Selling Medigap

New Agent Guide to Medicare Supplement Insurance

White Paper Contents

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OVERVIEW

The following guide will primarily be of use to insurance agents who are new to selling Medicare Supplement policies. However, more experienced agents may also find information in these pages that will aid them in guiding Medicare beneficiaries toward making the best choices regarding their health care coverage.

Original Medicare (also known as Traditional Medicare or Fee-for-Service Medicare) pays for a large portion, but not all, of the health care expenses of most Americans over the age of 65. Many people with Original Medicare, therefore acquire Medicare Supplemental insurance. These plans are sometimes called Medigap policies because they fill the "gaps" in coverage. (Medicare Supplement and Medigap are used interchangeably in this document) Medicare Supplemental policies shouldn't be confused with Medicare Advantage plans which are offered as an alternative to Original Medicare.

Medicare Supplements are offered by private insurance companies and frequently sold by insurance agents like you. These plans typically cover outstanding deductibles, coinsurance charges, and copayments that would otherwise be the responsibility of a person with Original Medicare. Additionally, Medicare Supplements may pay for health care expenses that Medicare doesn't cover at all, such as medical care received while out of the country. Keep in mind that your customers should not have a Medicare Supplement plan at the same time they have a Medicare Advantage plan.

There are as many as 10 Medigap policies. With the exceptions of Massachusetts, Minnesota and Wisconsin, which have different plans, these policies are simply identified by the letters A, B, C, D, F, G, K, L, M and N. Benefits are standardized by plan name, regardless of the state in which it's sold or which company sells it. Therefore, a G policy sold in Florida by ABC Insurance will provide the same coverage and benefits as a G policy sold in Texas by XYZ Insurance. However, the premiums for the same-name policies are frequently different, depending on the company that offers them.

MEDIGAP PLANS IN MASSACHUSETTS, MINNESOTA AND WISCONSIN

Medigap policies in Massachusetts, Minnesota and Wisconsin are standardized differently from how they are in other states and therefore are different from those described in this document. If your customer lives in Massachusetts, Minnesota, or Wisconsin, check with your agency office, CMS or your state Department of Insurance (DOI) website to learn policy details in these states.

COSTS COVERED BY MEDIGAP PLANS

It may be helpful to review what Medicare Parts A and B cost for Original Medicare with no Medical Supplement insurance. The following information is provided by the federal government's www.medicare.gov website:

Part A premium – Most people don't pay a monthly premium for Part A (sometimes

called "premium-free Part A"). With Part A, Medicare beneficiaries pay up to $471 each month in 2022. However, if a Medicare beneficiary paid Medicare taxes for less than 30 quarters, the standard Part A premium is $499. If they paid Medicare taxes for 30-39 quarters, the standard Part A premium is $274.

Original Medicare Costs at a Glance (2022)	
Part A premium	Most people don't pay a monthly premium for Part A (sometimes called "premium-free Part A"). If you buy Part A, you'll pay up to $499 each month in 2022. If you paid Medicare taxes for less than 30 quarters, the standard Part A premium is $499 in 2022. If you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $274 in 2022.
Part A hospital and skilled nursing facility inpatient deductible and coinsurance	You pay: • *$1,556 deductible for each benefit period* • *Days 1 – 60: $0 coinsurance for each benefit period* • *Days 61 – 90: $389 coinsurance per day of each benefit period* • *Days 91 and beyond: $778 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)* • *Beyond lifetime reserve days: all costs*
Part B premium	The standard Part B premium amount is $170.10 (or higher depending on your income).
Part B deductible and coinsurance	You pay $233. After your deductible is met, you typically pay 20% of the Medicare-Approved Amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and durable medical equipment (DME).

Though the various Medigap policies provide different levels of coverage, some costs are covered by all the plans:

Medicare Supplemental insurance – All Medigap policies offer additional inpatient hospital care beyond that covered by Original Medicare. For example, some Medicap plans cover emergency medical care outside the U.S. In some states, Medigap coverage may also provide fitness benefits or other types of supplemental coverage.

