



Medigap Changes in 2010: Q&A

Where do the standards for Medicare Supplement (Medigap) insurance originate? Before 1990, Medigap insurance policies were not standardized in many states. This made it hard for people to compare how one plan or another filled the various “gaps” in Medicare coverage. Through the Omnibus Budget Reconciliation Act (OBRA) of 1990, Congress directed the National Association of Insurance Commissioners (NAIC) to develop a model law and regulation that required all Medigap insurers to offer a standardized core plan (known as plan A) and that allowed companies to sell up to nine additional standard plans (Plans B - J). The Medicare Modernization Act (MMA) of 2003 added plans K and L to the array of standard plans, effective on January 1, 2006. Except for policies sold in Massachusetts, Minnesota, and Wisconsin, the NAIC model for 10 standard plans applied to all Medigap policies sold after November 5, 1991. The NAIC now refers to these plans as “1990 plans” to distinguish them from the “2010 plans” that will conform to revised standards that take effect on June 1, 2010.

Why is the model for the standard Medigap insurance policies being revised? The MMA encouraged the NAIC to modernize the Medigap insurance marketplace. The NAIC’s Senior Issues Task Force developed a revised Medigap model law and regulation. Then on July 15, 2008, Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA) that authorized the states to put the NAIC’s changes into effect. Congress saw that Medigap insurance had not kept up with some of Medicare’s changes.

What do these revisions change in 2010?

- They eliminate Medigap Plans E, H, I, J and high-deductible Plan J
- They eliminate the preventive care and at-home recovery benefits that have been available since 1990. The preventive care benefit in Plans E and J pays up to \$120 per year for health screening exams. This benefit

became outdated as Medicare added screening procedures for breast cancer, cervical cancer, colorectal cancer, and prostate cancer to its coverage. The at-home recovery benefit, available in Plans D, G, I, and J, was underutilized and outdated.

- They eliminate the Plan G benefit that paid 80 percent of the excess charge, increasing it to 100 percent, when providers do not accept assignment in Part B
- They create two new Medigap plans, Plans M and N (see below).
- They add a new Part A hospice cost-sharing benefit to the core benefit of all 2010 plans. It covers the 5 percent coinsurance charge for drugs and respite care.

When do the changes to the model standards for Medigap insurance take effect?

- September 24, 2009 was the deadline for states to adopt the new standards. Marketing starts after state regulators approve the insurers' forms and rates.
- June 1, 2010 is the earliest effective date for the new 2010 Medigap plans. Policies written under the earlier standards (1990 plans) cannot be sold on or after June 1, 2010. The 1990 plans, however, continue to be guaranteed renewable.

What stays the same?

- Core Benefit: A core or basic benefit, including full coverage for the Part A daily inpatient hospital coinsurance charges, all costs of hospital care after the Medicare benefit is used up, Part B coinsurance charges, the first three pints of blood, and now the Part A hospice coinsurance charges for palliative drugs and respite care, is offered through Medigap Plan A. Plans B, C, D, F, G, and M contain this core benefit and cover other gaps. Plans K, L, and N must cover at least part of these basic benefit coverage gaps.
- Part B Coinsurance Charge for Preventive Care: All plans cover 100 percent of any coinsurance charge that applies to Part B covered preventive care services.
- Part A Hospital Deductible: Six Medigap plans cover the Part A deductible (\$1,100 in 2010) in full at the start of a new benefit period. Plan L covers 75 percent. Plans K and M cover half.
- Part B Excess Charge: Full coverage of the excess charge for providers who do not accept assignment on Part B claims is offered in Plans F and G.
- Foreign Travel Emergency: This benefit, subject to its own \$250 deductible, is part of Plans C, D, F, G, M, and N.
- SNF Coinsurance Charges: Six plans cover 100 percent of the Skilled Nursing Facility (SNF) daily coinsurance charge. Plan K covers 50 percent; Plan L covers 75 percent.
- Part B Deductible: Plans C and F cover the annual Part B deductible (\$155 in 2010).

What are the new Medigap plans for 2010 and beyond?

