

*Medicare Supplements**

Although Medicare provides significant medical expense benefits to its beneficiaries, not all health insurance expenses of older clients are covered. This reading identifies these gaps and describes the ways in which they might be filled with a Medicare supplement policy.

GAPS IN THE ORIGINAL MEDICARE PROGRAM

The original Medicare program has many limitations. These limitations create out-of-pocket costs for beneficiaries, known as gaps in benefits, that fall into three categories: fully covered, partially covered, and uncovered services.

Benefit Gaps for Fully Covered Services

Benefit gaps for fully covered services include

- the Part A deductible for each hospital benefit period
- the Part B annual deductible
- the 20 percent participation share of charges for most covered services under Part B

Benefit Gaps for Partially Covered Services

Gaps in benefits for services that are only partially covered include

- home health care that does not meet the program's required conditions
- the first three pints of blood
- all costs for skilled-nursing facility care after day 100 in a benefit period

The only nursing home care that Medicare covers is skilled-nursing care that is provided in a Medicare-certified skilled-nursing facility and is typically needed after a serious illness or hospitalization.

* Reprinted with changes from *Individual Medical Expense Insurance*, 3rd edition. (The American College Press 2004) by Thomas P. O'Hare.

Benefit Gaps for Services That Are Not Covered

Gaps due to services that are not covered include

- vision or dental care
- hearing aids
- private duty nursing
- preventive services other than those mentioned in chapter 7
- emergency care while traveling outside the United States (except in limited cases)
- custodial/long-term care
- outpatient prescription drugs. However, an individual may have coverage under a Medicare prescription drug plan.

FILLING THE GAP WITH MEDICARE SUPPLEMENT INSURANCE

Estimates indicate 50 to 60 percent of Medicare beneficiaries have some type of coverage to supplement Medicare; these beneficiaries are split among those with coverage provided by a former employer, those who purchase a Medicare supplement policy in the individual marketplace, and those who elect Medicare Advantage plans. In addition, Medicaid can be a supplement to Medicare for certain persons with limited assets and income. This reading looks at Medicare supplement policies.

After the passage of the initial Medicare legislation in 1965, Medicare supplement policies became as diverse as the companies that sold them. This led to some confusion in the marketplace, especially among the older members of the population—the primary market for these products. It also led to some questionable sales practices and duplications of coverage. As a result, in 1990, the Medicare supplement market became directly subject to federal regulation. However, this legislation does not apply to employer-provided Medicare carve-out or Medicare supplement insurance.

Medicare supplement insurance

Congress directed the NAIC to develop a standardized array of individual policies, all of which would include at least a common core of basic benefits. The technical name of these plans is *Medicare supplement insurance*, but they are often referred to as medigap policies.

In addition to standardizing Medicare supplement policies, Congress mandated several other features, including a 6-month open enrollment period, limited preexisting-conditions exclusions, prohibition of the sale of duplicate coverage, increased individual loss ratios (defined as claims divided by premiums), and guaranteed renewability. Indeed, when describing the benefits of each of the Medicare supplement policies, insurance companies must use the same format, language, and definitions. They also are required to use a uniform chart and outline of coverage to summarize the benefits in each plan.

These requirements are intended to make it easier for beneficiaries to compare policies and to select between them based on service, reliability, and price.

Federal laws have also generated several restrictions on the markets to which Medicare supplement policies may be sold. Under these restrictions, known as antiduplication provisions, it is generally illegal for an insurance company to sell a Medicare supplement policy to

- a current Medicare supplement policyowner, unless that person states in writing that the first policy will be cancelled
- a Medicaid recipient
- an enrollee in a Medicare Advantage plan

An insurance company that violates these provisions is subject to criminal and/or civil penalties under federal law.

Standardization of Plans

The NAIC initially adopted ten standardized plans of benefits called A through J to fill the gaps in original Medicare. Plan A is the basic benefit package. Each of the other nine original plans includes the basic plan A package and a varying combination of additional benefits, with plan J providing the most comprehensive coverage of all the plans. There are now two additional standard plans (called K and L) that contain consumer-directed health plan features. (Note that plans A through L are often referred to as policies A through L.)

