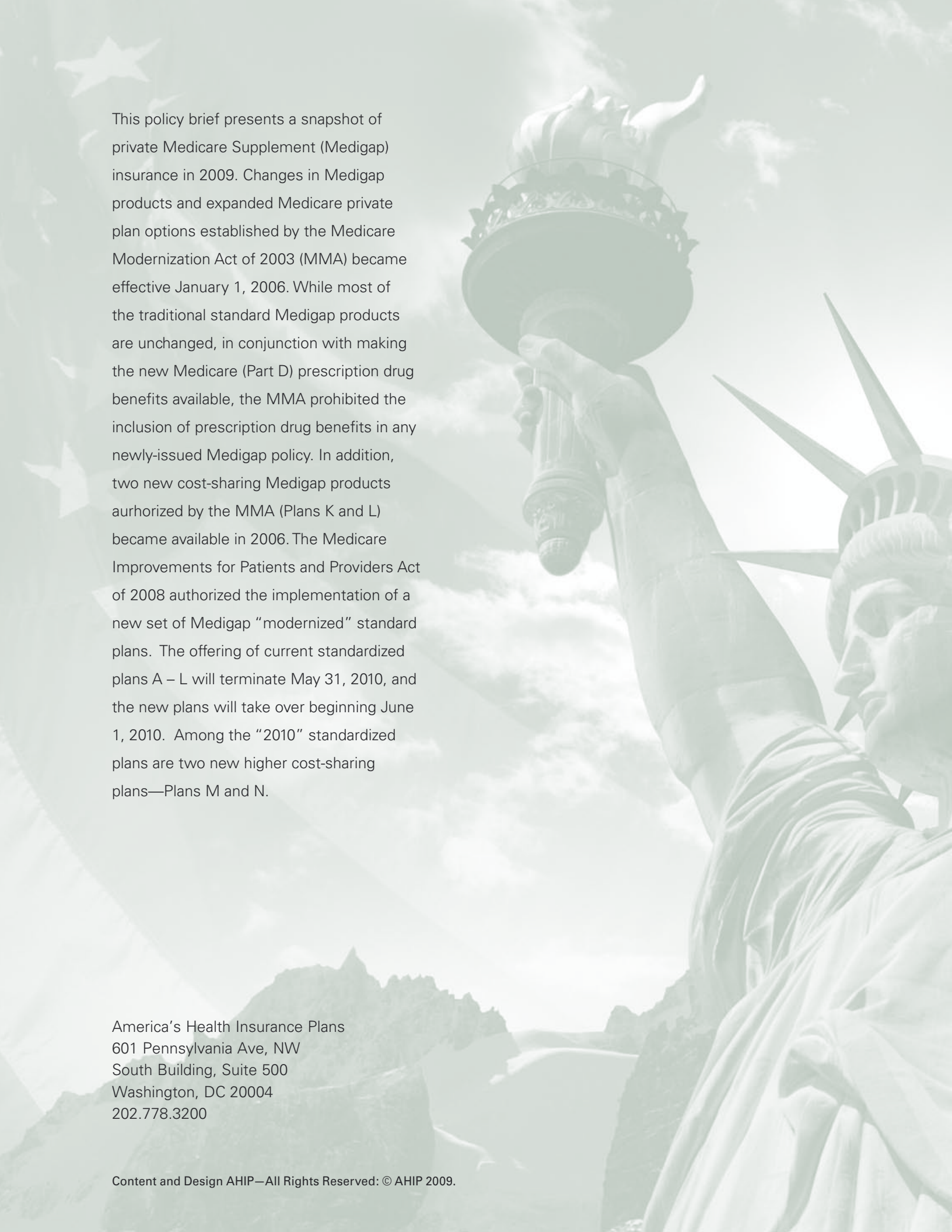




Medigap: What You Need To Know



June 2009



This policy brief presents a snapshot of private Medicare Supplement (Medigap) insurance in 2009. Changes in Medigap products and expanded Medicare private plan options established by the Medicare Modernization Act of 2003 (MMA) became effective January 1, 2006. While most of the traditional standard Medigap products are unchanged, in conjunction with making the new Medicare (Part D) prescription drug benefits available, the MMA prohibited the inclusion of prescription drug benefits in any newly-issued Medigap policy. In addition, two new cost-sharing Medigap products authorized by the MMA (Plans K and L) became available in 2006. The Medicare Improvements for Patients and Providers Act of 2008 authorized the implementation of a new set of Medigap “modernized” standard plans. The offering of current standardized plans A – L will terminate May 31, 2010, and the new plans will take over beginning June 1, 2010. Among the “2010” standardized plans are two new higher cost-sharing plans—Plans M and N.

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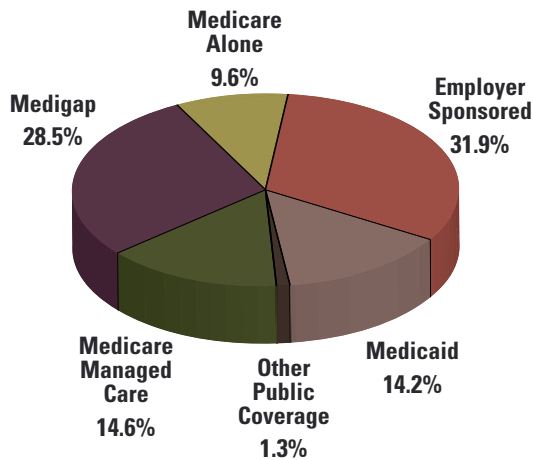
COVERAGE THAT SUPPLEMENTS MEDICARE BENEFITS

The fee-for-service Medicare program includes cost-sharing and benefit limits that result in significant out-of-pocket costs for Medicare beneficiaries. Nine out of ten Medicare beneficiaries have coverage that provides benefits in addition to Medicare, protecting them from these substantial costs. Major sources of coverage that provide benefits beyond Medicare fee-for-service coverage include individually-purchased insurance policies (“Medigap” plans), Medicare health plans, employer-sponsored plans, and Medicaid.

As **Figure 1** shows, Medigap plans are an important source of supplemental coverage for almost 29 percent of Medicare beneficiaries (2005). The National Association of Insurance Commissioners (NAIC) data indicated that roughly 87 percent of Medigap policyholders had federally standardized plans in 2006.¹

Figure 1

Sources of Supplemental Coverage Among Noninstitutionalized Medicare Beneficiaries, 2005



Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files, 2005.

Note: More recent data on sources of supplemental coverage are not available. Based upon discussions with MedPAC staff, we believe that Medigap’s share of the total in 2007 was approximately 22%.

WHO PURCHASES MEDIGAP?

The 2005 Medicare Current Beneficiary Survey (MCBS) data serves as a reminder of the critical role played by Medigap coverage. The statistics below are calculated from the publicly available MCBS Access to Care files and reported in a recent AHIP publication.²

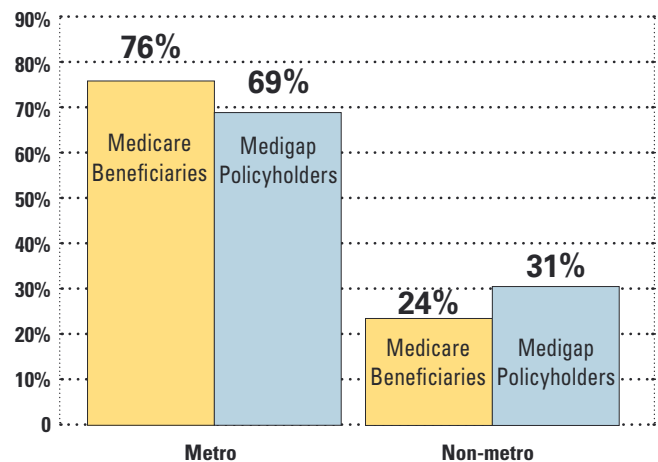
Medigap is particularly important to low-and moderate-income beneficiaries, especially those living in rural areas. Some of the key findings indicate that 31 percent of Medigap policyholders resided in rural areas in 2006; by comparison, only 24 percent of all Medicare beneficiaries resided in rural areas.

Other findings indicate that 41 percent of rural Medigap policyholders had incomes under \$20,000 in 2006, and 36 percent of all Medigap policyholders (living in rural and metropolitan areas) had incomes under \$20,000. Nearly two-thirds (66 percent) of rural Medigap policyholders and nearly 58 percent of all Medigap policyholders had incomes below \$30,000.

See **Figure 2**: Medicare Beneficiaries, By Area of Residence (2006), Low-Income & Rural Beneficiaries with Medigap Coverage, AHIP 2008 Study.

Figure 2

Medicare Beneficiaries, By Area of Residence (2006)*



Source: Low-Income & Rural Beneficiaries with Medigap Coverage, 2008 AHIP Study.

¹ America’s Health Insurance Plans (AHIP) 2007 analysis of Medigap Coverage Trends, 2004-2006.

² Low-Income and Rural Beneficiaries with Medigap Coverage, 2006. AHIP Study, 2008.

EXPENSES NOT COVERED BY MEDICARE

Major costs confronting beneficiaries in fee-for-service Medicare include the deductible for each episode of inpatient hospitalization covered under Medicare Part A (\$1,068 in 2009) and the annual deductible for physician and other outpatient benefits covered by Part B (\$135 in 2009).

Beneficiaries also may incur substantial costs due to the Medicare copayment for hospital stays exceeding 60 and 90 days (\$267 and \$534 respectively, in 2009) and the 20 percent coinsurance for physician services and other outpatient services covered by Part B. Fee-for-service Medicare places no limit on out-of-pocket expenditures for any of these payments. In addition, beneficiaries in the Medicare fee-for-service program are at risk of incurring significant expenses for benefits that Medicare does not cover at all. Appendix A lists the major health care expenses not covered by Medicare.

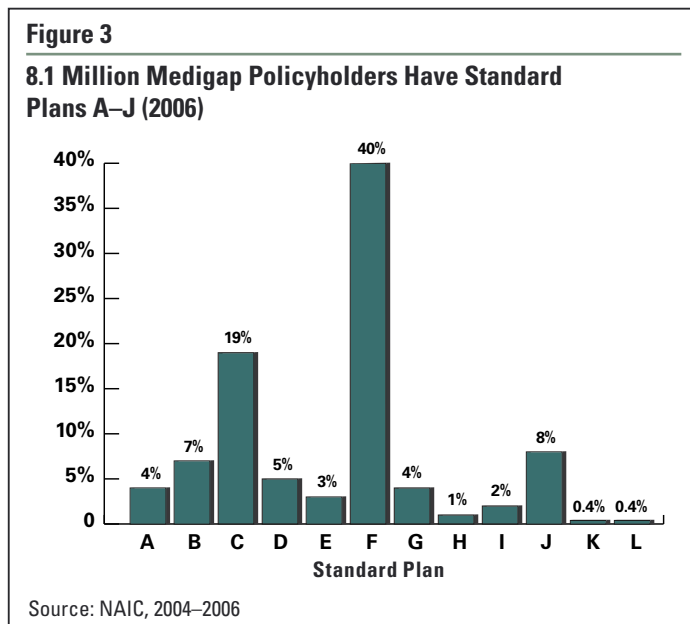
STANDARD MEDIGAP PLANS

Medigap policies currently issued must conform to one of the defined standard plan types, labeled Plans A through L. Appendix B shows the benefits available in each of the standard plans.

Beneficiaries who purchased “non-standard” plans issued before July 1992 may continue to renew them.

Some standard plans are considerably more popular than others.

Figure 3 shows the percentage of Medigap policyholders enrolled in each standard plan.



The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) required establishment of the ten standard Medigap Plans A through J.³ Each of these standard plans contains a core benefit package. Plan A consists of the core benefits alone; Plans B through J contain additional benefits such as coverage of copayments for care in a skilled nursing facility, benefits for at-home help, and coverage of physician charges in excess of Medicare’s approved amount.

In 1997, Congress authorized two new standard plan types – high deductible versions of Plan F and Plan J. Beneficiaries purchasing these plans must pay a deductible amount of \$1,900 (in 2008) before the standard Medigap Plan F or J benefits begin. According to the Centers for Medicare and Medicaid Services (CMS), “The deductible amount for the high deductible version of plans F and J represents the annual out-of-pocket expenses (excluding premiums) that a beneficiary who chooses one of these policies must pay before the policy begins paying benefits.” Additionally, the annual deductible amount for Medigap Plan F is updated each year, after the release of the August CPI-U figures by the Bureau of Labor Statistics.⁴

Plans H, I, and J, issued during 1992–2005, provide limited coverage for outpatient prescription drugs. Plans H and I contained a \$250 deductible for drug benefits and paid 50 percent of drug costs up to a maximum of \$1,250 per year. Plan J had the same deductible, but paid 50 percent of drug costs up to a maximum annual payment of \$3,000.

The Medicare Modernization Act of 2003 (MMA) requires elimination of prescription drug benefits from any Plan H, I, or J policy issued on or after January 1, 2006. While new Medigap policies may not be issued with prescription drug benefits on or after January 1, 2006, policyholders may continue to renew Medigap policies that contain drug benefits if they choose not to enroll in the Medicare prescription drug (Part D) program.

³ The high deductible F and high deductible J plan types were authorized by the Balanced Budget Act of 1997, Sec.1882(p) of the Social Security Act, 42 U.S.C 1395ss(p).

⁴ Centers for Medicare & Medicaid Services, F & J Deductible Announcements for 2009. Available at: http://www.cms.hhs.gov/pf/printpage.asp?ref=http://www.cms.hhs.gov/Medigap/02_FandJ.asp

The MMA authorized the establishment of two new standard Plans, K and L, beginning in 2006. Both new plans have the same hospitalization benefits as the original standard plans. They differ from Plans A through J primarily in that they provide less coverage for physician and other Part B services.

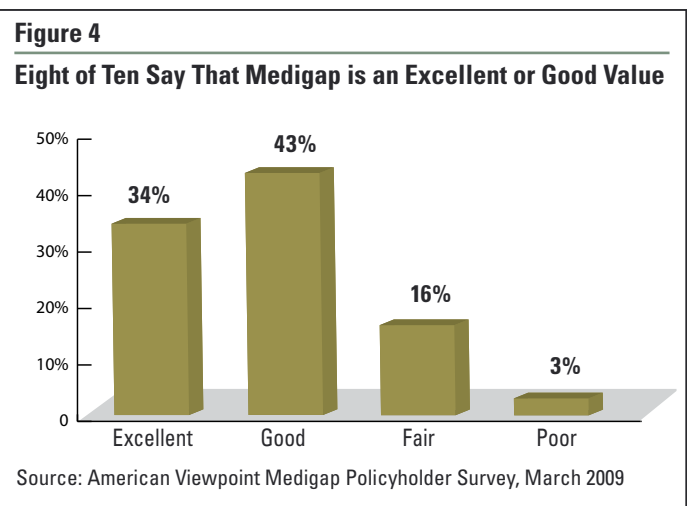
The Medicare Improvements for Patients and Physicians Act of 2008 (MIPPA) authorized the adoption of a new set of standardized plans which will replace the current standardized plans beginning June 1, 2010. Two new plan types will be introduced, Plans M and N, which will join Plans K and L in requiring higher out-of-pocket payments by policyholders than were required in the original Plans A – J.

With the addition of new plan types over the years, beneficiaries soon will have access to six standardized plan types that incorporate higher cost-sharing:

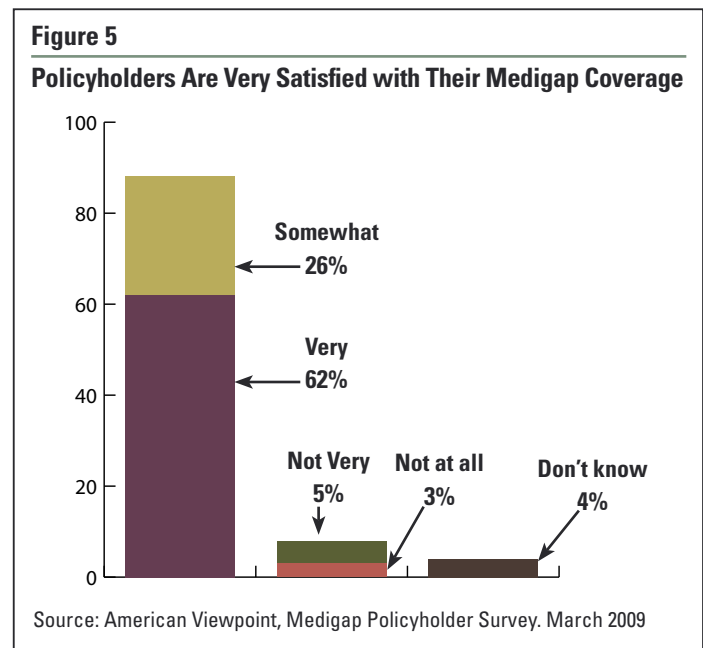
High Deductible Plans F and J	Both have a deductible of \$2,000 for calendar year 2009 before the policy begins to pay benefits.
Plans K and L	Both restrict coverage for Part B coinsurance: Plan K covers 50%, and Plan L covers 75% of Part B coinsurance amounts. Plans K and L also have out-of-pocket maximums to protect policyholders from catastrophic costs.
Plan M	Limits coverage of Part A deductible to 50 percent, making the policyholder responsible for \$534 (in 2009).
Plan N	Requires co-payments of up to \$20 for office visits and up to \$50 for emergency room visits.

CONSUMER SATISFACTION WITH MEDIGAP COVERAGE

Medicare beneficiaries overwhelmingly value their Medigap insurance. In a 2009 survey conducted by AmericanViewpoint,⁶ the vast majority of those surveyed (84 percent) said they would recommend the insurance to friends or relatives who are enrolling in Medicare. Seniors appreciate the choice, coordination of benefits, nationwide availability, and predictable premium costs that they experience with their Medigap policies. A total of 77 percent of those surveyed said their Medigap policy was an excellent or good value. See Figure 4.



Fully 88 percent of beneficiaries said they were either very satisfied (62 percent) or generally satisfied (22 percent) with their Medigap coverage. See Figure 5.



Similar results showing highly favorable views of Medigap insurance have been found in beneficiary surveys over the years.⁷

Additional evidence of the high value seniors place on Medigap is found in a June 2005 study issued by the Center for Studying Health System Change (HSC). HSC Issue Brief 96 reports that seniors are less willing than younger Americans to limit their choice of physicians and hospitals to save on out-of-pocket medical costs. See Figure 6.

⁵ Out-of-pocket limits for Medigap plans K&L for 2008 are at: http://www.cms.hhs.gov/Medigap/04_KandL.asp#TopOfPage

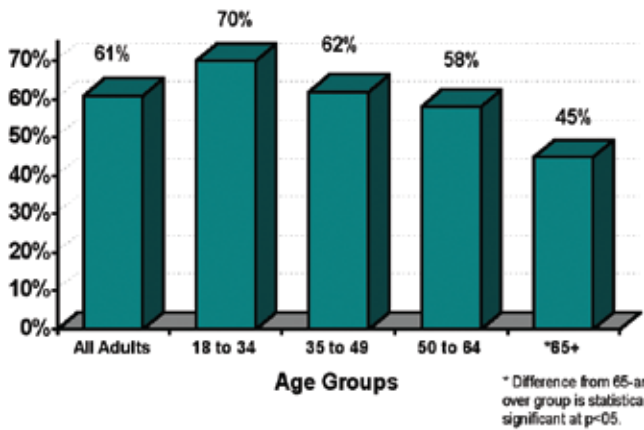
⁶ “National Medigap Enrollees Survey,” AmericanViewpoint for America’s Health

Insurance Plans and the Blue Cross Blue Shield Association, March 2009.

⁷ American Viewpoint Surveys, September 1999, June 2001.

Figure 6

Percentage of Adults Willing to Limit Provider Choice for Lower Out-of-Pocket Costs, by Age Group



Source: Tu, Ha T., "Medicare Seniors Much Less Willing to Limit Physician-Hospital Choice for Lower Costs," June 2005, Center for Studying Health Systems Change (Issue Brief 96)

The HSC survey also shows that seniors with Medicare and Medigap coverage are much less willing to trade-off free choice of providers for lower costs than seniors with other types of insurance coverage. Clearly, seniors with Medigap are willing to pay more to preserve their freedom of choice.

FEDERAL REQUIREMENTS RELATING TO OPEN ENROLLMENT AND PREMIUM RATES

In addition to standardizing Medigap policies, OBRA 90 established a six-month open enrollment period for Medigap coverage beginning when a beneficiary is age 65 or older and enrolls in Part B. A beneficiary applying for a Medigap policy during this period may not be denied coverage and cannot be charged a higher premium because of poor health. OBRA 90 also required that all Medigap policies be guaranteed renewable regardless of when the policy is issued, and established other regulatory standards.

Federal laws have expanded open enrollment for Medigap plans to include specific circumstances – for example, certain cases where a beneficiary terminates or loses coverage in a Medicare Advantage plan or loses coverage under an employer-sponsored plan.⁸ In addition to open enrollment requirements, federal law includes guarantee issue provisions, which are additional protections granted in cases of involuntary loss of coverage. The federal "GI" requirement has three components: guaranteed issuance; no discrimination in pricing based on health status; and no preexisting condition exclusions.⁹ The federal guarantee issue requirements are set as the minimum standard and in some cases states go beyond the minimum to enact more generous guarantee issue provisions for Medicare beneficiaries in their state.

OBRA 90 also requires Medigap insurers to report to the state the proportion of premiums paid as benefits, and meet certain loss ratio targets. If targets are not met, premium refunds are required in certain circumstances

⁸ The Balanced Budget Act of 1997 (BBA), the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and the

Medicare Modernization Act of 2003 (MMA) each expanded Medigap open enrollment opportunities.

⁹ Medigap Guarantee Issue Provisions in Federal Law, 42 U.S.C. §1395ss(s)

ROLE OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

In first enacting federal minimum standards as part of the Social Security Act for Medigap products and issuers in 1980 and in subsequent amendments to the law, Congress recognized the primary role of states in the regulation of private health insurance, including Medigap. Accordingly, the Social Security Act stipulates that federal minimum standards for Medigap insurance must incorporate the NAIC Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act (Model Regulation). A state's Medigap laws and regulations are deemed to meet the federal standards so long as its standards are equal to or more stringent than the federal statutory requirements and the NAIC Model Regulation standards. CMS recognizes any updated NAIC Model Regulation and incorporates its provisions into the federal requirements, and states amend their laws and regulations to conform to the new Model Regulation in order to be compliant with the federal law.

STATE REGULATION

As described above, federal law establishes certain minimum requirements for Medigap coverage, but the states have primary enforcement jurisdiction over Medigap insurers and policies. State regulatory authority includes review and approval of premium rates, regulation of rating practices and rules of enrollment, review and approval of policy forms, and all other aspects of insurance regulation. States may expand open enrollment and other guaranteed rights to Medigap coverage beyond the requirements established by federal law, and, in fact, many have done so.

APPENDIX A

Costs Not Covered By Medicare Traditional Fee-For-Service Program

Coverage	2009 Beneficiary Costs
PART A	
Inpatient	
Deductible for each hospital stay of 1-60 days	\$1068
Copayments for days 61-90	\$267 per day
Copayments for lifetime reserve days 91-150	\$534 per day
Beyond 90 days after exhausting 60 lifetime reserve days	All costs
Skilled Nursing Facility Care	
Days 1-20	Nothing for the first 20 days
Days 21-100	Up to \$133.50 per day
Beyond 100 days	All costs
Home Health Care	
Durable Medical Equipment	20% of approved amount
Hospice Care	
Outpatient drugs and inpatient respite care	Limited costs
Blood	
First three pints	All costs
PART B	
Medical expenses	\$135 annual deductible
Physician services	20% of allowable charges
Physician not accepting assignment	20% of allowable charges plus 100% of the difference between allowable charges and an additional capped amount
Outpatient hospital services	Variable copay amounts determined by formula*
Outpatient mental health services	50% of approved charges
Monthly premium	\$96.40 – \$308.30 (depending on income)
PART D	
Outpatient prescription drugs	Variable, depending on enrollment in Part D and particular drug plan selected. Out-of-pocket costs are capped at \$4,350.
OTHER SERVICES/ITEMS NOT COVERED BY MEDICARE	
Long-term care	All costs
Care outside United States	All costs
All costs that are not medically necessary	All costs
Dental, hearing, and vision care	All costs
Outpatient prescription drugs	For beneficiaries not enrolled in Medicare Part D, all costs**
*Under current law, copayments exceeding 20% are being phased down gradually to 20%.	
**Medicare Part B covers a limited number of drugs and antigens that cannot be self-administered.	

APPENDIX B

Standard Medigap Plan Benefits

This chart gives you a quick look at the standardized Medigap Plans A through L and their benefits. Every insurance company must make Medigap Plan A available if they offer any other Medigap policy. Not all Medigap policies may be available in your state.

How to read this chart: If a check mark appears in the column, this means that the Medigap policy covers 100% of the described benefit. If a column lists a percentage, this means the Medigap policy covers that percentage of the described benefit. If no percentage appears or if the column is blank, this means the Medigap policy doesn't cover that benefit. Note: The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).

WHAT MEDIGAP PLANS A THROUGH L COVER													
Medigap Benefits	A	B	C	D	E	F*	G	H	I	J*	K	L	
Part A coinsurance and Medigap Coverage for Hospital Benefits	X	X	X	X	X	X	X	X	X	X	X	X	
Medicare Part B coinsurance or Copayment	X	X	X	X	X	X	X	X	X	X	50%	75%	
Blood (First 3 Pints)	X	X	X	X	X	X	X	X	X	X	50%	75%	
Hospice care Coinsurance or Copayment											50%	75%	
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X	50%	75%	
Medicare Part A Deductible		X	X	X	X	X	X	X	X	X	50%	75%	
Medicare Part B Deductible			X			X				X			
Medicare Part B excess charges						X	80%		X	X			
Foreign travel emergency (Up to Plan Limits)**			X	X	X	X	X	X	X	X			
At-home Recovery (Up to Plan Limits)**				X			X		X	X			
Preventive Care Coinsurance (Included in the Part B Coinsurance)	X	X	X	X	X	X	X	X	X	X	X	X	
Preventive Care not covered by Medicare (up to \$120)					X					X			
											2009 out-of-pocket limit	\$4,620***	\$2,310***

* Medigap Plans F and J also offer a high-deductible option. You must pay the first \$2,000 (high-deductible in 2009) in Medigap-covered costs before the Medigap policy pays anything.

** You must also pay a separate deductible for foreign travel emergency (\$250 per year).

*** After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$135 in 2009), the plan pays 100% of covered services for the rest of the calendar year.

SOURCE: Centers for Medicare and Medicaid Services. 2009 Choosing A Medigap Policy: A Guide To Health Insurance For People With Medicare.





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