

Rhode Island Office of the Health Insurance Commissioner's Report

*Pursuant to Rhode Island General
Laws § 27-18.2-3.1(e)*

December 9, 2025

*This report presents the legislatively mandated
evaluation of the impact of adopting a community
rating structure for Medicare supplement plans
and a review of carrier notification processes for
Medicare Supplement enrollment periods.*



STATE OF RHODE ISLAND

Office of The Health Insurance Commissioner

Department of Business Regulation

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Table of Contents

| | |
|-------------------------------------------------------------------------|----|
| Executive Summary | 3 |
| Background | 3 |
| Data Sources, Reliance, and Methodology | 4 |
| Current Market Assessment | 5 |
| Results | 8 |
| Considerations and Limitations | 11 |
| Acknowledgement of Qualifications | 12 |
| Notification Requirements for Medicare Supplement Insurers | 12 |

Executive Summary

On July 2, 2025, the Rhode Island Governor signed into law Rhode Island House and Senate Bills H5494¹ and S0610². These bills covered multiple topics related to Medicare Supplement plans in Rhode Island, including the addition of R.I.G.L. §27-18.2-3.1(e), which directs the Office of the Health Insurance Commissioner (OHIC) to evaluate the impact of adopting a community rating structure for Medicare Supplement premiums in the state. This report is in response to R.I.G.L. §27-18.2-3.1(e).

In response to the directive under this bill, OHIC requested that Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) study the possible market changes that could result from implementing community rating for Medicare Supplement plans in Rhode Island.

This report presents a summary of the analysis related to the estimated impact that shifting to community rating could have on the Rhode Island market. Specifically, this report includes an: a) overview of the current Rhode Island Medicare Supplement market, b) illustrative premium impacts of community rating compared to attained age rating, c) estimated range of premium impacts of community rating for various carriers in Rhode Island and d) additional factors for the state to consider, including carrier perspectives, regarding a community rating structure in the current Rhode Island market environment.

A Summary of the findings of this report include:

- The implementation of community rating may initially increase premiums for younger enrollees (over the age of 65) and lower premiums for older enrollees. Based on an analysis of data, estimated premiums for the youngest Medicare Supplement enrollees could increase by up to 36% and that premiums for the oldest Medicare Supplement enrollees could decrease by up to 15%.
- Over time, the change in premium structure may result in adverse selection as younger Medicare beneficiaries may be more likely to enroll in a Medicare Advantage product or choose a lower level of Medicare Supplement coverage, putting upward pressure on premiums.
- The impact of the new guaranteed issue rules included in H5494/ S0610, which went into effect on October 15, 2025 for plans beginning calendar year 2026, is currently unknown. If community rating were adopted in Rhode Island, the new guaranteed issue rules could also contribute to adverse selection and increased premiums, particularly for the most comprehensive Medicare Supplement plan options.

Background

It is important to note that a Medicare Supplement plan differs from Medicare Advantage, which is also called Part C. Medicare Advantage, or Medicare Part C allows Medicare eligible individuals to receive their benefits through a private plan, rather than through traditional fee-for-service Medicare. The Centers for Medicare & Medicaid Services (CMS) has sole and exclusive authority over the regulation of Medicare Advantage plans. This report exclusively relates to Medicare Supplement, for which rate review is conducted by, and regulated by, OHIC.

Medicare Supplement plans are health plans offered by private insurance which cover deductibles, coinsurance, and copays not covered under traditional Medicare (Parts A & B). The level of coverage under these plans varies based on a set of standardized benefit offerings. Nationwide, in 2022, 42% of enrollees in traditional Medicare were also enrolled in a Medicare Supplement policy³.

¹ <https://webserver.rilegislature.gov/BillText/BillText25/HouseText25/H5494A.pdf>

² <https://webserver.rilegislature.gov/Billtext25/SenateText25/S0610B.pdf>

³ <https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>

Under federal law, individuals are entitled to a one-time, six-month open enrollment period for Medicare Supplement insurance. This period begins on the first day of the month in which an individual is **both 65 and** enrolled in Part B. During this six-month period, insurers must accept applications for any Medicare Supplement plan offered and may not deny coverage or vary premiums based on health status. After the initial open enrollment period ends, insurers may apply medical underwriting and are not required to issue policies to all applicants. Federal law does not provide for an annual Medicare Supplement open enrollment period, and guaranteed-issue rights apply only in limited situations, such as loss of employer coverage or termination of a Medicare Advantage plan.

