AHIP
Guiding Greater Health

The State of Medicare Supplement Coverage

TRENDS IN ENROLLMENT AND DEMOGRAPHICS

May 2024

Executive Summary

Medicare Supplement protects the health and financial security of more than 14 million American seniors.

Seniors deserve affordable coverage that provides them with access to high-quality health care, protecting both their health and financial security. Medicare Supplement delivers for them, helping to fill the gaps and pay for costs that traditional Medicare does not cover. Laws and regulations that increase Medicare Supplement premiums will make it unaffordable for millions of Americans, including many low-income seniors in rural America.

What Is Medicare Supplement?

Medicare Supplement (also called Medigap) plans are a type of private health insurance coverage that seniors may choose to help them pay for the costs that traditional Medicare doesn't cover. Seniors purchase Medicare Supplement coverage to protect themselves from high out-of-pocket costs not covered by traditional Medicare, to budget for medical expenses, and to avoid the confusion and inconvenience of handling complex bills from health care providers.

Key Takeaways

- Among fee-for-service (FFS) Medicare enrollees without additional insurance coverage (such as Medicaid, employer-provided insurance, etc.), **57% had Medicare Supplement coverage in 2021.**
- Between December 2017 and December 2022, the share of FFS Medicare enrollees who **purchase Medicare Supplement coverage increased from 35% to 41%.**
- **Medicare enrollees with Medicare Supplement coverage were nearly 3 times less likely to have problems paying medical bills compared to enrollees without Medicare Supplement policies.**
  - Only 2% of enrollees with Medicare Supplement coverage reported having difficulty paying medical bills in the last 12 months, compared to 6% of FFS Medicare enrollees without Medicare Supplement coverage.

Medicare Supplement policies are guaranteed renewable – so seniors will never lose access to their coverage or lose benefits year to year. There are several standardized Medicare Supplement plan designs from which Medicare beneficiaries may choose. In 2022, Plan F and Plan G were the popular, with 39% and 35% of all Medicare Supplement enrollees.

This report describes Medicare Supplement coverage options, demographics of enrollees with Medicare Supplement policies, and the most recent enrollment trends by using the latest available data sources: 2022 National Association of Insurance Commissioners (NAIC) data, 2022 California Department of Managed Health Care data, and 2021 Medicare Current Beneficiary Survey (MCBS) results.

Medicare Supplement Enrollees Value Their Coverage[1]

93% of seniors said they are satisfied with their Medicare Supplement plan, with **80% saying they are very or extremely satisfied.**

91% of seniors said they would be concerned about losing their financial security if they didn't have Medicare Supplement coverage, and **90% would be concerned** about paying co-pays and/or co-insurance.

83% of seniors rated the value of their Medicare Supplement coverage as **excellent or good.**

96% of seniors said they agree that Medicare Supplement coverage allows them to **see doctors and specialists they know and trust** without worrying too much about out-of-pocket costs.

How Does Medicare Supplement Work?

This report describes Medicare Supplement coverage options, demographics of enrollees with Medicare Supplement policies, and the most recent enrollment trends by using the latest available data sources: 2022 National Association of Insurance Commissioners (NAIC) data[2], 2022 California Department of Managed Health Care data, and 2021 Medicare Current Beneficiary Survey (MCBS) results.

Medicare Supplement (also known as Medigap) is a key source of additional coverage for Medicare enrollees to more fully protect their health and financial security. Seniors purchase Medicare Supplement coverage to protect themselves from high out-of-pocket costs not covered by original Medicare, to budget for medical expenses, and to avoid the confusion and inconvenience of handling complex bills from health care providers.

In 2022, the original Medicare program had a $1,556 deductible per benefit period for inpatient hospital care (Part A) and coinsurance beginning with day 61 of hospitalization.[3] Part B required 20% coinsurance for outpatient and physician care after an annual deductible of $233.[4]The original Medicare program does not have a limit on enrollees' potential out-of-pocket costs.

Appendix A, found at the end of this report, provides detailed information on the benefits and cost sharing features of 2022 standardized Medicare Supplement plans.

Standardized Plans. Over the last 30 years, Medicare Supplement plans have undergone major changes to benefit designs. First, the provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) required that policies sold after July 1992 conform to 1 of 10 uniform benefit packages, known among Medicare Supplemental plans as Plans A through J. Then in 2003, the Medicare Modernization Act (MMA) required elimination of prescription drug benefits from Medicare Supplement coverage, authorized 2 new plans (Plans K and L) with cost sharing features, and encouraged development of standardized benefit designs with additional cost-sharing features.

Further changes to standardized plans occurred in 2008 with the passage of the Medicare Improvements for Patients and Providers Act (MIPPA)[5] and included:

- Elimination of the at-home recovery benefit in favor of a new hospice benefit (described below).
- Addition of a new core hospice benefit that covers the cost sharing under Medicare FFS for palliative drugs and inpatient respite care.
- Removal of the preventive care benefit in recognition of the increased Medicare FFS coverage under Part B.
- Introduction of 2 new Medicare Supplement policies (Plans M and N) with increased enrollee cost-sharing features.
- Elimination of several standardized plans (Plans E, H, I, J and J with high deductible) that became duplicative or unnecessary due to benefit design changes.

All Medicare Supplement plans are "guaranteed renewable" regardless of when they were purchased. Therefore, some policyholders continue to maintain plans with previous benefits even though the plans can no longer be sold.

Most Medicare Supplement plans cover enrollees' Part A deductible and Part B coinsurance. Two plans—standardized plans C and F—offer full coverage for the Part B deductible.

Plans F and G can also be sold as a high-deductible plan. These plans also cover Part B coinsurance and copayment amounts, as do most, but not all, standardized plans.

Plans K and L do not cover the Medicare Part B deductible and cover a portion of enrollees' Part B coinsurance. However, there is a limit on enrollees' annual out-of-pocket costs for Medicare eligible expenses —$6,620 for Plan K and $3,310 for Plan L in 2022.[6]

New Plans M and N entered the market in June of 2010. Plan M covers half of the Part A deductible and does not cover the Part B deductible. Plan N covers all of the Part A deductible and does not cover the Part B deductible. Plan N also includes cost-sharing amounts of up to $20 for certain physician visits and up to $50 for certain emergency department visits.

Medicare SELECT plans are identical to standardized Medicare Supplement 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 Medicare Supplement plans.

In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This new law provided that beginning on January 1, 2020, Medicare Supplement insurance carriers can no longer sell Medicare Supplement plans covering the Part B deductible to individuals who are "newly eligible" for Medicare. People who attained age 65 before January 1, 2020, and those who were eligible for Medicare due to disability before that date, continued to have access to Plans C and F, which are the only standardized plans currently available for sale that cover the Part B deductible.

Waivered States. Three states (Massachusetts, Minnesota, and Wisconsin) offer standardized Medicare Supplement plans but are exempt from the OBRA 1990 standardized plan provisions (and subsequent revisions under the MMA or MIPPA). Standardized plans may therefore be changed by waivered states without federal approval. Individuals who purchase Medicare Supplement plans in 1 of these 3 states may keep their plans if they move to other states.

