CALIFORNIA HEALTH ADVOCATES

Supplementing Medicare: Medigap Plans

What are Medigap Policies?

Insurance companies sell supplemental insurance to cover part, or all, of Original Medicare's copayments and deductibles. These are known as Medigap or Medicare supplement insurance policies. A person enrolled in a Medicare Advantage plan, or planning to enroll in one, does not need a Medigap policy. Medigap benefits only work with Original Medicare. A person who has full Medi-Cal benefits in addition to Medicare also does not need a Medigap and it's illegal for agents to sell them one.

Some Medigap plans may include benefits for services that Medicare doesn't pay for, such as emergency medical costs incurred while traveling outside the U.S., or excess charges when seeing a provider who does not accept Medicare assignment. A Medigap policy is guaranteed to be renewable as long as the premium is paid. It cannot be cancelled because of a person's health condition or for any reason other than non-payment of the premium. By law, companies can offer only 10 standardized Medigap benefit packages, referred to as plans A through N and are lettered A, B, C, D, F, G, K, L, M and N. (As of June 2010, previous plans lettered E, H, I and J can no longer be sold). Plans F and G can also be sold with a high deductible option.

Newly Eligible: People whose 65th birthday occurred on or after January 1, 2020 , or those who first became eligible for Medicare on or after January 1, 2020 are known as "newly eligible." They will not be able to buy Medigap plans C or F because Congress recently passed legislation that prohibits the sale of those policies to people who are newly eligible for Medicare. Instead newly eligible people can buy Medigap plans D or G, or the new high deductible (HD) Medigap G.

People who have Medigap plans C or F can keep them, and anyone who was eligible for Medicare prior to January 1, 2020 can still buy them.

A standardized plan means that the benefits of a particular plan are the same regardless of which company sells it. For example, Medigap Plan F has the same benefits no matter which company you buy it from. Plans F and G can also be sold with a high deductible option, which means that the policy will pay only after you have met that annual deductible ($2,370 in 2021). Once the deductible is met, the plan pays its benefits for the rest of that year. The annual deductible increases each August and is effective the following year. (See attached chart for details.)

Note: Medigap policies sold before 1992 were not standardized, and a few Medicare beneficiaries may still have those older plans. The benefits of these pre-standardized plans varied widely in the services that are covered and the amount of benefit that would be paid. Some of these older plans, and others until 2010, also included a drug benefit that may be more generous than those in a Part D plan. The premiums for these plans can be very high, but a close look at the benefits may justify the higher premium. An accurate cost benefit analysis comparing any of these older plans to a current Medigap and a Medicare Part D plan is essential before deciding whether to keep or replace an older policy.

A Medicare SELECT plan is a hybrid that combines a Medigap policy with a Preferred Provider Organization (PPO) plan. A PPO is a group or network of hospitals and providers who have agreed to limit their charge to enrollees who receive their care from those

network providers. A Medicare SELECT plan covers part or all of your Medicare copayments and deductibles from providers in the plan's network. Some Medicare SELECT policies may require you to pay a small copayment when you visit a doctor, a feature that is not allowed in most standardized Medigap polices, except for Plan N (see chart below for details). If you use providers outside the Select network, the policy may not pay. You may have to pay most or all of the cost for the services you use.

The California Department of Insurance regulates insurance companies that sell most Medigap policies. The Department of Managed Health Care regulates Medigap policies sold by some companies, such as Anthem (a Blue Cross association plan), Blue Shield, or Health Net. Medigap plans are sold by licensed insurance agents, by sponsoring groups, or through the mail.

Retiree plans offered by former employers or unions do not have to conform to standardized requirements for Medigap policies. Retiree plans are generally not Medigap policies, even though they may work in a similar way to supplement Medicare. However, some employers may purchase standardized Medigap plans for their employees. (Note: Some employers arrange for their retirees to get coverage through an exchange. An employer may fully subsidize a premium, or contribute a defined amount towards a retiree benefit or a Medigap the retiree selects.)

For more information on retiree plans, please see our Other Health Insurance section under Medicare Topics at cahealthadvocates.org, or our Fact Sheet B-003, "Supplementing Medicare Retiree Plans".

