NEW YORK STATE OF OPPORTUNITY. Health Insurance Information, Counseling and Assistance Program

SHIP State Health Insurance Assistance Program

Technical Assistance Center

Module 7: MEDICARE SUPPLEMENT INSURANCE/MEDIGAP

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MODULE 7 LEARNING OBJECTIVES

1. Describe Medigap costs and coverage.
2. Support clients in comparing, choosing, and enrolling in Medigaps.

MEDIGAP BASICS

The Medicare program began in 1966 to help older adults pay health care costs. Beneficiaries soon learned that even with Medicare protection, they were still responsible for considerable out-of-pocket costs, or gaps in Medicare coverage. Gaps in Medicare coverage include Medicare's deductibles, coinsurance, excess charges by doctors who do not accept Medicare assignment, and medical services and supplies that Medicare does not cover at all. Medigaps were developed to provide extra protection beyond Medicare by filling some of the gaps in Medicare coverage.

Medigaps, also sometimes called Medicare supplement insurance, are health insurance policies that offer standardized benefits to work with Original Medicare (not with Medicare Advantage). They are sold by private insurance companies and are only available to people who are enrolled in Medicare Parts A and B. Medigaps pay part or all of certain remaining costs after Original Medicare pays first. Medigaps may cover outstanding deductibles, coinsurance, and copayments. Medigaps may also cover health care costs that Medicare does not cover at all, like care received when travelling abroad. Remember, Medigaps only work with Original Medicare. If someone has a Medicare Advantage Plan, they cannot buy a Medigap.

MEDIGAP COVERAGE

Insurance companies may offer up to 10 different Medigap policies labeled A, B, C, D, F, G, K, L, M, and N. Each lettered policy is standardized. This means that all policies labeled with the same letter have the same benefits, no matter which company provides them or their price. For example, Medigap policy A offered by company 1 provides exactly the same benefits as Medigap policy A offered by company 2. The two companies may charge very different premiums for this same Medigap, though. Companies are not required to offer all 10 standardized Medigap policies, meaning some may be unavailable to client

depending on where they live. (Note that Minnesota, Massachusetts, and Wisconsin have different ways of standardizing Medigap policies.)

Medigaps help pay certain Medicare costs, including deductibles, coinsurance, and copays. Medigaps do not help pay for Medicare premiums. All policies must offer the following basic benefits:

- Hospital coinsurance coverage
- 365 additional days of full hospital coverage, after lifetime reserve days are exhausted
- Full or partial coverage for the 20% coinsurance for provider charges and other Part B services
- Full or partial coverage for the first three pints of blood needed each year
- Hospice coinsurance for drugs and respite care

Beyond these basic benefits, each standardized Medigap covers a different amount of Medicare cost-sharing. Depending on which Medigap policy they choose, a beneficiary can get coverage for additional expenses, including:

- Hospital deductible
- Skilled nursing facility coinsurance
- Part B deductible
    - People eligible for Medicare on or after January 1, 2020 cannot purchase Medigaps that pay for the Part B deductible. See below for more information.
- Emergency care outside the U.S.
    - With this benefit, the policy will pay 80 percent of charges for medically necessary emergency hospital, physician, and medical care in a foreign country, after a $250 deductible is met. Emergency care, however, is paid only if it begins during the first 60 days of a trip. The deductible is first paid out of pocket. The policy will pay a lifetime maximum of $50,000 for foreign emergency care. This benefit is not sufficient coverage for people who plan lengthy stays in foreign countries.
- Preventive care that Medicare does not cover
- Excess physician's charges
    - The policy will pay the difference between the billed charge and the Medicare-approved amount when a person with Medicare's doctor or other provider does not accept assignment. Federal and state laws limit the amount a doctor who does not accept assignment may charge. Since unassigned physicians' charges in New York State are limited to five percent above the Medicare approved amount for most services, this benefit will usually pay only an extra five percent. Careful consideration must be given to whether the extra premium the person with Medicare pays for such a benefit will be beneficial, especially if most services and supplies are provided by doctors who accept assignment.