Pre-Standardized Plans. Historically, Medicare Supplement changes have been phased in for new purchasers, and existing policyholders were allowed to retain their pre-standardized policies. Although OBRA 1990 prohibited the sale of new pre-standardized plans, some enrollees still have pre-standardized policies.

Who Enrolls in Medicare Supplement?

In 2022, Medicare Supplement insurance coverage continued to grow and reached a record 41.4% of all Medicare fee-for-service enrollees (see Figure1). However, as enrollment in traditional, FFS Medicare has decreased (shrinking by more than a million enrollees in 2021-22 alone), national Medicare Supplement enrollment also fell by 1.9% in 2022 (see Table 1).

Table 1. Trends in National Medicare Supplement Enrollment, 2018-2022

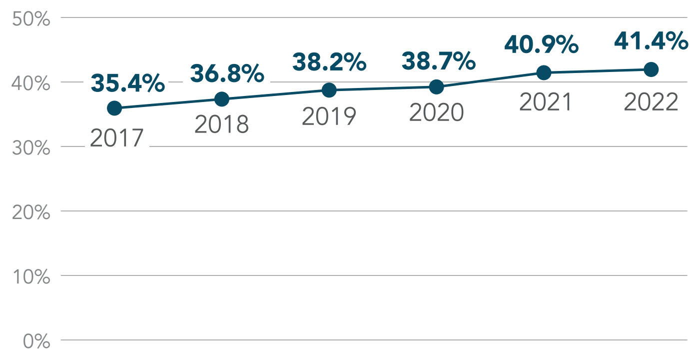
Statistic	Year				
	2018	2019	2020	2021	2022
• Enrollment reported to NAIC	13,546,429	14,013,086	13,900,107	14,077,889	13,790,813
• Enrollment reported to California DMHC	444,391	469,792	495,681	514,179	528,839
Total national Medicare Supplement enrollment	13,990,820	14,482,878	14,395,788	14,592,068	14,319,652
Annual percent change in total national Medicare Supplement enrollment, %	3.7%	3.5%	-0.6%	1.4%	-1.9%

Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibits, for the Years Ended Dec. 31, 2017; Dec. 31, 2018; Dec. 31, 2019; Dec. 31, 2020; Dec. 31, 2021; and Dec.31, 2022 and of the California DMHC Enrollment Summary Reports, 2017-2022.

The updated data demonstrate that the share of enrollees in Medicare Supplement has been steadily growing in recent years. This growth continued in 2022 when the proportion of FFS Medicare enrollees with Medicare supplement increased from 40.9% to 41.4% (See Figure 1).

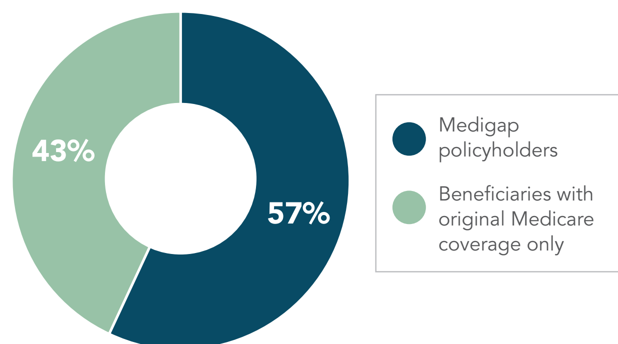
Nationwide, Medicare Current Beneficiary Survey (MCBS) estimates show that 57% of all non-institutionalized FFS Medicare enrollees without any additional coverage (i.e., Medicaid, Veterans Affairs coverage, employer-provided insurance, retiree drug subsidy plan, self-purchased specialty plan, etc.) chose Medicare Supplement policies in 2021.

Figure 1. Share of Medicare Fee-For-Service Enrollees with Medicare Supplement Insurance, 2017-2022



Source: National Association of Insurance Commisioners (2017-2022), California's Department of Managed Health Care (2017-2022).

Figure 2. Medicare Enrollees Without Any Additional Insurance Coverage That Had Medicare Supplement Coverage, 2021



Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS).

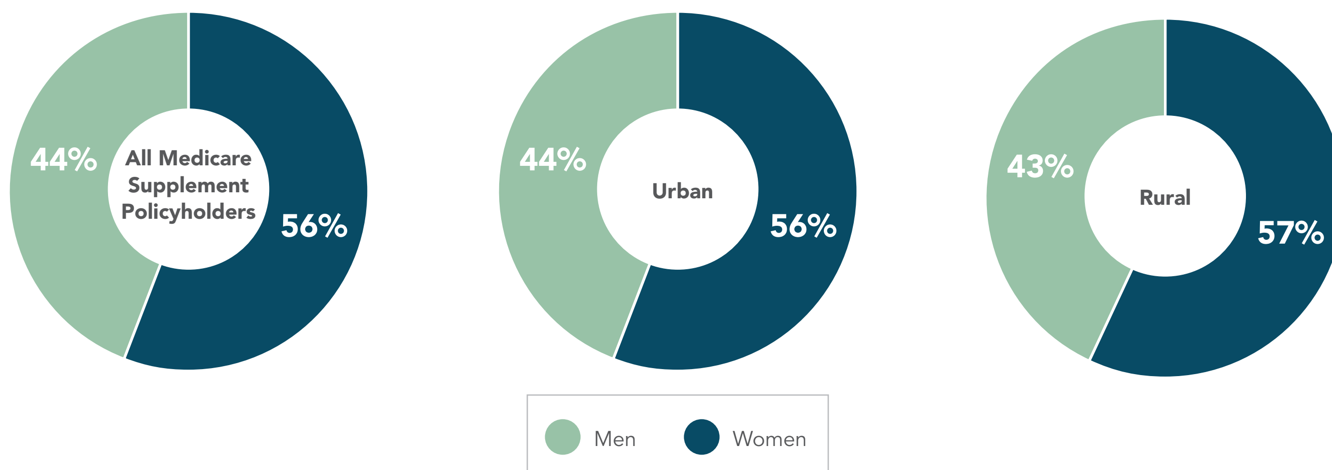
Demographic Characteristics of Medicare Supplement Enrollees

The demographic characteristics of Medicare Supplement enrollees are based on the Medicare Current Beneficiary Survey (MCBS) 2021 data, which is the latest year for which data is available.

Gender

Across the country, a majority—56% —of Medicare Supplement enrollees in 2020 were women (see Figure 3). This gender distribution did not change from the previous year.

