Chapter 5 Medicare Supplement Plans

Though Medicare covers many health care costs, recipients still have to pay Medicare's coinsurance and deductibles, and generally the Part B premiums. Medicare also does not cover certain medical services.

The first of the solutions to Medicare deficiencies is called a "supplement to the Original Medicare plan." Historically, a fully constituted Medicare plan had only two components:

1. Coverage provided by the Original Medicare program through Parts A and B
2. Medicare supplement insurance, also known as Medigap insurance

With the introduction in 1999 of Medicare Part C (Medicare Advantage), another program became available. In this chapter, we'll focus on Medicare supplements to the Original Medicare plan.

Background to Medicare Supplement Plans

While only the government calls a Medicare supplement policy "Medigap," they both mean the same thing. Medicare supplement policies are private insurance plans that help pay a person's Medicare cost-sharing amounts. The initial standardization of Medicare supplement plans in 1993 resulted in ten standard policies: Plans A through J. Each offered a different combination of benefits. MMA 2003 added two more plans, K and L, and eliminated the prescription drug benefits of plans H, I, and J. MMA 2003 also created Medicare Part D and "stand alone" Part D plans (PDPs) and Medicare Advantage plans that include Part D benefits (MAPDs), thereby transferring all prescription drug benefit references to the Part D program. As a result, no new Medicare supplement policies with drug coverage can be sold.

Then, in 2008, the Medicare Improvements for Patients and Providers Act directed CMS to use NAIC plan modeling to implement a revision to the series of Medicare supplement plans. The new modeling resulted in significant changes to the array of Medicare supplement plans. First, all companies selling Medicare supplement plans had to cease selling the "old" series of plans effective June 1, 2010. Plans that were sold before this date can remain in force, and insureds who are covered by these older plans will remain covered after this date. However, this has financial implications for these insureds. Because no new insureds can be added to the existing pool that these plans cover, the premiums for many covered under these policies have increased (or will increase). In Medicare and the Medicare supplement business, the older a book of business, the more expensive it becomes because of the utilization by an ever-aging demographic.

The 2008 MIPPA regulations also required and provided for a new set of Medicare supplement offerings, which eliminated some existing plans (E, H, I, and J); added new Plans M and N; and called for a change in the basic (core) benefits of all MS policies. We will cover this transformation in depth.

Basic Medicare Supplement Plans

A Medicare supplement plan is a private health insurance plan that fills the "gaps" in Original Medicare coverage. Each plan offers a different set of benefits. Any standardized plan can also be sold as a Medicare Select plan, if an issuing insurer chooses to make a Medicare Select plan available. Medicare Select plans usually cost less, because a person must use certain doctors and hospitals, except in an emergency.

A Medicare beneficiary has certain rights and protections related to Medicare supplement plans. Individuals need to be aware of what these rights and protections are as they shop for Medicare supplement plans. If individuals are in a Medicare Advantage plan, or if they are covered by Medicaid, they do not need a Medicare supplement plan. In fact, the "Medicare and You 2020" guidebook (the official U.S. government Medicare handbook distributed yearly to every Medicare recipient) contains language to the effect: "If you have a Medicare Advantage plan, it's illegal for

anyone to sell you a Medigap policy unless you're switching back to Original Medicare."

Every company that markets and sells Medicare supplement plans must offer Plan A, which includes certain "basic" or "core" benefits. The basic benefits included in all plans are these:

-Hospitalization, Medicare Part A coinsurance, plus coverage for 365 additional days during the insured's lifetime after Medicare benefits end
-Medical expenses, Medicare Part B coinsurance—generally 20 percent of Medicare-approved expenses, or co-payments for hospital outpatient services
-Coverage for the first three pints of blood each year
-Coverage for hospice care

The standard plans have certain prerequisites. For example, Medicare supplement policies assume that a person has both Medicare Part A and Part B coverage. The applicant must be enrolled in both parts. Each policy provides coverage for gaps in both parts of Medicare, and a person cannot buy a policy that deals with only one part or the other. Nor can a person buy a Medicare supplement policy without getting Medicare Part B coverage. In other words, for a plan to "supplement" Medicare, Part B Medicare coverage must be in place before an insurance policy can supplement it. (Some states and some Medicare supplement companies may have variances on these Part B qualifying rules.)