Federal law generally permits three methods for determining Medicare Supplement premiums. Under a community-rated methodology, all policyholders pay the same premium regardless of age. Issue-age-rated premiums are based on the age when the policy is first purchased and do not increase due to aging. Finally, attained-age-rated premiums are based on the policyholder's current age and increase as the individual gets older. In most states, including Rhode Island, insurers may use any of the three rating structures, subject to approval under OHIC's rate review process.

Data Sources, Reliance, and Methodology

Oliver Wyman analyzed information from a variety of sources in assessing the Rhode Island Medicare Supplement market and the potential impact of adopting community rating. The key data sources used in performing this analysis are outlined below.

A data call was sent to the four largest carriers, by market share, that currently offer Medicare Supplement plans in the Rhode Island market (Blue Cross Blue Shield of Rhode Island, Humana, UnitedHealthcare, and USAA Life). These carriers cover over 90% of market share in the state. The data provided represents approximately 403,000 member months in Rhode Island, almost all of which were enrollees over the age of 65.

The carriers were asked to provide the following data for calendar year 2024 for both Rhode Island experience and nationwide experience (when applicable):

1. Claims by plan and specific benefit category, separately for attained age and issue age policies
2. Enrollment by plan in total and split by age grouping (under 65, 65+)
3. Lifetime loss ratio estimates
4. Age curve and average age underlying the claims experience
5. Administrative expenses and contribution to reserve assumptions

While all carriers provided a response to the data call, not all carriers were able to provide the data at the level of detail requested. For example, multiple carriers were unable to provide claims data split by specific benefit category. Where carriers were not able to provide the requested information, the information was either supplemented or excluded from the carrier's experience as necessary and appropriate.

In addition to the carrier specific data, Oliver Wyman also developed estimates based on the "2023 Medicare 5% Sample". This data reflects detailed claims experience under traditional Medicare for a random sample of 5% of all Medicare beneficiaries nationwide, and for purposes of this study was limited to experience specific to Rhode Island. The Rhode Island experience is representative of over 36,000 member months of exposure in 2023, the most recent year of data available.

The objective of this analysis was to develop and compare estimated premiums for consumers in the Medicare Supplement market under both attained age and community rated premium structures. For purposes of this analysis, Oliver Wyman did not consider the impact on issue age policies as those represent a much smaller segment of the market (less than 1% of the Rhode Island data provided by the carriers).

For both premium structures, the process of premium development began as follows:

1. Using the 2023 Medicare 5% Sample data for beneficiaries in Rhode Island, cost sharing per member per month (PMPM) under traditional Medicare was calculated for each major benefit category (e.g., Part A deductible, Part A coinsurance, Part B deductible, Part B coinsurance). These costs were trended to CY 2026 using an annual trend factor of 7%.
2. For each plan, the total estimated Medicare Supplement claims costs PMPM was determined by adding together the costs associated with the benefits that are applicable to the given plan. For plans that cover a certain percentage of a certain benefit (e.g., plan M only 50% of the Part A deductible), the estimated claims were adjusted accordingly. Additionally, plans K and L, which have an out-of-pocket maximum (OOPM) that limits consumer costs, were adjusted to reflect the OOPM impact.
3. Administrative expenses and contributions to reserve were added to the claims cost to develop the premium estimate. The assumed loss ratio in premium development was 80%.

The premiums developed using the process noted above represented the overall rate based on the average age of the underlying Medicare 5% Sample data, or the community rated premiums. To estimate attained age premiums, Oliver Wyman used the Medicare 5% Sample claims data to develop an age curve. Based on the distribution of claims by age Oliver Wyman developed an age curve that considers how costs change as enrollees get older. The age curve was smoothed and adjusted to include a flattened premium rate for ages 80 and above, which is reflective of a common rating practice for Medicare Supplement policies. The age curve was then used to adjust the single average premium rate (i.e., the community rated premium) to various age-specific rates.

