26 Government Programs: Medicare

Objectives

After completing this module, you will be able to:

- describe the Medicare program, including its component parts and the options available to beneficiaries;
- tell how the Medicare Advantage program has developed;
- identify the different types of Medicare Advantage plans; and
- describe Medigap policies.

The federal government is a payor and purchaser of healthcare benefits. It provides health benefits directly or through grants, and it operates programs that serve populations such as the elderly and disabled (Medicare), low-income people (Medicaid), federal employees (FEHB), and active and retired members of the uniformed services and their dependents (TRICARE). The federal government also plays an important role in healthcare by maintaining standards for Medicare healthcare providers, federally qualified HMOs, and health plans for federal employees, as well as quality standards for hospitals, clinical laboratories, and many other healthcare entities. Most federal healthcare functions are under the Department of Health and Human Services (HHS), which includes the **Centers for Medicare and Medicaid Services (CMS)**.

This module examines the Medicare program, with special attention to the Medicare Advantage program, through which individuals can opt to receive Medicare coverage from a private-sector health plan. It also takes a look at Medicare supplement insurance. For all topics we note changes made by recent healthcare reform legislation.

In this module Medicare dollar amounts for 2010 are used. (They are adjusted annually for inflation.)

Medicare

Medicare is a federal program that was established under Title XVIII of the Social Security Act of 1965. It is social insurance that provides benefits for hospital care, medical services, and other healthcare expenses. It is available to persons 65 or older; people under 65 with severe, long-term disabilities; and persons with end-stage renal disease (ESRD) or ALS:

Medicare is an entitlement program—for individuals who meet the qualifications, benefits are a right. Medicare provides extensive coverage, but it does not cover all health-related expenses, and beneficiaries must pay significant deductibles, copayments, and coinsurance. Therefore individuals may want to supplement Medicare with private-sector insurance (discussed below).

Medicare consists of Parts A, B, C, and D:

- Medicare originally had two components: **Part A** (hospital coverage) and **Part B** (medical coverage). Parts A and B together are referred to as "**original Medicare**" or "traditional Medicare." Original Medicare is traditional fee-for-service coverage.

- IN 1997 **Part C** was added. This is the **Medicare Advantage (MA)** program, which gives beneficiaries the option of obtaining Part A and Part B coverage (and some other benefits) through a Medicare-approved private-sector health plan. Most MA plans are managed care plans.

- In 2006 **Part D** (prescription drug coverage) was added. Medicare beneficiaries choose whether to participate in Part D, and those who do pay an additional monthly premium. Part D benefits are provided by Medicare-approved private-sector prescription drug plans (PDPs) and by most Medicare Advantage plans.

A majority of Medicare beneficiaries receive coverage though original Medicare, but over 11 million (about 24 percent) choose Medicare Advantage (2010).[1] A majority of beneficiaries are also enrolled in Part D, either through a PDP or an MA plan.

Medicare Part A

Coverage

Medicare Part A includes benefits for the following:

- **Inpatient hospital care.** There is a large deductible ($1,100) per benefit period (usually a hospital stay), large daily copayments ($275) after 60 days, and a limit of 90 days per benefit period (except for 60 lifetime reserve days, for which there is a daily copayment of $550).

- **Skilled nursing facility care** following hospitalization. Skilled care must be medically necessary for recovery from an acute illness or injury, and other conditions must be met. There are a limit of 100 days per benefit period and large daily copayments ($137.50) after day 20.

- **Home healthcare** following hospitalization or nursing facility care. Intermittent skilled care must be medically necessary for recovery from an acute illness or injury, and other conditions must be met. There is no cost-sharing, but there is a limit of 100 home visits.

- **Hospice care,** provided to terminally ill persons. Only small copayment and coinsurance amounts for a few items are charged.