Figure 3. Gender Distribution of Medicare Supplement Policyholders, by Geographic Location, 2021



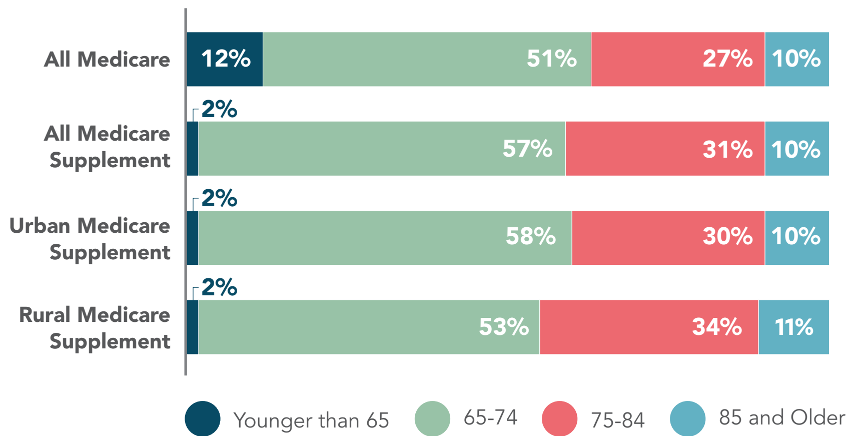
Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS).

Note: Calculations based on responses by non-institutionalized Medicare enrollees reporting gender.

Age

Medicare enrollees with Medicare Supplement insurance were older than the general Medicare population: 41% of Medicare Supplement policyholders were 75 years old or older compared with 37% for all Medicare enrollees (see Figure 4).

Figure 4. Age Distribution of Medicare Supplement Policyholders, by Geographic Location, 2021



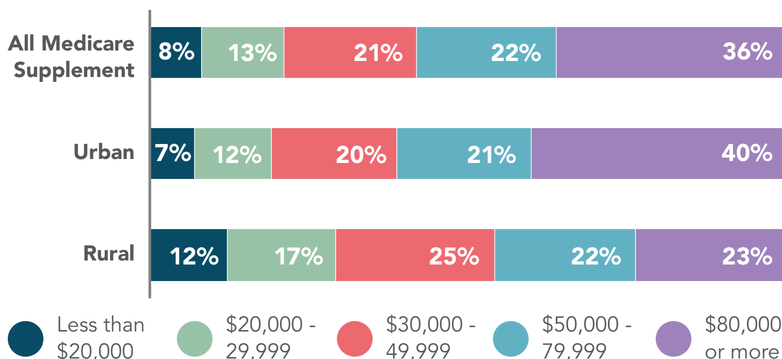
Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS).

Note: Calculations based on responses by non-institutionalized Medicare enrollees reporting income. The percentages in this table may not sum to 100 due to rounding.

Income and Financial Security

A significant number of Medicare Supplement policyholders were individuals with lower incomes: 8% had annual household incomes below $20,000 and 21% had incomes below $30,000. This pattern was more significant in rural areas, where 12% of Medicare Supplement policyholders had incomes below $20,000 (see Figure 5).

Figure 5. Income Range of Medigap Policyholders (Combined Income of Beneficiary and Spouse), By Geographic Location, 2021

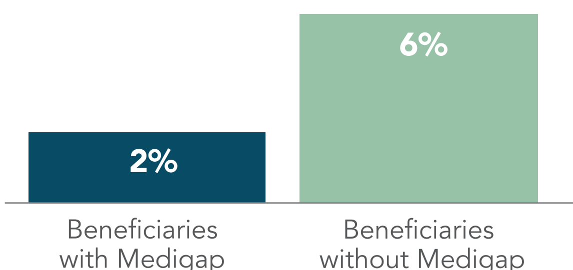


Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS).

Note: Calculations based on responses by non-institutionalized Medicare enrollees reporting income. The percentages in this table may not sum to 100 due to rounding.

FFS Medicare enrollees with Medicare Supplement coverage were nearly 3 times less likely to have problems paying medical bills compared to enrollees without Medicare Supplement policies (see Figure 6).

Figure 6. Share of Fee-For-Service Medicare Enrollees Who Had Problems Paying Medical Bills in Last 12 Months, by Medicare Supplement Insurance Status, 2021



Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS).

Note: The category of Medicare enrollees without Medicare Supplement excluded any enrollees who reported being enrolled in a Medicare Advantage plan at any time during the calendar year of the interview.

Geography

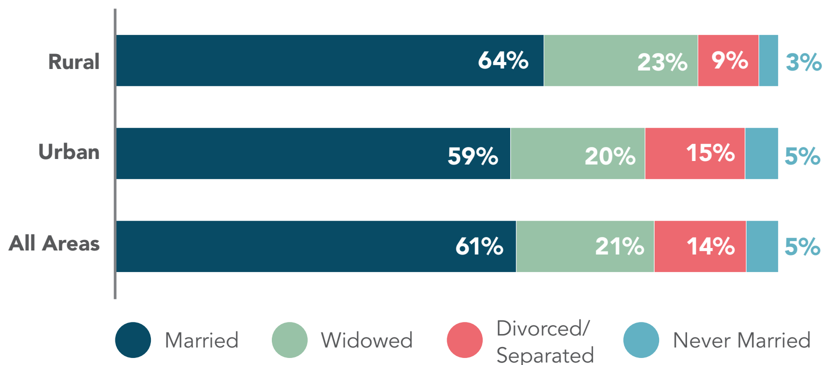
Data show that 24% of Medicare Supplement policyholders lived in rural, non-metropolitan areas (which, for the purpose of this report, include any area with an urban cluster of less than 50,000 people) in 2021.

Rural Medicare Supplement policyholders had substantially fewer financial resources than urban policyholders: only 23% of rural Medicare Supplement policyholders had household incomes of $80,000 or more compared to 40% for urban Medicare Supplement policyholders (see Figure 5).

Marital Status

Many Medicare Supplement enrollees live without a partner and thus have less robust support networks to rely on in case of financial or health problems: 39% of Medicare Supplement enrollees were widowed, divorced, separated, or never married in 2021 (see Figure 7). Medicare Supplement coverage provides an important source of security for this potentially vulnerable group.

Figure 7. Marital Status of Medicare Supplement Policyholders, by Geographic Location, 2021



Source: Medicare Current Beneficiary Survey Limited Data Set Files, 2021 (CMS).

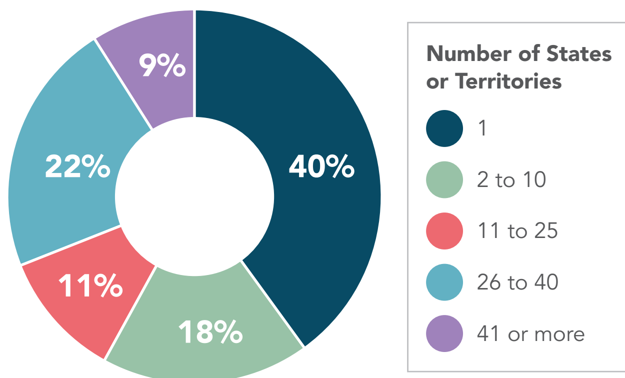
Note: Calculations based on responses by non-institutionalized Medicare enrollees reporting age. The percentages in this table may not sum to 100 due to rounding.

Companies That Offer Medicare Supplement

As of December 2022, 9% of companies offering standardized Medicare Supplement policies covered individuals in 41 or more states or territories, 22% of companies covered individuals in 26 to 40 states or territories, 11% covered individuals in 11 to 25 states or territories, and 18% of companies covered individuals with standardized Medicare Supplement plans in 2 to 10 states or territories. In addition, 40% of all Medicare Supplement companies had standardized policies in force in a single state or territory (see Figure 8).