This analysis and the process described above focused only on enrollees aged 65 and older. It should be noted that some enrollees under age 65 are eligible Medicare Supplement plans. In Rhode Island, Plan A is available to these enrollees.

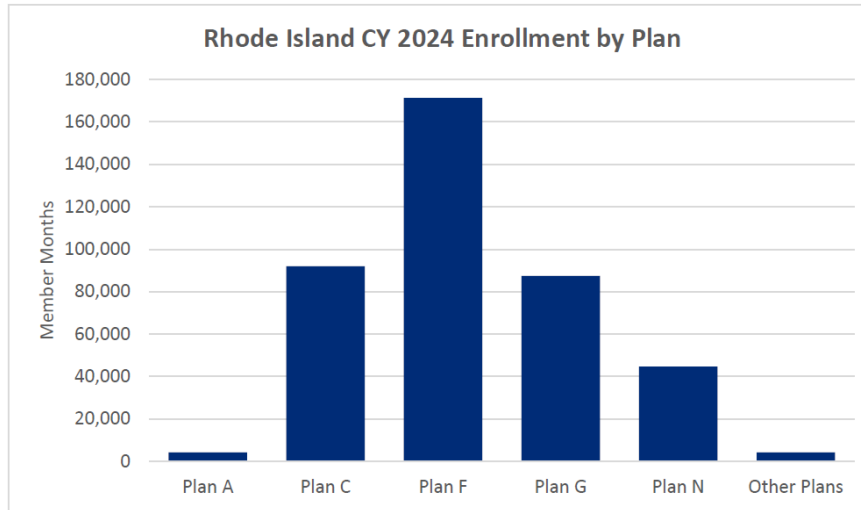
In addition to the process described above, the carrier data was considered in the analysis. For each carrier, estimated community rated and attained age premiums were developed based on the average premium by plan, the average age of enrollees by plan, and the age curve that was provided. Not all carriers were able to provide data by benefit for each plan, therefore a different approach relative to the one described above had to be used. While this premium development approach relied on the carrier specific data, it is important to note that carriers may include additional assumptions (e.g., adjustments for adverse selection) that would impact the community rated premium development.

Current Market Assessment

According to a National Association of Insurance Commissioners' report, in 2024, Rhode Island had just over 38,000 lives enrolled in Medicare Supplement across the individual and group markets⁴. The majority of plans are currently offered under an attained age rating structure in which rates increase each year based on a carrier specific age curve.

The graph below shows the combined enrollment and total premium by plan for these four carriers. Plan F is the most popular with 42% of consumers enrolling in this plan; plans C, G, and N are the next most popular plans with 23%, 22%, and 11% of enrollment, respectively. Under federal law passed as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Plans F and C are only available for new sales to enrollees that were eligible for Medicare prior to January 1, 2020.

⁴ <https://content.naic.org/sites/default/files/publication-med-bb-medicare-loss-report.pdf>