Eligibility and Premiums

Part A is provided without charge to U.S. citizens and certain resident aliens who are 65 or older and receiving or eligible for Social Security or Railroad Retirement Board (RRB) retirement benefits, as well as most persons participating in retirement programs for federal, state, or local government employees instead of Social Security. Other people

65 or older may enroll in Part A, but they must pay a premium (up to $461 a month). As a general rule, those who paid into the Medicare system while they were working by means of FICA payroll deductions for at least a minimal amount of time (or whose spouses did so) do not pay a premium, while those who did not must pay.

Medicare Part A is also available to disabled persons under 65 who meet certain criteria. They must qualify for Social Security or RRB disability benefits, which means that their disability must be total—that is, so severe that they are unable to engage in any substantially gainful work. And the disability must be long-term—they must have received SS or RRB disability benefits for at least 24 months. Because of these restrictive conditions, many disabled persons do not qualify.

Individuals of any age who suffer permanent kidney failure (end-stage renal disease, or ESRD) or amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease) are also eligible. To qualify on the basis of a disability, ESRD, or ALS, a person (or his or her spouse) must have paid into the Medicare system for at least minimal amount of time while working. Those who have not done so may not enroll by paying a premium, as can those 65 or older. Finally, healthcare reform extends Medicare eligibility to people who have developed certain health conditions as a result of living in an area where they were exposed to environmental health hazards.

Funding

Medicare Part A is funded primarily by payroll taxes on working people and their employers. Currently, employees and employers each pay 7.65 percent of wages in FICA taxes, of which 6.2 percent is for Social Security and 1.45 percent is for Medicare. While Social Security taxes are levied only on wages up to $106,800 per year, Medicare taxes apply to all wages, even those above this level. A self-employed person pays both the employer and the employee portion, for a total of 15.3 percent.

Healthcare reform makes two important changes to this system beginning in tax year 2013:

- **Tax increase on earned income.** Those with annual employment earnings above $200,000 (individual) or $250,000 (couple) will pay a higher Medicare employment tax rate on their earnings above that level (2.35 percent instead of the usual 1.45 percent). The employer contribution (1.45 percent) will not be increased. These thresholds will not be adjusted for inflation, so over time more people will be liable for this increased rate.

- **Tax on unearned income.** There will be a 3.8 percent Medicare tax on unearned income (investment income such as interest, dividends, and capital gains) of high-worth individuals, estates, and trusts. For individuals this tax will apply to net investment income or to modified adjusted gross income (MAGI) in excess of $200,000 (individual) or $250,000 (couples), whichever is less.

Medicare Part B

Coverage

Medicare Part B covers a wide array of services and supplies, including physician and surgeon services, services provided by some other healthcare practitioners, outpatient medical and surgical services, emergency room and ambulance services, laboratory services, therapy, mental healthcare, durable medical equipment, and others. Healthcare reform adds several preventive care services to Part B coverage, including annual wellness visits, various disease screenings, personalized disease prevention plans, cardiac rehabilitation programs (including exercise, education, and counseling), an EKG, and others.

With a few limited exceptions, original Medicare does not pay benefits for dental care and dentures, vision care and eyeglasses, hearing exams and hearing aids, foot care and orthopedic shoes, chiropractic services, healthcare delivered outside the United States, and some other health-related services and products. In the past Medicare coverage of preventive care was fairly limited, but it has been expanded in recent years, and as noted above, healthcare reform continues this trend. As a result, although there are still a few screenings and diagnostic tests that are not covered, this is no longer a major coverage gap.

For most Part B services and products beneficiaries must pay an annual deductible ($155) and 20 percent coinsurance. Healthcare reform eliminates this cost-sharing for most (but not all) preventive care. There is currently 45 percent coinsurance for outpatient mental healthcare, but from 2011 through 2014 this will be gradually lowered to 20 percent. Under both Part A and Part B, beneficiaries must pay for the first three pints of blood (if it is not donated by a blood bank, as is usually the case).

