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Medicare: Supplementary "Medigap" Coverage

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Summary

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Although the program provides broad protection against the costs of many, primarily acute care, services, it covers only about one-half of beneficiaries' total health care expenses. Most individuals have some coverage in addition to basic Medicare benefits. Some persons have additional benefits through a managed care plan. Most other individuals have some supplementary coverage through private insurers or public programs such as Medicaid. Private supplementary coverage can be obtained through an individually purchased policy, commonly referred to as a "Medigap" policy. It can also be obtained through a current or former employer. Some persons have both types of coverage.

Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of 10 standardized plans, though not all 10 plans are offered in all states. The 10 plans are known as Plans A through Plan J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-73) added a new voluntary prescription drug benefit under a new Medicare Part D. It also made a number of changes to the Medigap requirements. The first significant change was the addition of two new standardized plan types, Plan K and Plan L. There are two key differences between the benefits included under these options and those offered under Plans A-H. First, Plans K and L eliminate first-dollar coverage for most Medicare cost-sharing. Second, both Plans K and L include an annual out-of-pocket limit on Medicare cost-sharing charges.

The second major MMA change was the prohibition, beginning January 1, 2006, on the sale of Medigap policies with prescription drug coverage. Individuals who had such policies could renew them provided they did not enroll in a prescription drug plan under the new Part D. Alternatively, if they enrolled under Part D, they could continue to enroll in a Medigap plan, but without drug coverage.

MMA also required the Secretary of the Health and Human Services to request the National Association of Insurance Commissioners (NAIC) to review and revise the Medigap benefit packages, taking into account changes made by the new law. The NAIC announced its recommendations in March 2007. The Children's Health and Medicare Protection Act of 2007 (CHAMP), as passed by the House on August 1, 2007, incorporates these recommendations, as well as making additional Medigap changes. This report will be revised as circumstances warrant.

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Overview

Medicare is a nationwide health insurance program for the aged and certain disabled persons. Most Medicare beneficiaries obtain covered health services through the original fee-for-service program (also known as "original Medicare"). Under the fee-for-service program, beneficiaries obtain covered services through the providers of their choice and Medicare pays for each service or package of services rendered. The basic package of Medicare services (which includes a range of institutional and non-institutional services) is the same throughout the country.

Some beneficiaries are enrolled in a Medicare Advantage plan. These persons have elected to obtain all of their Medicare services through a managed care arrangement (such as a health maintenance organization (HMO)) instead of through the fee-for-service program. At a minimum, these beneficiaries are entitled to the basic Medicare benefit package. Some managed care enrollees may be entitled to additional benefits; the scope of additional benefits varies by plan.

The basic Medicare benefit package provides broad protection against the costs of many, primarily acute, health care services. However beneficiaries may still be faced with significant additional costs. Medicare requires cost-sharing for most covered services, provides only limited protection for some services (such as long-term care) and includes no protection against the costs of other services (such as hearing aids and dentures). Further, unlike most large group health insurance plans, Medicare contains no upper ("catastrophic") limit on out-of-pocket expenses. As a result, the program covers only about half of beneficiaries' total health costs.

Most Medicare beneficiaries have some form of public or private coverage to supplement their Medicare benefits. Public coverage is provided primarily through Medicaid. Private protection may be obtained through a current or former employer. It may also be obtained through an individually purchased policy, commonly referred to as a "Medigap policy." Federal law has established a number of requirements governing the sale of these Medigap policies.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-73) added a new voluntary prescription drug benefit under a new

Medicare Part D.[1] It also made a number of additional changes to the program including changes to the Medigap requirements. The most significant was the prohibition, beginning January 1, 2006, on the sale of Medigap policies with prescription drug coverage. Individuals who previously had such policies could renew them provided they did not enroll in a prescription drug plan under the new Part D. MMA also provided for the establishment of two additional plan types which may be sold as Medigap policies.

Medicare Coverage

Medicare consists of four distinct parts: Part A (Hospital Insurance [HI]); Part B (Supplementary Medical Insurance [SMI]); Part C (Medicare Advantage [MA]); and Part D (the prescription drug benefit added by MMA). Most beneficiaries get covered services through Medicare Parts A and B, also referred to as "original Medicare." Alternatively, beneficiaries can choose to receive all their Medicare services (otherwise covered under Parts A and B) through managed care plans under the MA program. Beginning January 1, 2006, Medicare beneficiaries have been able to purchase drug coverage through private plans offered by prescription drug plan (PDP) sponsors or through managed care organizations offering Medicare Advantage prescription drug (MA-PD) plans.

Table 1 provides a brief outline of the coverage offered under Parts A and B, including associated cost-sharing charges.

Table 1. Medicare Benefits, 2007

Benefit	Cost-sharing
Part A	
Hospital care	
Days 1-60	$992 deductible
Days 61-90	$248 daily coinsurance
60 lifetime reserve days	$496 daily coinsurance
Skilled nursing facility care	
Days 21-100	$124 daily coinsurance
Hospice care	nominal cost-sharing
Part B	
Physicians services, outpatient hospital services, durable medical equipment, and other medical services	$131 deductible; generally 20% coinsurance after deductible has been met
Parts A and B	
Home health care	none

[1] For an overview of MMA, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement and Modernization Act of 2003*, by Jennifer O'Sullivan, Hinda Chaikind, Sibyl Tilson, Jennifer Boulanger, and Paulette Morgan.

