A ROAD OF GOOD INTENTIONS PAVED WITH PREMIUM INCREASES: EXPANDING GUARANTEED ISSUANCE OF MEDIGAP INSURANCE POLICIES

Background

Currently the federal Social Security Act provides for an initial "open enrollment" into Medigap supplemental insurance for Medicare-eligible persons age 65 and older enrolled in Part B. Federal law also provides for guarantee issuance under specific named circumstances. Any additional "open enrollment" or guaranteed issuance of Medigap insurance is a matter of state law. About 20 states have expanded guaranteed issuance, and about 33 states require Medigap insurers to offer and issue coverage to persons under age 65. These state laws vary as to the groups included, coverage, and separate premium rating.

A principle concern of federal and state proposals to require Medigap insurers to expand guaranteed issuance of Medigap insurance or the offer and issuance of coverage to persons under age 65 is the initial and on-going "rate shock" effect on existing policyholders who already are subject to premium increases due to underlying Medicare benefit cost trends. This is an especially heightened concern specifically with the ESRD population. Some states that have expanded Medigap coverage to the under 65 but exclude the ESRD population, or establish special rules to mitigate premium "rate shock" for existing policyholders.

ESRD Expanded Guaranteed Issuance. Average Medicare spending per fee-for-service beneficiary in 2022 was: $12,749 (age 65 to 74); $17,336 (age 75 to 84), and $21,116 (age 85 and older). MedPAC states that, on average beneficiaries with ESRD incur spending that is more than six times greater than spending for aged beneficiaries - so averaging $76,494 for those with ESRD compared to those age 65 to 74 without ESRD). See MedPAC, *A Data Book: Health Care Spending and the Medicare Program* (July 2025) at pages 15-16. Expansion to the under 65 beneficiaries was estimated by the CBO to cost the Medicare program $14 billion over a 10 year period (2019 latest estimate).

Other Expanded Guaranteed Issuance. Several states have adopted additional guaranteed issuance requirements expanding the existing federal requirements. These have been prompted by Medicare Advantage enrollee dissatisfaction and disenrollment, or the concern that the federal prohibition on new enrollments in Plans C and F for "newly eligible" Medicare beneficiaries (enacted as part of MACRA in 2022) would result in escalating premiums for existing Plan C and F policyholders. Legislation was considered in California in 2024 and 2025 to establish an annual 90-day open enrollment period for all Medicare Advantage and Medigap policyholders. Premium increases were estimated to be 14% to 33% per member per month.

Issues

1. Protecting Existing Policyholders. The health risks of the ESRD population must be pooled separately from the existing Medigap policyholders to avoid initial and on-going "rate shock". See for example, Delaware SB 42 (signed July 15, 2013). Some Medigap insurers have experienced medical loss ratios of 130% and higher due to claims costs of the ESRD population. Medigap pricing assumes long-term policyholder retention. Annual policy switching increases uncertainty in persistency and morbidity and results in premium increases for the additional risk.

2. Predatory Provider Practices. Dialysis clinics have "targeted" the lowest priced Medigap insurers using social workers and employees to sign up their ESRD patients in order to obtain the cost-sharing amounts even though most clinics have "waived" the cost-sharing. As MedPAC has noted, on average beneficiaries with ESRD incur spending that is more than six times greater than average spending for aged beneficiaries. This has driven some Medigap insurers out of specific states due to "rate shock" for existing policyholders.

3. Medicare Advantage Plan Participation. States can mandate that Medigap insurers must offer and issue supplementary coverage to the under 65. However, states cannot require Medicare Advantage plans (which have heavily subsidized premiums, benefits, and marketing practices) to offer and issue coverage to a specific population. Medicare Advantage plans must accept ESRD enrollees (began January 1, 2021). See 21st Century Cures Act, Section 17006. However, Medicare Advantage Plans receive "risk adjusted" payments to account for risk selection. Medigap plans do not have the benefit of "risk adjustment".

4. Rate Shock and Cost of Expansion. Medigap premium increases and pricing volatility works to the advantage of Medicare Advantage plans that enjoy subsidized pricing, overpayments used to fund additional benefits or zero premiums, and to pay higher commissions to agents to encourage enrollment in Medicare Advantage plans over Original Medicare and Medigap. Medigap issuers should receive "risk adjustment" payments when required to take on higher risks annually. Medigap insurers do not receive risk adjusted payments for excess adverse selection.

