CHBRP

Senate Bill 1236 (2024)
Medicare Supplements
Analysis at a Glance

As introduced on February 15, 2024

Bill Summary

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.

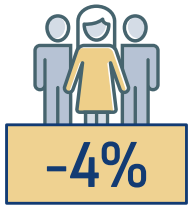
Federal law provides for the issuance of Medicare Supplement, also known as **Medigap**, which supplements reimbursements under the Medicare Program, including coverage of applicable deductible, copayment, or coinsurance amounts. In California, Medicare Supplement policies and plans are regulated by the CDI or the DMHC. The predicted increases in Medicare Supplement premiums due to SB 1236 are driven by 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 at baseline, which are based on attained age.

Postmandate, 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. Some may be in Medicare Advantage plans but will move to traditional Medicare with a Medicare Supplement to improve their ability to seek out care from more **providers not in their current Medicare Advantage network**. Conversely, 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. The resulting claims experience of enrollees in the Medicare Supplement would be higher, **resulting in higher premiums**. 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 **595,092 to 572,892**, a **4% decrease**. Overall, the average monthly premiums for Medicare Supplement will increase from **$239.03 to $362.64 per member per month (PMPM)**, a **52% increase**, because the average new enrollees in Medicare Supplements will use more services than the average enrollee at baseline.

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.

California Department of Insurance (CDI), California Department of Managed Health Care (DMHC), California Health Benefits Review Program (CHBRP) per member per month (PMPM), Senate Bill (SB)