 1,511 | 280 | 148,192 |
| Waiver | 1 | - | 90 | 193,289 | - | - | 547,310 |
| Pre-Standard | 25,251 | 3,658 | 14,410 | 19,466 | 5,640 | 1,813 | 769,127 |
| Total Covered Lives (State) | 266,877 | 38,461 | 200,022 | 233,555 | 65,293 | 30,750 | 9,660,427 |

Source: AHIP Center for Policy and Research analysis of the National Association of Insurance Commissioners' (NAIC) *Medicare Supplement Insurance Experience Exhibit, For the Year Ended December 31, 2010.*
Notes: Data includes policies issued in three states (MA, MN, WI) that received waivers from the standard product provisions of OBRA 1990.

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