Supplementary Coverage

Most beneficiaries have some form of private or public coverage to supplement Medicare. In 2004, only 9.3% of community-based beneficiaries relied solely on the traditional fee-for-service program. An additional 14.5% relied on coverage through their Medicare managed care organization. In 2004, 60.7% of community-based Medicare enrollees had private supplemental coverage, an additional 14.0% had coverage through Medicaid, and an additional 1.5% had other public sector coverage. Private insurance protection may be obtained through a current or former employer (31.9% had such coverage in 2004). It may also be obtained through an individually purchased policy, commonly referred to as a Medigap policy (28.8% had these plans in 2004).[2]

Medigap

Medigap policies are intended to fill in some of the gaps in "original Medicare." Persons enrolled in a Medicare Advantage plan generally do not need a Medigap plan because their MA plans generally cover some of the same benefits offered by Medigap plans.

Beneficiaries with Medigap insurance typically have coverage for some or all of Medicare's deductibles and coinsurance. When a beneficiary receives care, the Medicare contractor pays first; the contractor then forwards the claim directly to the Medigap insurer which then pays its portion of the bill.[3] Some Medigap policies also cover some items and services not covered by Medicare. In this case, the claim is sent directly to the Medigap insurer. The Social Security Act contains certain requirements governing the sale of Medigap policies.[4]

Policy Choices

Standardized Plans. Generally, insurance companies can not sell Medigap policies unless they conform to one of the standardized benefit packages. Individuals

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[2] Medicare Payment Review Commission (MedPAC), A Data Book: Healthcare Spending and the Medicare Program, June 2007. [http://www.medpac.gov/documents/Jun07 DataBook_Entire_report.pdf]

[3] Effective October 1, 2007, this claims crossover can only be accomplished through the coordination of benefits contractor (COBA) eligibility file-based crossover process. The COBA has assigned Medigap insurers claim-based identifiers which must be used when submitting claims.

[4] The law incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC). These minimum standards, known as the NAIC Model standards, are found in the NAIC Model Regulation. The Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare) published a Notice in the *Federal Register* on March 25, 2005, which recognized the latest version (with clarifications) adopted by the NAIC on September 8, 2004.

first purchasing a Medigap policy on or after July 30, 1992, have been able to select from one of 10 standardized plans, though not all 10 plans have been offered in all states. The 10 plans are known as Plans A through J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive. (See **Table 2**.)

The Balanced Budget Act of 1997 (BBA 97, P.L.105-33) added two high deductible plans to the list of 10 standard plans. With the exception of the high deductible feature, the benefit package under the high deductible plan is the same as that under Plan F or Plan H. The 2007 deductible under these plans is $1,860. This approach removed first-dollar coverage which was expected to result in a reduction in premiums. Reportedly, few insurers have offered these high deductible plans.

As noted in **Table 2**, Plans H, I, and J include coverage for prescription drugs. However, effective January 1, 2006 (the effective date of the Part D drug benefit), new sales of policies with drug coverage are prohibited. Thus, new H, I, and J policies sold on or after that date can not include drug coverage. Further, no Medigap policy with an outpatient prescription drug rider can be sold.

Individuals who purchased H, I, and J policies prior to January 1, 2006, may keep and renew such policies provided they do not enroll in a Part D plan. However, there are potential consequences to this decision. (See “Policy Selection,” below.)

Table 2. Benefits Under Standardized Medigap Plans A-H

Benefits	A	B	C	D	E	F *	G	H	I	J *
Basic benefits: Part A hospital coinsurance for days 61-90 in a benefit period.** ($248 a day in 2007) and 60 lifetime reserve days ($496 a day in 2007); 365 days of hospital care after exhaustion of Medicare benefits; Part B cost-sharing; and first three pints of blood.	x	x	x	x	x	x	x	x	x	x
Part A hospital deductible ($992 in 2007)		x	x	x	x	x	x	x	x	x
Skilled nursing facility care Billed charges up to coinsurance amount ($124 a day in 2007) for days 21-100 in a benefit period.			x	x	x	x	x	x	x	x
Part B deductible ($131 in 2007)			x			x				x
Medically necessary emergency care in a foreign country for services which would be covered by Medicare if provided in U.S. (80% after a $250 deductible; $50,000 lifetime maximum)			x	x	x	x	x	x	x	x
At-home recovery (Up to $1,600 per year for short-term assistance with activities of daily living, subject to certain limits)				x			x		x	x
Preventive care (up to $120 per year for physicals and various screenings)					x					x
Part B excess charges (Difference between Medicare's recognized amount and actual charges, subject to charge limitations set by Medicare or state law)						100%	80%		100%	100%
Basic drug benefit ($250 deductible; 50% coinsurance; $1,250 maximum ($2,750 total spending)). *This benefit cannot be included in any new policy sold after December 31, 2005*.								x	x	
Extended drug benefit ($250 deductible; 50% coinsurance; $3,000 maximum ($6,250 total spending). *This benefit cannot be included in any new policy sold after December 31, 2005*.										x

* Plan F and Plan J may also be available as high-deductible plans.