States may approve, and insurers may offer, fewer than the 12 standard plans, but all states must permit the basic benefit plan to be sold. Insurers must sell plan A if they wish to sell any other plan. Most states now permit the sale of all 12 plans, but a few states limit the types sold, and three states (Massachusetts, Minnesota, and Wisconsin) maintain somewhat different standardized plans that were already in place prior to the federal legislation. Despite their differences, the standardized plans in these three states are required to contain the basic Medicare supplement (plan A) benefits available in all other states.

The Basic Benefit Plan

The basic benefits contained in plan A, and that must be included in all the other nine original plans, consist of the following:

- hospitalization—payment of the beneficiary's percentage participation share of Medicare Part A expenses for the 61st through the 90th day of hospitalization and the 60 lifetime reserve days. In

addition, full coverage is extended for 365 additional days after Medicare benefits end.

- medical expenses—payment of the beneficiary’s percentage participation share (generally 20 percent) for Medicare-approved Part B charges for physicians’ and medical services
- blood—payment for the first three pints of blood each year

Table 8-1 compares benefit payments by original Medicare and Medicare supplement plan A with remaining beneficiary payment amounts. These are the amounts for 2006; many of the dollar amounts are subject to annual inflation adjustment.

Additional Medicare Supplement Plan Benefits

The other nine original Medicare supplement plans include, in addition to the basic benefits, an array of coverage and benefits that are not included in original Medicare. These additions encompass the following:

- paying the hospital inpatient Part A deductible for each benefit period
- paying the Part A percentage participation share for the 21st through the 100th day of skilled-nursing facility care
- paying the annual Part B deductible
- paying charges for physicians’ and medical services that exceed the Medicare-approved amount (either 80 or 100 percent of these charges up to the charge limitation set by Medicare or the state)
- paying 80 percent of the charges after a \$250 deductible for emergency care in a foreign hospital (with several limitations) and a \$50,000 lifetime maximum
- paying (up to \$1,600 per year) for a care provider to give assistance with activities of daily living (at-home recovery) while a beneficiary qualifies for Medicare home health care benefits (with certain limitations)
- certain preventive care that is not covered by Medicare, such as an annual physical

Plans H, I, and J were originally designed to pay 50 percent of outpatient prescription drug charges after a \$250 deductible up to an annual \$1,250 or \$3,000 calendar limit. Beginning in 2006, insurance companies may no longer issue these policies to new insureds with a drug benefit included. Persons already insured under these policies have several options. They may continue to renew them with drug benefits included as long as they do not enroll in the new Medicare prescription

TABLE 1 Comparison of Payment Responsibility (for 2006) by Original Medicare, Basic Medicare Supplement (Plan A), and the Beneficiary			
	Medicare Pays	Medicare Supplement (Plan A) Pays	Beneficiary Pays
Medicare Part A			
Deductible ^a	0	0	\$952
First 60 days	100%	0	0
61 to 90 days	All but \$238 a day	\$238 a day	0
91 to 150 days (lifetime reserve) ^b	All but \$476 a day	\$476 a day	0
Up to an additional 365 days (lifetime)	0	100% of Medicare-eligible expenses	0
Blood ^c	All but 3 pints	3 pints	0
Hospice care	Most expenses	0	Balance
Skilled-nursing facility			
First 20 days	100%	0	0
21 to 100 days	All but \$119 a day	0	Up to \$119 a day
Medicare Part B			
Deductible ^d	0	0	\$124
Coinsurance benefit ^e	80% (generally)	20% (generally)	0
Blood ^f	80% after 3 pints	3 pints and then 20%	0
Clinical laboratory services	100%	0	0
Home health care (includes Part A benefits)			
Skilled services and supplies	100%	0	0
Durable medical equipment	80%	20%	0
<p>a. The hospital inpatient deductible, applicable once per benefit period</p> <p>b. Sixty days of care after the first 90 days of a hospital stay, available for payment by Medicare, which the beneficiary may use only once during a lifetime</p> <p>c. Received in a hospital or skilled-nursing facility during a covered stay</p> <p>d. Deductible satisfied once per calendar year when the beneficiary is billed the first \$124 in approved amounts for all Part B services in that year</p> <p>e. Beneficiary responsible for all Part B excess charges (above Medicare-approved amounts) for approved services because such charges are unpaid by Medicare and not covered by plan A</p> <p>f. Received as an outpatient or as part of Part B covered services</p>			

drug program. However, they will then probably be subject to the penalty for late enrollment if they later enroll in the program because the benefits under the Medicare supplement policy will likely not qualify as creditable coverage. If they enroll in the Medicare prescription drug program, they may keep in force their existing Medicare supplement policies but with the drug benefit eliminated and the premium adjusted accordingly. Alternatively, they can switch to another available Medicare supplement policy that has no drug benefit. Such a switch is allowed without evidence of insurability or a penalty for preexisting conditions as long as it occurs during the initial Part D enrollment period.