5. Possible Solutions. The Medigap industry might create a private reinsurance arrangement to collect funds to make risk-adjustment payments to member companies experiencing excess adverse selection. Another option might be a high-risk pool for the ESRD population that equitably shares the costs of this high-cost population across all Medicare insurers and health care providers so that all policyholders are protected from "rate shock". At the federal level a broad funding mechanism could be used to pay for Original Medicare enrollee cost-sharing assistance to the ESRD population.

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Abbreviated Analysis

California Senate Bill 1236: Medicare Supplements

Report to the 2023–2024
California State Legislature

APRIL 16, 2024

CHBRP

California Health Benefits Review Program (CHBRP), Office of Research, University of California, Berkeley

www.chbrp.org

Revision History

Date	Description of Revisions
04/18/24	The national source (NAIC, 2021) initially used to estimate Californians enrolled in Medicare Supplement plans and policies did not take into account California's uniquely divided regulatory system for health insurance. It estimated only enrollment in Medicare Supplement policies regulated by the California Department of Insurance (CDI). This revision also uses information on Californians enrolled in Medicare Supplement plans regulated by the Department of Managed Health Care (DMHC), available through the DMHC "Enrollment Summary Report – 2023."[1]

[1] https://www.dmhc.ca.gov/DataResearch/FinancialSummaryData.aspx

Summary

The California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP).[2] conduct an abbreviated analysis of the financial impacts of California Senate Bill 1236, Medicare Supplements. SB 1236 would require two periods of open enrollment for Medicare Supplemental Insurance: (1) the 6-month period beginning with the first day of the month in which a beneficiary first enrolled for benefits under Medicare Part B; and (2) an annual 90-day period beginning each January 1. The second would be a new requirement. SB 1236 would also prohibit both pricing discrimination and denial/condition of issuance/effectiveness of the Medicare Supplement coverage contract based on applicant health status, claims experience, receipt of health care, medical condition, or age of applicant. The last would be a new prohibition.

The Medicare Program is a federal public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Federal law provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program, including coverage of applicable deductible, copayment, or coinsurance amounts. This analysis projects the potential impacts of SB 1236 on estimated baseline premiums and enrollment in Medicare Supplement policies and plans regulated by the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC). The predicted increases in Medicare Supplement premiums due to SB 1236 are driven by what is commonly known as adverse selection. Adverse selection occurs when lower cost or healthier patients forego buying insurance until they need it, while higher cost or sicker patients actively buy insurance to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase.

Analytic Approach and Key Assumptions

For this analysis, CHBRP has assumed that postmandate, premiums for Medicare Supplement insurance will be community rated without regard for age of the applicant, which contrasts to typical Medicare Supplement premium prices in California at baseline, which are based on attained age.

The people most likely to take advantage of the new open enrollment period, guaranteed issue coverage, and community-rated premiums are new enrollees with higher health care costs and perceived needs due to chronic illness, cancer, or injuries requiring rehabilitative skilled nursing services. These enrollees may have been denied Medicare Supplement coverage before or faced waiting periods or specific exclusions based on their individual characteristics (e.g., pre-existing conditions, receipt of health care, health status, age). However, there is also a group of eligible people who would take advantage of the new, annual open enrollment opportunities by cancelling their current Medicare Supplement or deciding not to purchase a Medicare Supplement, and waiting until they need services to enroll. Healthier, lower cost Medicare beneficiaries could cancel their Medicare supplemental insurance for two reasons: 1) premiums will increase, and they will decide they don't want to pay the higher premiums; or 2) they can now purchase a guaranteed-issue policy during a future open enrollment period when they perceive a need for the additional coverage. These people would be eligible for coverage but would save money by not enrolling and not paying premiums in a Medicare Supplement, whereas those enrolled in the Medicare Supplement postmandate would be those most likely to use services and incur cost sharing that would be covered by the Medicare Supplement policy. The claims

[2] Refer to CHBRP's full report for full citations and references.

experience of enrollees in the Medicare Supplement would be higher than under current law, resulting in higher premiums for those enrolled in the Medicare Supplement. Those higher premiums would act as a further impediment to healthy, lower cost people enrolling in the policy, resulting in further adverse selection and premium increases.