Beneficiaries, prospects, and insurance producers alike must be careful not to confuse Part A, Part B, Part C, or Part D of Medicare with Plan A, Plan B, Plan C, or Plan D of Medicare supplements.

The Producer's Dilemma: Pre- and Post-June 2010 Plans
With the series of standardized ("modernized") Medicare supplement plans introduced in 2010, the producer is caught in a "pre" versus "post" situation. For many years to come, a producer will have to discern what benefits were sold before June 1, 2010, with respect to Plans A through L. This will require some thinking if a policy replacement is being considered. All producers, new and old, will need to familiarize and "re-familiarize" themselves with the "old" plans in order to be able to conduct a sensible and accurate discussion with individuals who already own an existing Medicare supplement plan and are thinking about purchasing a new plan. For instance, some pre-existing conditions may totally rule out issuance of a new policy or may result in a six-month waiting period before they are covered.

With premiums sure to raise on the pre-June 2010 plan series, agents will be called on by potential clients to replace older policies with newer, less expensive policies. These newer policies will include the post-June 2010 benefit changes. Thus, to determine what may be appropriate or suitable for clients and prospects, agents will have to evaluate the pre-2010 policies when comparing the provisions, features, and benefits of these older policies with the provisions, features, and benefits of the newer policies. In addition, agents will have to remind their prospects that the prospect may have to answer medical questions to determine if he or she qualifies for a new plan.

This chapter presents an explanation of both series of Medicare supplement policies: those that are available now and those that were available before June 2010.

2020 Medicare Supplement Plans

Currently, there are 11 standardized Medigap plans, each comprising a defined combination of benefits. Plan A represents the most basic plan available, providing certain "core" benefits. All Medigap policies must include these basic benefits. The 11 standardized Medigap plans now available are:

-Plan A
-Plan B

-Plan C (available only to those who turned 65 before January 1, 2020)
-Plan D
-Plan F (standard) (available only to those who turned 65 before January 1, 2020)
-Plan F (high deductible) (available only to those who turned 65 before January 1, 2020)
-Plan G
-Plan K
-Plan L
-Plan M
-Plan N

As noted, Plans H, I, and J were eliminated from the line-up of Medigap policies in 2010 (Plan E had been eliminated earlier); however, those who had these plans when the new series was introduced were allowed to retain them. For this reason, they are included in the following explanation.

We will explain in detail the features of all Medicare supplement plans, past and previous, in the following section. We will also note which policies are no longer allowed to be sold after June 2010 (although they are allowed to remain in force since that time, those that covered any prescription drugs are now forbidden to so). This will allow a producer to understand what the older plans covered if he or she is asked to compare a new "modernized" plan.

Plan A—The Basic Policy
Plan A includes the following coverages:

-Coverage for the Part A coinsurance amount for days 60 through 90 of hospitalization in each Medicare benefit period
-Coverage for the Part A coinsurance amount for each of Medicare's 60 nonrenewable lifetime hospital reserve days
-After all Medicare hospital benefits are exhausted, coverage for 100 percent of the eligible Medicare Part A hospital expenses—coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid at the Medicare-approved rate
-Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood
-Full coverage for the coinsurance amount for Part B services (which is generally 20 percent of the approved amount, or 20 percent of approved charges for outpatient mental health services) after the annual deductible is met
-Coverage for hospice care. This benefit was added as a core benefit for post-June 2010 supplements and is subject to Medicare requirements, including a doctor's certification of terminal illness. Medicare covers all but a very limited co-payment/coinsurance amount; Medigap plans must pay these co-payment/coinsurance amounts as part of the basic benefits of the policy.

Plan B
Medigap Plan B includes all of the Plan A basic benefits, plus coverage for the Medicare Part A inpatient hospital deductible.

Plan C
Medigap Plan C includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for the Medicare Part B deductible
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the USA, after a $250 deductible, to

a lifetime maximum benefit of $50,000

Note: Plan C is not available for issue to newly Medicare eligibles—those who turn 65 after January 1, 2020—but will still be available to those who turned 65 before this date.