This distribution has changed very little in the last several years.

Figure 8. Distribution of Medicare Supplement Companies with Standardized Medicare Supplement Policies in Force, by Market Size, December 2022



Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibit, for the Year Ended Dec. 31, 2022.

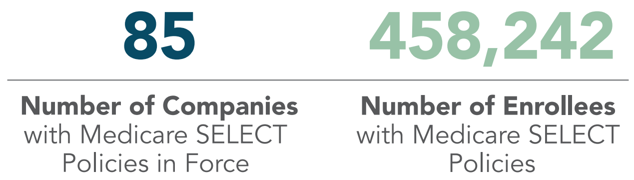
Notes: The enrollment data for this Figure do not include Medicare Supplement enrollment numbers reported by insurance providers in 2022 to the California DMHC. Data in this table depicting the number of states is based on companies with standardized Medicare Supplement policies in force; data do not include companies with only pre-standardized policies in force. The data for standardized policies include Medicare SELECT plans and those issued in 3 states (MA, MN, and WI) that received waivers from the standardized product provisions of OBRA 1990. The number of companies with standardized Medicare Supplement policies in force reporting to the NAIC for 2022 was 307. The U.S. territories are Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands. Percentages may not sum to 100 due to rounding.

Eighty-five companies had Medicare SELECT policies in force for about 460,000 Medicare enrollees on December 31, 2022 (see Figure 9). Companies with Medicare SELECT policies in force were located across the country in 41 states on December 31, 2022.

Overall, the percentage distribution of reporting companies with standardized Medicare Supplement policies in force by plan type experienced only minor changes in the last 5 years (see Table 2). In 2022, the most commonly offered plans were Plan F (85%), Plan A (77%), and Plan G (75%).

In accordance with previous trends, Plan N continued to increase in popularity and rose from 67% to 68% of insurance providers with policies in force. Plan A, Plan B, and Plan C continued a slow, but sustained decline of previous several years: the share of companies offering them in 2022 compared to the prior year decreased from 79% to 77% for Plan A, from 53% to 51% for Plan B, and from 69% to 68% for Plan C.

Figure 9. Number of Companies with Medicare Select Policies in Force and Number of Enrollees with Medicare Select Plans, December 2022



Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2022.

Notes: The enrollment data for this Figure do not include Medicare Supplement enrollment numbers reported by insurers in 2022 to the California DMHC.

Table 2. Percent of Companies with Standardized Medicare Supplement Policies in Force, by Plan Type, 2018 – 2022

	Percent of Companies				
Plan Type	**2018**	**2019**	**2020**	**2021**	**2022**
A	81%	83%	82%	79%	77%
B	55%	54%	53%	53%	51%
C	74%	72%	69%	69%	68%
D	42%	42%	47%	45%	46%
E	24%	23%	22%	21%	20%
F	85%	85%	85%	86%	85%
G	66%	70%	73%	75%	75%
H	21%	21%	20%	20%	19%
I	19%	18%	18%	17%	17%
J	22%	22%	21%	20%	20%
K	15%	15%	15%	15%	15%
L	14%	15%	15%	14%	13%
M	9%	9%	8%	9%	8%
N	59%	62%	64%	67%	68%
Waivered State Plans	34%	35%	35%	33%	35%

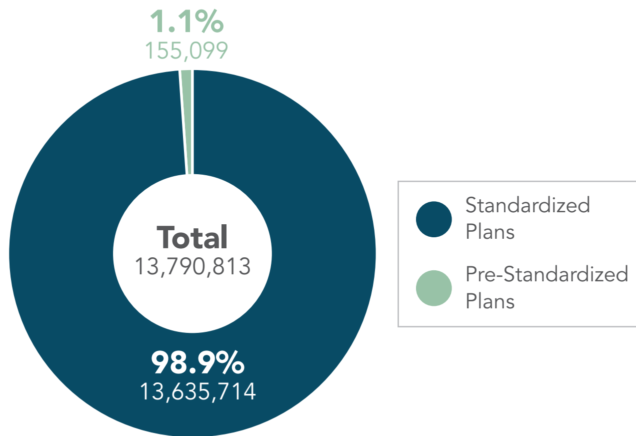
Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibits, for the Years Ended December 31, 2018, December 31, 2019, December 31, 2020, December 31, 2021, and December 31, 2022.

Notes: The enrollment data for this Figure do not include Medicare Supplement enrollment numbers reported by insurance providers to the California DMHC. The data for standardized policies include Medicare SELECT plans and those issued in 3 states (MA, MN, and WI) that received waivers from the standardized product provisions of OBRA 1990. The number of companies with standardized Medicare Supplement policies in force was 289 for 2018, 292 for 2019, 295 for 2020, 299 in 2021, and 307 in 2022. All plans offering new coverage must offer Plan A. Plans E, H, I and J are no longer sold but some policyholders have retained their coverage for these plans.

Medicare Supplement Policies in Force

According to the NAIC data, almost all of Medicare Supplement policies in force on December 31, 2022, were standardized plans, at 98.9%. Pre-standardized plans, which were no longer sold after July 1992, account for only 1.1% of all Medicare Supplement policies (see Figure 10).

Figure 10. Number of Policies for Standardized and Pre-Standardized Medicare Supplement Plans, December 31, 2022



Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibit, for the Year Ended December 31, 2022.

Note: The data for standardized plans contain both pre- and post-MIPPA plans. See page 3-4 for further explanation.

Among enrollees with Medicare Supplement standardized plans, Plan F retained its position as the plan with by far the highest number of enrollees. However, it continued to lose its market share, declining from 49% in 2019 to 39% in 2022. On the other hand, Plan G similarly continued its previous fast growth, increasing from 22% of the total enrollment in 2019 to 36% in 2022 (see Tables 3-4). If these trends continue, Plan G may replace Plan F as the top plan by enrollment in the next several years.

Despite the variety of standardized Medicare Supplement plans in the market, 3 plan types (F, G, and N) accounted for 85% of the total enrollment. At the same time, 5 standardized Medicare Supplement plans with the lowest enrollment (E, H, I, L, and M) combined added up to less than 1% of all standardized policies (see Tables 3-4).

Table 3. Distribution of Enrollment by Standardized Plan Type, 2018-2022

	Percent of Enrollment			
Standardized Plan	**2019**	**2020**	**2021**	**2022**
A	1%	1%	1%	1%
B	2%	1%	1%	1%
C	5%	4%	3%	3%
D	1%	1%	1%	1%
E	< 0.5%	< 0.5%	< 0.5%	< 0.5%
F*	49%	46%	41%	39%
G**	22%	27%	32%	36%
H	< 0.5%	< 0.5%	< 0.5%	< 0.5%
I	1%	< 0.5%	< 0.5%	< 0.5%
J	3%	2%	2%	2%
K	1%	1%	1%	< 0.5%
L	< 0.5%	< 0.5%	< 0.5%	< 0.5%
M	< 0.5%	< 0.5%	< 0.5%	< 0.5%
N	10%	10%	10%	10%
Waivered State Plans	6%	6%	6%	6%

* Includes high-deductible Plan F.