Eligibility and Premiums

All U.S. citizens (and certain resident aliens) 65 or older have the option of receiving Medicare Part B. Persons with disabilities, ESRD, or ALS who are eligible for Medicare Part A are also eligible for Part B. Because Part B covers important healthcare services not covered by Part A, almost all those enrolled in Part A choose Part B as well.

All Part B enrollees pay a monthly premium. Most people—those with annual income at or below $85,000 (individual) or $170,000 (couple)—pay the standard premium, while those with greater income pay higher amounts based on their income. In 2010 the standard premium is $110.30, but only new enrollees and those not receiving Social Security pay this amount; most people continue to pay the 2009 amount of $96.40.[2] Under healthcare reform, the income level above which beneficiaries must pay a higher-than-standard Part B premium will be frozen from 2011 through 2019, so that as incomes rise more beneficiaries will pay the higher premium.

Part A and Part B Enrollment

People who receive Social Security or RRB retirement benefits are automatically enrolled in Medicare Part A when they turn 65. Disabled persons are automatically enrolled after they have received SS or RRB disability benefits for 24 months. Both of these groups are also enrolled in Part B unless they indicate that they want to opt out. Others eligible for Medicare (such as those who are 65 or older but still working and not receiving Social Security) must sign up for Part A and Part B if they want it.

Those who must pay for Medicare Part A can enroll during an initial enrollment period (three months before and after they turn 65) or later during a general enrollment period (every year from January 1 through March 31). Persons who have employer-sponsored health insurance can enroll at any time while they are still covered by the employer plan and up to eight months after this coverage ends. People who opt out of Medicare Part B when they first become eligible may enroll later during a general enrollment period, and those with employer-sponsored coverage have until eight months after that coverage ends.

Individuals who do not enroll in Part A or Part B when they first become eligible and are not covered by employer-sponsored insurance may have to pay a late enrollment penalty, in the form of a higher premium, if they enroll later. The Part A premium is increased by 10 percent and the Part B premium by 10 percent for every 12-month period the person waits to enroll.

Medicare Part C (Medicare Advantage)

Medicare Advantage (Medicare Part C) is an alternative to original Medicare. Those entitled to Medicare can choose to receive coverage through original Medicare, or (in most areas of the country) they have the option of instead participating in a Medicare Advantage (MA) plan. MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and others (described below).

Medicare Advantage plans are Medicare-approved private-sector health insurance plans. The Medicare program pays an MA plan a fixed amount each month for each person it serves, and the plan provides Medicare coverage. An MA plan must provide all Part A and Part B coverage. Most MA plans provide additional benefits, such as coverage of Medicare cost-sharing payments, and some provide coverage that goes beyond original Medicare such as dental care, hearing aids, and eyeglasses. Finally, most Medicare Advantage plans offer Medicare Part D prescription drug benefits (usually at an additional cost).

Premiums and Enrollment

Enrollees pay their MA plan a monthly premium that covers the Medicare Part B premium and pays for any benefits in addition to Medicare Part A and B that the plan provides. MA participants also pay copayments and sometimes deductibles and coinsurance for some services. The extent of coverage beyond original Medicare, premium rates, and cost-sharing payments vary from plan to plan.

To enroll in a Medicare Advantage plan, a person must be enrolled in or eligible for Medicare Part A and Part B and live in the area covered by the MA plan. A person can enroll in an MA plan when she first becomes eligible for Medicare (three months before and after she turns 65 or three months before and after her 24th month of disability). There are also enrollment periods each year during which a person can switch from original Medicare to an MA plan, or from an MA plan to original Medicare, or from one MA plan to another.