Note: If you receive full Medi-Cal benefits, you do not need a Medigap policy; in fact, it is illegal for companies to sell you one, with certain exceptions. However, if you have Medi-Cal with a share of cost (SOC), you do have the option of buying a Medigap policy, but you must apply for it during a month before you meet your share of cost. The premium can reduce the amount of your share of cost. You have six months to buy a Medigap when a share of cost is first imposed, or if it changes.

If you give up a Medigap when you first become eligible for Medi-Cal, you can reinstate your Medigap up to 24 months later in case you lose your eligibility for Medi-Cal. You must notify the insurer that you are eligible for Medi-Cal when you stop paying premiums and the insurer will place your Medigap on hold for up to 24 months. People who take advantage of one of these options might be able to see a doctor who doesn't otherwise take patients with Medi-Cal.

Health Screening

You can apply for a Medigap policy at any time, but companies selling Medigap plans can refuse to sell you one because of a past or current health condition. Insurance companies may use health screening by asking questions about your health before deciding to sell you a Medigap policy. There are certain times, however, when, by law, companies must sell you a Medigap plan regardless of your health condition. These times are called "Open Enrollment" and "Guaranteed Issue" periods, which follow specific events that resulted in the loss of existing coverage. For more information on Medigap open enrollment period and guaranteed issue rights, see our online Medicare Topics section on Medigap at cahealthadvocates.org, or see our Fact Sheet B-005, "Your Rights to Purchase a Medigap".

Note: In California, Medicare beneficiaries younger than 65 years who have Medicare because of a disability, *but not if they have End Stage Renal Disease (ESRD)*, have an open enrollment period to buy a Medigap policy without health screening. The 6-month open enrollment period starts on the effective date of your Medicare Part B benefits. Companies are allowed to charge beneficiaries with a disability, who are younger than 65, a higher premium than beneficiaries 65 years or older. For more information, please see our online Medicare Topics section on Medigap and click on the link, Your Rights to Purchase a Medigap Policy.

Waiting Period

In general, companies are allowed to impose a waiting period of up to 6 months for any health condition you had that was treated or diagnosed within 6 months before the date your Medigap coverage will begin. However, if you had any health coverage during that period, including Medicare or Medi-Cal, before purchasing a Medigap plan, the company must subtract those months of coverage from any waiting period.

For example, if you had coverage for only 3 months prior to purchasing a Medigap plan, the company must subtract 3 months from any waiting period that applies. If you had health coverage for at least 6 months before purchasing a Medigap plan, companies cannot impose a waiting period. You may be asked to provide evidence of your prior coverage to verify your previous health insurance.

If you buy a new Medigap policy to replace another Medigap plan or you are in a guaranteed issue period, the company cannot impose any waiting period for your new policy regardless of your health condition.

Premiums

Even though Medigap policies are standardized, premiums can vary from company to company. There are 3 methods companies use to set their premiums: issue age, attained age, and community age rating.

Issue age – The issue age method bases the premium and future increases on the age of the beneficiary when the policy was first issued. For instance, a company using this method can charge a higher premium to a beneficiary who first buys the Medigap policy at 72 years old than to a beneficiary who first buys it at 65 years old.

Attained age – The attained age method bases any premium increases on the enrollee's current age at the time of the increase. In other words, a premium can increase based on your age as you get older in addition to other factors.

Community age – The community age method bases the premium and any premium increases on the average age of everyone who has the same policy in a geographic area.

Some companies charge smokers a higher premium than non-smokers while other companies offer a variety of discounts. Very few companies charge everyone the same price, regardless of their age or marital status. Many companies charge a higher premium for a person with a disability who is younger than 65 years old than for someone 65 years or older for the same policy. Companies increase the amount of their premiums each year due to increases in the cost of medical care and increases in the Medicare deductibles. It is important to compare policies and premiums from different companies before buying a policy. You can find information about companies selling Medigap plans in California and some sample premiums at the California Department of Insurance website: insurance.ca.gov.

Basic Benefits in Plans A–G, M and N

Medigap plans A – G, M and N must offer the following ***basic*** benefits. Plan A has only the basic benefits. (Plans K and L are structured differently. See additional chart for these plans below.)

- Coinsurance for hospital days 61-90 ($371/day in 2021) and coinsurance for the 60 lifetime reserve days ($742/day in 2021).
- 100% of the cost of hospital care beyond 150 days covered by Medicare, up to a maximum of 365 lifetime days.
- Hospice cost share
- 20% coinsurance for Medicare-approved charges after the $203 annual Part B Medicare deductible has been met.
- The first 3 pints of blood in each calendar year.