** Includes high-deductible Plan G.

Source: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibits, for the Years Ended December 31, 2019; December 31, 2020; December 31, 2021, and December 31, 2022.

Notes: The enrollment data for this Figure do not include Medicare Supplement enrollment numbers reported by insurance providers to the California DMHC. The data for standardized policies include Medicare SELECT plans and those issued in 3 states (MA, MN, and WI) that received waivers from the standardized product provisions of OBRA 1990. Percentages may not sum to 100 due to rounding.

Table 4. Change in Medicare Supplement Enrollment, Standardized, Pre-Standardized and Waivered-State Policies, December 2019 to December 2022, by Plan Type

Plan Type	Enrollment				Change in Enrollment 2021-2022	Percent Change 2021-2022
	2019	2020	2021	2022		
A	107,919	99,809	92,828	96,899	4,071	4%
B	206,587	182,388	181,741	159,437	-22,304	-12%
C	624,321	542,229	478,702	401,964	-76,738	-16%
D	123,117	125,899	151,327	124,701	-26,626	-18%
E	51,203	45,485	38,371	33,452	-4,919	-13%
F	6,804,076	6,238,576	5,749,712	5,332,340	-417,372	-7%
G	3,067,424	3,727,474	4,513,504	4,856,256	342,752	8%
H	31,014	27,259	21,891	18,858	-3,033	-14%
I	74,338	56,501	46,350	40,096	-6,254	-13%
J	371,432	332,461	300,074	269,401	-30,673	-10%
K	80,527	76,331	69,866	64,054	-5,812	-8%
L	42,546	38,949	33,648	30,612	-3,036	-9%
M	4,151	3,782	4,546	4,469	-77	-2%
N	1,359,949	1,362,694	1,384,304	1,377,952	-6,352	0%
Waivered State Plans	857,757	849,518	840,834	825,223	-15,611	-2%
Pre-Standardized Plans	206,725	190,752	170,191	155,099	-15,092	-9%
Total	**14,013,086**	**13,900,107**	**14,077,889**	**3,790,813**	**-287,076**	**-2%**

Sources: AHIP Center for Policy and Research analysis of the NAIC Medicare Supplement Insurance Experience Exhibit, for the Years Ended December 31, 2019, 2020, 2021, and 2022.

Notes: The enrollment data for this Figure do not include Medicare Supplement enrollment numbers reported by insurance providers in 2019- 2022 to the California DMHC. The data for standardized policies include Medicare SELECT plans and those issued in 3 states (MA, MN, and WI) that received waivers from the standardized product provisions of OBRA 1990.

Fast Growing Medicare Supplement Plans

In 2022, the only plans that posted the enrollment increases were plans G and A.

In the continuation of a multi-year trend of rapid growth, the enrollment in Plan G, which covers all Medicare deductible and coinsurance amounts except the Part B deductible, increased by 8% from 2021 to 2022, by 343,000 enrollees. Plan G also has a high-deductible option, the deductible for which was $2,490 in 2022.[7] As was true in the 3 previous years, Plan G posted the fastest rate of growth in 2022 in both relative and absolute terms.

In another sign of growth, Plan A posted an enrollment growth of 4% in 2022, reversing several years of declining enrollment. Plan A is a basic Medicare Supplement Insurance plan with low premiums.

The enrollment in the largest Medicare Supplement plan, Plan F, decreased by 7% in 2022 compared to the previous year. The regular version of Plan F provides coverage for Medicare deductibles and coinsurance amounts. Like Plan G, Plan F also includes a high-deductible option that allows for a deductible amount of $2,490 (in 2022) before the policy can begin paying benefits.

Similarly, the enrollment in several other Medicare Supplement plan types continued to decline. Double-digit enrollment declines occurred in Plan D (-18%), Plan C (-16%), Plan H (-14%), Plan E (-13%), Plan I (-13%), Plan B (-12%), and Plan J (-10%).

Medicare Supplement Policies by State

Table 5 shows enrollment in Medicare Supplement by jurisdiction—including the District of Columbia and U.S. territories—and plan type as of December 31, 2022.

Figure 11 is a map of the United States representing the number of Medicare Supplement enrollees by state, the District of Columbia, and U.S. territories. Figure 12 is a map of the United States showing Medicare Supplement enrollees as a percentage of FFS Medicare enrollees by state, the District of Columbia, and U.S. territories.

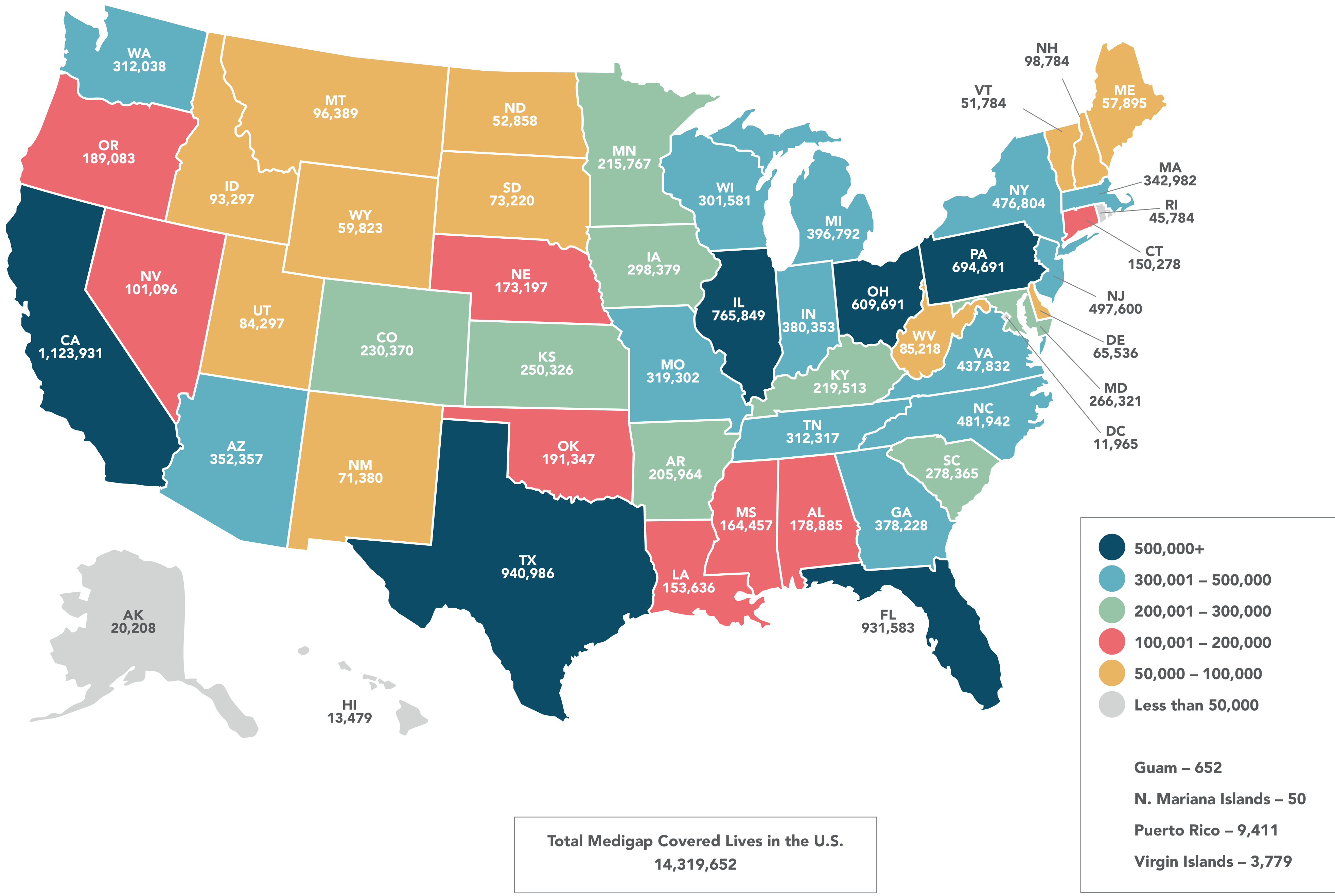
Table 5: Enrollment: Plan Type by State and Territory, As Reported to the NAIC, December 2022