Plan D
Medigap Plan D includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the U.S. after a $250 deductible, to a lifetime maximum benefit of $50,000

Medigap Plan D plans issued before June 2010 include coverage for at-home recovery care for short-term personal care assistance to help with recovery from an injury or sickness for which Medicare approved a home care treatment plan. Due to underutilization, this benefit was eliminated from Plan D plans sold after June 2010. Note: Plan D remains as it did prior to January 1, 2020.

Plan E
Medigap Plan E was eliminated from the Medicare supplement series prior to 2010. No new plans could be sold as of the date of elimination, but existing policies may remain in force.

Plan E includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the United States, after a $250 deductible, to a lifetime maximum benefit of $50,000
-Coverage for preventive medical care not covered by Medicare (The preventive medical care benefit pays up to $120 per year for such items as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test, administered or ordered by a doctor when not covered by Medicare.)

Plan F
Medigap Plan F includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for the Medicare Part B deductible
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000
-Coverage for 100 percent of Medicare Part B excess charges—Plan F pays a specified percentage of the difference between Medicare's approved amount for Part B services and t he actual charges up to the amount of charge limitations set by either Medicare or state law.

Plan F is also available with a high-deductible option. The high-deductible Plan F pays the same amounts and offers the same benefits as the standard Plan F, after the insured has paid a calendar year deductible ($2,340 as of 2020). Benefits from a high-deductible Plan F will not begin until out-of-pocket expenses have reached this deductible amount.

Note: Plan F will not be available to newly Medicare eligibles—those who turn 65 after January 1, 2020, but will still be available to those who turned 65 before this date.

Plan G
Medigap Plan G includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for 100 percent of Medicare Part B excess charges—Plan G pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges up to the amount of charge limitations set by either Medicare or state law.
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000

Plan G plans issued before June 2010 include coverage for at-home recovery care for short-term personal care assistance to help with recovery from an injury or sickness for which Medicare approved a home care treatment plan. Due to underutilization, this benefit was eliminated from Plan G plans sold after June 2010. Note that Plan G does not cover the Part B deductible—that is the only difference between Plan G and Plan F. Also, Plan G provisions remain the same as before January 1, 2020.

Plan H
Medigap Plan H was eliminated from the Medicare supplement series in 2010. As of June 1, 2010, no new Plan H policies can be sold, but existing policies may remain in force.

Plan H includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000

Plan I
Medigap Plan I was eliminated from the Medicare supplement series in 2010. As of June 1, 2010, no new Plan I policies can be sold, but existing policies may remain in force.

Plan I includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for 100 percent of Medicare Part B excess charges—Plan I pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges up to the amount of charge limitations set by either Medicare or state law.
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000

Coverage for at-home recovery—The at-home recovery benefit pays up to $1,600 per year for short-term personal care assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an injury or sickness, for which Medicare approved a home care treatment plan. There are various benefit requirements and limitations.

Plan J
Medigap Plan J was eliminated from the Medicare supplement series in 2010. As of June 1, 2010, no new Plan J policies can be sold, but existing policies may remain in force.

Plan J includes all of the Plan A basic benefits, plus:

-Coverage for the Medicare Part A inpatient hospital deductible
-Coverage for the skilled nursing facility care coinsurance amount
-Coverage for the Medicare Part B deductible
-Coverage for 100 percent of Medicare Part B excess charges—Plan J pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges up to the amount of charge limitations set by either Medicare or state law.
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside of the USA, after a $250 deductible, to a lifetime maximum benefit of $50,000
-Coverage for at-home recovery—Provides for (limited) at-home recovery care for short-term personal care assistance to help with recovery from an injury or sickness for which
-Medicare approved a home care treatment plan.
-Coverage for preventive medical care not covered by Medicare—The preventive medical care benefit pays up to $120 per year for such items as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test, administered or ordered by a doctor when not covered by Medicare. (This benefit has been undermined given Medicare's expanded coverage of preventive care treatment.)

Plan J was also available with a high-deductible option. The high-deductible Plan J pays the same amounts and offers the same benefits as the standard Plan J, after the insured has paid a calendar year deductible. Benefits from a high-deductible Plan J will not begin until out-of-pocket expenses have reached this deductible.