Enrollment and Premium Impacts

Postmandate, the number of enrollees in Medicare Supplement policies will decrease from 1,131,751 to 1,027,251, a 9% decrease. Overall, the average monthly premiums for Medicare Supplement will increase from $239.03 to $319.04 per member per month (PMPM), a 33% increase, because the average new enrollees in Medicare Supplements will use more services than the average enrollee at baseline. The new entrants to the Medicare Supplement market are likely to be higher cost enrollees, and they will displace lower cost enrollees who find it advantageous to disenroll from their Medicare Supplement rather than pay higher premiums to continue their coverage postmandate. The new entrants will include people who were denied Medicare Supplement coverage in the past, or faced waiting periods or specific exclusions, who will have a new opportunity to enroll when the new open enrollment opportunities are expanded by SB 1236. Some high-cost, high-need patients may be in Medicare Advantage plans currently but will move to traditional Medicare with a Medicare Supplement to improve their ability to seek out care from more providers that may not be in their current Medicare Advantage network.

Other Considerations

It is possible that SB 1236 will result in insurers leaving the Medicare Supplement market in California due to the expanded open enrollment period and community-rated premiums, resulting in fewer choices for Californians with traditional Medicare.

Abbreviated Analysis

California Senate Bill 242 Medicare Supplement Coverage: Open Enrollment Periods

Report to the 2025–2026
California State Legislature

APRIL 20, 2025

California Health Benefits
Review Program (CHBRP),
University of California, Berkeley

chbrp.org

KEY FINDINGS

Abbreviated Analysis of California Senate Bill 242

Medicare Supplement Coverage - Open Enrollment Periods

Summary to the 2025–2026 California State Legislature, April 20, 2025

CHBRP

Summary

California Senate Bill (SB) 242, as analyzed by California Health Benefits Review Program (CHBRP), would require an annual 90-day open enrollment period beginning each January 1st in which Medicare Supplement plans would be required to provide "guaranteed issue enrollment." Guaranteed issue policies ensure health insurance coverage to all applicants, regardless of their health status, claims experience, medical conditions, or age. This means insurers cannot deny coverage or charge higher premiums based on these factors. The bill also would allow beneficiaries with end-stage renal disease under the age of 65 years to enroll as well. Currently, the period of open enrollment for Medicare Supplemental Insurance occurs during the 6-month period beginning with the first day of the month in which a beneficiary first enrolls for benefits under Medicare Part B.

In 2026, approximately 6.6 million Californians will be enrolled in Medicare. This includes:

- 5 million with Medicare-only coverage, with sizable numbers of those enrolled in Medicare Supplement plans (Medigap) or Medicare Advantage plans.
- 1.6 million beneficiaries dually enrolled in Medicare and Medi-Cal with Medi-Cal providing coverage for Medicare deductibles and coinsurance (and Medi-Cal–only services).

Impact

- CHBRP estimates the average monthly premiums for Medicare Supplement policies will increase by $40.00 (14%) per member per month (PMPM). This is due to new enrollees in Medicare Supplements using disproportionately more services than the average enrollee at baseline. This is referred to as adverse selection.
- SB 242 is unlikely to impact Medi-Cal.

Context

Existing federal law provides for the Medicare Program, which is a public health insurance program for people 65 years of age and older, and eligible individuals with disabilities who are under 65 years of age. Existing federal law also provides for the issuance of Medicare Supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to the Medicare Program for hospital, medical, or surgical expenses. These expenses include coverage of Medicare deductible, copayment, or coinsurance amounts.

Existing California law places requirements on Medicare Supplement plans and policies that are regulated by the California Department of Insurance (CDI) or the California Department of Managed Health Care (DMHC). Existing law already allows for open enrollment during the 6-month period beginning with the first day of the month in which a beneficiary first enrolled for benefits under Medicare Part B.

Connecticut, Massachusetts, Maine, New York, Rhode Island, and Vermont require either continuous or annual guaranteed issue protections for Medicare Supplement for all beneficiaries in traditional Medicare ages 65 years and older, regardless of medical history.

Beneficiaries who currently have a Medicare Advantage plan or Traditional Medicare do not have federal guaranteed issue protection to switch into Medicare Supplement policies. They also do not have guaranteed issue protection if they voluntarily drop Medicare Supplement and wish to purchase a policy again later. However, there are some limited exceptions noted in the *Policy Context* section.