** A benefit period begins when a beneficiary enters a hospital and ends when he or she has not been in a hospital or skilled nursing facility for 60 days.

New Plan Options. MMA established two new standardized plan options which are known as Plan K and Plan L. There are two key differences between the benefits included under the new options and those offered under Plans A-H. First, Plans K and L pay less than 100% of beneficiary cost-sharing until spending reaches a specified level. Second, once spending reaches the annual out-of-pocket limit, the policy covers 100% of Medicare Part A and B cost-sharing charges for the remainder of the year. Note that neither plan includes any coverage for Part D cost-sharing. (See **Table 3**.)

Table 3. Portion of Cost-Sharing Charges Paid Under Standardized Plans K and L

Benefits	Plan K	Plan L
Part A hospital deductible. ($992 in 2007)	50%	75%
Part A hospital care. Part A hospital coinsurance for days 61-90 in a benefit period.* ($248 a day in 2007) and 60 lifetime reserve days ($496 a day in 2007); 365 days of hospital care after exhaustion of Medicare benefits.	100%	100%
Skilled nursing facility care. Billed charges up to coinsurance amount coinsurance ($124 a day in 2007) for days 21-100 in a benefit period.	50%	75%
Hospice care. Nominal cost-sharing	50%	75%
Blood deductible. First three pints	50%	75%
Part B deductible. $131 in 2007	not covered	not covered
Part B cost-sharing. Generally 20% coinsurance	50%	75%
Cost-sharing for Medicare Preventive Services.	100%	100%
Annual out-of-pocket limit. Coverage of all Part A and Part B cost-sharing once beneficiary has reached limit.**	$4,140 limit in 2007; $4,440 in 2008 (indexed in future years)	$2070 limit in 2007; $2,220 in 2008 (indexed in future years)

* A benefit period begins when a beneficiary enters a hospital and ends when he or she has not been in a hospital or skilled nursing facility for 60 days.

** Payments for excess charges do not count toward the out-of-pocket limit.

Other Plan Types. Some Medicare beneficiaries may be able to purchase Medigap policies not meeting the requirements applicable for standardized plans.

Waivered States. The standardized plans do not apply to residents of Massachusetts, Minnesota, and Wisconsin. These states operated their own simplification programs prior to the enactment of the standardization requirements

and were allowed to continue these programs. They were, however, required to modify their regulatory programs to come into compliance with the MMA requirements.

Pre-Standardized Plans. Beneficiaries first purchasing Medigap policies prior to July 30, 1992 may continue to renew such policies provided the insurer keeps offering them. However, the insurer may not sell these policies to any new enrollees. There is considerable variation among the benefit packages offered by these pre-standardized plans.

SELECT. Medicare SELECT is a type of Medigap policy which is available in some states. A SELECT policy is one of the 10 standardized policies A-J. However, purchasers of SELECT policies are required (except in an emergency) to obtain care through specified hospitals and doctors in order to have the SELECT plan pay its share of costs. (Medicare always pays its share of costs regardless of whether or not the provider is or is not a SELECT provider.)

Policy Selection; Interaction with Medicare Part D Choices

Individuals purchase Medigap policies based on decisions relating to health care needs and policy costs. As a result of the enactment of MMA, individuals who previously had Medigap policies with drug coverage (Medigap Rx policies) had to make some decisions regarding their coverage after December 31, 2005. Medicare RX polices were defined as Plans H, I, and J, prestandardized policies with drug coverage, and Medigap policies with drug coverage riders.

MMA established specific rules relating to Medigap policies and drug coverage. New Medigap Rx policies could no longer be sold after December 31, 2005. Further, drug coverage had to be eliminated from polices for persons who enrolled in a drug plan under Part D. This included Medigap policies with a separate drug coverage rider. Medigap issuers had to provide a written disclosure notice to each person who had a Medigap Rx policy. Individuals receiving the notice had several choices. They could enroll in a drug plan under Part D and keep their existing Medigap policy with the drug coverage removed (and an appropriate adjustment made to their premium). If they enrolled in a Part D plan during the initial enrollment period (which closed May 15, 2006), they also had a guaranteed right to buy another plan from the same issuer. They could buy Plan A, B, C, F, K, or L if these plans were offered by the issuer and available to new enrollees.

If an individual did not enroll in Part D during the initial enrollment period, he or she could keep their existing Medigap Rx policy. However, the individual lost the right to buy another Medigap policy on a guaranteed issue basis. Further, there are consequences if the individual subsequently decides to enroll in Part D. First, the individual can only enroll in Part D during an annual open enrollment period (November 15-December 31for the following year). Second, the individual will be subject to a delayed enrollment penalty (i.e., premium surcharge) unless the Medigap Rx policy is considered to have creditable coverage (i.e., meet the standard for actuarial equivalence, that is, having the same or greater dollar value, as Part D standard coverage).

CMS stated that Medigap issuers were responsible for determining if their policies met the requirements for creditable coverage. It stated that it could not offer guidance for the likelihood that any particular prestandardized policy or policy in a waivered state would meet the requirements. However, it determined that no Medigap policy H or I could qualify. Further, it was possible, but unlikely that a Plan J would qualify.