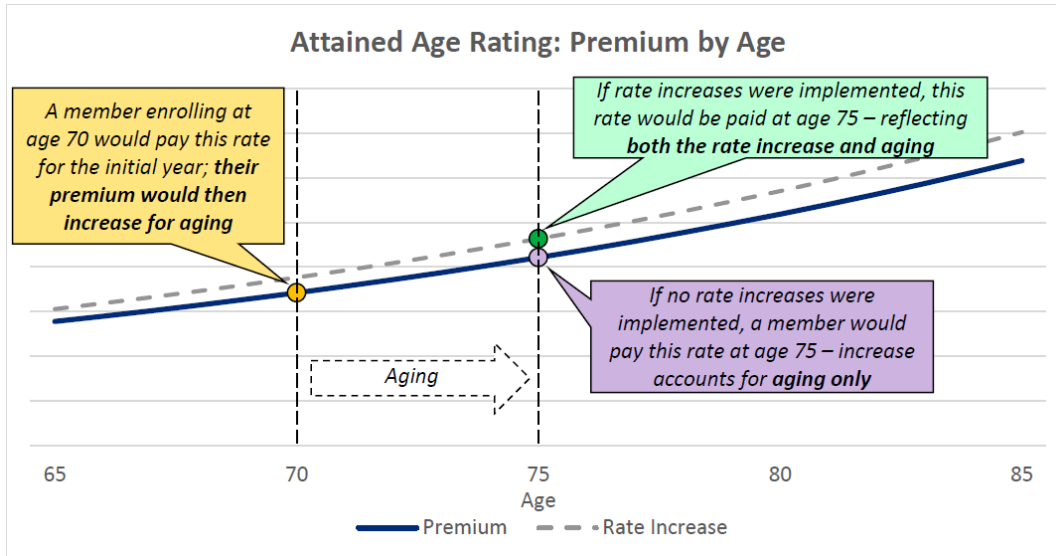


Carriers also provided historical and expected future and lifetime loss ratios for their current Rhode Island experience. A table showing the average loss ratio across the four carriers, weighted by calendar year 2024 premium, is included below. The overall projected lifetime loss ratio for these carriers is 84% in Rhode Island. Plan A has a higher loss ratio as this plan includes enrollees under the age of 65 who are eligible for Medicare due to disability or End Stage Renal Disease (ESRD). In Rhode Island, enrollees under the age of 65 who are eligible for Medicare due to disability or ESRD may only enroll in Plan A. Less than 1% of the enrollment in the data provided reflected enrollees under the age of 65.

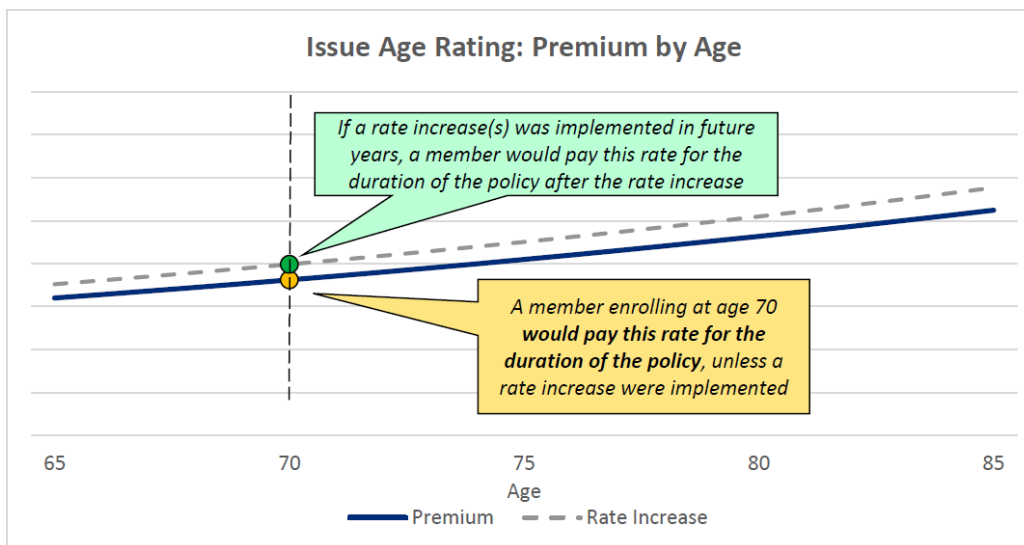
Loss Ratios by Plan at December 31, 2024

| Plan | CY 2024 Member Months | Past Loss Ratio | Future Loss Ratio | Lifetime Loss Ratio |
|--------------|-----------------------|-----------------|-------------------|---------------------|
| A | 4,181 | 170% | 135% | 165% |
| B | 820 | 76% | 81% | 77% |
| C | 91,943 | 88% | 81% | 87% |
| D | 149 | 76% | 105% | 79% |
| F | 171,351 | 78% | 79% | 78% |
| F-HD | 985 | 41% | 67% | 48% |
| G | 87,465 | 91% | 89% | 89% |
| G-HD | 224 | 23% | 60% | 46% |
| K | 1,328 | 69% | 78% | 72% |
| L | 681 | 105% | 108% | 105% |
| M | 0 | N/A | N/A | N/A |
| N | 44,713 | 77% | 80% | 78% |
| Total | 403,840 | 84% | 83% | 84% |