Medicare Part D

Medicare Part D provides outpatient prescription drug coverage. Persons eligible for Medicare choose whether to participate in Part D, and those who do pay an additional monthly premium. Part D benefits are provided by Medicare-approved private-sector **prescription drug plans (PDPs)**. A Medicare beneficiary enrolls in the PDP of her choice, receives benefits from that PDP, and pays her Part D premium directly to the PDP. Most Medicare Advantage plans also offer Part D benefits (usually at an additional cost). A majority of Medicare beneficiaries have Part D coverage, 38 percent from a PDP, 19 percent from an MA plan.[3]

Medicare beneficiaries usually have many PDPs to choose from, and PDPs vary in the benefit packages they offer. But all plans must provide a minimal level of benefits, and Medicare also specifies certain drugs that all PDPs must cover. The benefits and cost-sharing of a PDP are typically structured as follows:

- **Annual deductible.** The standard amount in 2010 is $310, but this may vary, and not all PDPs have a deductible.

- **Copayments and/or coinsurance.** Coinsurance percentages are often 25 or 33 percent. Copayment amounts vary widely from plan to plan.

- **Coverage gap.** Once the total amount both the beneficiary and the PDP have paid for drugs reaches a certain level (the initial coverage limit), there is a coverage gap, during which the beneficiary pays all costs and the PDP pays nothing. Some PDPs cover some drugs during the coverage gap, but they charge a higher premium.

- **Catastrophic coverage.** If the amount the beneficiary has paid for drugs reaches a certain level (the out-of-pocket limit), catastrophic coverage is triggered, and the coverage gap ends. From this point until the end of the year, the beneficiary pays only small copayment or coinsurance amounts.

Let's look at an example of how Part D works: Kate is a Medicare beneficiary enrolled in a PDP. She takes several prescription drugs. How much of her costs does the PDP pay, and how much does Kate have to pay herself?

- Each year, Kate must pay the first $310 of costs to satisfy her plan's deductible. Then, under the rules of her plan, she pays 25 percent coinsurance—that is, she pays 25 percent of costs and the PDP pays the rest. (Other plans charge a different percentage or flat-dollar copayment amounts.)

- After several months, the amount Kate has paid (for the deductible and coinsurance) plus the amount the PDP has paid together total $2,830, the initial coverage limit (2010). The coverage gap begins, and Kate must pay the full cost of her prescriptions for the remainder of the year (although she benefits from discounts negotiated by her PDP).

- Now suppose Kate's costs (deductible, coinsurance, and costs she pays herself after the initial coverage limit) reach $4,550, the out-of-pocket limit (2010). Catastrophic coverage is triggered, and from then until the end of the year, Kate pays only small coinsurance or copayment amounts.

Healthcare reform makes substantial changes to this system. In 2010 beneficiaries who have to pay their own costs during the coverage gap will receive a $250 rebate. From 2011 through 2020, the portion of costs beneficiaries pay during the coverage gap will be gradually reduced to 25 percent, effectively eliminating the gap. Also during those years the level at which catastrophic coverage is triggered will be lowered. And starting in 2011 drug manufacturers will be required to give those in the coverage gap a 50 percent discount on brand-name drugs, and additional federal subsidies for generic drugs will be phased in.

People with low income and limited assets may qualify for "extra help"—Medicare may help pay their premiums, deductibles, and copayments and coinsurance, and there is no coverage gap.

A person can enroll in Part D when he first becomes eligible for Medicare or later, during an annual enrollment period (November 15 through December 31 of each year, with coverage beginning January 1). However, for those who enroll after they first become eligible there is generally a late enrollment penalty—they pay a higher premium for as long as they are enrolled in Medicare Part D. There is an exception for those who have employer-sponsored drug coverage—they may wait to enroll, and there is no penalty as long as they enroll no later than 63 days after losing their employer coverage.

