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Medigap

FINARC

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What is Medigap?

Because Medicare coverage has limitations, many people purchase supplemental insurance policies that are specifically designed to cover some of the gaps. This supplemental insurance is provided by private health insurance companies, not the government, although it is typically called Medigap. In general, you will not need a Medigap policy if your Medicare coverage is through a managed care plan or if you are qualified for Medicaid because of a low income. Specific income requirements for Medicaid eligibility are determined by individual states. In either case, your managed care plan or Medicaid generally fills the gaps in Medicare coverage.

What services are covered?

The federal government regulation of Medigap insurance generally requires that only 12 kinds of plans (Plans A through L) can be offered as Medigap plans, and that all 12 cover these services:

- Part A coinsurance and for the cost of 365 extra days of hospital care after Medicare coverage ends
- Part B coinsurance (usually 20 percent of the Medicare approved payment amount)
- The first three pints of blood

A Plan A Medigap policy will cover only the above expenses. Plans B through L offer Plan A benefits plus some combination of these additional benefits:

- Coverage of your Part A deductible ($1,024for each inpatient hospital stay in 2008)
- Coverage of your Part B deductible ($135 in 2008)
- The daily co-payment requirement for the 21st to 100th day of skilled nursing facility care ($128 per day in 2008)
- Eighty percent of medically necessary emergency care while you are in a foreign country, after you pay a $250 deductible
- All or part of Medicare Part B excess charges
- Coverage for at-home recovery, including assistance with daily living tasks, up to $1,600 per year
- Preventive medical care, up to $120 per year
- Coinsurance for respite care and other Medicare Part A-covered services
- Annual out-of-pocket maximum; pays 100 percent of Medicare Part A and Medicare Part B coinsurance, co-payments, and deductibles after out-of-pocket maximum ($4,000 for Part K or $2,000 for Part L) has been reached

Medigap Plans A through L - Benefits Offered

Plan	A	B	C	D	E	F	G	H	I	J	K	L
Basic Plan	X	X	X	X	X	X	X	X	X	X	Partial	Partial
Skilled Nursing Co-pay			X	X	X	X	X	X	X	X	50%	75%
Part A Deductible		X	X	X	X	X	X	X	X	X	50%	75%
Part B Deductible			X			X				X		
Part B Excess Charges						X	80%		X	X		
Emergency Care on Travel			X	X	X	X	X	X	X	X		
At-Home Recovery				X			X		X	X		
Preventive Care					X					X	X	X
Hospice Care											50%	75%
Out-of-Pocket Maximum											$4,000	$2,000

All 12 plans may not be offered in your state, yet all 12 are standardized and certified by the U.S. Department of Health and Human Services so that each plan provides exactly the same kind of coverage no matter what state you live in (except for Massachusetts, Minnesota, and Wisconsin which have their own standardized plans).

What consumer safeguards are available?

The federal government has mandated that several consumer safeguards be required in all Medigap plans:

- There must be what is called a "free-look" provision, permitting you to get a full refund of any money you paid if you decide to cancel the policy within a certain time period, usually 30 days. The specific time period may actually be longer in your state.
- The policy must be guaranteed renewable, absent your not paying premiums or making false statements on your application.

- If you purchase Medigap insurance within six months of enrolling in Part B, you cannot be denied coverage, regardless of any illnesses or medical conditions you may have, although you may have to wait up to a maximum of six months to get coverage of a pre-existing condition. Pre-existing conditions are any illnesses you had before signing on to an insurance plan. Moreover, if you switch from one Medigap policy to another, the new policy cannot restrict or deny payment for pre-existing conditions that were covered in your original policy, as long as you had the original policy for at least six months. This restriction may be eased even further in the future.

- An insurance company cannot sell you a policy that substantially duplicates any existing coverage you have, including Medicare, or sell you more than one Medigap policy.

- An insurance company cannot claim a policy is a Medigap policy if it duplicates Medicare coverage.

- If an insurance company offers a plan that looks like a Medigap policy but does not conform to one of the 12 standardized plans, there must be a clear disclaimer that it is not a Medigap policy.

In addition, most regulation of insurance is actually done on the state level, and there may be additional consumer safeguards in your state.

What is Medicare SELECT?

Medicare SELECT is offered in some states as a managed care Medigap plan that provides full coverage only if you use the plan's network of health care providers. These policies have lower premiums than the Medigap plans that do not restrict your choice of provider.

Can you use your employer plan as your Medigap?

Many baby boomers who delayed financial commitments such as buying a house or having children may find themselves needing to continue working after age 65. In that case, you may choose to keep your employer-provided health insurance as well as sign up for Medicare. Companies with 20 or more employees must offer employees over 65 the same health insurance choices they do to their other employees.

Your employer-sponsored insurance will be your primary payer so your claims need to be submitted to them first. Medicare will be the secondary payer, paying costs not covered by your employer plan. If you submit your claim to Medicare first, it will be rejected. When Medicare is the secondary payer, it requires documentation that your primary payer will not pay. Medicare coverage will be subject to the same rules of coverage as if you did not have an employer plan. In other words, the amount it will pay will still be the Medicare-approved amounts, and it will only pay for the kinds of service covered by Medicare.

> **Example(s):** Laura is 70 and still working. She continues to receive the same coverage under her employer's health insurance plan that she always has, and she is also covered under Medicare. She recently needed some home health care service following surgery and knew that her employer's plan would not cover it, so she submitted it to Medicare. Medicare rejected the claim, however, because she did not provide any documentation that her primary payer would not pay. When she submitted the claim to her employer's plan and got a notice that it would not pay, she resubmitted her claim to Medicare along with the notice from her employer's plan, and Medicare paid.

Since Part A coverage is free, you surely should sign up for it, and you may have to pay a penalty if you do not sign up when you become eligible at 65. However, you may not want to sign up for Part B, which carries a monthly premium, because you are receiving sufficient coverage from your employer's plan. As long as you remain on the employer's plan, you will not be penalized the annual 10 percent increases in Part B premiums for those who delay signing up after becoming Medicare eligible. There is another good reason not to enroll in Part B while receiving insurance from your employer: Medigap's six-month open enrollment period begins with your enrolling in Part B. It is only during this open enrollment period when you cannot be denied coverage under a Medigap policy or charged a higher premium.

Example(s): Bob will continue working until his last child finishes college, when he will be 67. Bob's employer has always provided him health insurance and continues to even after he becomes eligible for Medicare at age 65. When he does reach age 65, Bob enrolls in Medicare Part A, which costs him nothing. He decides not to enroll in Part B because it would provide little or no additional coverage to him above the coverage provided by his employer, and he would have to pay the Part B monthly premium. He also has to consider whether to purchase a Medigap policy--he has emphysema and is concerned that if he wants a Medigap policy, he needs to enroll in the open enrollment period. At that time, he is sure that he will not be denied coverage because of his emphysema.

If you decline coverage under your employer's health insurance, the employer cannot instead give you a Medigap policy. It can only give you a policy that covers services Medicare does not cover at all.

Can you use your retirement health plan as your Medigap insurance?

If you will receive an employer-sponsored health plan when you retire, your employer plan will be your primary payer, and Medicare will be your secondary payer. An employer-provided plan for retirees may be converted into a Medigap policy; in fact, some insurance policies automatically change coverage when you reach age 65 because they assume you will sign up for Medicare.

If you are not eligible for an employer-provided retiree health insurance plan, you have eight months from your termination of employment to transfer from an employer plan to Medicare. You do not have to wait until the general open enrollment period of the first three months of a calendar year.

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