Plan K
Basic benefits for Plan K include similar services as Plans A through G, but cost sharing for the basic benefits is at different levels:

-100 percent of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end
-50 percent hospice cost sharing
-50 percent of Medicare-eligible expenses for the first three pints of blood
-50 percent Part B coinsurance, except for the 100 percent coinsurance for the Part B preventive services
-50 percent skilled nursing facility coinsurance
-50 percent Part A deductible
-A $5,880 out-of-pocket annual limit (as of 2020). Once the insured's out-of-pocket expenses reach the limit, any remaining benefits paid during the year are paid at 100 percent. (Note that this is considered a "partly self-insured" plan.)

Plan L
Basic benefits for Plan L include similar services as Plans A through G, but as with Plan K, cost sharing for the basic benefits is at different levels:

-100 percent of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end
-75 percent hospice cost sharing
-75 percent of Medicare-eligible expenses for the first three pints of blood
-75 percent Part B coinsurance, except for the 100 percent coinsurance for the Part B

preventive services
-75 percent skilled nursing facility coinsurance
-75 percent Part A deductible
a $2,040 out-of-pocket annual limit (as of 2020). Once the insured's out-of-pocket expenses reach the limit, any remaining benefits paid during the year are paid at 100 percent. (Note that this is considered a "partly self-insured" plan.)

Plan M
Plan M was introduced with the post-June 2010 Medigap series to provide a lower premium policy option through higher cost sharing on the part of the insured. Plan M includes all the Plan A basic benefits, plus:

-50 percent coverage of the Part A deductible
-Full coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the U.S., after a $250 deductible, to a lifetime maximum benefit of $50,000 (This, too, is considered a "partly self-insured" plan.)

Plan N
Plan N was also introduced with the post-June 2010 Medigap series as another cost sharing, lower premium policy. Plan N includes the basic benefits of Plan A, but with the following change:

100 percent coverage of the Part B coinsurance, except $20 co-payments for office visits and up to a $50 co-payment for emergency room care (which is waived if the patient is admitted to the hospital)

In addition, Plan N provides for:

-Full coverage of the Part A deductible
-Full coverage for the skilled nursing facility care coinsurance amount
-80 percent coverage for medically necessary emergency care in a foreign country, beginning during the first 60 days of each trip outside the U.S., after a $250 deductible, to a lifetime maximum benefit of $50,000 (Plan N is also considered a "partly self-insured" plan.)

The federal Medicare and CHIP Reauthorization Act (MACRA), signed into law in April 2015, has had a significant effect on Medicare supplement policies. MACRA prohibits the sale of supplement policies that cover Part B deductibles to new Medicare enrollees who:

-Reach age 65 on or after January 1, 2020, or
-First become eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020

Consequently, after January 1, 2020, Medicare supplement Plans C and F will not be available to these "newly eligible" Medicare enrollees; however, those who were already on Medicare as of January 1, 2020, can still elect to enroll (or re-enroll) in these plans (though they will have different alphabetical designations). Industry experts predict that the Medicare supplement market will be "split" into two groups: those who enrolled in Medicare prior to January 1, 2020, and those who enroll in Medicare on or after January 1, 2020.

About Replacement
With the options that the 2010 plans provide consumers (and with premiums likely increasing for many of the pre-2010 policies), many policyowners will want to know whether they should replace their existing Medicare supplement policies with one of the newer options. While replacement is

legal and often beneficial, the producer will have to be aware of the requirements that must be followed for Medigap replacements. One of these requirements is a "replacement" form, which serves to explain the reason for the replacement.

Medicare Select

Medicare Select is another type of Medicare supplemental health insurance sold by insurance companies throughout most of the country. Medicare Select is the same as standard Medicare supplement insurance but was only available with Plans A through J. The only difference between Medicare Select and standard Medicare supplement insurance is that each insurer has specific hospitals, and in some cases, specific doctors, that the insured must use, except in an emergency, to be eligible for full benefits. Medicare Select policies generally have lower premiums (10 to 15 percent) than other Medicare supplement policies because of this provider hospitalization requirement.