Medigap Plans C and F

Medigap Plans C and F are only available to those who became eligible for Medicare before January 1, 2020. This is because people eligible for Medicare on or after January 1, 2020 cannot purchase Medigaps that pay the Part B deductible.

If a beneficiary became Medicare-eligible before this date, they will still be able to purchase Plan C or Plan F. If they were eligible for Medicare before this time but did not enroll until after, Plan C or Plan F are still available to them. If a client currently has Medigap Plan C or Plan F, they can continue to renew it from insurers in their state.

Policies sold before June 1, 2010

Keep in mind that policies sold today have slightly different benefits from those offered before June 1, 2010. Also, policies E, H, I, and J are no longer sold. If a client bought their Medigap before June 1, 2010, and have a discontinued policy, they can keep it as long as they like. The insurance company must continue to renew the discontinued Medigap policy each year a beneficiary wishes to keep it.

Medicare Select

Medicare Select is a type of Medigap policy that requires the insured to use specific hospitals, and in some cases, specific doctors (except in an emergency or where a service is not available) in order to be eligible for full benefits. Other than the limitation on hospitals and providers, Medicare Select policies must meet all the requirements that apply to a regular Medigap policy. Medicare Select policies may have lower premiums because of the requirement to use network providers.

When a person with Medicare uses the Medicare Select network hospitals and providers, Medicare pays its share of approved charges and the insurance company is responsible for all supplemental benefits in the Medicare Select policy. In general, Medicare Select policies are not required to pay any benefits if the person with Medicare does not use a network provider for non-emergency services. However, Medicare will still pay its share of approved charges no matter what provider is used.

The availability of Medicare Select coverage is limited to the geographic areas of the state serviced by the particular policy's network of hospitals and doctors.

Note: Currently no insurers are offering Medicare Select coverage in New York State.

Medigap Plan Benefits

For plans sold on or after June 1, 2020

	A	B	C	D	F*	G*	K**	L**	M	N
Hospital coinsurance Coinsurance for days 61-150 in hospital; Payment in full for 365 additional lifetime days	×	×	×	×	×	×	×	×	×	×
Part B coinsurance	×	×	×	×	×		50%	75%	×	Except 20$ for office visits and $50 for emergency visits
First three pints of blood	×	×	×	×	×		50%	75%	×	×
Hospital deductible		×	×	×	×		50%	75%	50%	×
Skilled nursing facility (SNF) daily coinsurance Covers days 21-100 each benefit period			×	×	×		50%	75%	×	×
Part B annual deductible			×		×					
Part B excess charges benefits					×					
Emergency care outside the U.S.			×	×	×				×	×
100% of coinsurance for Part B-covered preventive care services after the Part B deductible has been paid	×	×	×	×	×	×	×	×	×	×
Hospice care Coinsurance for respite care and other Part A-covered services	×	×	×	×	×	×	50%	75%	×	×

Note: Plans C and F are only available for those who became eligible for Medicare before January 1, 2020.
*Plans F and G also offer a high-deductible option.
**Plans K and L pay 100% of Part A and Part B coinsurance/copays after a beneficiary spends a certain amount out of pocket.

This chart does not apply to Massachusetts, Minnesota, and Wisconsin. Those states have their own Medigap systems.

MEDIGAP COSTS

When choosing a Medigap policy, it is best to look at policies from a range of insurance companies, especially if the client has already decided on a particular standardized policy. Policies with the same

letter name offer the same benefits, but premiums can vary from company to company. For example: Policy A bought from company 1 has the same benefits as Policy A bought from company 2, but company 1 and company 2 can charge different rates.

Medigap premiums in New York are no-age-rated (also called community-rated). This means that Medigap premiums vary depending on where in New York someone lives but are unaffected by age or health status. This means that premiums are the same for everyone living in a specific area, regardless of age. This way of setting Medigap premiums generally means that they are the least expensive over someone's lifetime. Visit the New York State Department of Financial Services website for current Medigap policy premiums.