Bill Summary

SB 242 would require an annual 90-day period beginning each January 1st requiring "guaranteed issue" into Medicare Supplement plans. This new guaranteed enrollment period does not conflict or replace the existing 6-month open enrollment period that every Medicare beneficiary experiences when they sign up for

Part B. This bill would also remove the exclusion of otherwise qualified applicants who have end-stage renal disease (under the age of 65 years), thereby making Medicare Supplement benefit plans available to those individuals.

Impacts

Enrollment and Expenditures

The number of enrollees in Medicare Supplement policies will decrease by 6,400 (−1%) postmandate (see Table 3). Overall, the average monthly premiums for Medicare Supplement policies will increase by $40.00 (14%) per member per month (PMPM) due to SB 242, because new enrollees in Medicare Supplements will use more services than the average enrollee at baseline. 90,700 enrollees at baseline would disenroll from their coverage postmandate due to increases in premiums, whereas there are 84,300 new enrollees who will enroll in Medicare Supplements postmandate. The new entrants to the Medicare Supplement market are likely to be higher cost enrollees, and they will displace lower cost enrollees who find it advantageous to disenroll from their Medicare Supplement rather than pay higher premiums to continue their coverage. Note: these estimates are lower than those in the 2024 CHBRP analysis of bill AB 1236 (in 2024) because based on additional studies from other states, we have reduced the estimated disenrollment to 8% from last year's estimate (of SB 1236) of 14%, lowered the assumed shift of high cost cohorts to 7.5% from 20%, and also included the assumption of members leaving Medicare Advantage for Medicare Supplement policies due to network frustrations.

Adverse selection

Adverse selection occurs when lower cost or healthier patients opt out of more expensive plans or forego buying insurance until they need it, while higher cost or sicker patients actively buy more protective insurance (with additional out-of-pocket protections and/or benefits) to protect them from risk. This imbalance in enrollment results in fewer lower cost or healthier enrollees and a greater number of higher cost or sicker enrollees in insurance products. The higher use of services by higher cost or sicker patients causes premiums to increase in that insurance product.

The expected increase in Medicare Supplement premiums from assuring Medicare Advantage enrollees who switch to Traditional Medicare can access affordable Medicare Supplement coverage would depend on the degree of adverse selection. It would also depend on the number of beneficiaries who, when switching to Traditional Medicare, enroll in Medicare Supplement compared to the number of overall Medicare Supplement enrollees. The degree of adverse selection for those switching to Traditional Medicare would likely increase if beneficiaries leaving Medicare Advantage had assured access to affordable Medicare Supplement coverage.

Medi-Cal

SB 242 is unlikely to impact Medi-Cal beneficiaries. Medicare Supplement plans are not generally needed (nor eligible) for individuals who are also eligible for Medicaid. Medicare Supplement plans are private insurance policies that help pay for out-of-pocket costs like copayments, coinsurance, and deductibles that Traditional Medicare doesn't cover. If a person is eligible for Medicaid, their Medicaid coverage often covers these same costs, making a Medicare Supplement plan redundant or unnecessary. However, beneficiaries may suspend Medicare Supplement for up to 2 years if they become eligible for Medicaid, in which case, they have no new medical underwriting or waiting periods for pre-existing conditions when they restart their Medicare Supplement.

Long-Term Impacts

CHBRP's estimated premium increase is highly dependent upon the chosen assumptions. However, based on current market conditions and the assumption that 7.5% of higher cost or higher need applicants would enroll in a plan, it is likely that an equilibrium will be established in the Medicare Supplement market around the estimated premium increase of 14%, as stated in this report.