Medicare Select is a type of standardized Medicare supplement plan. If a person buys a Medicare Select plan, he or she is buying one of the basic standardized plans. What makes Medicare Select different from regular Medicare supplement insurance is that the insurance company and the hospital have an agreement that says that the hospital will "forgive," or waive, the Part A deductible for the patient enrolled in the Medicare Select plan. The idea is that the hospital will attract more customers through the efforts of the agents of the Medicare supplement company. This theory would be effective in a county or area of competing hospitals.

When a person goes to the Medicare Select preferred providers, Medicare pays its share of the approved charges, and the insurance company is responsible for all supplemental benefits in the Medicare Select plan. In general, Medicare Select plans are not required to pay for any benefits if the insured does not use a preferred provider for non-emergency services. Medicare, however, will still pay its share of approved charges with any Medicare certified provider the insured chooses.

Few companies offer Medicare Select Plans these days, though some do. Producers should check with the companies they represent to determine of the companies still sell Medicare Select plans.

Medicare Supplement Enrollment

The best time to buy a policy is during a person's Medicare supplement initial open enrollment period. The initial open enrollment period is the six-month period from the date a person is first enrolled in Medicare Part B and is age 65 or older. During this period, a person has a right to buy a Medicare supplement policy of his or her choice without denial by the insurance company based on pre-existing conditions.

Medicare Supplement Issue Guaranteed During Open Enrollment

The person cannot be turned down or charged higher premiums because of poor health if he or she buys a policy during this period. Once the person's Medicare supplement open enrollment period ends, he or she may not be able to buy the policy of choice because of pre-existing conditions or may encounter a six-month pre-existing condition exclusion if a policy is issued. As a result, the person may have to accept whatever Medicare supplement policy an insurance company is willing to sell him or her. Applicants may even be denied coverage because of their health if application for coverage is made after their open enrollment period has ended.

Unlike Medicare Advantage or Medicare Part D plans which have open enrollment periods every year, the only open enrollment period for a Medicare supplement plan is the six-month period following the date a person turns 65 and first enrolls in Medicare Part B. This is not to say that a person has to buy a supplement policy during this period or that he or she cannot switch to another policy in the future. However, after an individual's open enrollment period passes, any purchase of a new or replacement supplement plan will be subject to medical underwriting and policy issue is not guaranteed.

When inquiring about a Medicare supplement plan, a person should find out whether it limits or excludes coverage for pre-existing conditions after the open enrollment period. If a person has a health problem, and the company limits or excludes coverage for pre-existing health conditions (for up to six months), the insurance company may not cover the costs for any care related to that health problem. During this period, the insured would still receive benefits from Medicare Parts A and B; it's the deductibles and coverage gaps that might not be covered during the six-month period.

Medicare Supplement Replacements
Medicare supplement plans are designed so that people do not need other similar coverage. In fact, it is illegal for an insurance company to knowingly sell anyone a second Medicare supplement plan, even if the coverage is to "overlap" for as little as one day. For that reason, the Medicare supplement replacement form was developed to be used if a person chooses to replace an existing Medicare supplement plan with another. Replacement is not illegal if the benefits of the new policy will be greater, or if the new premium will be equal or less, or the new policy will contain fewer benefits and lesser premium; however, applicants must sign a notice that indicates they are aware of the differences of the transaction. It is also illegal to sell someone a Medicare supplement plan if he or she is in a Medicare Advantage plan (unless that person disenrolls from the MA plan and returns to Original Medicare).

Producers should ensure that their prospects and clients have good reasons for switching from one Medicare supplement plan to another—they should only switch for different or better benefits, better service, or a more affordable price. On the other hand, no one should keep an inadequate plan or even an adequate plan without reviewing it simply because he or she has had it for a long time.

Policy Delivery
The insurance company should, and more than likely will, deliver a plan within 30 days. If it does not, individuals can call and ask the company to put the reason for the delay in writing. If 20 days go by without an answer, individuals should call their state insurance department. It is unlawful for an insurance company or agent to use high-pressure tactics to force or frighten a client into buying a Medicare supplement plan, or to make false or misleading comparisons to get a person to switch from one company or plan to another. The same holds true for a Medicare Advantage producer.

Medicare supplement plans are neither sold nor serviced by the state or federal government. State insurance departments approve the standardized Medicare supplement plans sold by private insurance companies, but approval only means that the company and the Medicare supplement plan meet the requirements of state law.