State	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Waivered	Pre-standardized	Total covered lives (state)
AK	191	70	284	46	22	9,307	7,058	4	123	627	289	164	0	1,997	.	26	20,208
AL	2,948	62,561	1,612	429	60	55,981	43,168	14	79	688	356	139	2	10,769	0	79	178,885
AR	289	192	708	349	30	31,987	44,632	8	72	1,107	358	167	3	9,570	0	116,492	205,964
AZ	1,336	524	6,043	641	217	151,381	154,117	251	629	6,322	1,732	782	13	28,077	0	292	352,357
CA	4,193	1,927	6,125	1,369	513	329,990	142,430	424	2,522	32,849	5,574	2,198	15	63,272	0	1,691	595,092
CO	1,055	446	1,462	829	134	78,291	118,429	275	393	3,390	1,263	924	6	23,311	0	162	230,370
CT	1,322	1,171	2,867	518	254	51,169	35,296	164.00	537	10,588	1,460	688	0	35,219	0	9,025	150,278
DC	113	60	199	39	19	6,486	2,972	3	66	807	107	46	1	1,005	0	42	11,965
DE	428	420	1,271	1,599	230	28,238	18,792	62	628	2,455	631	223	0	10,474	0	85	65,536
FL	5,231	16,497	33,285	29,847	4,805	503,963	178,593	882	3,544	47,641	7,408	2,865	91	94,324	.	2,607	931,583
GA	1,383	1,298	7,155	1,440	3,288	147,305	170,390	47	686	6,580	1,282	530	7	36,219	6	612	378,228
GU	12	29	110	.	.	339	96	.	.	16	4	4	.	42	.	.	652
HI	75	38	188	22	6	6,656	3,294	5	35	336	265	53	0	2,488	0	18	13,479
IA	1,084	121	891	979	1,120	170,178	111,255	74	98	1,819	206	398	1	9,157	0	998	298,379
ID	394	145	601	125	37	34,432	46,478	123	79	2,012	824	209	9	7,784	0	45	93,297
IL	2,910	1,933	10,072	11,710	663	361,620	309,834	2,723	517	4,142	1,299	1,279	4	55,410	0	1,733	765,849
IN	2,403	1,150	4,359	2,879	672	134,412	192,692	367	754	4,137	791	619	16	34,517	0	585	380,353

State	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Waivered	Pre-standardized	Total covered lives (state)
KS	1,068	263	10,722	1,042	306	110,796	105,246	20	240	1,130	882	240	3	18,079	0	289	250,326
KY	1,112	1,803	7,172	1,008	2,443	96,426	84,568	922	446	1,692	653	329	2	20,467	0	470	219,513
LA	343	1,182	1,122	276	64	68,369	66,559	68	273	696	574	350	0	13,435	0	325	153,636
MA	106	39	434	34	56	2,873	351	16	109	726	93	37	2,044	912	334,959	193	342,982
MD	4,525	2,346	7,712	1,784	259	107,099	91,988	535	337	6,324	2,199	1,007	37	39,398	0	771	266,321
ME	619	350	2,928	180	251	27,629	15,069	17	705	1,829	266	121	46	7,855	0	30	57,895
MI	5,603	560	66,894	2,867	215	107,117	149,890	50	535	3,618	1,419	495	3	55,843	0	1,683	396,792
MN	114	1,723	143	10	3,733	1,727	255	23	98	938	40	34	490	1,225	205,067	147	215,767
MO	1,207	1,081	5,372	2,691	469	127,081	153,651	202	1,011	4,903	714	564	8	19,640	0	708	319,302
MP	.	4	5	.	.	21	11	.	.	.	.	1	.	8	.	.	50
MS	1,787	464	1,397	442	52	76,626	69,199	24	102	2,074	465	247	1	11,345	0	232	164,457
MT	389	190	1,985	527	34	36,953	46,295	65	225	1,253	403	146	1,371	6,446	.	107	96,389
NC	2,230	1,304	5,479	3,204	504	202,206	217,763	168	1,480	12,790	1,342	724	52	31,960	0	736	481,942
ND	236	31	470	58	3	32,308	17,682	6	35	293	31	21	0	1,638	.	46	52,858
NE	846	288	1,357	472	20	71,601	90,196	87	109	988	163	291	12	6,393	0	374	173,197
NH	673	381	1,032	466	297	33,755	33,520	108	174	7,295	479	331	92	19,684	0	497	98,784
NJ	5,068	1,682	38,028	5,476	267	162,486	161,969	1,637	5,101	19,061	2,715	2,385	7	89,791	0	1,927	497,600
NM	519	404	829	216	44	32,063	27,576	28	384	2,046	389	193	4	6,583	.	102	71,380
NV	695	247	804	159	63	43,479	40,406	99	227	2,267	617	330	0	11,652	0	51	101,096
NY	11,429	10,320	13,464	826	2,262	216,672	67,088	1,304	3,897	4,695	8,527	2,210	5	133,093	.	1,012	476,804
OH	2,082	1,802	26,069	4,026	789	199,500	275,434	341	1,570	7,142	2,077	2,339	33	85,568	0	919	609,691
OK	3,392	410	1,397	1,154	119	88,658	78,385	31	232	1,873	663	549	4	14,139	0	341	191,347
OR	700	220	1,571	556	89	59,333	104,853	28	326	1,660	964	336	3	18,124	0	320	189,083
PA	7,580	28,864	68,462	20,301	4,796	210,493	227,362	5,788	3,720	8,323	2,001	1,269	11	105,097	0	624	694,691
PR	26	49	3,778	132	7	3,941	622	13	18	597	19	9	.	190	.	10	9,411