- Plan M: The plan covers 50 percent of the Part A inpatient hospital deductible. It does not cover the Part B deductible. It also fully covers the core benefit and SNF daily coinsurance charges. It also has the foreign travel emergency benefit.
- Plan N: The plan has 100 percent coverage for the Part A inpatient deductible. It does not cover the Part B deductible. Plan N's coverage for the Part B coinsurance charge is subject to a new copayment structure with co-pays of up to \$20 for office visits and up to \$50 for emergency room visits.

What happens to beneficiaries who have Medigap policies that were in effect prior to June 1, 2010?

- They do not have to make any changes, and their coverage remains in effect as long as they pay premiums. The 1990 policies may, however, become more expensive over time as the number of policy holders declines.
 - The NAIC's model regulation allows for, but does not require, companies to offer existing policyholders an opportunity to switch to one of the new policies without medical underwriting.
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Thousands To Receive Coverage Gap Rebate in June

As required by the new health care reform law, on June 15, the Department of Health and Human Services (HHS) will begin sending \$250 rebate checks to Medicare consumers who have entered the Part D prescription drug coverage gap this year. HHS will continue to mail checks approximately every six weeks, said Department Secretary Kathleen Sebelius in a letter to congressional leaders.



An estimated four million Medicare consumers will receive a check in 2010, and about 80,000 individuals will receive their checks in June. People who qualify for the rebate will receive the check automatically and will not need to fill out any forms.

Secretary Sebelius's letter also addressed other provisions of health care reform that go into effect in 2010. These include the Early Retiree Reinsurance Program, which will reimburse participating employment-based plans for part of the costs of providing health coverage to retirees from age 55 to 64.

[Read the letter from Secretary Sebelius](#)

Facts About Medicare and Kidney Transplantation

1. Having Part A the month of the transplant protects the Part B immunosuppressant coverage any month the patient has Part B coverage.
2. Medicare Part A does not have to have paid anything for the transplant to protect the immunosuppressant benefit any time the patient has Part B coverage
3. A person who has an employer group health plan who has neither Part A or Part B can sign up for Medicare Part A and B or Part A alone the month the transplant occurs and ask SSA to start Medicare coverage that month. Doing this will protect the Part B immunosuppressant coverage benefit any time that the patient is enrolled in Part B.
4. Someone who fails to sign up for Medicare Part A the month of transplant has **up to 12 months** to sign up for Part A and to ask for it to be backdated to the month of the transplant. This will protect the Part B immunosuppressant benefit any time that he/she has Part B coverage.
5. If the patient took Part A because it was free and waived Part B during his/her initial enrollment period for Medicare, he/she can only enroll in Part B during the general enrollment period (GEP) which is January-March annually and Part B will start the following July 1.
6. Medicare is secondary to an EGHP (including coverage for immunosuppressants) during the Medicare secondary payer period. It's important to know when the MSP period ends to be sure that if the patient delayed signing up for Part B, he/she signs up soon enough for Medicare Part B that it is in effect in time to avoid any gap in coverage between when the EGHP coverage is no longer primary (or if the EGHP coverage ends for any reason) and the July that Medicare B takes effect.
7. If a patient delays enrolling in Part B from when he/she takes Part A, the patient will pay a **10% premium penalty for every 12 months he/she delays signing up for Part B**. The premium

penalty will be 10% of the current monthly premium (which increases) and the premium penalty will continue until the patient has another reason for Medicare eligibility (age or disability). Getting a transplant is NOT a new reason for Medicare eligibility when someone has been on dialysis and already took Part A.

**For more Medicare Q&A's see the Network of New England's Brochure
[Medicare Entitlement Update.](#)**

Additional Resources:

****The Medicare manual on eligibility, enrollment, and entitlement, especially Section 10.4 and 20.3.1 and 20.3.2. <http://www.cms.gov/manuals/downloads/ge101c02.pdf>

****Much of this information can also be found in the publication for the general public:

<http://www.medicare.gov/Publications/Pubs/pdf/10128.pdf>

****Social Security Program Operations Manual System entitled "Effect of Immunosuppressive Drug Coverage on Filing for R-HI and R-SMI" (Note: R-HI is Part A based on ESRD and R-SMI is Part B based on ESRD): <https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801248>