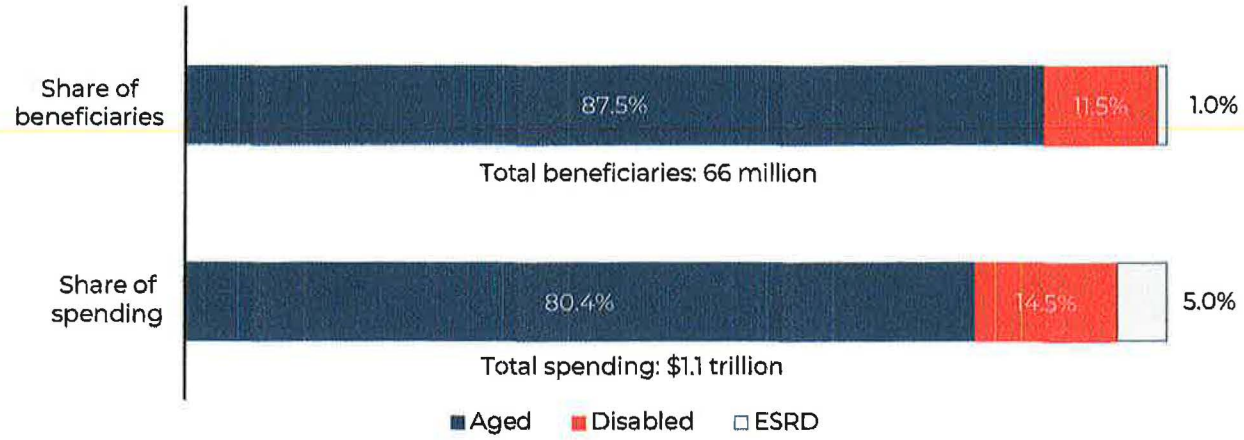
JULY 2025

A DATA BOOK

Health Care Spending and the Medicare Program

MEDPAC | Medicare Payment Advisory Commission

Chart 2-1 Aged beneficiaries accounted for the greatest share of the Medicare population and program spending, 2022



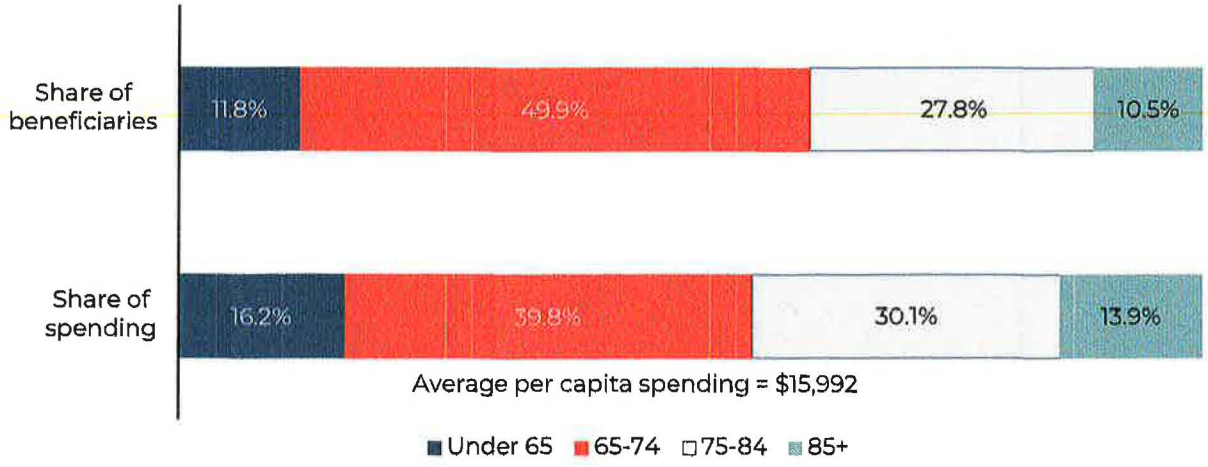
Note: ESRD (end-stage renal disease). The "aged" category comprises beneficiaries ages 65 and older without ESRD. The "disabled" category comprises beneficiaries under age 65 without ESRD. The "ESRD" category comprises beneficiaries with ESRD, regardless of age. Results include both community-dwelling and institutionalized beneficiaries enrolled in fee-for-service and Medicare Advantage plans. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2022.

> In 2022, beneficiaries ages 65 and older without ESRD composed 87.5 percent of the beneficiary population and accounted for 80.4 percent of Medicare spending. Beneficiaries under 65 with a disability and beneficiaries with ESRD accounted for the remaining population and spending.

> Medicare beneficiaries with ESRD incur a disproportionate share of Medicare expenditures. On average, spending on an ESRD beneficiary is almost six times greater than spending on an aged beneficiary (age 65 years or older without ESRD) and more than four times greater than spending for a beneficiary under age 65 with a disability (non-ESRD) (data not shown).