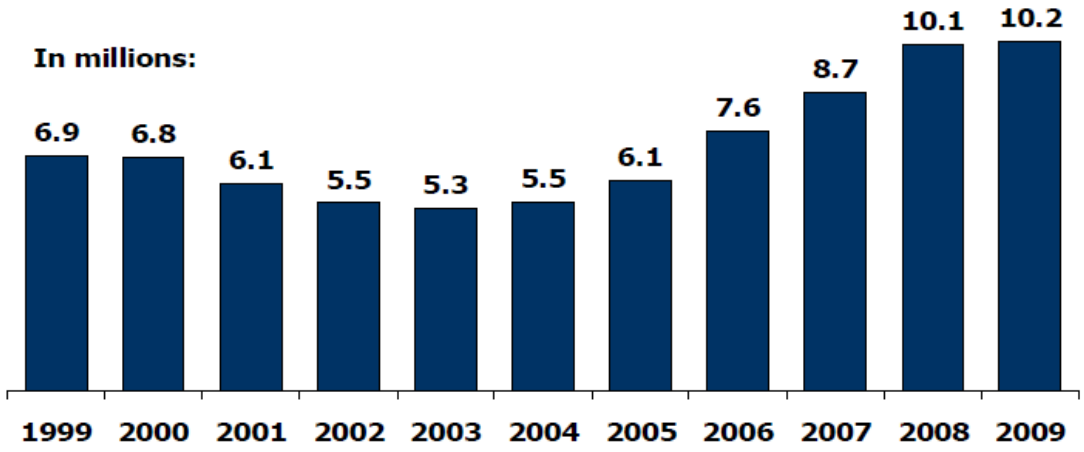
The History of Medicare Managed Care

Medicare beneficiaries pose unique challenges for Medicare health plans, which take on the financial risk for the provision of services under fixed payments received from the federal government. Medicare beneficiaries have a higher incidence of both acute illness and chronic illness than does the general population, and they are more likely to become disabled and require long periods of rehabilitation. At the same time, health plans have a much greater ability than fee-for-service insurance to effectively manage the delivery of multiple or complex medical services and contain costs through emphasis on preventive care services, utilization management, and coordinated care through network providers. The federal government seeks to bring these attributes to Medicare by encouraging private-sector options. Figure 25.1 demonstrates the growth in enrollment in Medicare Advantage plans over time.

Figure 25.1

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2009



Note: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, Cost contracts, Demonstrations, HCPP, and PACE contracts.
Source: Mathematica Policy Research, Inc. "Tracking Medicare Health and Prescription Drug Plans Monthly Report" 1999-2009.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 introduced managed care into Medicare. Under TEFRA, health plans entered into contracts with Medicare to provide Part A and/or Part B benefits on either a cost basis or a risk basis. Organizations with cost contracts received monthly payments from the federal government based on estimates of the reasonable cost of delivering covered services, which could be adjusted to reflect actual costs. Cost plans accepted no risk and allowed beneficiaries to use doctors and hospitals outside the plan networks. Enrollees were required to pay a large portion of their healthcare expenses through premiums and deductibles. Health plans could contract on a cost basis for both Medicare Part A and Part B coverage or for Part B services only. Health plans that offered Part A and B were referred to as reasonable cost contracts or cost contracts. Health plans that offered only Part B coverage were classified as healthcare prepayment plans (HCPPs).

Health plans that participated in Medicare risk contracts received a specified geographically based capitation payment from CMS each month for each plan member, regardless of the amount or cost of services the member actually received. The health plans were at risk for delivering the contracted-for level of services at these fixed rates. Medicare risk contracts were attractive to beneficiaries because they typically offered preventive care and other benefits beyond the traditional Medicare Part A and Part B services for the same or only slightly higher premiums. For services to be covered, however, they needed to be obtained from the Medicare risk plan's network of providers and were subject to other utilization controls.

The Balanced Budget Act (BBA) of 1997

The Balanced Budget Act (BBA) of 1997 again restructured the Medicare program, absorbing the TEFRA Medicare risk contracts into the new **Medicare+Choice** program. Medicare plans that complied with CMS requirements were automatically transitioned into Medicare+Choice. Cost contracts were initially to be phased out by December 31, 2002, but subsequent legislation extended their operation first by two more years and then indefinitely under certain conditions set out by the Medicare Modernization Act of 2003.