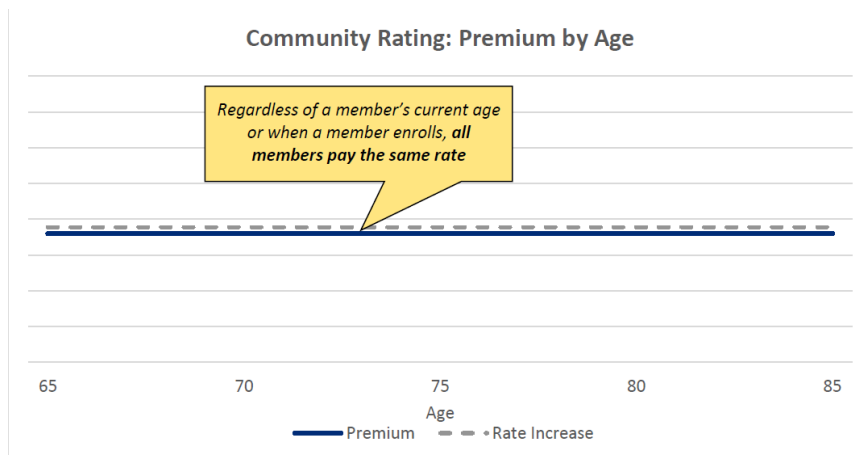
The most common rating structure used in the Medicare Supplement market, and the predominant current rating structure in Rhode Island, is attained age rating. Under an attained age rate, the member's premium is based on their current age (regardless of how old they were when they initially enrolled) and increases each year due to aging. If a carrier also files for a rate increase, the member's premium would increase for both aging and the rate increase. The graph below illustrates the premium by age assuming an attained age structure.



Under issue age rating, a member's premium is based on their age at the time of enrollment. The member will pay the same premium throughout the duration of their enrollment unless the carrier files for a rate increase, in which case the member premium would increase accordingly. Under this rating structure, the rates are set such that premiums charged at younger ages are used to pre-fund costs at older ages.



Under a community rating structure, all members are charged the same premium regardless of their current age or the age at the time the policy was issued. Relative to attained age rating and, to a lesser extent, issue age rating, premium rates for younger enrollees will be higher and rates for older enrollees would be lower under community rating. The member will pay the same premium throughout the duration of their enrollment unless the carrier files for a rate increase, in which case the member premium would increase accordingly. Under this structure, premiums charged to younger beneficiaries are essentially used to subsidize costs for members at older ages. The graph below illustrates the premium by age assuming a community rated premium structure.



Results

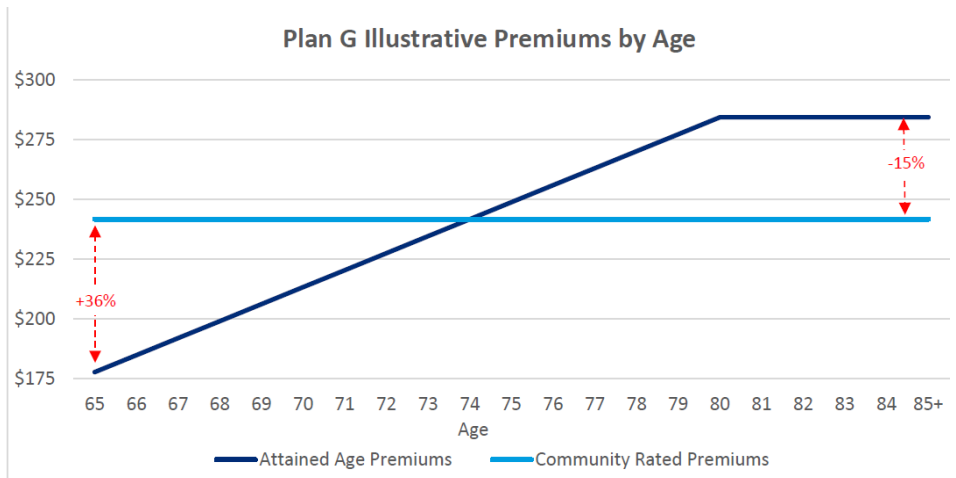
As noted in the methodology section of the report, the objective of this analysis was to compare the premiums under both attained age and community rated premium structures. While the results of the analysis shown below attempt to capture the differences in premium rates between the different rating structures, it should be noted that each carrier will develop their own assumptions and premiums. The analysis below is meant to be an illustrative comparison between these two rating approaches, not an explicit estimate of premiums expected to be offered in the market.