Chart 2-2 Beneficiaries younger than 65 accounted for a disproportionate share of Medicare spending, 2022



Note: The "65–74," "75–84," and "85+" categories comprise beneficiaries ages 65 and older without end-stage renal disease (ESRD). The "Under 65" category comprises beneficiaries under age 65 with and without ESRD. Results include both community-dwelling and institutionalized beneficiaries enrolled in fee-for-service and Medicare Advantage plans. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2022.

> Beneficiaries younger than 65 made up 11.8 percent of the beneficiary population in 2022 but accounted for 16.2 percent of Medicare spending.

> In 2022, average Medicare spending per beneficiary was $15,992.

> For the aged population (65 and older), per capita expenditures increase with age. In 2022, per capita expenditures were $12,749 for beneficiaries 65 to 74 years old, $17,336 for those 75 to 84 years old, and $21,116 for those 85 or older (data not shown).

> In 2022, per capita expenditures for Medicare beneficiaries under age 65 who were enrolled because of ESRD or disability were $21,954 (data not shown).

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

December 10, 2019

Honorable Frank Pallone Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington DC 20515

Re: *Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act*

Dear Mr. Chairman:

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have completed an analysis of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, as posted by the House Committee on Rules on December 6, 2019 (Rules Committee Print 116-41), and including modifications discussed with staff.[1]

Summary

CBO and JCT estimate that enacting the current version of H.R. 3 would increase direct spending by about $40 billion and increase revenues by about $46 billion over the 2020-2029 period (see Table 1). The net effect would be to reduce unified federal deficits by about $5 billion over that 10-year period.

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1. In October, CBO released an analysis of an earlier version of H.R. 3, concerning the effects of title I on federal spending for Medicare's Part D (the outpatient prescription drug benefit). See Congressional Budget Office, letter to the Honorable Frank Pallone concerning the effects of drug price negotiation stemming from title I of H.R. 3, the Lower Drug Costs Now Act of 2019, on spending and revenues related to Part D of Medicare (October 11, 2019), www.cbo.gov/publication/55722. Modifications to the Rules Print include changing the implementation date to 2022 for sections 501 through 507, and changing the implementation date to 2023 for sections 602 and 603.

sharing. The modifications to both programs would increase spending by about $105 billion over the 2020-2029 period. About $55 billion of the estimated increase in direct spending from title V would occur in the Medicaid program.

Title VI, Providing for Dental, Vision, and Hearing Coverage Under the Medicare Program

Title VI would add new benefits for dental, vision, and hearing care (including dentures, glasses, hearing aids, and preventive services) to the Medicare program. CBO estimates that those provisions would increase direct spending by about $358 billion over the 2020-2029 period. Of that amount, almost $238 billion would pay for dental care, $30 billion would pay for vision care, and $89 billion would pay for hearing services.

Title VII, NIH, FDA, and Opioids Funding

H.R. 3 would appropriate funding for activities at the National Institutes of Health and the Food and Drug Administration to support activities related to medical research and the development of new drugs. Based on historical spending patterns for those agencies' activities, CBO estimates that H.R. 3 would increase direct spending by almost $9 billion over the 2020-2029 period.

Title VII also would appropriate funding related to federal responses to opioid use disorder. The bill would create an Opioid Epidemic Response Fund to support activities at six federal agencies, including the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention. Based on historical spending patterns for those agencies and similar activities, CBO estimates that the bill would increase direct spending by almost $10 billion over the 2020-2029 period.

Title VIII, Miscellaneous

Title VIII would make many changes to Medicare, as well as fund or reauthorize several programs. CBO estimates that title VIII would increase direct spending by almost $42 billion over the 2020-2029 period, mostly for the following provisions:

- Guaranteed issue of certain Medicare supplemental insurance policies ($14 billion),
- Increased Medicare payments to physicians ($11 billion),