Table 8-2 indicates which of these other benefits plans B through J provide.

Consumer-Directed Plans

Plans K and L provide the basic Medicare supplement benefits previously described plus the Part A hospital deductible and skilled-nursing facility care for days 21 through 100. They also pay a portion of any cost sharing for hospice care and respite care covered by Medicare Part A.

	A	B	C	D	E	F	G	H	I	J
Basic benefits	X	X	X	X	X	X	X	X	X	X
Skilled-nursing facility (days 21–100)			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B excess charges						100%	80%		100%	100%
Foreign travel emergency			X	X	X	X	X	X	X	X
At-home recovery				X			X		X	X
Preventive medical care					X					X
Prescription drugs								\$1,250*	\$1,250*	\$3,000*
* Not available with the new plans; can be eliminated by persons who enroll in a Medicare prescription drug plan										

Compared to the ten original Medicare supplement plans, plans K and L require cost sharing by the insured for certain covered services, subject to an out-of-pocket limit.

Plan K requires the insured to pay 50 percent of the following:

- the Part A deductible
- the daily copayment for days 21 through 100 of skilled-nursing facility care
- the first three pints of blood
- the percentage participation for Part B services except preventive services, which are covered at 100 percent
- hospice and respite care cost sharing

When the insured's out-of-pocket payments for these services plus the Part B deductible equal \$4,000, plan K will pay 100 percent of the self-responsible amounts (any required copayments and percentage participation) for Medicare services for the rest of the calendar year. However, provider charges that exceed Medicare-approved amounts (excess charges) do not count toward the annual out-of-pocket limit.

Plan L is identical to plan K except that the percentage the insured must pay is 25 percent rather than 50 percent. In addition, the out-of-pocket limit is \$2,000.

Medicare Supplement Variations

Except for conformance with the alternative standards in Massachusetts, Minnesota, and Wisconsin, insurance companies cannot offer Medicare supplement policies that differ from these standardized options and cannot change the combination of benefits or the letter names of any of the policies. However, there are two allowable variations: high-deductible policies and Medicare SELECT policies.

High-Deductible Policies. Companies can offer two high-deductible Medicare supplement standard policies. These policies are identical to plans F and J except that they have a high-deductible amount (\$1,790 for 2006, subject to annual adjustment) before the plan pays any benefit. Separate annual deductibles for prescription drugs (\$250) in plan J and foreign travel emergencies (\$250) in plans F and J also apply. The monthly premium for plans F and J under the high-deductible option is generally less than the monthly premium for plans F and J without a high-deductible option. However, the savings may be offset by the out-of-pocket payments for services required before satisfying the deductible. Perhaps reflecting their lack of popularity, few insurers offer high-deductible Medicare supplement policies.

Medicare SELECT

Medicare SELECT. Medicare SELECT may be any one of the 12 standardized Medicare supplement insurance policies (although plans C, D, and F are most popular) in which the beneficiary must use the insurance plan's designated hospitals and doctors for nonemergency services to be eligible for full supplemental insurance benefits. Medicare SELECT policies are issued by insurance companies as PPO products and by some HMOs.

When a beneficiary goes to the Medicare SELECT preferred provider, Medicare pays its share of the approved charges and the insurance company is responsible for all supplemental benefits in the Medicare SELECT policy. In general, Medicare SELECT policies are required to pay full benefits only if a preferred provider is used for nonemergency services. However, Medicare pays its share of approved charges in any case. As an inducement to increase beneficiary and provider participation, physicians and suppliers under contract with Medicare SELECT insurers may waive Part B service cost-sharing amounts for beneficiaries under Medicare SELECT policies. Medicare SELECT policy premiums are generally 15 to 25 percent less than the monthly premium for the same plan without the required use of a preferred-provider network.

A beneficiary who has had a Medicare SELECT policy for at least 6 months has the right to switch to a regular Medicare supplement policy sold by the same company, as long as the new policy has equal or less coverage than the Medicare SELECT policy. This right is in addition to the other enrollment options discussed in the following section on eligibility.