One key feature of community rating is that premiums for the highest-cost members at older ages are held to a lower level than they would be for attained age and issue age policies, all else equal. While community rating and issue age rating both have an element of year-over-year predictability built in, aside from overall rate increases that can be requested by carriers, community rating also incorporates subsidization of premiums across ages. This alleviates the impact of premium increases that seniors enrolled in Medicare Supplement policies typically experience as they age. However, while premiums for older beneficiaries may be lower, premiums for younger beneficiaries typically need to be increased in order to adequately fund the overall expected claim cost.

As described in the methodology section, example premiums were developed under both attained age and community rating structures using a sample population of Medicare enrollees in Rhode Island. The graph below demonstrates the estimated premium difference assuming an attained age structure and a community rated structure based on the Medicare 5% Sample data. The immediate result of moving to community rated premiums would likely be an increase for younger enrollees while older enrollees would be expected to see materially lower premiums.

This exercise shows that premiums for the youngest enrollees in Plan G could increase by approximately 36% while premiums for older individuals could decrease by about 15%. This is prior to any assumption of adverse selection as a result of the rating structure change that carriers may include in their rates. It is important to note that the variance in premium is driven by the age curve used in the development of the attained age premium rates; the average premium between the two rating approaches across the sample population is equal.

The age curve used in the analysis was developed to reflect claims differences in the Rhode Island Medicare 5% Sample data used in the analysis as well as typical rating curves of the market. However, each carrier develops their own age curve based on their data and assumptions. Differences in the slope of the assumed age curve would result in different relativities between attained age and community rated premiums.



The carrier data was also reviewed and the impact of moving from attained age rating to community rating was estimated for the four carriers that provided data. The average age of each carrier’s experience will drive their community rate, though it is important to note that not all carriers have credible data and they may rely on their national experience or other credible sources, if available, to develop premiums.

Blocks with older average ages will have higher community rated premiums than groups with younger enrollees. Additionally, the carrier specific age curve is very impactful in determining the impact of shifting from attained age rating to community rating. A steeper age curve will result in larger differences between the youngest and oldest attained age premiums and the community rated premiums. An age curve that is banded at either the highest or lowest ages will also impact the relative change of the enrollee premium between attained age and community rated premiums.

When reviewing the carrier information that was provided, the average age for their Rhode Island experience ranged from 72 to 85 years old (when excluding enrollees younger than 65). The estimated range of premium impacts when moving from attained age rating to community rating varied significantly by carrier. The estimated increase in premiums that was calculated for enrollees at younger ages ranged from 32% to 42% and the estimated decrease in premiums for enrollees at older ages ranged from 9% to 25%. It is important to note that these estimates are based on the data provided and do not include any additional assumptions for adverse selection or other carrier specific assumptions that may be made if a community rating approach is adopted. Additionally, these estimates rely on Rhode Island specific data which is not credible for all carriers. Several carriers in the state may rely on nationwide data, which likely would result in different premium impacts than were calculated in this analysis.