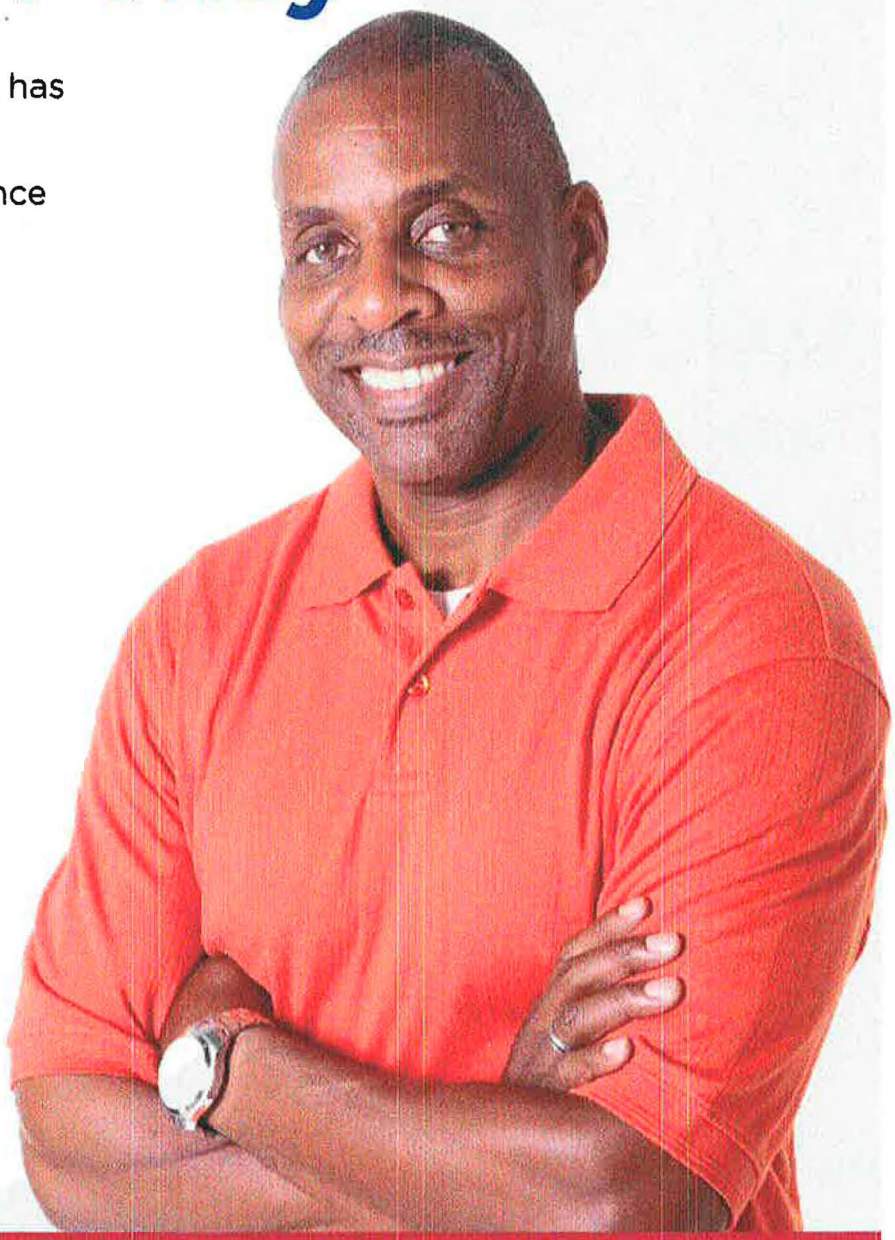
2025

Choosing a Medigap Policy

This **official government guide** has important information about:

- Medicare Supplement Insurance (Medigap) basics
- What Medigap policies cover
- Buying a Medigap policy

Medicare.gov



Developed jointly by the Centers for Medicare & Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC)

Medicare

Section 3:

Your right to buy a Medigap policy

What are guaranteed issue rights?

Guaranteed issue rights or "Medigap protections" are your rights to buy certain Medigap policies in limited situations outside of your Medigap Open Enrollment Period. In these situations, an insurance company:

- Must sell you a Medigap policy.
- Must cover all your pre-existing health conditions.
- Can't charge you more for a Medigap policy because of past or present health problems.

If you live in Massachusetts, Minnesota, or Wisconsin, you have guaranteed issue rights to buy a Medigap policy, but the Medigap policies are different. Go to pages 35–37 for your Medigap policy choices.

Note: Go to page 40 for definitions of blue words

When do I have guaranteed issue rights?

In most cases, you have a **guaranteed issue right** when your other health coverage changes in some way, like if you lose your other coverage. You may also have a "trial right" to try a Medicare Advantage Plan (Part C) and still buy a Medigap policy if you change your mind. For information on trial rights, go to pages 18–19.