State	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Waivered	Pre-standardized	Total covered lives (state)
RI	476	91	14,868	294	25	16,866	7,320	5	60	596	126	84	1	4,947	0	25	45,784
SC	1,140	1,204	4,525	8,490	160	123,973	109,738	73	421	3,400	807	520	4	23,629	0	281	278,365
SD	309	50	219	48	47	36,006	33,198	7	19	282	102	60	2	2,631	0	240	73,220
TN	1,710	1,010	7,223	3,840	1,282	136,128	132,884	104	660	6,026	769	313	32	19,910	0	426	312,317
TX	6,202	2,120	7,876	5,201	493	357,135	468,397	889	2,106	14,564	3,462	1,647	19	69,931	0	944	940,986
UT	605	155	1,126	477	122	35,101	36,010	169	158	1,313	451	227	0	8,278	0	105	84,297
VA	2,720	1,438	4,049	1,237	643	190,355	185,821	366	2,640	13,518	1,383	706	12	31,629	0	1,315	437,832
VI	61	51	331	32	3	2,290	434	5	17	229	39	23	.	262	.	2	3,779
VT	840	342	8,889	2,395	1,115	16,820	6,097	92	26	2,564	282	140	0	12,034	0	148	51,784
WA	1,762	484	3,899	984	229	134,207	107,148	45	1,336	4,142	4,429	638	3	48,322	1	4,409	312,038
WI	2,362	7,329	302	173	18	2,012	2,874	3	30	308	34	23	.	405	285,190	518	301,581
WV	692	444	2,060	682	73	36,473	33,475	80	409	1,741	288	215	0	8,374	0	212	85,218
WY	304	130	739	120	30	24,027	27,396	14	98	989	338	170	0	5,400	0	68	59,823

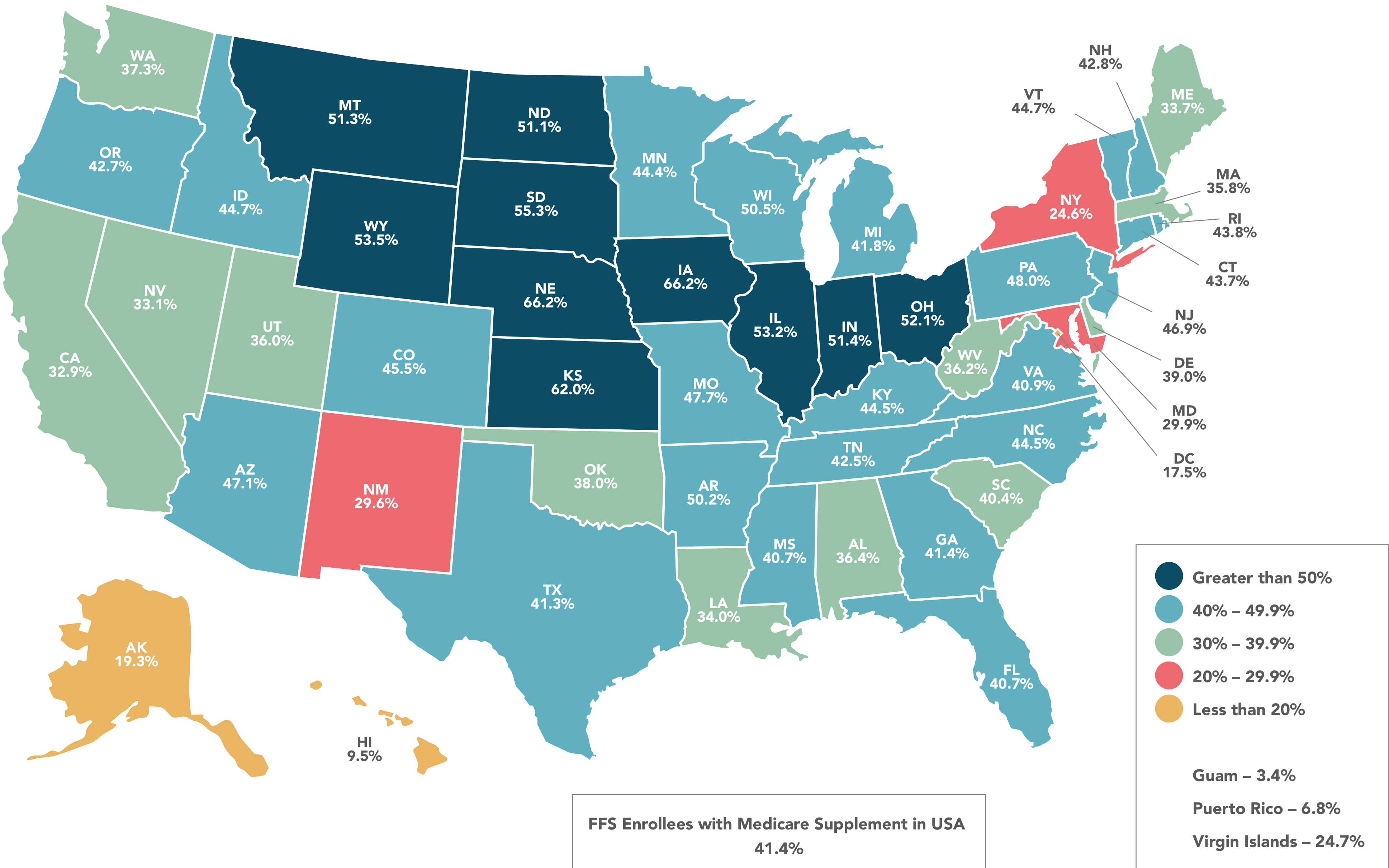
Figure 11. Number of Medicare Supplement Enrollees by State and U.S. Territory, December 2022



Source: National Association of Insurance Commissioners (2022), California's Department of Managed Health Care (2022).

Notes: The enrollment data for this Figure include Medicare Supplement enrollment numbers reported by insurers in 2022 to the California DMH (528,839 covered lives).

Figure 12. Percent of original Medicare Enrollees with Medicare Supplement, by State and U.S. Territory, December 2022



Source: National Association of Insurance Commissioners (2022), California's Department of Managed Health Care (2022).

Notes: The enrollment data for this Figure include Medicare Supplement enrollment numbers reported by insurers in 2022 to the California DMH (528,839 covered lives).

Methodology

For this report we analyzed 2022 Medicare Supplement data from the National Association of Insurance Commissioners (NAIC). Health insurance providers submit their annual statement data directly to the NAIC using an electronic filing portal. Each state sets its own requirements for filing.

Data from 3 health insurance providers are not included in the 2022 NAIC data; they are required to report their data to the California's Department of Managed Health Care (DMHC), which does not report Medicare Supplement enrollment data to the NAIC. Since, as in previous years, the DMHC does not provide the breakdown of the Medicare Supplement enrollment by plan type or market size, the data from the three Medicare Supplement insurance providers reporting to DMHC were included only in the tables and graphs presenting national and state Medicare Supplement enrollment and penetration, while all of the tables further subdividing Medicare Supplement enrollment by market size, Medicare Select policies, and Medicare Supplement plan type have been calculated using exclusively the data from the NAIC.