Given the subsidization across ages that occurs under community rating and the requisite increase in premiums that would be expected at younger ages relative to attained age rates, there may be several consumer responses:

1. Older beneficiaries enrolled in Medicare Supplement may be better able to maintain their existing coverage as they age.
2. Coverage through a Medicare Advantage plan may become more attractive to younger beneficiaries considering many of those plans are available at a low or even \$0 premium. However, there are other distinguishing features of Medicare Advantage that may deter some beneficiaries from making a switch to those products, such as higher levels of cost sharing and provider network restrictions.
3. Younger beneficiaries could elect to enroll in a Medicare Supplement plan with leaner benefits in exchange for a lower premium.
4. Under other provisions included in H5494/ S0610, which allow Medicare Supplement enrollees to change plans without underwriting during an annual guaranteed issue period, beneficiaries could

enroll in a lower cost plan with fewer benefits at younger ages and then later increase their coverage to a plan offering more comprehensive benefits as their health care expenditures increase at later ages.

As a result of these potential consumer responses, the long-term impact of community rating may be a deterioration of the risk pool enrolled in Medicare Supplement plans leading to higher overall premiums. If a higher proportion of older, higher-cost enrollees remain in Medicare Supplement plans while younger, lower-cost members elect to enroll in Medicare Advantage plans or forego supplemental coverage all together, the result could be a higher overall level of claims that leads to higher overall premiums. Similarly, if younger beneficiaries choose to enroll in Medicare Supplement plans with leaner benefits and later increase coverage as their health care needs increase, the average cost of services in benefit categories only covered under the richest plans would also be expected to increase, leading to higher premiums in those more comprehensive plans.

Based on the illustrative example shown earlier that relied on the Medicare 5% Sample data, Oliver Wyman have also estimated the premium increase that could result if some proportion of younger members (i.e., enrollees under 75 years old) exited the market, resulting in a higher average age of the Medicare Supplement population. For the various enrollment decrement rates that were assumed, the premium calculation for the community rates was updated to reflect the change in distribution by age. The estimated premium impact reflects only the estimated impact in premium due to the changes in enrollment distribution by age and includes no consideration of potential adverse selection impacts that carriers may include in the initial community rated premiums if this policy were implemented.

Estimated Average Medicare Supplement Premium Impact of Changes in Average Age

| Assumed Reduction in Under Age 75 Enrollees | Estimated Average Premium Impact |
|----------------------------------------------------|-----------------------------------------|
| 10% | +0.7% |
| 20% | +1.5% |
| 30% | +2.4% |
| 40% | +3.3% |
| 50% | +4.5% |

When determining whether to implement a community rating structure in Rhode Island, there are additional considerations that should be contemplated.

1. A change in rating structure would result in carriers updating their premiums and rating methodology. This could lead to market disruption to the extent the carriers' competitive positions materially change due to the new methodology and the assumptions each of the carriers implement in their pricing. It may be difficult for carriers to accurately project the population they will attract in the new environment resulting in rates that are misaligned to their final enrolled populations, which can result in increased uncertainty and higher future rate increases.
2. An additional provision included in H5494/ S0610 provides annual guaranteed issue rights to individuals who have been covered by Medicare Supplement or Medicare Advantage plans since their Medicare Initial Enrollment Period, without a gap in coverage of more than 90 days. This change will allow enrollees to switch between Medicare Supplement and Medicare Advantage plans depending on their perceived health needs; the lower premiums of Medicare Advantage plans may be more attractive to younger and healthier members while the rich level of coverage of Medicare Supplement plans may attract older members or members with more intensive coverage needs. This ability to switch between Medicare Supplement and Medicare

Advantage plans could compound the potential adverse selection impacts of moving to a community rating structure.

3. OHIC would need to carefully consider what blocks and plans would be allowed to be pooled for pricing purposes. The new guaranteed issue provision will allow for individuals currently enrolled in closed blocks to move into open blocks that may have lower premiums; this could result in these closed blocks fully running out at a faster rate than otherwise expected.

Through the data call, carriers were asked to provide comment on the considerations and impacts of moving to a community rating structure. The following items summarize the comments carriers provided in their responses, many of which were discussed in further detail above.