Plan Popularity

The most widely available Medicare supplement plans are A, C, D, and F. Plan A generally represents less than 5 percent of Medicare supplement sales, however. Plan F represents more than half, while plans C and D make up approximately a third of total sales. Medicare SELECT policies, which are generally less available, represent no more than 10 percent of total Medicare supplement sales.

The popularity of plan F is presumed to result from seniors' desire to obtain its coverage of easily identified and likely to be incurred out-of-pocket amounts for deductibles, percentage participation shares, and excess physician charges. In addition, plan F premiums may be more attractive because they are unburdened by desirable but costly benefits for prescription drugs, preventive medical care, and/or at-home recovery featured in other plans.

Eligibility

In the absence of any Medicare supplement regulation to the contrary, insurers are free to conduct normal underwriting, including premium rating,

preexisting-conditions exclusions, and waiting periods. However, federal regulation creates a broad area of protected enrollment circumstances for beneficiaries who purchase Medicare supplement policies. These protected circumstances are categorized as either normal open enrollment or specified coverage changes. However, even outside of these circumstances, when a beneficiary replaces a Medicare supplement policy, federal requirements may apply.

Open Enrollment

There is an open enrollment period for the purchase of a Medicare supplement policy during the 6-month period that starts on the first day of the month in which a beneficiary is both age 65 or older *and* enrolled in Medicare Part B. During this 6-month period, a beneficiary may buy any Medicare supplement policy sold by a company doing Medicare supplement business in the beneficiary's state. The insurance company cannot deny insurance coverage, place conditions on a policy (like delaying the start of coverage), or change the price of a policy because of past or present health problems. The company can use preexisting-conditions restrictions or exclusion periods for up to 6 months after the effective date of the policy for medical treatments or advice the beneficiary received within 6 months before the date that the policy goes into effect. However, such restrictions are limited, as the company must reduce even this exclusion period for any period of creditable coverage. Thus, if the beneficiary had at least 6 months of creditable coverage, any health problem would be covered immediately. In general, creditable coverage includes medical coverage under a group, individual, or government-sponsored health plan, including the time already spent under Medicare Part A or enrolled in Part B. In order to receive credit toward preexisting-conditions restrictions, breaks in health coverage must last no longer than 63 calendar days.

Specified Coverage Changes

Three specific situations involving health care coverage changes permit the beneficiary to buy a Medicare supplement policy under protected enrollment circumstances (also known as Medicare supplement protection rights) after the normal Medicare supplement open enrollment period has ended. These circumstances, which are subject to very specific conditions, can be summarized as (1) when existing coverage ends involuntarily, (2) after Medicare supplement coverage is dropped to enter a Medicare Advantage plan for the first time, and (3) when an initially selected Medicare Advantage alternative to the original Medicare program is dropped. In each case, the beneficiary receives the same enrollment protection provided under normal open enrollment with immediate coverage for all preexisting

conditions. However, the beneficiary must apply for the new Medicare supplement policy within 63 days after the end of the previous coverage.

When Existing Coverage Ends Involuntarily. A protected Medicare supplement enrollment period exists if the beneficiary's current health coverage that pays for Medicare services—including a Medicare Advantage alternative plan, employer group health plan, Medicare supplement policy, or Medicare SELECT policy—ends involuntarily because

- an alternative plan no longer provides Medicare services to beneficiaries in the enrollee's area
- the beneficiary moves outside the alternative plan's service area
- the alternative health plan fails to meet its contract obligations
- a Medicare supplement insurance company discontinues a Medicare supplement or Medicare SELECT policy (must cancel all policies of the same type in a state)

Under these circumstances, the beneficiary has the right to buy Medicare supplement plan A, B, C, or F (whichever is available in the beneficiary's state). However, the beneficiary must remain with the existing health plan until its coverage ends.

After Medicare Supplement Coverage Is Dropped to Enter an Alternative Medicare Plan for the First Time. A protected Medicare supplement enrollment period exists if a beneficiary drops coverage under a Medicare supplement policy to join a Medicare Advantage alternative plan or purchase a Medicare SELECT policy for the first time and then leaves that plan or policy within one year to return to original Medicare. The beneficiary is allowed to return to his or her former Medicare supplement plan from the same insurance company, if it is available. If the same policy is unavailable, the beneficiary may choose among Medicare supplement plans A, B, C, and F, whichever are available in his or her state. In either case, the beneficiary must apply for Medicare supplement coverage within 63 calendar days after the previous health plan coverage ends. Again, all the open enrollment protections apply, as well as immediate coverage of all preexisting conditions.