We recoded the data for one of the insurance products: its 2022 filings described it as being Plan H, while the same filing provided its marketing name as "Modernized Plan High Deductible F" and it has been filed as Plan F type in the 2021 filing. Given the totality of the information, we treated this product's description as Plan H as a filing mistake and recoded it into Plan F.

We derived the total Medicare Supplement enrollment during 2022 by adding 2 variables together: 1) the number of policies issued before 2011, and 2) the total number of policies issued from 2011 to 2022. The NAIC requires Medicare Supplement companies to report these data separately. Only 1 person is covered per Medicare Supplement policy.

All analyses in the report contain data from the 50 states, the District of Columbia, and the U.S. territories. The territories are Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands.

The NAIC data set is structured so that reported enrollment is a point-in-time measure for December 31, 2022. Other data set measures, such as those for premiums and claims, are for the full year. Therefore, it is possible that a company may submit information on a plan type even though at the end of the year enrollment was zero. To show the number of companies with policies in force as of December 31, 2022, we selected records where the number of people covered was greater than zero.

We calculated the percent of fee-for-service (FFS) enrollees with Medicare Supplement plans for 2018 to 2022 by dividing the number of Medicare Supplement enrollees by the number of FFS Medicare enrollees for each year. For the numerator we obtained the number of Medicare Supplement enrollees from the current and previous AHIP reports on Medicare Supplement trends.[8] The denominator was the number of FFS Medicare enrollees from the Centers for Medicare & Medicaid Services (CMS) data for December of each year.[9] The CMS data set provided the number of enrollees eligible for Medicare and the number of enrollees enrolled in Medicare Advantage. We subtracted the number of enrollees with Medicare Advantage from the number of eligible Medicare enrollees to get the number of FFS Medicare enrollees. Figures 4 and 5 show these data by state and territory.

Data describing the demographic makeup of Medicare Supplement enrollees came from the 2021 Medicare Current Beneficiary Survey (MCBS) Access to Care Limited Data Sets Files (LDS), maintained by CMS. Likewise, we used SAS Enterprise Guide® 7.15[10] software to analyze the data.

Our analysis includes data on non-institutionalized enrollees in the 50 states, the District of Columbia, and Puerto Rico eligible for Medicare as of January 1, 2021. June 2021 was the point in time for which enrollees' records were selected for inclusion.

Medicare enrollees were identified as Medicare Supplement policyholders based on survey responses indicating the June 2021 coverage via a self-purchased, non-specialty private insurance. Additionally, in case of multiple insurance coverage, those enrolled in Medicare Advantage plans according to CMS administrative data, were excluded from the Medicare Supplement covered category.

The current MCBS data format does not allow for the separation of enrollees enrolled in Medicare Advantage plans from enrollees enrolled in non-Medicare Advantage capitated plans. As a result, all of the statistics in this report presented as Medicare Advantage may include some enrollees in non-Medicare Advantage capitated plans.

In the MCBS dataset, Medicare enrollees were classified as residing in either metropolitan, micropolitan or rural areas in 2021 based on CMS administrative data. CMS used information from the Office of Management and Budget to define a metropolitan statistical area, which is used to define the "urban" category in this report. The "urban" category in our report includes individuals living in Metropolitan Statistical Areas (MSA), which are defined by the Office of Management and Budget as urban clusters with a population of 50,000 or more, while the "rural" category includes all enrollees living outside of the MSAs.

As a general rule, all records in the MCBS dataset containing data values such as "unknown" or "refused" were dropped from the analyses.

Data Limitations

As noted, the total number of enrollees with Medicare Supplement is slightly understated because California does not require all insurance companies to report their data to the NAIC; only 3 companies in California are required to report their data to the California Department of Managed Health Care. Data from these companies represent 528,839 Medicare Supplement enrollees,[11] about 4% of all Medicare Supplement enrollment in the United States and are not included in the subset of analyses describing Medicare Supplement insurers by market size, Medicare SELECT policies, and Medicare Supplement plan type.

Enrollees have an option to purchase Plan F as a high-deductible plan. However, due to the way data are reported to the NAIC we are unable to determine what percent of enrollees in Plan F have a high-deductible policy or what percent of companies offer high-deductible Plan F. Therefore, data in this report representing Plan F may also include the high-deductible version.

Medicare Supplement plans are guaranteed renewable, therefore policyholders may keep their plans even though the plan may have been discontinued or the standard benefit design changed. This report does not make a distinction among standardized Medicare Supplement policies in force in December 2022 with respect to whether their benefit designs comply with requirements under OBRA 1990, MMA, or MIPPA.

Appendix A

Medicare Supplement Benefits 2022	Standardized Medicare Supplement Plans									
	A	B	C	D	F*	G**	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes****
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charges	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit***	N/A	N/A	N/A	N/A	N/A	N/A	$6,620	$3,310	N/A	N/A

Notes: This table reflects the benefit design for standardized Medicare Supplement plans under the 2015 Medicare Access and CHIP Reauthorization Act of 2015. Plans C and F (and F with a high deductible) will be available ONLY for enrollees eligible prior to January 1, 2020. Plans C and F are redesignated Plans D and G for enrollees newly eligible after January 1, 2020.

*Plan F also offers a high-deductible plan. If the enrollee chooses this option, he/she must pay Medicare covered costs up to the deductible amount of $2,490 in 2022 before the Medicare Supplement plan pays anything.

**Plan G offers a high deductible for those enrollees newly eligible after January 1, 2020.

*** For Plans K and L, after meeting the out-of-pocket yearly limit and the yearly Part B deductible ($233 in 2022), the Medicare Supplement plan pays 100% of covered services for the rest of the year.

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

Questions About This Report?

For further information, please contact AHIP's Center for Policy and Research at 202.778.3200
or visit our website at www.ahip.org/research.

Endnotes

1 According to a survey carried out by Global Strategy Group on behalf of AHIP in January 2023. www.ahip.org/news/press-releases/new-research-seniors-continue-to-be-overwhelmingly-satisfied-with-their-medicare-supplement-coverage

2 Data Source: National Association of Insurance Commissioners, by permission. The NAIC does not endorse any analysis or conclusions based upon the use of its data.

3 There is no coinsurance for inpatient hospital care for the first 60 days of hospitalization, per benefit period. Enrollees would pay $389 in coinsurance per day per benefit period from days 61 to 90; and would pay $778 for coinsurance per each "lifetime reserve day" per benefit period after day 90 (up to 60 days over lifetime). After that all inpatient costs are borne by the enrollee. www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment

4 Ibid.

5 Effective June 1, 2010.

6 www.cms.gov/files/document/cy2022-oop-limits-medigap-plans-kl.pdf

7 www.cms.gov/files/document/cy-2022-fg-j-deductible-amount-medigap-high-deductible-options.pdf

8 State of Medigap 2018, 2019, State of Medicare Supplement Coverage (2021, 2022, 2023) accessed October 31, 2023. https://www.ahip.org/research

9 CMS Medicare Advantage Penetration Reports, 2017-2022, accessed October 31, 2023. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-State

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11 California Department of Managed Health Care, Enrollment Summary Report 2022, accessed October 31, 2022 at www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx