AHIP
America's Health Insurance Plans

Medigap: What You Need To Know

May 2011

This policy brief presents a snapshot of private Medicare supplement (Medigap) insurance.

Medigap coverage continues to be a vitally important product for seniors and other beneficiaries who choose Medicare's original fee-for-service (FFS) program. Year after year, beneficiary out-of-pocket costs for Medicare FFS coverage increases. Medigap coverage works in tandem with the original Medicare program, allowing seniors to budget for medical costs, and to avoid the confusion and inconvenience of handling complex bills from health care providers. According to the U.S. Census Bureau, in 2009 10.5 million Medicare beneficiaries had Medigap coverage, and that figure is expected to increase over time.

Efforts to overhaul the original Medicare program have resulted in similar activity to modernize Medigap coverage. The Medigap benefit packages were most recently updated to conform to the federal statutory changes made by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). These modifications were based on recommendations developed by the National Assocaition of Insurance Commissioners (NAIC), in consultation with consumer advocates, industry representatives, and other interested parties. Medigap carriers had to make the new (2010) standardized plans available effective June 1, 2010. Each of the new 2010 plans incorporates the following benefit changes:

- Elimination of the at-home recovery benefit in favor of a new hospice benefit (described below);
- Addition of a new core hospice benefit that covers the cost-sharing under Medicare FFS for palliative drugs and inpatient respite care; and
- Removal of the preventive care benefit in recognition of the increased Medicare FFS coverage under Part B.

MIPPA also called for the introduction of two new Medigap policies (Plans M and N) with increased beneficiary cost-sharing features and the elimination of several standardized plan options (Plans E, H, I, J, and J with high deductible) that became duplicative or unnecessary.

- Plan M includes increased consumer cost-sharing responsibilities with 50 percent coinsurance for the Medicare Part A deductible and no coverage of the Part B deductible.
- Plan N increases consumer cost-sharing responsibilities by: (1) not offering coverage for the Part B deductible, and (2) imposing as much as $20 for a copay for doctor visits and up to a $50 copay for emergency room visits that do not result in an inpatient admission.

The Affordable Care Act of 2010 (ACA) also included a provision that could further modify Medigap's benefit design. Specifically, ACA requires the NAIC to review Plans C and F for potential revision to include "nominal cost-sharing to encourage the use of appropriate physician services under (Medicare) Part B." The new benefit standards are to be made available, to the extent practicable, beginning January 1, 2015.

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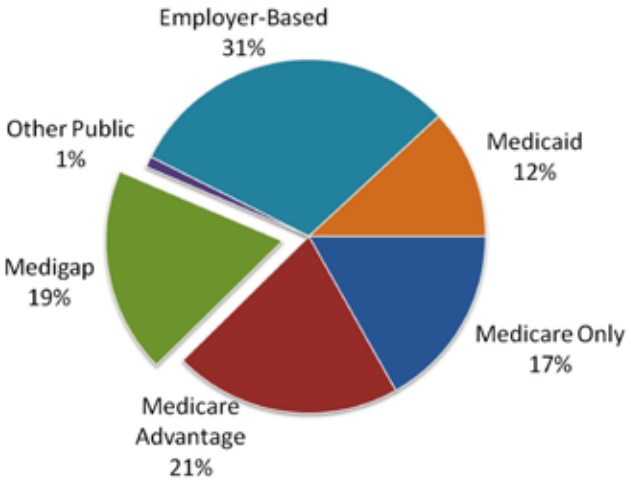
COVERAGE THAT SUPPLEMENTS MEDICARE BENEFITS

The Medicare fee-for-service (FFS) program (Parts A and B) includes cost-sharing and benefit limits that can result in significant out-of-pocket costs for Medicare beneficiaries. In 2008, more than eight out of ten Medicare beneficiaries had supplemental coverage that provided benefits in addition to Medicare, protecting them from these substantial costs.[1] Major sources of coverage that supplement the benefits provided under the Medicare FFS program or provide benefits beyond Medicare FFS include: individually-purchased insurance policies (Medigap and Medicare SELECT plans), Medicare Advantage, employer-sponsored plans, and Medicaid.

As **Figure 1** indicates, Medigap plans are an important source of supplemental coverage for 19 percent of Medicare beneficiaries. The National Association of Insurance Commissioners (NAIC) data indicated that roughly 91 percent of Medigap policyholders had federally standardized plans in 2008.[2]

Figure 1

Sources of Supplemental Coverage Among Noninstitutionalized Medicare Beneficiaries, 2008



Source: Low-Income & Rural Beneficiaries with Medigap Coverage, 2008. AHIP Study 2010.

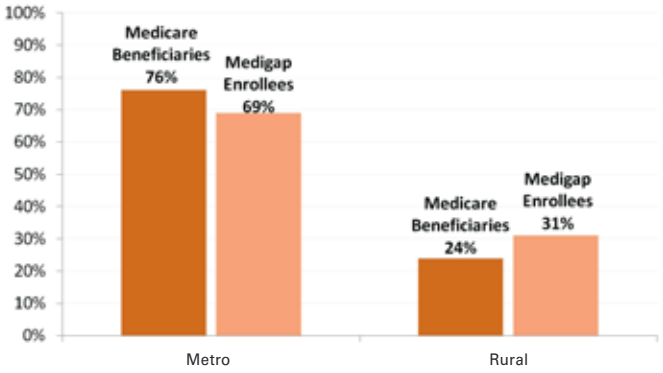
WHO PURCHASES MEDIGAP?

Analysis of the 2008 Medicare Current Beneficiary Survey (MCBS) 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.[3]

Medigap is of significant value to low- and moderate-income beneficiaries, especially those living in rural areas. Some of the key findings, as shown in **Figure 2**, indicate that 31 percent of Medigap policyholders resided in rural areas in 2008; by comparison, only 24 percent of all Medicare beneficiaries resided in rural areas.

Figure 2

Medicare Beneficiaries, by Area of Residence (2008)



Source: Low-Income & Rural Beneficiaries with Medigap Coverage, 2008. AHIP Study 2010.

Other findings indicate that 36 percent of rural Medigap policyholders had annual incomes under $20,000 in 2008, and 33 percent of all Medigap policyholders (living in rural or metropolitan areas) had annual incomes under $20,000. Nearly 62 percent of rural Medigap policyholders and nearly 54 percent of all Medigap policyholders had annual incomes below $30,000.

[1] Low-Income and Rural Beneficiaries with Medigap Coverage, 2008. AHIP Study 2010.

[2] Characteristics of Medigap Policies, December 2009. AHIP Study 2010.

[3] Low-Income and Rural Beneficiaries with Medigap Coverage, 2008. AHIP Study 2010.

EXPENSES NOT COVERED BY MEDICARE

Major costs confronting beneficiaries under the Medicare FFS program include the deductible for each benefit period of inpatient hospitalization covered under Part A ($1,132 in 2011) and the annual deductible for physician and other outpatient benefits covered by Part B ($162 in 2011).[4]

Beneficiaries also may incur substantial costs due to the Medicare copays for hospital stays exceeding 60 and 90 days ($283 per day and $566 per day respectively, in 2011) and the 20 percent coinsurance for physician services and other outpatient services covered by Part B. The Medicare FFS program places no limit on consumer out-of-pocket exposure for any of these payments. In addition, Medicare FFS beneficiaries are at risk of incurring significant expenses for benefits that Medicare does not cover at all. See Appendix A for a list of the major health care expenses not covered by the Medicare FFS program.

STANDARDIZED MEDIGAP PLANS

Medigap coverage is private health insurance designed to supplement Medicare and it offers coverage, at varying levels, for the Medicare FFS deductibles, coinsurance, and copays. Medigap policies currently issued must conform to one of the federally-defined standardized benefit packages.[5] The benefit design for Medicare FFS and Medigap plans has evolved over several decades. Generally speaking, each of today's Medigap plans contains the same core benefits, no matter which insurance carrier sells it. This includes the following basic benefits: (1) the Part A inpatient hospital coinsurance (for 61–90 days), (2) the Part A inpatient hospital costs up to an additional 365 days after Medicare benefits are exhausted, (3) the 20 percent Part B coinsurance or copayment, and (4) the first three pints of blood.

Medigap Plan A consists of these core benefits alone and Medigap Plans K and L include beneficiary cost-sharing on these benefits until the annual out-of-pocket limit is reached. Plans B to N, in varying degrees, also offer coverage in addition to the core benefits. By way of example, some provide coverage for the Medicare FFS skilled nursing facility coinsurance and /or the physician charges under Part B in excess of Medicare's approved amount. See Appendix B for a brief description of the standardized Medigap plans currently available and a summary of the benefits of each plan.

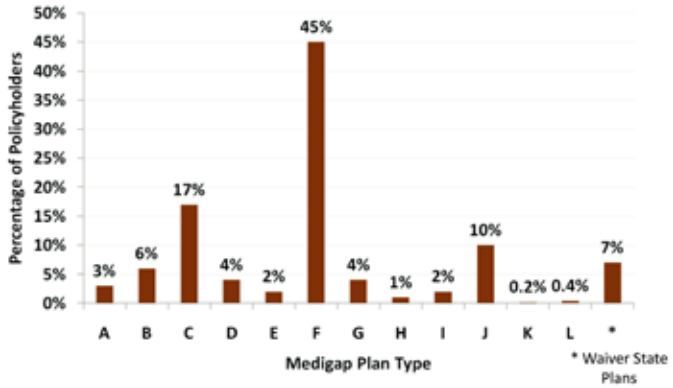
The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) first required the establishment of standardized Medigap plans, with the creation of Plans A through J. In 1997, Congress authorized two new standard plan types—high deductible versions of Plans F and J. These new versions were designed to add options with lower premiums and increase cost-sharing among policyholders.[6]

The Medicare Modernization Act of 2003 (MMA) brought the next wave of significant changes to the Medigap standardized benefit design and continued the trend of increasing beneficiary cost-sharing. The MMA required elimination of prescription drug benefits from any Medigap plan issued on or after January 1, 2006, and also authorized the establishment of new Plans K and L. Plans K and L increase beneficiary cost-sharing and require the beneficiary to satisfy the Part B deductible ($162 in 2011) and the annual out-of-pocket limit ($4,640 for Plan K and $2,320 for Plan L for 2011) before Medigap coverage begins.[7]

Figure 3 shows the percentage of Medigap policyholders enrolled in each standardized plan available during 2009. Plan F was the most popular Medigap plan, followed by Plan C. Both of these plans provide 100 percent coverage for the Part B deductible.

Figure 3

Distribution of Enrollment, Medigap Policyholders by Plans A–L (2009)*



Source: Characteristics of Medigap Policies, December 2009. AHIP Study 2010.
*The study was based on 9.5 million covered lives (10.5 million actual).

[4] 2011 Official U.S. Government Medicare Handbook: http://www.medicare.gov/publications/pubs/pdf/10050.pdf

[5] In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

[6] The high deductible F and high deductable 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).

[7] Out-of-pocket limits for Medigap plans K and L for 2010 are at: http://www.cms.gov/Medigap/downloads/OOPMaximumKL2011.pdf

Congress adopted recommendations developed by the NAIC to modernize Medigap and called for the introduction of two new policies (Plans M and N) as part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Figure 4 highlights the cost-sharing features of new Plans M and N. MIPPA made several more benefit changes to all of the Medigap standardized plans, including the elimination of the at-home recovery benefit, the addition of a new core hospice benefit, and the removal of the preventive care benefit. It also eliminated Medigap Plans E, H, I, and J (including high deductible Plan J) as they were duplicative or unnecessary.

Figure 4

Features of New Standard Plans M and N

Lower Premiums	Premiums for Plans M and N are projected to be lower than the formerly lowest cost plan alternatives, K and L.
Higher out-of-pocket costs	Plan M pays 50 percent of the Part A deductible, and none of the Part B deductible. Once the deductibles are met, the Medigap carrier covers 100% of covered services for the rest of the calendar year. Plan N pays for all of the Part A deductible and none of the Part B deductible. It also pays 100% of the Part B coinsurance, except for a copay of up to $20 for some office visits and up to a $50 copay for emergency room visits that do not result in an inpatient admission (2011).

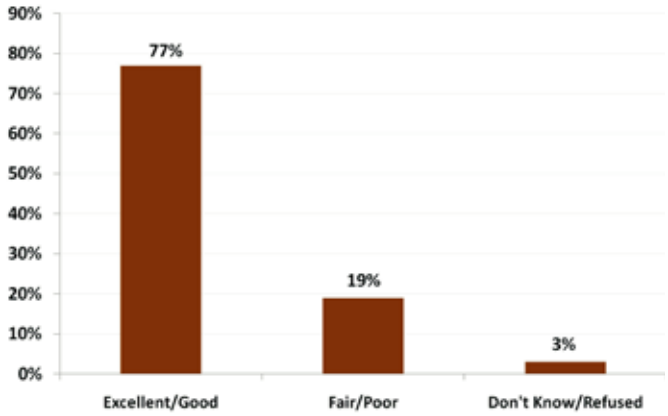
Medicare SELECT plans are identical to standardized Medigap plans but require policyholders to use hospital networks. Because of the narrowed scope of providers, Medicare SELECT plans generally cost less than comparable Medigap plans. As of 2009, there were over 900,000 individuals with Medicare SELECT policies.[8]

CONSUMER SATISFACTION WITH MEDIGAP COVERAGE

Medicare beneficiaries overwhelmingly value their Medigap insurance. In a 2009 survey conducted by AmericanViewpoint,[9] the vast majority of those surveyed (87 percent) said they would recommend the insurance to friends or relatives who are enrolling in the Medicare FFS program. The report noted that seniors and other beneficiaries appreciate the choice, coordination of benefits, nationwide availability, and predictable costs that they experience with their Medigap coverage. A total of 77 percent of those surveyed said their Medigap policy was an excellent or good value. **See Figure 5**.

Figure 5

Nearly 8 of 10 Policyholders Say Medigap is an Excellent or Good Value

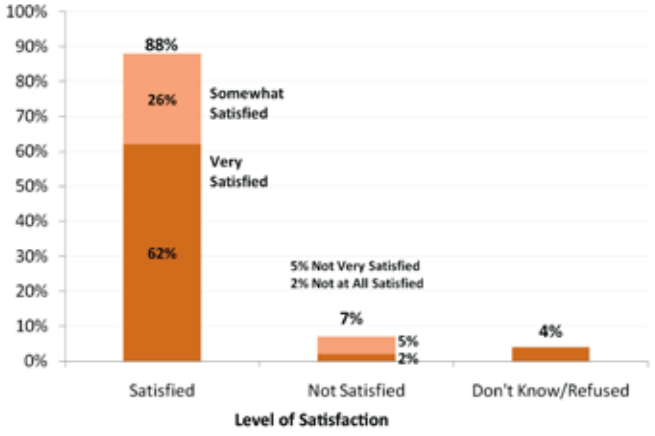


Source: American Viewpoint, 2009 Medigap Satisfaction Survey. March 2009.

In the same 2009 survey, 88 percent of beneficiaries said they were either very satisfied (62 percent) or somewhat satisfied (26 percent) with their Medigap coverage.[10] **See Figure 6**.

Figure 6

Enrollees Are Overwhelmingly Satisfied with Their Medigap Coverage



Source: American Viewpoint, 2009 Medigap Satisfaction Survey. March 2009

[8] Characteristics of Medigap Policies, December 2009. AHIP study 2010.

[9] "National Medigap Enrollees Survey," AmericanViewpoint for the Coalition to Promote Choice for Seniors, March 2009.

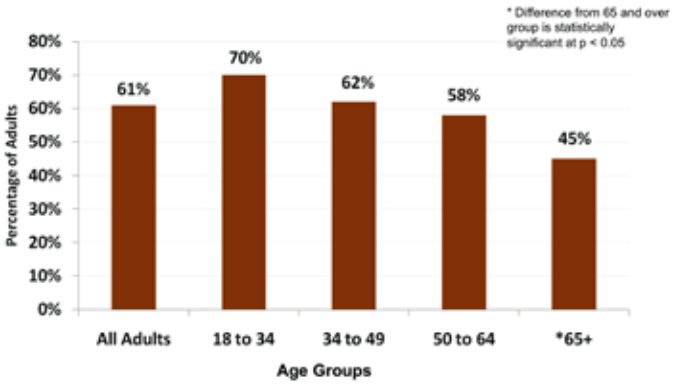
[10] Ibid.

Similar results showing highly favorable views of Medigap insurance have been found in beneficiary surveys over the years.[11]

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 7**. The HSC survey shows that seniors value unrestricted access to physicians and hospitals. It also notes that the Medicare beneficiaries who are least willing to sacrifice provider choice to save on costs are those with supplemental coverage, including Medigap.

Figure 7

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 System Change (Issue Brief 96).

FEDERAL REQUIREMENTS RELATING TO OPEN ENROLLMENT AND GUARANTEE ISSUE

In addition to standardizing the benefit package, OBRA 90 established a federal six-month open enrollment period for Medigap coverage beginning when a beneficiary is age 65 or older and enrolled in Medicare Part B. A beneficiary applying for a Medigap plan 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,[12] including coverage issued prior to the enactment of the federal law.

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

Over the last two decades, federal laws have expanded access to Medigap plans to include specific guarantee issue (GI) opportunities upon the occurrence of certain qualifying events and subject to certain limitations.[13] For example, a beneficiary may have a right to Medigap coverage on a GI basis if he terminates or loses coverage in a Medicare Advantage plan or loses coverage under an employer-sponsored plan or loss of certain other coverage. **Figure 8** highlights the key differences between the federal Medigap open enrollment and GI rights.

Figure 8

Key Differences Between Federal Open Enrollment and Guarantee Issue Opportunities

	OPEN ENROLLMENT	GUARANTEE ISSUE
Eligibility	When the individual is at least 65 years old and is enrolled in Medicare Part B	Upon the occurrence of a qualifying event
Timing	6 months, beginning the first day of the month when an individual is both 65 or older and enrolled in Part B	63 days from the qualifying event
Pre-Existing Condition Exclusions	Allowed Maximum 6 months, reduced for prior creditable coverage	Prohibited
Choice of Policies	Any Medigap Plan available to new policyholders from any Medigap insurer in the state	Certain specified Medigap Plans from designated insurers (varies by qualifying event)

The federal open enrollment and GI requirements are set as the minimum standard and in some cases states go beyond the minimum to enact more generous open enrollment and/or GI provisions for Medicare beneficiaries in their state.

[11] American Viewpoint Surveys, September 1999, June 2001, April 2005.

[12] "Guaranteed renewable" means the policy cannot be cancelled, except under certain limited circumstances (e.g., nonpayment of premium, material misrepresentation).

[13] 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.

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 coverage 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. The Centers for Medicare & Medicaid Services has recognized the NAIC Model Regulation (and accompanying updates) and incorporated its provisions into federal regulations published in the Federal Register. States similarly have amended their requirements to conform to the new versions of the Model Regulation and remain compliant with the federal law.

The NAIC continues to play a critical leadership role in the modernization of Medigap coverage. In consultation with stakeholders, the NAIC developed changes to the 1990 standardized benefit packages to respond to changes in the marketplace and consumer preferences that arose since the creation of the original benefit packages in 1990. These changes were implemented as part of MIPPA with the new plans made available in the market effective June 1, 2010. Currently, the NAIC is reviewing Medigap Plans C and F in response to a provision under the Affordable Care Act (ACA) for potential revision to incorporate "nominal" cost-sharing. The new benefit packages are to be made available, to the extent practicable, beginning January 1, 2015, and should be designed to encourage use of appropriate physician services under Part B.

STATE REGULATION

As described above, federal law establishes certain minimum requirements for Medigap coverage, but the states have primary responsibility for oversight and enforcement of the Medigap market. State regulatory authority includes review and approval of premium rates, regulation of rating practices and rules of enrollment, licensure and oversight of agents and brokers, 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 many provide additional Medigap rights.

APPENDIX A

2011 Costs Not Covered By Medicare Traditional Fee-For-Service (FFS) Program[14]

Coverage	2011 Beneficiary Costs
PART A	
Inpatient	
Deductible for each hospital stay of 1-60 days	$1132
Copayments for days 61-90	$283 per day
Copayments for lifetime reserve days 91-150	$566 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 $141.50 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	Up to $5 copayment for palliative drugs and 5 percent coinsurance for inpatient respite care
Blood	
First three pints	All costs
PART B	
Medical expenses	$162 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 or $110.50 for current beneficiaries (income < $85,000 individual and < $170,000 for joint filers); • $115.40 for new beneficiaries (income < $85,000 individual and < $170,000 for joint filers); and • $115.40 plus an additional amount ($46.10, $115.30, $184.50, or $253.70, respectively) for higher-income beneficiaries based on these income-related monthly adjustment amounts (IRMAA). **https://questions.medicare.gov/app/answers/detail/a_id/2306**
PART D	
Outpatient prescription drugs	Variable, depending on enrollment in Part D and particular drug plan selected. Part D National Base Beneficiary Premium in 2011 is $32.34. Out-of-pocket costs are capped at $ 4,550.
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	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.

[14] 2011 Official U.S. Government Medicare Handbook: http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

APPENDIX B

Medigap Benefits	2011 Medigap Standardized Plans									
	A	B	C	D	F*	G	K	L	M	N
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	+	+	+	+	+	+	+	+	+	+
Medicare Part B Coinsurance or Copayment	+	+	+	+	+	+	50%	75%	+	+***
Blood (First 3 Pints)	+	+	+	+	+	+	50%	75%	+	+
Part A Hospice Care Coinsurance or Copayment	+	+	+	+	+	+	50%	75%	+	+
Skilled Nursing Facility Coinsurance			+	+	+	+	50%	75%	+	+
Medicare Part A Deductible		+	+	+	+	+	50%	75%	50%	+
Medicare Part B Deductible			+		+					
Medicare Part B Excess Charges					+	+				
Foreign travel emergency (Up to plan limits)			+	+	+	+			+	+
Out of Pocket Limit							**$4,640****	**$2,320****		

* Plan F also offers a high-deductible plan. If beneficiary chooses this option, the beneficiary must pay for Medicare-covered costs up to the deductible amount of $2,000 in 2011 before the Medigap plan pays anything.

** After beneficiary meets the out-of-pocket yearly limit and the yearly Part B deductible ($162 in 2011), the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

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