1. Experience in other markets with community rating structures show high loss-ratios.
2. Carriers expect that a shift to community rating would result in high levels of voluntary termination among younger enrollees as they will see premiums increase (relative to attained age rating).
3. Older enrollees would be expected to see lower premium rates after the initial implementation, but long-term deterioration of the block could result in higher premiums.
4. As young people exit and older enrollees stay, the carriers expect the morbidity of the market to deteriorate and result in higher overall premiums.
5. Carriers are concerned with the ability for consumers to move to richer plans as their health care needs increase, contributing to additional adverse selection, due to the annual enrollment policy included in H5494/ S0610.

Implementation of a community rated premium structure in Rhode Island may initially increase premiums for younger enrollees (over the age of 65) and lower premiums for older enrollees. Over time, the change in premium structure may result in adverse selection as younger Medicare beneficiaries could be more likely to enroll in a Medicare Advantage product or choose a lower level of Medicare Supplement coverage, putting upward pressure on premium rates.

Considerations and Limitations

Oliver Wyman's analysis relied on publicly available data, data provided by certain Rhode Island carriers who offer Medicare Supplement coverage, and information provided by OHIC without independent audit. While Oliver Wyman reviewed the data for reasonableness and consistency, it has not further audited or otherwise verified this data. The review of data may not always reveal imperfections. Oliver Wyman has assumed that the data provided is both accurate and complete, unless otherwise noted. The results of this analysis is dependent on this assumption. If this data or information is inaccurate or incomplete, the findings and conclusions might therefore be unreliable.

Oliver Wyman based its conclusions on the estimation of the outcome of many contingent events. Oliver Wyman developed estimates from historical experience, with adjustments for anticipated changes. Unless otherwise stated, these estimates make no provision for the emergence of new types of risks not sufficiently represented in the historical data on which Oliver Wyman relied or which are not yet quantifiable.

The sources of uncertainty affecting our estimates are numerous and include factors internal and external to the client named herein. Internal factors include items such as changes in provider reimbursement and claims adjudication practices. The most significant external influences include, but are not limited to, changes in the legal, social, or regulatory environment, and the potential for emerging diseases.

Uncontrollable factors such as general economic conditions also contribute to the variability.

While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events and are subject to economic and statistical variations from expected values. Oliver Wyman has not anticipated any extraordinary changes to the regulatory, legal, social, or economic environment or the emergence of new diseases or catastrophes that might affect our results. For these reasons, it provides no assurance that the emergence of actual experience will correspond to the projections in this analysis.

Acknowledgement of Qualifications

The Rhode Island Office of the Health Insurance Commissioner engaged Oliver Wyman Actuarial Consulting, Inc. to study the impact of community rating on the Medicare Supplement market in the State.

Corryn Brown, Steven Armstrong, and Ryan Schultz are responsible for this actuarial communication. Corryn Brown and Ryan Schultz are both Fellows of the Society of Actuaries; Steven Armstrong is an Associate of the Society of Actuaries. They are all Members of the American Academy of Actuaries and meet the requirements to issue this report.

Notification Requirements for Medicare Supplement Insurers

In addition to directing OHIC to evaluate the impact of adopting a community rating structure, R.I.G.L. §27-18.2-3.1(e) further directed the office to *“review the notification process for enrollment periods, frequency, and outreach by the insurers.”*

As noted above, Rhode Island, historically has modeled its open enrollment requirements for Medicare Supplement plans after the federal law. As such, because there had been no ongoing or annual open enrollment opportunity for Medicare Supplement beneficiaries prior to the amendments made to 27-18.2-3(h) via bills H5494 and S0610, there is no existing state law or guidance requiring insurers offering Medicare Supplement plans to provide annual notification to policyholders regarding enrollment periods.

Nationally there does not appear to be consistent, standardized issuer notification requirements for states which have annual or ongoing open enrollment rights. However, California state law requires insurers to notify policyholders of their open enrollment rights (60-day annual open enrollment period beginning on the individual’s birthday) at least 30 (thirty) but no more than 60 (sixty) days before the open enrollment period begins, and again with any notice concerning a benefit change or premium adjustment.

Should the General Assembly determine that an annual notification requirement would serve Rhode Island beneficiaries, amended legislation would need to be passed for OHIC to enforce such a notification provision.