Enrollment

The law contains certain requirements relating to enrollment in Medigap plans. In certain cases, beneficiaries are guaranteed the right to enroll in specified Medigap plans under certain conditions. These are known as *guaranteed issue* provisions.

Six-Month Open Enrollment. Federal law establishes an open enrollment period for the aged. All insurers offering Medigap policies are required to offer open enrollment for six months from the date a person first enrolls in Part B (generally when the enrollee turns 65).[5] During this time an insurer cannot deny the issuance, or discriminate in the pricing of a policy because of an individual's medical history, health status or claims experience. This requirement is known as *guaranteed open enrollment*.

If an individual applies for a Medigap policy after the open enrollment period, the company is permitted to use medical underwriting. This means that the company can use an individual's medical history to decide whether or not to accept the application and how much to charge for the policy.

There is no guaranteed open enrollment period for the non-aged disabled population. However, when a disabled person turns 65, that individual has the same open enrollment period as other aged persons.

Guaranteed Issue. The law guarantees issuance of specified Medigap policies *(without an exclusion based on a pre-existing condition)* for certain persons whose previous supplementary coverage was terminated. Guaranteed issue also applies to certain persons who elect to try out a Medicare Advantage plan. In these cases, individuals are guaranteed issue of specific Medigap plans (generally A, B, C, F, K or L) that are sold to new enrollees by Medigap insurers in the state.[6] The insurer is prohibited from discriminating in the pricing of such a policy on the basis of the individual's health status, claims experience, receipt of health care or medical condition. *This right must be exercised within 63 days of termination of other enrollment.*

Table 4 summarizes the guarantee issue protections of the law. Under certain very specific conditions, these protections apply to persons who lose coverage under employer-based plans, Medicare Advantage plans, or other Medigap plans. **Table**

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[5] Some persons who turn 65 and are still working may delay enrollment in Part B. The six-month enrollment period for these individuals would not begin until they actually enrolled in Part B.

[6] Note that Plans B, C, F, K, or L may not be available in a particular state.

4 highlights the event that triggers these protections, the time period during which an affected individual can enroll in a Medigap plan, and the types of Medigap plans that are guaranteed.

Table 4. Guarantee Issue Protections

Current coverage; trigger event	First day to apply for Medigap under guaranteed issue provisions	Last day to apply for Medigap under guaranteed issue provisions	Medigap plans guaranteed
Employer-based plan			
An individual enrolled under a plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide all such supplemental benefits	Date received notice of termination or cessation of benefits (in some cases this could be in a letter saying that a claim has been denied because coverage has ended).	63 days after the latest of: date coverage ends, date on termination notice (if provided), or date on claim denial (if this is the only way individual knows coverage is ending)	A, B, C, F, K, or L
Medicare Advantage (MA) plan			
A. Plan leaves area or stops providing coverage. An individual enrolled with a MA plan* whose enrollment is discontinued because the plan's certification has been terminated (or there is an impending termination) or the plan is leaving the Medicare program or is no longer providing coverage in the individual's service area. (See also C and D, which may apply in these cases)	In case of involuntary termination, the date the termination notice is received. In the case of voluntary disenrollment, 60 days before the effective date of disenrollment.	63 days after coverage ends	A, B, C, F, K, or L
B. Enrollee moves. The individual moves outside of the entity's* service area.	In case of involuntary termination, the date the termination notice is received. In the case of voluntary disenrollment, 60 days before the effective date of disenrollment.	63 days after coverage ends	A, B, C, F, K, or L
C. Medicare Advantage trial. An individual was: (1) enrolled in a Medigap policy; (2) subsequently terminated enrollment in that policy and enrolled in a MA organization* for the first time; and (3) then terminated enrollment with the MA organization within 12 months.**	In case of involuntary termination, the date the termination notice is received. In the case of voluntary disenrollment, 60 days before the effective date of disenrollment.	63 days after coverage ends	Former Medigap policy (If the same policy is no longer sold by the insurer, the guarantee is for plans A, B, C, F, K, or L)
D. MA enrollment upon turning 65. An individual, upon turning 65 and becoming eligible for Part A, joins a MA plan and subsequently leaves the plan*** within 12 months.**	In case of involuntary termination, the date the termination notice is received. In the case of voluntary disenrollment, 60 days before the effective date of disenrollment.	63 days after coverage ends or end of six-month open enrollment period, whichever is later	Any Medigap policy

Current coverage; trigger event	First day to apply for Medigap under guaranteed issue provisions	Last day to apply for Medigap under guaranteed issue provisions	Medigap plans guaranteed
E. Entity fails to meet contract obligations. The individual elects to disenroll with a MA organization* due to cause (for example, the marketing materials were misleading or quality standards were not met).	In case of involuntary termination, the date the termination notice is received. In the case of voluntary disenrollment, 60 days before the effective date of disenrollment.	63 days after coverage ends	A, B, C, F, K, or L
Medigap			
A. Bankruptcy or insolvency of issuer. An individual enrolled under a Medigap policy if enrollment ceases because of the bankruptcy or insolvency of the issuer or because of other involuntary termination of enrollment and there is no provision under state law for continuation of such coverage.	Earlier of the date that the notification of termination is received or the date the coverage ends	63 days after coverage ends	A, B, C, F, K, or L
B. Cause. The individual disenrolls because the issuer violated a material provision of the policy or materially misrepresented the policy's provisions.	60 days before disenrollment date	63 days after coverage ends	A, B, C, F, K, or L
Enrollment in Part D			
Individual was enrolled with a Medicare Rx plan, received notice from issuer during the required notice period (September 16, 2005-November 15, 2005); elected to enroll in Part D during initial enrollment period (November 15, 2005-May 15, 2006), and therefore terminated Medigap Rx enrollment.	Date individual received notice	63 days after effective date of individual's Part D coverage	A, B, C, F, K, or L