Age Rating
Medicare supplement companies use different methods of calculating and presenting premium rates. With attained age rating, an insured's premium will increase as he or she gets older. If individuals buy the plan at age 65, they will pay what the company charges 65-year-old customers. Then at age 66, they will pay whatever the company is charging 66-year-old customers.

With issue age rating, if individuals first buy the plan at age 65, they will always pay the premium that the company charges 65-year-old customers, no matter what their age. If they first buy the plan at age 70, they will always pay the premium that the company charges 70-year-old customers.

Producers should be careful not to lead prospects and policyholders to believe that the age-65 premium or any other "issue age" premium will never increase. They may increase, and often do, depending on the company's future price increase structures.

For many years, some companies used community rating, wherein all policyholders were charged the same rate. As Medicare costs began to soar, the companies that used community rating realized that older policyholders created a greater expense than younger policyholders, which made the rating system unfair to younger policyholders. As a result, these companies dropped this rating method.

The issue of whether to buy an attained age plan or an issue age plan becomes somewhat irrelevant when we see a disparity of as much as $1,000 annually between companies on their "street rate" (the rate charged at the original purchase date). One company may argue that its issue age policy is superior to attained age-rated policies, but the whole issue becomes insignificant when most companies raise rates for all people in all classifications each year anyway.

The attained age-rated company may raise rates on an "across-the-board" basis, and the issue age-rated company will raise rates for each band simultaneously. Most rate increases are related to the rise in the cost of deductibles and coinsurance due to high inflation in health care nationwide, as has been the case for over two decades.

Other factors that may affect a person's premium are:

-Discounts for nonsmokers
-Discounts for couples
-All Medicare supplement premiums generally go up each year because of inflation.

When to Buy
For the reasons discussed, most individuals should purchase a Medicare supplement plan during their initial open enrollment period, which ensures that they will be enrolled in the plan of their choice. There are certain situations, however, when individuals may have the right to purchase a Medicare supplement plan after their open enrollment period. In these cases, the insurance company cannot deny someone coverage or change the price of a plan because of past or present health problems. Some examples include:

-Insureds lose their health coverage through no fault of their own under a Medicare Advantage plan, Medicare supplement plan, Medicare Select plan, or employer coverage. (The company goes broke or their Medicare Advantage plan is terminated.) After losing Medicare Advantage through an involuntary reason, there is a 63-day "open window" during which insureds must apply to the Medicare supplement company and provide the insurer with a letter of plan termination or involuntary termination. This letter must accompany a Medicare supplement application. If a person applies for a Medicare supplement policy within that 63-day window and provides confirmation of the involuntary disenrollment, the Medicare supplement company cannot:

-Refuse to sell the person any Medicare supplement policy designated A, B, C, or F that the insurer sells in the state (although after January 1, 2020, Plans C and F cannot be sold to newly eligible Medicare enrollees)
-Discriminate in the pricing of such a policy because of health status, claims experience, receipt of health care, or medical condition
-Impose a pre-existing condition exclusion

-Insureds join a Medicare Advantage plan for the first time and within one year of joining, they decide they want to leave Medicare Advantage.

-Many people are eligible for Medicare based on age but choose to continue to work and to receive coverage through their employer group health plans. When terminating employment or the group's health coverage, people have the right, within eight months, to apply for a Medicare supplement policy and not be subject to pre-existing condition clauses if the group health plan is

considered "creditable coverage," which Medicare supplement companies must honor, and for which they cannot apply a pre-existing clause to the applicant's policy. COBRA benefits, on the other hand, are not considered "creditable coverage," so even though COBRA benefits can last for a period of 18 months, the application would have to be made within the eight-month creditable coverage timeline.

"Doc Fix" Bill

Of importance to all Medicare supplement producers is the recent repeal of the Medicare Sustainable Growth Rate (SGR) method of controlling fees paid to physicians. The SGR had provided annual targets for physician services under Medicare and was intended to control the growth of Medicare expenditures for physician services. For nearly two decades, physicians operated under SGR, whose formula typically produced annual reductions in the amount of payment doctors would receive from Medicare, and each year, Congress had to change the formula to one that would generate slight increases in payments, rather than lowered payments as called for in SGR. Congress and physicians obviously grew weary of the uncertainty of payments. Thus, in 2015, through the Medicare Access and CHIP Reauthorization Act (MACRA), SGR was repealed and replaced with formulas for doctors to receive fees in accordance with better managed care programs rather than a simple fee-for-service formula. So, that part of the problem was solved. (MACRA became known as the "Doc Fix" act.)

