



CALIFORNIA HEALTH ADVOCATES

Supplementing Medicare: Medigap Plans (Jan-May 2010)

What are Medigap Policies?

Insurance companies sell supplemental insurance to cover part, or all, of Medicare's copayments and deductibles. These are known as Medigap or Medicare supplement insurance policies. Some plans may include benefits for services that Medicare doesn't pay for, such as emergency medical costs incurred while traveling outside the U.S. or excess charges when seeing a provider who does not accept Medicare assignment. A Medigap policy is guaranteed to be renewable as long as the premium is paid. It cannot be cancelled because of a person's health condition or for any reason other than non-payment of the premium.

By law, companies can offer only 12 standardized Medigap benefit packages, referred to as plans A through L. A standardized plan means that the benefits are the same regardless of which company sells it. For example, Medigap Plan F has the same benefits no matter which company you buy it from.

A high deductible rider can also be sold with Plans F and J, which means that the policy will pay only after you have met the annual deductible (\$2,000). Once the deductible is met, the plan pays its benefits for the rest of that year. The annual deductible increases in August each year. (See attached chart for details.)

A Medicare SELECT plan is a hybrid that combines a Medigap policy with a Preferred Provider Organization (PPO) plan. A PPO is a group or network of providers who have agreed to limit their charge to enrollees who receive their care from providers in the network. A Medicare SELECT plan covers part or all of your Medicare copayments and deductibles from providers in the plan's network. Some Medicare SELECT policies may require you to pay a small copayment when you visit a doctor, a feature that is not allowed in other standardized Medigap policies. If you use providers outside the network, you may have to pay most or all of the cost for the services you use.

The California Department of Insurance regulates insurance companies that sell most Medigap policies. The Department of Managed Health Care, however, regulates Medigap policies sold by companies, such as Blue Cross or Blue Shield, that require you to use network providers. Medigap plans are sold through licensed insurance agents, by sponsoring groups, or through the mail. Retiree plans offered by former employers or unions do not have to conform to these standardized requirements and are not called Medigap policies, even though they may work in a similar way to supplement Medicare.

Note: If you receive full Medi-Cal benefits you do not need a Medigap policy; in fact, it is illegal for companies to sell you one, with certain exceptions. If you already have a Medigap policy when you become eligible for Medi-Cal, you have the option of keeping it if you want to see providers that don't take Medi-Cal. Or you can place your policy on hold for up to 24 months after you become eligible for Medi-Cal. If you have Medi-Cal with a share of cost (SOC), you do have the option of buying a Medigap policy.

Health Screening

You may apply for a Medigap policy at any time, but companies selling Medigap plans can refuse to sell you one because of a past or current health condition. Insurance companies may require that you go through health screening before deciding to sell you a Medigap policy. There are certain times, however, when, by law, companies must sell you a Medigap plan regardless of your health condition. These times are called "Open Enrollment" and "Guaranteed Issue" periods, which follow specific events that result in the loss of existing coverage. For more information on the Medigap open enrollment period and guaranteed issue rights, see our fact sheet "Supplementing Medicare: Your Rights to Purchase a Medigap Policy" at cahealthadvocates.org.

Note: In California, Medicare beneficiaries younger than 65 years who have Medicare because of a disability, but not if they have End Stage Renal Disease (ESRD), have an open enrollment period to buy a Medigap policy. The 6-month open enrollment period starts on your Medicare Part B effective date. Companies are allowed to charge a higher premium for people who are not yet 65 years old. For more information, please see our fact sheet “Medicare for People with Disabilities” at cahealthadvocates.org.

Waiting Period

Companies that sell Medigap policies may impose a waiting period before paying benefits for a pre-existing condition. This waiting period cannot last more than 6 months, and it applies only to those conditions that were treated during the 6 months prior to purchasing the policy. Companies may impose this waiting period when a beneficiary buys a Medigap policy during his/her open enrollment period.

Note: If you had health coverage during the 6 months prior to purchasing a Medigap plan, however, there will be no waiting period. If you are in a guaranteed issue period or you are buying a new Medigap policy to replace another Medigap plan, the company cannot impose any waiting period for your new policy regardless of your health condition.

Premiums

Even though Medigap policies are standardized, premiums can vary from company to company. There are 3 methods companies use to set their premiums: issue age, attained age, and community age rate.

1. **Issue age** – The issue age method bases the premium and future increases on the age of the beneficiary when the policy was first issued. For instance, a company using this method can charge a higher premium to a beneficiary who first buys the Medigap policy

at 72 years old than to a beneficiary who first buys it at 65 years old.

2. **Attained age** – The attained age method bases any premium increases on the enrollee’s current age at the time of the increase. In other words, a premium can increase based on your age as you get older in addition to other factors.
3. **Community age** – The community age method bases the premium and any premium increases on the average age of everyone in the plan.