* Also applies to (1) Programs of All-Inclusive Care for the Elderly (PACE) program (for persons 65 or older) that covers Medicare benefits and certain long-term care services; (2) Medicare health maintenance organization cost contracts; (3) Medicare managed care demonstration projects; and (4) Medicare SELECT plans if there is no provision under applicable state law for continuation or conversion of coverage under such policy.

** In general, the guarantee only applies if the individual was never previously enrolled in a MA or similar plan. However, special rules apply if an individual enrolls for the first time with a MA organization and was in the plan less than one year before the plan left the program or stopped giving care in the area. In this case, the individual may enroll in another MA plan for up to one year and still keep the right to return to his or her old Medigap policy.

*** Also applies to enrollees in a PACE program.

Pre-Existing Condition Exclusions. For purposes of Medigap, pre-existing conditions are defined as those diagnosed or treated during the six months immediately preceding the start of a Medigap policy. At the time insurers sell a Medigap policy they are generally permitted to limit or exclude coverage for services related to a preexisting health condition. Such *pre-existing condition exclusions* cannot be imposed for more than six months. However, preexisting limitations *may not* be imposed at all in the following cases:

- Any individual who falls into one of the qualifying events categories discussed above under "Guaranteed Issue." These include persons whose previous coverage was involuntarily terminated or persons who elect to try out Medicare Advantage.

- During the first six-month open enrollment period, if on the date of application, the individual had at least six-months of health insurance coverage meeting the definition of "creditable coverage" under the Health Insurance Portability and Accountability Act. If the individual has less than six months of creditable coverage, the waiting period is reduced by the number of months of creditable coverage. (*Note that the insurer may impose a pre-existing exclusion limitation if the individual did not have such creditable coverage*.)

- An individual who met the pre-existing condition limitation in one Medigap policy. The individual does not have to meet the requirement under a new policy for previously covered benefits; however, an insurer could impose exclusions for newly covered benefits (i.e., for at-home recovery if not covered under the previous policy).

The prohibition applies to persons who had coverage under a prior policy for at least six months. If the individual has less than six months prior coverage, the policy must reduce the pre-existing exclusion by the amount of the prior coverage.

Implications of guaranteed issue protections. The guaranteed issue provisions apply only to policies actually offered by insurers. For example, Plans "B," "C" or "F" may not actually be available in a particular state.

While beneficiaries leaving a terminating MA plan may be able to obtain Medigap coverage, their out-of-pocket expenditures are likely to increase. First, they will have to pay the Medigap premium. Second, they may have to pay out-of-pocket for some services previously covered by the managed care plan but not covered under original Medicare or their Medigap policy. Finally, it is possible that the drug coverage available through a stand-alone Part D drug plan may be more expensive than that available through the MA plan.

The guaranteed issue protections (except for the one for persons who try MA upon turning 65 and disenroll within 12 months) apply to both aged and disabled Medicare enrollees. However, not all disabled persons will be able to take advantage of them because many Medigap insurers do not market to the under-65 population,

nor does federal law require these insurers to market to the disabled. However, a number of states have instituted requirements guaranteeing access to Medigap coverage for at least some of the disabled; beneficiaries in these states may be able to take advantage of state rules.[7]

Policy Renewal. Standardized policies are guaranteed renewable. Insurance companies in some states may refuse to renew prestandardized policies. If a company makes a nonrenewal decision, it must cancel all policies of the same type in the state. The affected individuals have the right to purchase a Medigap Plan A, B, C, F, K or L sold in the state.

Additional Requirements

The law and regulations contain a number of additional provisions relating to the sale of Medigap policies. **Appendix A** provides an overview of these requirements including those relating to state regulatory programs, Medigap policies and policy issuers, and policy sales.

Medigap Premiums

There is wide variation in Medigap premiums nationwide. This reflects a number of factors including differences in the benefits of Plan A through Plan L (as well as differences in non-standardized policies), differences in underwriting practices, and the difference in pricing structures. Medigap insurers typically use one of three pricing mechanisms — *age at issue* (which bases the premium on the policyholder's age when they first sign up), *attained age* (which bases the premium on the current age of the policyholder), or *community rating* (under which all policyholders pay the same rate). Attained age policies, which are rapidly becoming the norm, generally offer good rates to younger enrollees; however, premiums go up significantly as the policyholders age. Community-rated policies, are not widely available.

The last available survey of Medigap premiums is for 2005, the year before implementation of the Part D drug benefit. The survey, conducted by Weiss Ratings, Inc. found wide disparities in rates.[8] Not only were there substantial variations between geographic regions, but there were also dramatic differences for individuals purchasing identical plans in the same location. There were significant differences between the minimum and maximum premium for each policy type. For example, for Plan C, one of the most popular plan types, premiums ranged from $651 to

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[7] The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare) reports that in 2007 the following states require insurance companies to offer at least one kind of Medigap policy during a special open enrollment period to people with Medicare under age 65: California, Colorado, Connecticut, Hawaii, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, and Wisconsin.