Effect on Medicare Supplements Plans

As noted earlier, MACRA includes a provision that bars those who enroll in Medicare after January 1, 2020, from enrolling in Medicare Supplement Plans C and F. The reason given was that Plans C and F, which provide for first-dollar coverage of the Part B deductible, were being overutilized by policyholders of those plans, and eliminating these plans would save Medicare money. This matter was disputed by many associations and companies, but nevertheless, the "Doc Fix" bill calls for an end to newly eligible enrollments in Plans C and F.

Medicare Supplement Replacement—Ethics and Legality

With the options that the 2010 Medicare supplement "modernized" plans provide consumers (and with premiums likely to increase for many of the pre-2010 policies), many policyowners will want to know whether they should replace their existing Medicare supplement policies with one of the newer options. While replacement is legal and many times beneficial, the producer must be aware of the requirements that must be followed for Medigap replacements.

Features of Current vs. Replacing Plan

Even though they are now quite dated, some Medicare supplement policies sold before July 1, 1993, were better than the current standardized policy series. Some policies contained provisions that paid the client an automatic 80 (or more) days of nursing home care at any level of care—skilled, intermediate, or custodial. In today's environment, that amounts to about a $16,000 to $24,000 benefit, which was included automatically as a built-in feature. Replacement of that, or similar products, would result in a loss of benefits to the insured, a practice that is unethical because the policyholder may not be aware that the feature is not available in any standardized plan sold after July 1, 1993.

Rolling

Also unethical is replacing an existing policy to obtain a new first-year commission. Most states have enacted legislation that allows only level commission on policy renewal. This is meant to discourage, and even outlaw, the practice of rolling, in which agents switch people each year to obtain higher first-year commissions. The legislation has been highly successful.

Stacking

The practice of stacking—selling more than one policy to a client—is illegal under federal Medicare law, but some unethical agents still ignore or overlook the law and continue to take advantage of the client in their desperation to seek new sales. Another illegal practice is duplicating Medicare

supplement policies.

Factors to Consider
Replacing Medicare supplement policies is legal, and in some cases, can be beneficial to the client. Because all Medicare supplement policies currently sold are identical by plan (Plan A, Plan B, etc.), the benefits of any single plan cannot vary. However, the agent must compare "apples with apples." Comparing a Plan B, which is normally less expensive, with a Plan F, which offers more benefits, means that the client must be made aware of a loss of benefits if he or she chooses to replace the F plan with a B plan, even in consideration of premium.

Clients must evaluate what is in their own best interest, or at least what is in their pocketbook, when considering loss of benefits. In all instances, a replacement form ("Notice To Applicant Regarding Replacement of Medicare Supplement Insurance"), which discloses the reason for the replacement (lower premiums, change of plan, etc.), must be signed by the applicant and the agent at the time of the replacement and forwarded to the replacing company for it to determine if the replacement procedure is, in fact, suitable to the client. Depending on the premiums involved and coverages replaced, replacement is legal and, if done correctly, ethical. Duplicating coverage, even for one day, is illegal. In addition, not indicating that the new application is a replacement is illegal.

Variations in annual premiums between two companies may be as high as $500 for a Plan C product and as high as $1,000 for a Plan F product, depending on the age of the client. Replacing a Plan C product with another Plan C product that costs $500 less or replacing a Plan F product with another Plan F product that costs $1,000 less are examples of ethical replacements of existing policies—"apples-to-apples" replacements. The client receives the same coverage and the same benefits for much less money.

Above all, no potential client should be made to feel pressured into switching Medicare supplement policies, or switching from Medicare supplement to Medicare Advantage, or vice versa. Some agents are still being found guilty of "high pressure" tactics and unethical marketing practices.

In addition, policyholders should not cancel their existing policies until a new policy is generated and in the hands of the policyholder to see that the new policy has the correct plan, correct effective dates, and correct payment methods.