Some companies charge smokers a higher premium while other companies offer a variety of discounts. Very few companies charge everyone the same price, regardless of their age or marital status. Many companies charge a higher premium for a person with a disability who is younger than 65 years old than for someone 65 years or older for the same policy. Most companies increase the amount of their premiums each year due to increases in the cost of medical care. It is important to compare policies and premiums from different companies before buying a policy. You can find information about companies selling Medigap plans in California and some sample premiums at the California Department of Insurance website: insurance.ca.gov.

Basic Benefits in All A - J Plans

Medigap plans A – J must offer the following basic benefits:

- Coinsurance for hospital days 61-90 (\$275/day in 2010) and coinsurance for the 60 lifetime reserve days (\$550/day in 2010).
- 100% of the cost of hospital care beyond 150 days covered by Medicare, up to a maximum of 365 lifetime days.
- 20% coinsurance for Medicare-approved charges after the \$155 annual Part B Medicare deductible has been met.
- The first 3 pints of blood in each calendar year.

Plan A has only the basic benefits.

Standardized Medigap Plans

	A	B	C	D	E	F ¹	G	H	I	J ¹
Basic Benefits: All Part A hospital co-insurance plus 100% of costs for a lifetime maximum of 365 additional hospital days; Part B coinsurance (20% of the Medicare-approved amount); first 3 pints of blood in a calendar year	X	X	X	X	X	X	X	X	X	X
Part A Hospital Deductible: First day deductible, \$1,100 in 2010 (per benefit period) ²		X	X	X	X	X	X	X	X	X
Skilled Nursing Facility (SNF) Copayment: \$137.50 per day for days 21-100 of Medicare-covered stay in a skilled nursing facility (per benefit period) ²			X	X	X	X	X	X	X	X
Part B Deductible: First \$155 of Part B services each year			X			X				X
Part B Excess Charges: 80% or 100% of the limiting charge (15% of the Medicare-approved amount -- physicians who do not accept assignment can add this amount)						100%	80%		100%	100%
Foreign Travel Emergency Care: 80% of emergency care during the first 2 months of each trip outside the USA after a \$250 deductible, for a lifetime maximum of \$50,000			X	X	X	X	X	X	X	X
At-Home Recovery Maximum of \$40/visit up to \$1,600 a year, while receiving Medicare-covered home health care, or up to 8 weeks of home care after Medicarecovered home care ends				X			X		X	X
Preventive Care: \$120/year for preventive care not covered by Medicare					X					X

1. Plans F and J may be sold with a high deductible option of \$2,000. The benefits remain the same, but the deductible must be met each year before any claims will be paid.

2. A “benefit period” begins the day you are admitted into a hospital or a SNF (for care covered by Medicare) and ends 60 consecutive days later during which you were neither an inpatient of a hospital nor receiving Medicare-covered care in a SNF.

NOTE: Since January 1, 2006 when Medicare Prescription Drug Coverage (Part D) began, Plans H, I and J are no longer sold with drug coverage.

Standardized Medigap Plans K and L

Medigap plans K and L are structured differently than Medigap Plans A-J.

	K	L
Part A hospital coinsurance plus coverage for 365 additional hospital days (lifetime maximum) after Medicare benefits end	100%	100%
Part A Hospital Deductible	50%	75%
SNF Copayment	50%	75%
Hospice Cost-Share	50%	75%
First 3 Pints of Blood	50%	75%
Part B Coinsurance	50%	75%
Medicare-covered Preventive Care coinsurance	100%	100%
Part B Annual Deductible³	0	0
Part B Excess Charges	0	0
Total Out-of-Pocket Limit	\$4,620 ⁴	\$2,310 ⁵

3. Your payment of the Part B annual deductible is credited towards the annual out-of-pocket limit of each plan.

4. After you have paid \$4,620 in out-of-pocket expenses for covered benefits during a calendar year, the plan then pays 100% of any remaining covered benefits for the remainder of that calendar year. The Part B deductible (\$155 in 2010) is not a covered benefit but it does count towards the \$4,620 out-of-pocket limit. Part B excess charges are not a covered benefit and payment of Part B excess charges does not count toward the \$4,620 out-of-pocket limit.

5. After you have paid \$2,310 in out-of-pocket expenses for covered benefits during a calendar year, the plan then pays 100% of any remaining covered benefits for the remainder of that calendar year. The Part B deductible (\$155 in 2010) is not a covered benefit but it does count towards the \$2,310 out of pocket limit. Part B excess charges are not a covered benefit and payment of Part B excess charges does not count toward the \$2,310 out-of-pocket limit.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call 1-800-434-0222 to make an appointment at the HICAP office nearest you, or go online at cahealthadvocates.org to find the HICAP office in your area.