Part A hospital coinsurance – A Medigap policy will pay the coinsurance charge for days 61 – 90 of hospital inpatient care during a benefit period, plus the daily coinsurance cost for up to 60 hospital inpatient lifetime reserve days. An additional 365 inpatient hospital days during the policy holder's lifetime will also be covered by their Medigap policy.

Note: *A "benefit period" is how Original Medicare counts a patient's time in a hospital or a skilled nursing facility (SNF). The benefit period begins the day they are admitted to the hospital and concludes after they have been out of the SNF for 60 or more consecutive days.*

Part B coinsurance – The 20% coinsurance for Medicare-covered outpatient medical services, such as x-rays, durable medical equipment, and doctors' visits will be paid by the Medigap policy. Some Medigap plans (Plans K, L, and N) cover a portion, but not all, of the Part B coinsurance, but they do pay the full cost of Part B coinsurance for some preventive services that Medicare does not cover at

... some Medigap plans do cover emergency health care in a foreign country.

100%. For instance, a glaucoma screening is a preventive service that Medicare covers at 80% of its approved rate. A Medigap Plan N, however, will take care of the 20% coinsurance cost when the policy holder receive this service from a provider who accepts Medicare patients.

First three pints of blood – If a Medicare beneficiary is hospitalized and needs a blood transfusion, their Medigap will pay for the first three pints. This expense is fully covered by most plans and is partially covered by the others. Without a Medicare Supplement policy, the Medicare beneficiary would have to pay the entire cost.

Part A hospice care coinsurance or copay – As long as the Medigap was purchased on or after June 1, 2010, the full cost of hospice coinsurance charges and copays (including hospice-related drugs and respite care) will be fully covered. ("Respite care" is care received as a hospital inpatient while the regular caregiver takes a break.)

Other medical care and services are provided by varying degrees (or not at all) under different Medicare Supplement plans. These include:

- ***Part A skilled nursing facility (SNF) coinsurance –*** The coinsurance charge for the covered days in an SNF during a benefit period will be paid by some Medicare Supplements.
- ***Part A deductible –*** The Part A inpatient hospital deductible — the amount owed at the start of a benefit period — may be covered by some Medicare Supplements.
- ***Part B deductible –*** Out-of-pocket expensed before Part B begins to cover the cost of outpatient care — the deductible — is covered by some Medicare Supplements.
- ***Part B excess charges –*** Non-participating medical service providers (those who do not take Medicare assignments) can charge up to 15% more than the Medicare-approved cost for services. (Participating providers cannot bill for excess charges.) Some Medigap plans will cover excess charges and will reimburse policy holders who see a non-participating provider for these amounts.
- ***Foreign travel –*** Only in rare circumstances does Medicare cover medical services received outside of the U.S., but some Medigap plans do cover emergency health care in a foreign country. Coverage will be 80% of the emergency care costs abroad during the first two months of your trip. There is a lifetime limit of $50,000 once the deductible has been met.

Comparing Medigap Plans

The following chart, as provided by the federal government's medicare.gov website, shows the basic information about the different benefits that various Medicare Medigap plans cover as of January 2022. If a percentage appears, the plan covers that portion of the benefit and customers will be responsible for the rest. Visit https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies for more information

Medigap Benefits	Plan									
	A	B	C	D	F*	G*	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first three pints)		Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Medicare Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Medicare Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Medicare Part B excess charges	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel emergency (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit in 2022**							$6,620	$3,310		

Note: Policies may not cover all the costs that a buyer must pay for medical care during the coverage period.

* *Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of$2,490 in 2022 before your policy pays anything. (Plans C and F aren't available to people who were newly eligible for Medicare on or after January 1, 2020.)*

** *For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.*

*** *Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.*

Different states may allow age to be considered differently.

MEDIGAP POLICY COSTS

All Medicare Supplemental policies have a monthly premium, and though plans with the same letter name provide the same benefits and coverage, these premiums differ by insurance company.