The BBA expanded the number of delivery options for Medicare services and also established operational requirements for plans participating in Medicare+Choice. These requirements have a direct impact on the types of administrative and healthcare services that Medicare health plans offer and the steps that health plans must take to maintain the quality of those services, and they were carried over to the next Medicare program restructuring.

The Medicare Modernization Act (MMA) of 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (commonly called the Medicare Modernization Act, or MMA) renamed the Medicare+Choice program Medicare Advantage. The Medicare Advantage (MA) program was largely based on the Medicare+Choice program in terms of program operations, benefits, and quality of care initiatives, but it expanded the existing private health plan product options available to Medicare beneficiaries. Coordinated care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs), as well as private fee-for-service plans, are the available options under Medicare Advantage. The MMA expanded the types of options to include new regional PPOs in 2005.

Regional MA-PPOs

Beginning in 2006, beneficiaries had the option of enrolling in Medicare Advantage regional PPOs (regional MA-PPOs) that offer network and out-of-network benefits as well as caps on beneficiary out-of-pocket costs. Unlike local MA plans, which serve individual counties and/or groups of counties, the new regional MA-PPOs bid to serve an entire region, which may be a state or multi-state area.

Unlike original Medicare, with its separate deductibles for Parts A and B, regional MA-PPOs are required to have a single, unified deductible (if they have one at all). They may waive this deductible for preventive care and other services. Regional PPOs must also have catastrophic limits on out-of-pocket expenditures for in-network services and for all covered services. Benefit packages and premiums must be uniform across the entire region.

Local MA Plans

In addition to regional MA-PPOs, there are the following categories of local MA plans:

- **Coordinated care plans (CCPs)** include health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs).

- **Private fee-for-service (PFFS) plans.** PFFS plans do not have a network. Members can go to any Medicare-approved provider that accepts payment from the PFFS plan. However, not all providers accept such payment, so plan members may have limited choices. Some PFFS plans offer prescription drug coverage, but some do not. (If not, members can enroll in a Medicare Part D PDP if they wish.) The requirements for PFFS plans are changing effective 2011, causing them to shift to a provider network or cease operation.

- **Medicare medical savings account (MMSA) plans.** MMSA plans work like health savings accounts (HSAs), discussed in an earlier module. Participants are covered by a qualified high-deductible health plan (HDHP) and can withdraw money from a tax-advantaged account into which the plan makes an annual deposit. Participants must pay for their care out of their own pockets until they have satisfied the deductible, after which the plan pays. They can use money from their account to pay out-of-pocket costs, but the amount deposited each year is usually less than the deductible, so they generally have to pay at least some costs out of their own funds. MMSA plans do not include drug coverage, but participants can enroll in a PDP.

- **Special needs plans (SNPs).** SNPs serve special populations, such as Medicare/Medicaid dual eligibles, those with certain chronic and debilitating diseases (such as diabetes or HIV/AIDS), or nursing home residents. They operate like an HMO—they have a network, and care must normally be obtained from network providers. Members must have a primary care physician or a care coordinator and must have a referral to see a specialist. All SNPs provide drug coverage.

Healthcare Reform

Healthcare reform includes provisions designed to reduce government expenditures on Medicare Advantage and make MA plans operate more efficiently.

- Government payments to MA plans will be reduced beginning in 2012. This could result in higher premiums or reduced benefits for plan members. MA plans will not be allowed to compensate for this reduction by charging higher cost-sharing than original Medicare.

- On the other hand, MA plans that meet certain quality standards will receive bonuses (to be phased in from 2011 through 2013). A plan must use this money first to reduce costs, then to add prevention and wellness coverage, and if any money remains, to add coverage of such items as vision and dental care.

- Beginning in 2014 MA plans will be required to maintain a medical loss ratio of at least 85 percent.