For context, other states may use another way of setting premiums:

- Issue-age-rated: Premiums are based on someone's age when they first bought the policy. The younger someone is when they purchase a Medigap, the cheaper the premium. (Note: Premiums will still increase over time due to inflation, but not due to age).
- Attained-age-rated: Premiums are initially based on age when someone purchases a policy, and they increase with age (meaning someone pays a different price at age 65 than they do at age 70). These premiums may be the lowest when someone first buys them, but they are generally the most expensive over someone's lifetime.

ENROLLMENT AND CONSUMER PROTECTIONS

The federal law reforming Medigaps included important consumer protections to resolve many of the problems older adults faced when shopping for, when buying, and when using this type of insurance. New York State has mandated even more extensive consumer protections.

Open Enrollment Period

Older adults or disabled people who become eligible for Medicare may already have an illness or injury. Insurance companies call that illness or injury a preexisting condition. In the past, insurers could refuse to sell a person with Medicare a Medigap policy if they had a serious illness.

Federal Medigap reform ensures that they will be able to buy any Medigap policy during the first six months of their Medicare enrollment. This six-month period is called the open enrollment period. The open enrollment period begins the month someone is 65 or older and enrolled in Medicare Part B.

New York State residents have even more protections. New York State laws and regulations continue this open enrollment period, and a person enrolled in Medicare Parts A and B may purchase a Medigap policy at any time. Insurers may not consider an applicant's health status, claims experience, or age. However,

there are limited circumstances when a person may not be sold a Medigap policy, such as where coverage may be duplicated.

Laws in New York also prohibit insurers from basing Medigap premiums on age and charging a higher premium as they grow older. An insurer must charge all Medigap buyers in their geographic area level premiums and the same premium amount for a specific policy, whatever their gender, health, or age. The premium for that policy will, however, vary from company to company and from area to area (e.g., a policy will cost more if your client lives in Manhattan than if they live in Corning). Nondiscrimination by age is especially important to those under age 65 who are eligible for Medicare because of disability. It guarantees that Medigap policies are available to all Medicare beneficiaries, even those not yet 65.

Preexisting condition limitation

Medigap insurers may impose up to a six-month waiting period to be covered for any preexisting conditions a person may have. Federal law and New York State regulation define a preexisting condition as any condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

Under New York State regulation, the waiting period may be either reduced or waived entirely, depending upon whether an individual has had previous health insurance coverage. Medigap insurers are required to reduce the preexisting condition waiting period by the number of days an individual was covered under some form of creditable coverage so long as there were no breaks in coverage of more than 63 calendar days. Coverage is considered creditable if it is one of the following types of coverage:

- A group health plan
- Health insurance coverage
- Part A or B of Medicare – Note: Credit for the time that a person was covered under Medicare shall be accepted only if the applicant submits an application for Medigap insurance prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B;
- Medicaid
- CHAMPUS and TRICARE health care programs for the uniformed military services
- A medical care program of the Indian Health Service or of a tribal organization
- A State health benefits risk pool
- Federal Employees Health Benefits Program
- A public health plan
- A health benefit plan issued under the Peace Corps Act
- Medicare supplement insurance, Medicare select coverage or Medicare Advantage (Medicare HMO, PPO, or PFFS plan)

Note: Medical benefits from the Veterans Administration (VA) are considered creditable coverage for reducing the Medigap pre-existing condition waiting period.

Under New York State regulation, an individual applying for a Medigap policy always receives credit for previous coverage if it falls within the definition of creditable coverage and the break in coverage does not exceed 63 days. However, the credit for previous Medicare coverage is limited. Once an individual attains age 65 and has been enrolled in Medicare Part B for more than six months, they will not get credit for the previous Medicare coverage. In this situation, the preexisting condition waiting period would not be reduced by the Medicare coverage. For all other types of creditable coverage, the individual applying for a Medigap policy will have the policy's preexisting condition waiting period reduced or eliminated regardless of when such application is made so long as there is not a break in coverage of more than 63 days between the previous plan and the new Medigap plan.

Free look provision

Once a Medigap policy is purchased, a buyer has 30 days from the day the policy is received to review it. If they decide the policy does not meet their needs, they may return the policy to the insurer for a full refund during this free look period.