[8] This survey is no longer conducted.

$9,798, with an average premium of $1,766. For Plan F, the other most popular plan type, premiums ranged from $516 to $10,799, with an average premium of $1,756.[9]

Current Issues

Currently, the major issues facing Medigap are the types of policy options provided to Medicare beneficiaries.

Standardized Plan Options

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) assigned the federal government responsibility for regulating Medigap policies. This legislation was enacted in response both to widespread marketing abuses in the sale of supplemental policies and consumer confusion with the wide array of policy choices. Among other things, OBRA 90 provided for the standardization of Medigap policies.

For a number of years, observers suggested that the existing standardized Plans A-J over-emphasized first-dollar coverage (namely coverage of Medicare's cost-sharing charges) which many beneficiaries could potentially budget for. The plans included no out-of-pocket protection for Medicare cost-sharing charges. Further, they provided limited or no protection for services not covered by Medicare such as long-term care services.

Another consideration was the impact of private coverage on Medicare spending. Some studies estimated that *Medicare* spending for beneficiaries with supplemental coverage was significantly higher than expenditures for those without such coverage.[10/11] Higher Medicare spending reflected higher overall use of services. High service use among those with private supplementary coverage (particularly Medigap) appeared to be a direct consequence of having such insurance. Beneficiaries who faced little or no out-of-pocket costs at the time they used services, even though they paid an often substantial monthly premium for Medigap, may have perceived the services to be free. Comparison of service use between those with and without private supplementary coverage suggested that there may be some

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[9] [http://www.weissratings.com/News/Ins_Medigap/20050830medigap.pdf].

[10] A review of 1995 data by the Physician Payment Review Commission (PPRC) showed that Medicare spending for Medicare beneficiaries having Medicare coverage *only* was less than 75% of that for beneficiaries with Medigap. Medicare beneficiaries with employer-provided benefits averaged 10% less than that for persons with Medigap. (Physician Payment Review Commission, Annual Report to Congress, 1997, Washington, 1997.

[11] A study of 1994 data reported that Medicare enrollees with Medigap used 28% more services (both inpatient and outpatient) than those with no supplementary coverage, while those with employer-based coverage used 17% more. The authors attributed the differences to the fact that Medigap plans often covered all of Medicare's cost-sharing charges, while employer-based plans typically did not. (Sandra Christensen, and Judy Shinogle, "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review*, vol. 19, no. 1 [fall 1997], 5-17).

overutilization of services. However, some of the increase may represent appropriate service use.

These observations prompted a number of recommendations for change. Some observers recommended that the standardized plans should be prohibited from offering first-dollar coverage for Medicare's cost-sharing charges. Medigap policies would begin paying only after the beneficiary had incurred some out-of-pocket costs.[12] This approach would be expected to make beneficiaries more cost conscious in their use of services and thereby hold down Medicare's expenditures. Proponents asserted that Medigap premiums should drop and therefore become more affordable. Other observers noted that the elderly are risk adverse and may not want to be liable for any out-of-pocket costs. Further they argued that beneficiaries might forgo needed medical services because they would be unable to pay the cost-sharing charges.

MMA Changes

MMA provided for the establishment of two additional plan types which may be sold as Medigap policies. Unlike Plans A-H, these plans include significant beneficiary cost-sharing coupled with a catastrophic limit on out-of-pocket costs. The legislation did not however, eliminate existing beneficiary choices. They are still able to purchase Plans A-H (with the requisite modifications in Plans H, I, and J).

In theory, insurers should be able to offer these policies for lower premiums, thereby attracting some purchasers. However, the risk adverse nature of the elderly population may encourage them to continue purchasing plans that offer coverage for most out-of-pocket costs.

There are also questions relating to the interaction of Part D with Medigap purchase decisions. It is possible that with the addition of drug coverage under Part D, and the accompanying premium, some beneficiaries may elect to forgo Medigap entirely. Data are not available to answer these questions.

NAIC Recommendations

MMA required the Secretary to request the NAIC to review and revise the Medigap benefit packages, taking into account changes made by the new law. The NAIC announced its recommendations in March 2007. The recommendations as described by the NAIC would:

- Eliminate unnecessary and duplicative plans by eliminating Plans H, I, and J (which contained drug benefits) and Plan E (which becomes identical to another plan).

- Add 2 plan options with higher cost-sharing and lower estimated premiums:

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[12] These out-of-pocket costs would, however, be considerably less than under the high deductible plans discussed earlier.

- New Plan M would include 50% coverage of the Medicare Part A deductible and not cover the Part B deductible;
- New Plan N would not cover the Part B deductible and would add a copayment of $10 for each physician visit and $50 for each emergency room visit (waived upon admission to the hospital)

- Modernize certain benefits:
  - Eliminate at-home recovery benefit (currently offered under Plans D, G, I, and J) and substitute hospice benefit in all plans
  - Eliminate preventive care benefit (in Plans E and J) in recognition of additions to Medicare over the years;
  - Increase the 80% Part B excess benefit (under Plan G) to 100%.