This means ABC Insurance could sell Policy G for $125, while XYZ Insurance sells Policy G for $150. This being the case, you will want to present a wide range of insurance companies to help your client identify the best value for their money.

Though the Medigap premiums vary from company to company, several factors are fairly uniform across the industry in determining what the monthly cost of a policy will be.

Customers are generally better served by purchasing a Medicare Supplement during an open enrollment period or when they have a guaranteed-issue right because at those times their premiums cannot vary based on their health status.

Keep in mind the ways in which Medigap companies rate age when establishing premiums. Different states may allow age to be considered differently. Depending on the state, the approach may be:

- ***Attained-age-rated*** **–** Initially based on the client's age when the policy is first purchased, the premiums increase as the customer gets older. Though these premiums may appear to be a good value when first bought, they could easily become the most expensive to own over your client's lifetime.
- ***Issue-age-rated*** **–** The amount of the premium depends on your client's age when the policy was first purchased, which creates an incentive to buy Medigap at a younger age. Growing older will not cause premiums to increase, but they may still rise due to inflation.
- ***Community-rated (also known as no-age-rated)*** **–** Generally, the least expensive long term, premiums are the same for everyone residing in a particular area, without regard to age.

CONSIDERATIONS FOR SUGGESTING A MEDICARE SUPPLEMENTAL POLICY

Before presenting Medicare Supplements, check into the best time for your customer to buy one in your state. Typically, states require insurance companies to sell these policies at specific periods during the year provided certain requirements are met. Client costs may go up and their options may be limited if your customer misses the window of opportunity to buy a Medigap. Additionally, missing this period may prevent a Medicare beneficiary from buying Medicare Supplemental insurance at all.

The right to purchase a Medigap policy is guaranteed by federal law, provided your client:

- Is age 65 and also enrolled in Medicare
- Purchased the policy within a protected enrollment period

If a Medigap policy is acquired during a protected enrollment period, the insurance company is not allowed to:

- Deny coverage
- Charge more for a policy because of current or past health problems

Protected Periods for Purchasing Medigap Insurance

In most circumstances, your customers should enroll in a Medicare Supplement plan during the federal Medigap open enrollment period. The U.S. government has established a six-month window that starts the month your client is 65 or older and enrolled in Medicare Part B. At this time, Medigap companies must sell a policy at the best available rate without regard to your client's health status, and they do not have the option of denying coverage.

What you should realize, however, is that the "best available rate" still allows companies to consider a variety of factors (age, gender, tobacco use, etc.). During the open enrollment period, companies are also limited in their ability to deny coverage for any pre-existing conditions.

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Guaranteed-Issue Rights

Beyond the Medicare Supplement enrollment period, Medicare beneficiaries may also purchase a Medigap policy by virtue of a guaranteed-issue right. Provided that they are at least 65, they automatically have the right to guaranteed issue within 63 days of losing or ending certain kinds of medical coverage. Medicare beneficiaries may also have a guaranteed-issue right provided:

- They lost a group health plan coverage for Medicare cost-sharing (meaning it paid secondary to Medicare) through no fault of their own.
- They purchased a Medicare Advantage Plan upon first becoming eligible for Medicare but disenrolled within 12 months.
- They had a Medigap policy, Medicare Advantage Plan, or were in a Program of All-Inclusive Care for the Elderly (PACE) program that ended coverage or committed fraud
- They moved out of the service area for their Medicare Advantage Plan, Medicare SELECT policy or PACE program.
- Proof that lost coverage fits within the parameters for a guaranteed issue right may be established by producing letters, notices, postmarked envelopes or claim denials.

As is the case with protected periods, Medigap insurers must offer a policy at the best available rate for people with the same characteristics (age, sex, tobacco use, etc.). They cannot deny coverage because of health status. Additionally, companies cannot impose a waiting period before covering any pre-existing conditions.

