

MEDICARE SUPPLEMENT (“MEDIGAP”) POLICIES

What are they?

Medicare supplement (“Medigap”) policies help fill in the gaps in coverage under the Medicare program. (For information on Medicare coverage, see Chapter 14.) Generally, Medigap policies are designed to offset some of the cost-sharing requirements of the Medicare program. For instance, a Medigap policy may pay the Medicare deductible that a patient would otherwise pay out of pocket. Some Medigap policies also cover services not otherwise covered by Medicare, such as prescription drugs.

Who are they for?

Medigap policies are available only to people who are eligible for Medicare. There are different rules governing Medigap policies for older adults and for those who are eligible for Medicare based on disability. In general, people who receive Medicare based on disability may find it more difficult to purchase a Medigap policy. Each state may have different laws for disabled people to purchase Medigap policies.

Not everyone purchases Medigap insurance — it is not a mandatory program. These policies may seem expensive for people on a fixed or limited income. In deciding whether to purchase a Medigap policy, you should consider the gaps in traditional Medicare coverage and other coverage options available. Medicare also imposes deductibles (an amount you pay before Medicare benefits begin to be paid) and requires cost-sharing (an amount you are required to pay out of pocket when you use certain medical services). It is estimated that Medicare actually covers only about half of a covered person’s medical costs. People on Medicare who are also covered by Medicaid, an employer’s health plan for retirees, or under a Medicare + Choice plan (described below) may feel that they do not need a Medigap policy.

How to obtain coverage

Close to 30 companies offer Medigap insurance in North Carolina. The North Carolina Department of Insurance offers the Seniors’ Health Insurance Information Program (SHIIP) which provides free information and advice on Medigap policies (as well as other insurance issues for seniors). SHIIP’s phone number and website are listed at the end of this chapter. They can send you their “Medicare Supplement Comparison Guide,” which gives comprehensive information on Medigap, companies offering these policies, and the different premiums charged. Alternatively, you may want to speak to a reputable insurance agent who can help you understand the difference between the plans offered and the companies selling Medigap coverage in North Carolina.

INTRODUCTION

In 1990, Congress enacted laws to regulate the sale of Medicare supplement policies. The new laws were designed to standardize these policies, making it easier for people on Medicare to understand what they were purchasing. The federal laws also provide significant consumer protections to older individuals.

There are ten standard Medigap plans available in North Carolina. If you purchased a Medigap policy before January of 1992, you are entitled to continue your coverage under that policy as long as you pay the premiums. Anyone who purchases a policy after that date must choose from among the ten standard plans.

BENEFITS

All ten of the Medigap policies provide the following core benefits:

- ◆ \$210/day for Part A copayment for days 61–90 of a hospital stay
- ◆ \$420/day for Part A copayment for days 91–150 of a hospital stay
- ◆ All approved costs not paid by Medicare after day 150 to a total of 365 hospital days lifetime
- ◆ Charges for the first three pints of blood not covered by Medicare
- ◆ Part B coinsurance for medical services. (Note: A Medigap policy pays only 20% of Medicare's approved charges for medical services.)

In addition to the core benefits, the plans provide the following additional benefits:

Plan A

Plan A is the core benefits policy. No additional benefits are covered if you purchase Plan A.

Plan B

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period

Plan C

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ \$100 Part B deductible/year

- ◆ Coverage for medically necessary emergency care in a foreign country. (Note: this benefit is subject to a \$250 deductible. After the deductible is met, then the plan will pay 80% of the billed charges for Medicare-eligible expenses, provided the illness or injury begins during the first 60 consecutive days of each trip. This is subject to a \$50,000 lifetime maximum.)

Plan D

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery. (Note: this benefit provides coverage for up to \$1,600 per year for short-term, at-home assistance with activities of daily living, such as bathing, dressing, personal hygiene, eating, etc., for those recovering from illness, injury, or surgery. The total number of visits may not exceed the number of Medicare-approved home health visits and each visit will pay a maximum of \$40. A patient may receive up to seven visits per week.)

Plan E

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ Foreign travel emergency care as in Plan C
- ◆ Preventive medical care. (Note: this may include any of the following: fecal occult blood test, digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, flu shot, tetanus and diphtheria booster. This benefit is limited to \$120/year.)

Plan F

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ \$100 Part B deductible/year
- ◆ 100% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C

Plan G

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ 80% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery as in Plan D

Plan H

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ Foreign travel emergency care as in Plan C
- ◆ A “basic” prescription drug benefit. The basic drug benefit has a \$250 annual deductible and a maximum annual benefit of \$1,250. People with Plan H pay 50% coinsurance on prescription drugs.

Plan I

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ 100% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery as in Plan D
- ◆ The basic prescription drug benefit as in Plan H

Plan J

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ 100% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery as in Plan D
- ◆ Preventive medical care as in Plan E
- ◆ Extended prescription drug benefits. People with Plan J pay a \$250 annual deductible and 50% coinsurance as in Plans H and I. However, under Plan J, the annual maximum benefit is \$3,000.