Standardized Medigap Plans (A-G, M and N)

	A	B	C	D	F[1]	G[1]	M	N
Basic Benefits: See above	✓	✓	✓	✓	✓	✓	✓	✓ Copay for office & ER visit[3]
Part A Hospital Deductible: First day deductible, $1,484 in 2021 (per benefit period)[2]		✓	✓	✓	✓	✓	50%	✓
Skilled Nursing Facility (SNF) Copayment: $185.50 per day for days 21-100 of *Medicare-covered stay* in a skilled nursing facility (per benefit period)[2]			✓	✓	✓	✓	✓	✓
Part B Deductible: First $203 of Part B services each year			✓		✓			
Part B Excess Charges: 100% of the limiting charge (15% of the Medicare-approved amount – physicians who do not accept assignment can charge this much more)					✓	✓		
Foreign Travel Emergency Care: 80% of emergency care during the first 2 months of each trip outside the USA after a $250 deductible, for a lifetime maximum of $50,000			✓	✓	✓	✓	✓	✓

1. Plans F and G may be sold with a high deductible of $2,370. The benefits remain the same, but the deductible must be met each year before any claims will be paid.
2. A "benefit period" begins the day you are admitted into a hospital or a SNF (for care covered by Medicare Part A) and ends 60 consecutive days later during which you were neither an inpatient of a hospital nor receiving Medicare Part A-covered care in a SNF.
3. You pay up to $20 for each office visit. Plan N pays the remainder of any Part B coinsurance charges. The office visit copay applies to all office visits with providers authorized to bill Medicare for those visits. There is no annual limit on this copayment. It must be paid for each office visit, even if you have a few visits on the same day. The copay (up to $50) for emergency room use is waived only if you are admitted to a hospital and Medicare covers the stay under Part A.

Standardized Medigap Plans K and L

Medigap plans K and L are structured differently than Medigap Plans A-G, M and N.

	K	L
Part A hospital coinsurance plus coverage for 365 additional hospital days (lifetime maximum) after Medicare benefits end	100%	100%
Part A Hospital Deductible	50%	75%
SNF Copayment	50%	75%
Hospice Cost-Share	50%	75%
First 3 Pints of Blood	50%	75%
Part B Coinsurance	50%	75%
Medicare-covered Preventive Care coinsurance	100%	100%
Part B Annual Deductible[4]	0	0
Part B Excess Charges[5]	0	0
Total Out-of-Pocket Limit	$6,220 [6]	$3,110 [7]

4. The Part B deductible is not a covered benefit in Plan K or Plan L. But your payment of the Part B annual deductible ($203 in 2021) is credited towards the annual out-of-pocket limit of each plan.
5. Part B excess charges are not a covered benefit in Plan K or Plan L. Your payment of Part B excess charges does not count toward the annual out-of-pocket limit.
6. After you pay $6,220 in out-of-pocket expenses for covered benefits during a calendar year, the plan then pays 100% of any remaining covered benefits for the remainder of that calendar year.
7. After you pay $3,110 in out-of-pocket expenses for covered benefits during a calendar year, the plan then pays 100% of any remaining covered benefits for the remainder of that calendar year.

Note: Some companies have begun selling a Medigap with additional benefits added to one or more of their policies. Under federal law, states can approve the addition of certain "innovative" benefits to a Medigap, but they must be benefits that are not otherwise available and have added value. Those benefits can't cover an expense for which there is already a Medigap benefit available. For instance, a company couldn't add an excess charge benefit to one of the Medigap plans that didn't cover that expense. Innovative benefits are usually such things as hearing, dental, or vision services, or preventive care not otherwise covered. These benefits must comply with all other requirements of a Medigap policy whether provided as an integral benefit within the policy or added by rider. For instance, innovative benefits must meet all other requirements of the underlying coverage of a Medigap such as guaranteed issue rights. In addition, the premium for these innovative benefits must be disclosed to the purchaser separately from the premium for the policy.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call 1-800-434-0222 to make an appointment at the HICAP office nearest you, or go online at cahealthadvocates.org to find the HICAP office in your area.

Note: Online access to all CHA fact sheets on Medicare and related topics is available for an annual subscription. See cahealthadvocates.org/fact-sheets/.