Medigap guaranteed issue right situations

This information describes the most common situations under federal law where you may be able to buy a Medigap or **Medicare SELECT** policy outside your **Medigap Open Enrollment Period**, the kind of policy you can buy, and when you can or must apply for it. You may have additional rights under state law. Check with your State Insurance Department about what rights you might have under state law.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
You have a Medicare Advantage Plan, and any of the following are true: • Your plan is leaving Medicare • Your plan stops giving care in your area • You move out of the plan's service area You only have this right if you switch to Original Medicare (rather than join another Medicare Advantage Plan).	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	• 60 days before the date your Medicare Advantage Plan coverage ends. • No more than 63 days after your Medicare Advantage Plan coverage ends. **Note:** Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
You have Original Medicare and an employer group health plan (including retiree, COBRA, or union coverage) that pays after Medicare pays and that plan is ending. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until your COBRA coverage ends.	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	No more than 63 days after the latest of these 3 dates: 1. Date your current coverage ends. 2. Date on the notice you get telling you that your coverage is ending (if you get one). 3. Date on a claim denial, if this is the only way you know that your coverage ended.
You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. **Call the Medicare SELECT insurance company for more information about your options.**	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state or the state you're moving to.	• 60 days before your Medicare SELECT coverage ends. • No more than 63 days after your Medicare SELECT coverage ends.

***Note:** Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plan D or G instead of Plan C or F.

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
You joined a Medicare Advantage Plan or Program of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare. (Trial right)	Any Medigap policy that's sold by an insurance company in your state.*	• 60 days before your coverage ends. • No more than 63 days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances. Check with your State Insurance Department.
You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back. (Trial right)	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If your former Medigap policy **isn't** available, you can buy Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	• 60 days before the date your coverage ends. • No more than 63 days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances. Check with your State Insurance Department.
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	No more than 63 days after your current Medigap coverage ends.
You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	Medigap Plan A, B, C*, D*, F*, or G* that's sold by an insurance company in your state.	No more than 63 after your coverage ends.

***Note:** Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but haven't yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plan D or G instead of Plan C or F.

Section 6:

Medigap policies for people with a disability or ESRD

You may have Medicare before 65 due to a disability or End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

If you're under 65 and have Medicare because of a disability or ESRD, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. Federal law generally doesn't require insurance companies to sell Medigap policies to people who are under 65. However, in some states insurance companies do offer Medigap policies to people under 65.

Important: This section provides information on the minimum federal standards for Medigap policies. Your state may have different requirements. Call your **State Insurance Department** or State Health Insurance Assistance Program (SHIP) to get state-specific information. Visit **content.naic.org/state-insurance-departments** to find your State Insurance Department. Visit **shiphelp.org** to get the number for your local SHIP.

Note: Go to page 40 for definitions of **blue** words

Which states offer Medigap policies to people with Medicare under 65?

At the time of printing this guide, these states require insurance companies to offer at least one kind of Medigap policy to people with Medicare under 65:

- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Vermont
- Wisconsin

Note: Some states provide these rights to all people with Medicare under 65, while others only extend them to people eligible for Medicare because of disability or only to people with ESRD. Check with your State Insurance Department about what rights you have in your state.

Even if your state isn't listed above, some insurance companies may voluntarily sell Medigap policies to people who are under 65, although they'll probably cost more than Medigap policies sold to people over 65, and they probably use **medical underwriting**. Some of the federal guaranteed rights are available to people with Medicare under 65. (Go to pages 21–24.) Check with your State Insurance Department about what additional rights you might have under state law. Visit **content.naic.org/state-insurance-departments** to find your State Insurance Department.

If you already have Medicare Part B (Medical Insurance), you'll still get a Medigap Open Enrollment Period when you turn 65. You'll probably have more Medigap policy options and be able to get a lower **premium** at that time. During the **Medigap Open Enrollment Period**, insurance companies can't refuse to sell you any Medigap policy due to a disability or other health problem, or charge you a higher premium (based on health status) than they charge other people who are 65.

Because Medicare Part A (Hospital Insurance) and/or Part B (Medical Insurance) is creditable coverage, if you had Medicare for more than 6 months before you turned 65, you may not have a pre-existing condition waiting period. For more information about the Medigap Open Enrollment Period and pre-existing conditions, go to pages 10–11. If you have questions, call your State Health Insurance Assistance Program (SHIP). Visit **shiphelp.org** to get the number for your local SHIP.