Guaranteed renewability

Federal law and New York State law mandates that Medigap policies be guaranteed renewable. The policy cannot be canceled unless a person with Medicare stops paying the premium or makes a material misrepresentation. If the policy they buy later becomes too expensive, they may downgrade to a less costly plan. An insurer may limit changes in coverage initiated by a policyholder to an anniversary date or other regular interval, so long as the interval is every 12 months or less.

Medicaid provision

What happens if a person with Medicare buys a Medigap plan, but later becomes eligible for Medicaid? Beneficiaries do not need both Medicaid and a Medicare supplement policy. The person with Medicare may suspend their policy if they become eligible for Medicaid. If Medicaid eligibility ends within two years, they may reactivate their policy with no new waiting period for preexisting conditions.

Medigap sales

Agents must note in writing what other insurance they have sold to an individual. With limited exceptions, it is against the law for agents to sell anyone a policy if they are covered by Medicaid or are enrolled in the Qualified Medicare Beneficiary (QMB) Medicare Savings Program. The exceptions are:

- When the state Medicaid programs pays the Medigap premium
- Medigap policies with prescription drug coverage may be sold to people with the Qualified Medicare Beneficiary (QMB) Medicare Savings Program

  - Medigap policies may be sold to those with the Qualifying Individual (QI) level of the Medicare Savings Program
- Agents may sell an individual a new Medigap policy only if they agree to cancel their original Medigap policy. The new insurer must remind the insured within six months to terminate one of their Medigap policies.

Agents are not permitted to use high pressure or misleading statements to induce someone to switch policies. High pressure means any words or actions that force or frighten someone into buying a policy. Insurers and their agents are prohibited from using mailings or ads that promise Medicare information to solicit a person unless the mailing or ad clearly states that the consumer will be approached by an insurance salesperson. Call the New York State Department of Financial Services at 1-800-342-3736 or file a complaint online to report any violations of these laws.

Medicaid, QMB, QI

Federal law prohibits the sale of Medigap policies to Medicaid beneficiaries. In addition to the existing exception for situations in which Medicaid pays the Medigap premium, the Federal statute allowed the sale of a Medigap policy to a Qualified Medicare Beneficiary (QMB) if the policy provides benefits for outpatient prescription drugs. This allowed insurers to sell Medigap standard plans H, I, and J to those with QMB. However, plans H, I and J with drug coverage were no longer sold to new enrollees as of January 1, 2006, and these plans are no longer sold at all. Those with QMB are automatically deemed eligible to receive Extra Help with Medicare Part D prescription drug costs. (Refer to HIICAP Notebook Module 10: Extra Help).

Additionally, Medigap policies can be sold to people who only have the QI level of the Medicare Savings Program. Those with QI are only entitled to have Medicaid pay the monthly Medicare Part B premium. Again, there is no prohibition on the sale of Medigap policies to those with QI.
Refer clients with QMB or QI to their Medicaid agency to discuss the impact, if any, of a Medigap policy.

COMPARING AND CHOOSING MEDIGAPS

Does everyone need a Medigap policy?

It is a common misconception that once a person enrolls in Medicare, they will need to buy a Medicare supplement or Medigap policy. Not everyone enrolled in Medicare needs a Medigap policy.

If a person with Medicare qualifies for Medicaid or the Qualified Medicare Beneficiary (QMB) program, they won't need to purchase a Medicare supplement policy, unless their doctors do not accept Medicaid patients. Medicaid and QMB can fill many of Medicare's gaps for those eligible.

A retiree, who has health insurance from their former employer may find that that coverage provides comprehensive coverage for a reasonable cost. A Medigap policy would, in most cases, duplicate the

hospital and medical benefits offered by their retiree plan and would potentially be a waste of hundreds of dollars in premiums each year. However, for retirees with very limited employer-sponsored health insurance benefits, a Medigap policy may be necessary.

A person with Medicare covered by TRICARE for Life (TFL) may not need a Medigap since TFL acts as a secondary payer to Medicare. If a TFL-eligible beneficiary has a Medigap policy, the Medigap will pay before TFL.

Medicare beneficiaries will not be able to purchase a Medigap policy if they elect Medicare coverage through a Medicare Advantage Plan. Medicare Advantage Plans usually provide coverage for most health care needs (see HIICAP Notebook Module 5 for a description of Medicare Advantage Plans).