Note: The amount of the deductible and copayment which the plans will pay is based on the Medicare cost-sharing amounts. They are revised on January 1st of each year. The amounts listed in this chapter are current as of January 1, 2003.

Insurance companies are not required to offer all ten plans in North Carolina. However, if they offer any plan, they must offer Plan A.

ELIGIBILITY

Anyone who is eligible for Medicare may purchase a Medicare supplement policy. Medicare beneficiaries who are age 65 and older may purchase a Medigap policy any time after becoming eligible for Medicare. If you purchase your Medigap policy during the first six months after enrolling in Medicare Part B (the “open enrollment” period), you are guaranteed coverage. That is, the insurance company may not deny you coverage or charge you a higher premium based on your health status. If you do not purchase during this special enrollment period, or if you qualify for Medicare because of a disability, different rules apply.

Older adults who do not purchase a Medigap policy during the open enrollment period may be subject to medical underwriting. That is, the insurance company will look at their prior health history and at the likelihood of future use of medical services before deciding whether to offer health insurance coverage.

As of October 1, 2001, persons receiving Medicare due to a disability may purchase Medigap plans A, C, and J during the open enrollment period (the first six months after qualifying for Medicare). After the period of open enrollment, there is no requirement to provide supplemental insurance to the disabled. This law also guarantees the right to purchase insurance for disabled individuals who were enrolled in a Medicare managed care plan that discontinued its coverage, for 63 days after the

termination. In either case, companies may still develop premiums specific to the disabled population, so premiums may be higher than those for people over age 65. Contact SHIP for more information.

As with other insurance policies, with Medigap policies you are entitled to a “free-look” period. Medicare supplement policies offer a 30-day “free-look” period. During that time you may review the policy and, if you are not satisfied with it, you may return it to the insurance company for a full refund. The 30-day period begins the day you receive the certificate or policy — not the day you first apply for coverage.

LIMITATIONS AND EXCLUSIONS

People who enroll during the open enrollment period may still be subject to a waiting period of up to six months for coverage of pre-existing conditions (“pre-existing condition exclusion”). During this period, Medicare supplement policies will cover all conditions except the pre-existing condition. Once you have met the requirements of a pre-existing condition waiting period, you are not subject to another waiting period, even if you later change your insurance plan and/or company. Medigap policies are not allowed to impose “riders” that is, they cannot refuse to cover specific conditions. Pre-existing conditions are waived if you have prior creditable coverage and do not have a gap in health insurance coverage for more than 63 days.

RENEWABILITY

All Medicare supplement policies are guaranteed renewable. That is, an insurance company may not cancel a Medigap policy even if the person covered later becomes very ill. This is also true for people with disabilities who are able to purchase a Medigap policy.

PREMIUMS

In general, the more extensive the benefits, the more expensive the premiums. So, for instance, Plan G is generally more expensive than Plan B. You should note, however, that there are wide variations in premiums even among these standardized plans:

- ◆ Different companies charge different rates for the same plan. So, for instance, Insurance Company #1 might charge \$100 a month for Plan A while Insurance Company #2 charges \$120 for Plan A. Differences in charges have to do with factors other than benefits: remember, all Plan As have the same benefits. So, although \$100 a month sounds like a better bargain than \$120, check to see if there are drawbacks.
- ◆ In addition, companies may charge more if you first purchase a policy when you are older. Company #3 may charge \$110 a month for Plan A if you purchase it

when you are first eligible for Medicare (age 65), and \$120 a month for the same plan if you purchase it when you are 68.

- ◆ Some policies increase your premiums as you age (you pay \$110 a month for Plan A when you are 65 and \$120 when you are 69). Others do not — your age doesn't make the premium increase automatically.
- ◆ You should also note that some companies charge more depending on where you live. Others do not.

Before purchasing a Medigap policy, you should study the differences carefully and be sure that you understand the details. SHIIP or an insurance agent can help.

Insurance companies must file proposed rate increases with the Commissioner of Insurance. The Commissioner decides whether a rate increase is justified based on a set mathematical formula.

SOURCES OF LAW

Federal law(s):	42 U.S.C. § 1395ss
State law(s):	N.C.G.S. §§ 58-54-1 through 58-54-40
State regulation(s):	11 N.C.A.C. § 12.0800 <i>et seq.</i>

FOR MORE INFORMATION

Seniors Health Insurance Information Program (SHIIP)

N.C. Department of Insurance

P.O. Box 26387
Raleigh, NC 27611
919-733-0111
800-443-9354

<http://www.ncshiip.com>

SHIIP provides information and advice on Medicare, Medicare supplement insurance, Medicare managed care, claims, and long-term care insurance. SHIIP has easy-to-understand printed materials on comparing different Medigap policies, including differences in premiums, as well as other publications. SHIIP also provides personal, free health insurance counseling. SHIIP has trained volunteers in all 100 counties in North Carolina.