Medicare Supplement Insurance

As we have seen, although original Medicare provides extensive coverage, it does not pay all healthcare expenses. It has substantial deductibles, copayments, and coinsurance, and it does not cover dental care and dentures, vision care and eyeglasses, hearing aids, and a number of other health-related services and products.

To fill some of these gaps, those enrolled in original Medicare may purchase **Medicare supplement insurance** (commonly called **Medigap policies**). Because Medicare Advantage plans offer more comprehensive coverage, MA enrollees do not need (and are not permitted to purchase) Medigap policies.

A Medigap policy is a state-approved, private-sector individual insurance policy that provides reimbursement for expenses not covered by original Medicare. Medigap policies primarily cover cost-sharing payments Medicare beneficiaries must make. Some policies also provide benefits for a few healthcare expenses not covered by Medicare, such as emergency care received outside the U.S. Medigap policies do not cover dental, vision, or hearing care.

Standard Medigap Plans

Medigap policies are subject to extensive government regulation. A limited number of standard Medigap plans, each with a certain combination of benefits, have been established, and insurers are required to offer only these plans. In addition, all insurers must use the same standardized format, language, and definitions in describing the benefits of the plans. This standardization is intended to make it easier for consumers to compare plans and premiums. Since insurers offer the same standard plans, they compete on the basis of price and customer service. (This system applies in all states except Massachusetts, Minnesota, and Wisconsin, which have their own regulations.) Changes have been made to this system over the years, and new rules went into effect June 1, 2010.

Figure 25.2 shows the standard Medigap plans as of June 1, 2010, and Figure 25.3 shows the earlier system. Only plans in Figure 25.2 can be sold now, but plans sold earlier may continue in force.[4]

All Medigap plans must provide at least a basic benefit package. This includes Part A daily hospital copayments, up to 365 days of hospital coverage per lifetime after Medicare hospital benefits are exhausted, hospice copayments and coinsurance, Part B coinsurance, and the first three pints of blood each year. Since the establishment of Medicare Part D in 2006, new Medigap policies may not include prescription drug benefits, but some policies sold before then do.

Healthcare reform will make further changes to the standardized Medigap plans. It mandates the creation of new plans C and F, with nominal cost-sharing designed to encourage the use of appropriate physician services under Medicare Part B. These new plans C and F will become available in 2015.

Medigap Plans Effective on or after June 1, 2010

How to read the chart:

If a checkmark appears in a column of this chart, the Medigap policy covers 100% of the described benefit. If a column lists a percentage, the policy covers that percentage of the described benefit. If a column is blank, the policy doesn't cover that benefit. **Note:** The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).

You may buy the following Medigap Plans which become effective June 1, 2010:

	Medigap Plans Effective June 1, 2010									
Medigap Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A Coinsurance 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 Care 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)			✓	✓	✓	✓			✓	✓
Medicare Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
							Out-of-Pocket Limit**			
							$4,620	$2,310		

*Plan F also offers a high-deductible plan. This means you must pay for Medicare-covered costs up to the deductible amount $2,000 in 2010 before your Medigap plan pays anything.

**After you meet your out-of-pocket yearly limit and your yearly Part B deductible ($155 in 2010), the Medigap plan pays 100% of covered services for the rest of the calendar year. Out-of-pocket limit is the maximum amount you would pay for coinsurance and copayments.

***Plan N pays 100% of the Part B coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits.

Medigap Plans with effective dates through May 31, 2010

How to read the chart:

If a checkmark appears in a column of this chart, the Medigap policy covers 100% of the described benefit. If a column lists a percentage, the policy covers that percentage of the described benefit. If a column is blank, the policy doesn't cover that benefit.
Note: The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).