The NAIC cautioned that these changes would require federal action before they could be implemented.

Children's Health and Medicare Protection (CHAMP) Act

CHAMP (H.R. 3162), passed by the House on August 1, 2007, contains a number of Medicare provisions.[13] Section 907 of the bill would require the Secretary to accept the recommendations made by the NAIC in March 2007, as further modified by CHAMP. The section would require policy issuers to offer, in addition to the core package, at least policies classified as "C" or "F." The provision would also eliminate policies classified as "K" and "L," which were added by MMA.

As of this writing, the Senate has not considered a Medicare package this year. At this time, it is unclear how Congress will proceed on any Medicare legislation.

[13] Subsequently, Congress passed H.R. 976, which incorporated provisions relating to the state health children's health insurance program (SCHIP). The SCHIP provisions were a revised version of the comparable provisions contained in CHAMP.

Appendix A: Requirements for State Regulatory Programs, Policy Issuers, and Insurance Sales

The law states that no Medigap policy may be issued in a state unless: (1) the state's regulatory program has been approved by the Secretary of the Department of Health and Human Services as providing for the application and enforcement of the National Association of Insurance Commissioners' (NAIC's) Model Standards; or (2) (if the state's program has not been approved), the policy has been approved by the Secretary as meeting the standards. CMS published a Notice in the *Federal Register* on March 25, 2005, which recognized the latest version (with clarifications) adopted by the NAIC on September 8, 2004.

The following sections detail the requirements applicable to state regulatory programs, Medigap policies and policy issuers, and sellers of Medigap policies.

Requirements Applicable to State Regulatory Programs

In order to approve a state regulatory program established under state law, the Secretary must determine that it:

- provides for application and enforcement of standards equal to or more stringent than the NAIC standards;
- includes specified requirements for policies and policy issuers at least as stringent as those specified in law;
- provides that either information on loss ratios (i.e., ratios of aggregate benefits to premiums) will be reported to the state on forms conforming to NAIC standards or such ratios will be monitored in an alternative manner approved by the Secretary;
- provides for application of these standards (specified in the previous three items) to all Medigap policies issued in the state;
- provides to the Secretary, at least annually, a list of policy issuers including changes from previous report;
- reports to the Secretary on implementation and enforcement of standards, and information on loss ratios of policies sold, at intervals established by the Secretary;
- provides a process for approving or disapproving premium increases and establishes a policy for the holding of public hearings prior to approval of a premium increase; and
- provides for application of standards for Medicare SELECT policies (which may limit items and services furnished by certain entities or reduce benefits when items and services are furnished by other entities) that are at least as stringent as those established in law.

The Secretary is required to periodically review state programs to determine if they continue to meet the standards. If a state fails to meet requirements, it is given the opportunity to adopt a correction plan. If the Secretary makes a final determination that the regulatory program fails to meet the standards and requirements, the state would no longer be considered to have a program meeting such requirements. Medigap policies are not considered to meet the standards for

state programs unless the policy issuer provides a copy of any advertisement to the Commissioner of Insurance (or other comparable officer) for review or approval, to the extent required by state law.

Requirements for Policies and Policy Issuers

The following minimum standards apply to policies or policy issuers:

- the policies meet or exceed NAIC model standards (with certain exceptions for SELECT policies) ;
- the policies meet minimum loss ratio standards of 75% for group polices and 65% for individual policies and provide for refunds where appropriate to meet these standards;
- the policy issuer accepts a notice from the Part B carrier for a claim from a participating physician or supplier as a claim for Medigap benefits, provides appropriate notice to the physician or supplier and beneficiary on the claim, provides each enrollee with a card listing where the notice is to be sent, and agrees to pay any user fees established for transmittal of information;
- the policy issuer permits full refund of premiums for at least 30 days after issuance;
- each policy meets standards relating to benefits;
- each policy is guaranteed renewable;
- policies provide, on the request of a policyholder, for the suspension of premiums and benefits when a policyholder becomes eligible for Medicaid and reinstatement if it is requested during the first 24 months and within 90 days of the loss of Medicaid;
- policies provide, on the request of a disabled policyholder, for the suspension of premiums and benefits if the beneficiary is eligible under a group health plan and reinstatement if the policyholder provides notification of loss of group coverage within 90 days;
- issuers of replacement policies waive any time periods applicable to pre-existing conditions to the extent time was spent under the original policy for similar conditions;
- pre-existing condition exclusions are not applied for longer than six months;
- policies comply with six-month open enrollment requirement for persons turning 65; and
- policies comply with guaranteed issue provisions for persons in specified circumstances (such as involuntary loss of other coverage).

The standards relating to benefits specify that with limited exceptions no more than 12 different specified benefit packages (plus two high deductible packages) may be offered in all states and by all insurers. One package must cover only a "core" group of basic benefits and nine others must include the core benefits. Two policy types added by MMA differ from the other 10 options by eliminating first-dollar coverage for most Medicare cost-sharing. and including an annual out-of-pocket limit on Medicare cost-sharing charges.