Purchasing Medigap Outside of Protected Enrollment Periods

States may offer additional protections when purchasing a Medigap policy. For example, it may let people enroll in Medigap plans at times other than the federally protected periods. In New York and Connecticut, for instance, residents may enroll throughout the year. Insurers in these states must also offer Medicare Supplement policies to residents under age 65.

Customers may still be able to purchase a policy if a company agrees to sell one, even if they do not have guaranteed-issue rights to buy a Medicare Supplement where they live. Insurance companies, however, will be free to charge a higher price due to health or some other considerations.

During a protected period, Medicare Supplement policies are required to reduce the pre-existing condition waiting period by the number of months the client previously had creditable coverage.

Companies may also require a six-month waiting period before the Medicare Supplement will cover any pre-existing conditions. If your customer needs to purchase a Medigap outside of the six-month protected enrollment period or under a guaranteed-issue right, help them identify the insurers in your state to find out which might sell a policy.

CANCELLING A MEDICARE SUPPLEMENT POLICY

During the first 30 days with a new Medicare Supplement, policy holders have the right to cancel it for a full refund. After that first 30 days, they can still cancel their policy at any time, but may not be able to purchase another policy. Additionally, companies may charge more because of health conditions.

Medicare beneficiaries may also take advantage of a 30-day period to determine if they would like to switch one Medigap for another. Customers will have to pay for both policy premiums during this 30-day timeframe while they decide if they prefer the second Medigap. This 30-day period starts the day the customer is enrolled in a new Medigap policy. It's better to not cancel a first Medigap policy during this period, because the customer may be unable to get it back.

PRE-EXISTING CONDITIONS

If your client cancels one Medigap policy and buys another, federal law allows insurers to refuse to cover pre-existing medical conditions during the first six months they have their new policy. (A pre-existing condition is an infirmity someone was diagnosed with or one in which someone is being treated prior to the new health care coverage beginning). Your clients can avoid such waiting periods by purchasing their policies when they have a guaranteed issue right.

To shorten a pre-existing condition waiting period, your customer can purchase a policy during the open enrollment period. During a protected period, Medicare Supplement policies are required to reduce the pre-existing condition waiting period by the number of months the client previously had creditable coverage. (Most health coverage will be considered creditable.) Suppose, for instance, that your customer had creditable coverage for two months before purchasing a Medigap. The insurer could only require a four-month waiting period rather than six. If your client had creditable coverage for six or more months, the insurer could impose no waiting period at all.

Understand, however, that a break in coverage for more than 63 days nullifies the ability to use creditable coverage to reduce a pre-existing waiting period. If your client is worried about a waiting period, help them explore options by looking into different Medigap policies. You may be able to suggest policies that do not impose any waiting periods for prior conditions.

HELPING CLIENTS CHOOSE A MEDICARE SUPPLEMENT POLICY

Budget, expenses and overall health need to be taken into consideration when deciding which plan and company is right for them. As you research their options, you'll want to get answers to these very important questions:

1. Is your client enrolled in Medicare Part A and B? Having both is a requirement for purchasing a Medicare Supplement policy.

2. When is your client enrolling?

   a. *Turning 65 (Open Enrollment)*
   b. *During a guaranteed-issue period*
   c. *Already has a Medicare Supplement policy and wants to make a change (requires underwriting)*
   d. *65 1/2 + and is enrolling in Medicare Part B for the first time (Open Enrollment)*
   e. *Under 65 and on Medicare disability or have End-Stage Renal Disease (ESRD)*
   f. *Applying during a trial right:*
      i. *Your client joined a Medicare Advantage Plan when they were first eligible for Medicare Part A, and within the first year, decided to switch to Original Medicare.*
      ii. *Your client dropped a Medicare Supplement to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy), they've been in that plan for less than 12 months and want to switch back.*