How to choose

Choosing a Medigap plan that is best for a person with Medicare requires a three-part study:

- The policy benefits;
- The insurance company's reputation, reliability, customer service, and financial status; and
- The premium.

Relate the study to their specific situation, and then answer the following questions: Is this a benefit that their medical history or their medical condition makes them likely to need? Is this insurer known for easy claim filing procedures and prompt, accurate payments? Will this insurer be ready to help when they have questions? Can they afford the premium, even if it increases in coming years?

Before a person with Medicare purchases a Medigap policy, guide them through these steps:

- Compare plans A through N. Decide which plan best suits both their health care needs and their financial situation. Medigap policy A is often the least expensive, but it only covers the basic benefits listed above. Policies that add benefits beyond Plan A's core benefits will have premiums that increase with the number of added benefits. Policies C and F are the most comprehensive, but they generally cost more.
- Compare at least three different companies. Companies differ in service and financial stability.
- Know whom your client is dealing with. Be sure the companies they are considering are registered and the agents licensed by the New York State Department of Financial Services. When in doubt, call the Department of Financial Services at 1-800-342-3736.
- Investigate the insurer's credit rating. Independent rating firms such as A. M. Best, Standard and Poor's, and Weiss Research report on insurance companies' financial fitness. Choose an insurance company with highest grades from at least two of these agencies.
- Compare premiums. The premium for Plan D, for example, varies from one insurer to another. When two insurers are equal in service and financial stability, premiums may be your client's

deciding factor. Go to the Department of Financial Services website to see current premiums for all carriers in New York State.

- Consider personal health status. Then find out how long, if at all, they'll have to wait to be covered for their preexisting conditions. Be aware that only a recent or current health condition, which was diagnosed or treated in the six months before the policy was purchased, can be considered a preexisting condition.
- Be aware of the policy's maximum payment, if any, for each benefit. This limit is expressed in terms of dollars payable or number of payable days and generally coordinates with Medicare payments. For example, Medicare pays part of the costs for days 21 through 100 in a skilled nursing facility when certain requirements are met, after which benefits end. Standardized Medigap plans that include the skilled nursing facility benefit will pay a beneficiary's coinsurance only to the same limit of 100 days.
- Encourage a person with Medicare to take their time. Don't let a high-pressure salesperson rush them into buying a particular policy.

If they buy a Medigap, the following actions should be taken to prevent problems before they occur.

- Complete the application form carefully. Omitting information or providing incorrect information can result in denied claims.
- Expect an outline of coverage. The outline should be a clearly worded summary of the policy. The beneficiary should read it carefully.
- Never pay cash. Pay by check or money order made payable to the insurance company, not to the agent.
- Use the free look provision. The law gives the person with Medicare 30 days from the day they receive their policy to examine it and return the policy for a full refund if it does not meet their needs.
- And expect prompt delivery of their policy or a refund. If 60 days go by without receiving information, the person with Medicare should contact the New York State Department of Financial Services at 1-800-342-3736.

Sources of Assistance

NYSOFA HIICAP Hotline
1-800-701-0501

Medicare
1-800-MEDICARE (1-800-633-4227)
Call for questions about Medicare coverage, claims, or how Medicare works with your clients' other insurance.

http://www.medicare.gov

Social Security Administration
Hotline: 1-800-772-1213
Fax: 1-833-914-2016
Call for Medicare eligibility and enrollment information, lost Medicare card replacement and general Social Security issues. Visit www.ssa.gov/locator to find your local SSA office and contact information for that office.

Insurance Questions, Problems, and Complaints
NYS Department of Financial Services: 1-800-342-3736
Consumer Assistance Unit: 1-518-474-6600
1 Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

NYS Department of Financial Services
1- 212-480-6400
Consumer Assistance Unit
One State Street
New York, NY 10004

Additional Resources

Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, CMS Publication #02110
https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Standardized Medicare Supplement Monthly Premiums, New York State Department of Financial Services
https://www.dfs.ny.gov/consumers/health_insurance/supplement_plans_rates