All insurers offering any of the Medigap policies for sale other than the core plan must also offer the core plan. Uniform language, definitions, and format are to be used in the policies to facilitate comparison among Medigap policies and with Medicare. The following exceptions apply: (1) states that have received a waiver because they had a stringent regulatory program in effect prior to standardization may provide different benefit packages (applies only in Massachusetts, Minnesota, and Wisconsin); (2) states may approve the addition of new or innovative benefits to an otherwise approved plan; and (3) while a state must approve a core plan for sale, it does not have to permit all of the other plans to be sold in the state.

Medicare SELECT policies are considered to meet benefit requirements if:

- full benefits are provided for services furnished through network providers;
- full benefits are provided when furnished by other entities if medically necessary and immediately required;
- the network offers sufficient access;
- the issuer of the policy has arrangements for an ongoing quality assurance program;
- each enrollee is provided information on the policy's coverage and limitations, and each enrollee acknowledges receipt of this explanation; and
- the issuer makes available any other Medigap policy otherwise offered by the issuer in the state.

Insurance Sales Provisions

The law contains a number of provisions relating to Medigap sales practices and includes penalties for failure to meet these requirements.

Anti-Duplication. The law contains anti-duplication provisions. Under these provisions it is unlawful to sell:

- a health insurance policy with the knowledge that it duplicates benefits under Medicare or Medicaid;
- a Medigap policy to an individual (not enrolled in Medicare Advantage with knowledge that the individual is entitled to benefits under another Medigap policy, or in the case of a MA enrollee, with knowledge that the benefits duplicate MA benefits or benefits under another Medigap policy; or
- a health insurance policy (other than a Medigap policy) with knowledge that the benefits duplicate benefits to which the individual is otherwise entitled except as required by state or federal law.

A health insurance policy is not considered to duplicate benefits if it pays for benefits without regard to other coverage. A health insurance policy is also considered not to duplicate benefits if it: (1) provides health care benefits only for long-term care, nursing home care, community-based care or any combination of these; (2) coordinates against or excludes items and services available or paid for

under Medicare or another health insurance policy; and (3) discloses such coordination or exclusion in the policy's outline of coverage.

Disclosure Statement. Medicare beneficiaries applying for health insurance must be furnished a disclosure statement containing specified language including the statement that the policy is not a Medigap policy. This requirement is not applicable to: Medigap policies; those policies, described above, which are not considered to duplicate benefits; or certain polices enumerated in regulations (including policies that do not duplicate Medicare even incidentally, life insurance policies, disability insurance polices, property and casualty policies, and employer and union group plans).

It is unlawful to sell a Medigap policy unless the seller obtains a signed statement from the applicant detailing the other insurance the individual has. The statement is to be on a form that states that:

- a Medicare beneficiary needs only one Medigap policy;
- a beneficiary eligible for Medicaid usually does not need a Medigap policy and that benefits and premiums can, at the request of the policyholder be suspended for up to 24 months and be reinstituted upon loss of Medicaid entitlement (see above); and
- counseling services may be available in the state to assist the applicant.

Selling a policy to an individual who indicates in the statement that they have a another Medigap policy is considered a violation of the anti-duplication provision unless the individual indicates that they intend to terminate their other Medigap policy. Selling a policy to an individual who indicates in the statement that they have Medicaid coverage is considered a violation of the anti-duplication provision unless: (1) the state pays the Medigap premiums; or (2) the only Medicaid coverage the individual is entitled to is payment of Medicare Part B premiums.

Sanctions. The law contains sanctions provisions for persons violating the anti-duplication and disclosure requirements. Specifically penalties are established for:

- making false statements or misrepresentation of material facts;
- pretending to be acting on behalf of any federal agency;
- violating anti-duplication provisions;
- failing to furnish the required disclosure statement;
- violating requirements relating to obtaining a signed statement from the applicant; and
- advertizing or soliciting through the mails a policy which has not been approved in the state.

The law includes additional sanctions related to selling of policies which fail to meet specific requirements. Penalties are established for anyone issuing a policy in a state unless the state's regulatory program provides for the application and enforcement of the NAIC standards. Penalties are also established for anyone who sells a Medigap policy: (1) in violation of the requirements relating to standardized

benefits and guaranteed renewal; (2) without making available a policy offering only the core benefits or failing to provide the applicant an outline of the coverage provided; or (3) which fails to comply with provisions relating to suspension of policies for Medicaid beneficiaries or disabled beneficiaries with group health coverage. Penalties are also provided for failure to make refunds to policyholders when required to meet loss ratio requirements.

Issuers of SELECT policies are subject to penalties if they fail to substantially provide medically necessary items and services, impose premiums in excess of those approved by the state, expel an enrollee for reasons other than non-payment of premiums, or do not provide the enrollee the requisite explanation of benefits at the time of application.

It is also unlawful to sell a health insurance policy to an individual with the knowledge that such individual has elected a Medicare medical savings account (MSA) or a MA private fee-for-service plan. Certain types of policies such as liability policies, policies for specified diseases, or policies paying a specified amount per day for hospitalization are exempt form this prohibition.

The Secretary is required to provide to beneficiaries (and to the extent feasible, persons about to become beneficiaries) information: (1) to help them evaluate Medigap policies; (2) about actions subject to sanctions under the duplication and disclosure provisions; and (3) listing addresses and telephone numbers of state and federal agencies who can assist them with selection of Medigap policies.