Through May 31, 2010 you may buy the following Medigap Plans:

	Medigap Plans A through L											
Medigap Benefits	**A**	**B**	**C**	**D**	**E**	**F***	**G**	**H**	**I**	**J***	**K**	**L**
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment (Except for preventive services)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Hospice Care Coinsurance or Copayment											50%	75%
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Medicare Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Medicare Part B Deductible			✓			✓				✓		
Medicare Part B Excess Charges						✓	80%		✓	✓		
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓	✓	✓	✓	✓		
At-home Recovery (Up to Plan Limits)				✓			✓		✓	✓		
Medicare Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Preventive Care not Covered by Medicare (up to $120)					✓					✓		
Out-of-Pocket Limit**											$4,620	$2,310

*Plans F and J also offer a high-deductible plan. This means you must pay for Medicare-covered costs up to the deductible amount of $2,000 in 2010 before your Medigap plan pays anything.

**After you meet your out-of-pocket yearly limit and your yearly Part B deductible ($155 in 2010), the Medigap plan pays 100% of covered services for the rest of the calendar year. Out-of-pocket limit is the maximum amount you would pay for coinsurance and copayments.

Medicare SELECT

A **Medicare SELECT policy** is a type of Medigap policy. Like other Medigap policies, a SELECT policy must provide the benefit package of one of the standard Medigap plans. The difference is that it operates like a preferred provider organization (PPO)—it has a network of healthcare providers, and beneficiaries are given financial incentives to use hospitals and in some cases physicians affiliated with the network. If they use non-network providers, they may incur cost-sharing payments. On the other hand, because the use of a provider network tends to hold down costs, a SELECT plan can usually charge a lower premium.

Eligibility and Enrollment

To be eligible for Medigap insurance, an individual must be enrolled in original Medicare, both Part A and Part B. As noted, those participating in a Medicare Advantage plan do not need and may not buy a Medigap policy.

If a person applies for a Medigap policy during her Medigap open enrollment period, guaranteed issue applies—that is, the insurer cannot subject her to medical underwriting, deny her coverage, make her wait for coverage, or charge her more than the standard premium. A person's open enrollment period begins the first day of the first month in which she is both 65 or older and enrolled in Medicare Part B, and it lasts for six months. In addition, in certain circumstances an individual is entitled to guaranteed issue after her open enrollment period, such as when a person does not enroll in Medigap coverage because she has an employer-sponsored health plan but applies

later when that coverage terminates, or when a person's Medigap coverage ends through no fault of her own and she wants to buy a new policy. If a person is not entitled to guaranteed issue, the insurer has the right to conduct underwriting, decline to offer her coverage, or charge her a higher-than-standard premium.

Conclusion

The federal Medicare program provides healthcare coverage to the elderly, some disabled persons, and a few others. But Medicare does not pay all health-related expenses, and many beneficiaries buy an individual Medicare supplement (Medigap) insurance policy to fill some of the gaps (mostly Medicare deductibles, copayments, and coinsurance). The Medicare Advantage (MA) program offers an alternative—individuals eligible for Medicare can enroll in a private-sector MA plan and receive Medicare coverage; benefits comparable to Medigap; usually additional coverage (such as dental care, hearing aids, and eyeglasses); and in most cases Medicare Part D prescription drug benefits.

Notes

[1] The Henry J. Kaiser Family Foundation, "Medicare Advantage 2010 Data Spotlight, Plan Enrollment Patterns and Trends," June 2010.

[2] Most people have their Part B premium deducted from their Social Security check. In 2010 Social Security benefits were not increased since the cost of living did not rise. This means that if a higher Part B premium were deducted from a person's Social Security check, she would receive less than the previous year, and this is not allowed under Social Security rules. Therefore, anyone who has been having the standard Part B premium deducted from her Social Security continues to pay the 2009 amount ($96.40). Only people who begin Medicare in 2010 or who do not have their premium deducted from Social Security pay the official 2010 amount ($110.30).

[3] The Henry J. Kaiser Family Foundation, "Analysis of the Medicare Current Beneficiary Survey, Access to Care File, 2007."

[4] Both tables are from "Choosing a Medigap Policy 2010," published by the Centers for Medicare and Medicaid Services and available at www.Medicare.gov.