3. What factors determine how much a Medicare Supplement will cost?

   a. *Resident state*
   b. *Plan selection*
   c. *Age*
   d. *Gender*
   e. *Discounts available based on marital status and/or living arrangements (some companies offer discounts for one or both scenarios)*
      i. *Married and both own a policy from the same carrier*
      ii. *Currently living with someone 18+ (age range and length of time together vary by carrier)*
   f. *If applying outside of an Open Enrollment or guaranteed-issue period:*
      i. *Tobacco use – (standard rating, higher premiums)*
      ii. *Health – it's possible, based on overall health, that your clients' options for coverage could be limited by the carrier that is willing at accept that level of risk.*
   g. *Premium rating options: (see page 6 for details)*
      i. *Attained-age-rated (most common)*
      ii. *Issue-age-rated*
      iii. *Community-rated*

Help your customers carefully consider their options as you present plans that best meet their needs and budgets.

You should also become familiar with the insurance companies current processes and track record regarding the following points:

1. Application processing times for all business types.
2. Underwriting turnaround times. As noted throughout this guide, if applying outside of an Open Enrollment or guaranteed-issue period, an insurance carrier has the right to deny coverage to anyone who cannot medically qualify for the product. It's always helpful to know what level of risk the carrier is willing to accept. This can be done by reading the carrier's marketing materials such as the agent guide, paying special attention to items such as the declinable drug list and height/weight chart. It's important to know that while the plans are standardized, these underwriting guidelines vary by carrier.
3. The company's rate increase history, and length of time in the market.
4. The responsiveness of the company's customer service department.
5. Carrier's financial strength

Reference Material (for you and your clients):

1. The outline of coverage (provided by the carrier), which lists the covered services, what Medicare pays, what the particular plan will pay, and any portion remaining that would be the policyholder's responsibility.
2. www.Medicare.gov/publications
   a. *"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"*
   b. *"Medicare & You"*

MEDIGAP WITH ORIGINAL MEDICARE

As you may remember, Medicare Supplements covers most, if not all, of the costs left over after Original Medicare has paid its part. Suppose the client has Original Medicare and a Medicare Supplement, and they visit an outpatient clinic for a chest x-ray. Original Medicare will pay 80% of the Medicare-approved cost for this health care service. The remaining 20% will be paid by the Medigap policy. Without the Medicare Supplement, a Medicare beneficiary would be responsible for paying everything that Original Medicare didn't pay.

Your customers may be comfortable with other forms of secondary insurance in which the insurer decides whether or not to pay for a medical treatment or service (such as retiree coverage). As long as Medicare covers its portion of the costs, their Medigap policies cannot deny payment for at least part of the remaining coinsurance charges.

MEDIGAP SELECT WITH ORIGINAL MEDICARE

Medigap SELECT policies are a type of Medigap that is offered in some states. With a Medigap SELECT policy, the Medicare beneficiary may be required to receive medical care services from within a network to receive the full benefits of your coverage. Apart from the network restrictions, the coverage for a Medigap SELECT policy will be the same as a non-SELECT policy. The advantage of a SELECT plan, is that this coverage is often less expensive than non-SELECT Medigap insurance.

MEDIGAP PLANS WITH MEDICARE SAVINGS PROGRAMS AND MEDICAID

Medicare Savings Programs (MSPs) and Medicaid are financial assistance programs that help low-income individuals pay for their health care costs. MSPs will pay for Part B premiums and Medicaid covers some health care expenses after Medicare and any other insurance has paid. For the most part, it would be illegal for someone to sell a Medigap insurance if the customer is a Qualified Medicare Beneficiary (QMB) in the MSP program.

If your customer purchased a Medigap before being enrolled in a QMB, however, they will be allowed to keep their coverage. In some states, the Medigap premium can lower the Medicare beneficiary's monthly income by the premium amount which may help them get under the limit for Medicaid or MSP assistance. Additionally, a Medicare Supplement can pay for health care services that the customer receives from a provider who doesn't accept Medicaid.

Do note, however, that the preceding circumstances apply ONLY if your client had a Medigap plan BEFORE they enroll in Medicaid or an MSP. After they are enrolled in an MSP, they cannot buy a Medicare Supplement.