When an Initially Selected Medicare Advantage Plan Is Dropped to Return to Original Medicare. A protected Medicare supplement enrollment period exists when a beneficiary joins a Medicare Advantage plan after first becoming eligible for Medicare at age 65 and voluntarily leaves that plan within 1 year to enroll in original Medicare. The beneficiary must be allowed to buy any Medicare supplement policy sold in his or her state.

Other Voluntary Replacements. Finally, a beneficiary may wish to replace an existing Medicare supplement policy with a new one from the same insurer or another company to obtain better benefits, more extensive services, or a more affordable premium. If the existing plan is a standardized Medicare supplement plan issued subject to federal regulations, the insurer must give credit for the time the policy was in effect toward the 6-month preexisting-conditions restrictions in the new policy. However, if a benefit is included in the new policy that was not in the old one, a waiting period of up to 6 months may be applied to that particular benefit. As noted earlier, the insurer must obtain a statement that the beneficiary intends to cancel the existing policy.

The federal Medicare supplement requirements do not apply to Medicare supplement policies sold before such policies were standardized. Consequently, some beneficiaries may be required to switch if an older policy was not guaranteed renewable and the company discontinues that type of Medicare supplement coverage. Others with guaranteed renewable policies may wish to switch to a standardized Medicare supplement policy for better rates and/or service. In both cases, the beneficiaries may face medical underwriting and are not allowed to go back to the previous nonstandardized Medicare supplement policy.

Medicare Supplement Policy Premiums

While health status is prohibited from being used as a factor, insurers, subject to state law, set their own premium rates for the Medicare supplement policies that they offer. Thus, Medicare supplement premiums differ depending on the company issuing the policy and the geographic location and age of the enrollee.

Insurance companies have three different ways of pricing policies based on age. No-age-rated, or community-rated, policies charge everyone the same rate no matter his or her age. Issue-age-rated policies charge a premium based on enrollee age when the policy is first purchased. The cost does not automatically increase as the enrollee gets older, and it is the same for anyone buying the policy for the first time at the same age. Attained-age-rated policies are based on the enrollee's age each year. So while attained-age policies cost less at age 65, their costs go up automatically as the enrollee gets older. Regardless of the method used, premiums can and do increase because of inflation and rising health care costs.

A few states require companies to sell only community-rated policies, and several allow only issue-age rates. Insurers generally favor attained-age rates because the resulting lower initial premiums can be more attractive to price-sensitive shoppers comparing standardized products. However, some companies may offer their customers a choice of attained-age or issue-age

rates. Insurers may vary Medicare supplement premium rates or offer discounts based on gender, health habits (such as tobacco use), and marital status.

Under-Age-65 Enrollment Issues

In addition to covering persons aged 65 or older, Medicare also covers the disabled and those with end-stage renal disease under age 65. These beneficiaries may also purchase any available Medicare supplement policy during the 6-month period that begins on the first day of the month in which they become 65 and are also enrolled in Part B, even if the Part B enrollment occurred prior to age 65.

More than a third of the states go beyond federal law and require insurance companies in the Medicare supplement market to offer at least one kind of Medicare supplement policy during an open enrollment period for Part B beneficiaries under age 65. These beneficiaries will also receive the normal Medicare supplement open enrollment opportunity when they become 65. Some companies voluntarily sell Medicare supplement policies to people with Medicare under age 65.

Medicare supplement policies sold to Medicare eligibles under age 65, whether by state mandate or voluntarily, must conform to the same standardized requirements as programs sold to beneficiaries who are age 65 and older.

Ease of Claims Filing

Under most circumstances, the beneficiary obtains services that are covered by both Medicare and Medicare supplement insurance without having to file a separate claim with the Medicare supplement insurer. By law, the Medicare carrier that processes Medicare Part B claims must send the claim to the Medicare supplement insurer. The Medicare supplement insurance company makes payments directly to the doctor or other provider when the following conditions are met:

- the doctor or supplier has signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries
- the beneficiary has a Medicare supplement policy
- the beneficiary indicates on the Medicare claim form that payment of the Medicare supplement benefit is to be made to the participating provider

In most cases, Medicare supplement insurance companies have special agreements with Medicare under which claims are sent directly to the insurance company, even if the doctor does not accept assignment.