



# MEDIGAP INSURANCE AND OTHER SUPPLEMENTAL INSURANCE

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## MEDICARE SUPPLEMENT INSURANCE - MEDIGAP

### Medigap Overview

Medigap insurance is health insurance sold by private insurance companies that fill some of the cost and benefit “gaps” in the Original Medicare program. The official name for these policies is “Medicare Supplement Insurance.” State insurance departments regulate the companies and agents that sell this insurance.

Before 1990, Medigap insurance policies were not standardized in many states. As a result, it was hard for consumers to compare one plan to another as to how well they filled Medicare’s gaps. Since 1991, insurance companies in most states must sell Medigap insurance policies that conform to minimum standards set by the National Association of Insurance Commissioners (NAIC). Massachusetts, Minnesota, and Wisconsin had their own Medigap standardization laws in place before the NAIC developed its national model law and regulation and are exempt from the NAIC rules. From 1991 to 2005, the NAIC model had 10 standard Medigap plans lettered A-J. The Medicare Modernization Act of 2003 added plans K and L to the array of standard plans. Plans K and L took effect on January 1, 2006, the same day that Medicare began its Part D prescription drug program.

A revised NAIC model law and rule takes effect on June 1, 2010. After that date, insurers can no longer sell some of the 10 original standardized Medigap plans (E, H, I, J, and high deductible J) because, when Medigap drug benefits were removed from plans H, I, and J in 2006, the result was that the plans duplicated other plans. The revised NAIC model also eliminates the preventive care, at-home recovery, and 80 percent payment for excess charge benefits. This is because with changes in Original Medicare's coverage and claims procedures, they are now outdated.

Since Congress authorized the model law in 1990, the NAIC refers to the plans issued under the old model rules as "1990 plans." These plans will remain in effect as long as their policy holders pay premiums. They may, however, become more expensive over time as the number of policy holders declines.

The revised NAIC model also creates two new Medigap plans, M and N, and adds a new hospice cost-sharing benefit to the core benefit of all plans that take effect on or after June 1, 2010. The revised NAIC model law calls the 11 Medigap policies (A, B, C, D, F, high deductible F, G, K, L, M, and N) that conform to the new rules "2010 plans."

Here are some key points about Medigap insurance that apply to both the 1990 and 2010 plans:

- Beneficiaries who have Original Medicare and a Medigap policy have access to most hospitals, physicians, and other providers in the country.
- Medigap coverage is tied to Original Medicare's coverage. If Medicare approves payment on a claim, so does the Medigap policy. If Medicare denies a claim, generally so does the Medigap policy.
- A person generally must have Medicare Part A and Part B to purchase a Medigap policy.
- Medigap policies do not work with Medicare Advantage plans, that is, Medicare HMOs, PPOs, Private-Fee-for-Service (PFFS) plans, Special Need Plans, and Medicare Savings Accounts (MSA). Medicare Advantage plan members should not buy Medigap insurance.
- Many companies have "crossover claim" agreements with Medicare. Medicare shares its coverage and payment information electronically with the Medigap insurer. The company in turn automatically pays its share of the claim. When providers accept assignment, this enables bills to be paid in full with no paperwork for the beneficiary.
- Insurance companies are not required to sell all standard plans, but they must offer Plan A and either Plan C or Plan F if they want to sell any of the others.

## Covered Gaps and the Basic Benefit

Each of the standard Medigap policies covers the same gaps regardless of the company that sells it. Thus, for example, Medigap Plan C from Mutual of Omaha covers exactly the same gaps as Plan C from Golden Rule. This means that SHIP counselors and their clients can make “apples to apples” comparisons among the standard policies. Prices for Medigap insurance tend to increase based on the number of gaps the policies fill. Plan A which covers a basic, or core, benefit is usually the cheapest.

Medigap policies are designed to cover some or all of these gaps in Original Medicare:

- Part A deductible per benefit period (\$1,100 in 2010)
- Part A hospital daily coinsurance (\$275 for days 61-90; \$550 for days 91-150, in 2010)
- No hospital coverage after 150 days in a benefit period
- No psychiatric hospital coverage after 190 days in a lifetime
- SNF daily coinsurance charge (\$137.50 for days 21-100, in 2010)
- Hospice coinsurance charges for palliative medications and respite care
- First three pints of blood
- Part B annual deductible (\$155 in 2010)
- Part B coinsurance charge (20 percent of the approved amount in most cases, but more for many outpatient hospital services, and for outpatient mental health)
- Part B excess charge (the difference between Medicare’s approved amount and Medicare’s 15 percent limiting charge for physician services)
- Emergency care received outside the U.S.A.

The NAIC standards and state law define a “basic benefit,” also called the core benefit. The 1990 plans contain a core benefit that includes the features below except for coverage for the hospice coinsurance charges. The 2010 plans must contain all the elements of the core benefit, though it is important to note that some plans cover these costs in full while others only cover a set percentage of the costs. The basic, or core, benefit includes coverage for the:

- Part A inpatient hospital coinsurance charges
- 365 days of hospitalization after Medicare coverage ends (starting on the 151<sup>st</sup> medically necessary inpatient hospital day in a Part A benefit period)
- Hospice coinsurance charges for palliative medications and respite care
- Part B 20 percent coinsurance charge
- First three pints of blood

## The Standard Medigap Insurance Policies

Medigap Plan A covers only the core benefit. The other Medigap plans build on this core benefit to cover different combinations of coverage gaps. Keep in mind that the basic benefit does not include coverage for the Part A inpatient hospital deductible or the Part B annual deductible. Several of the 1990 and 2010 plans, however, cover the Part A deductible in full. Note that Plans K, L, M, and N take a slightly different approach to covering the features of the basic benefit. Here are the main features of the standard Medicare Supplement Insurance (Medigap) policies (the list includes and identifies the 1990 plans that will not be issued after June 1, 2010):

- Plan A covers the basic benefit. It does not cover the Part A or Part B deductibles, the Part A SNF daily coinsurance charge, foreign travel emergencies, or Part B excess charges.
- Plan B covers the basic benefit and the Part A inpatient hospital deductible. It does not cover the Part A SNF daily coinsurance charge, the Part B deductible, foreign travel emergencies, or the Part B excess charges.
- Plan C covers the basic benefit, the Part A inpatient hospital deductible, the Part B deductible, the SNF daily coinsurance charge, and foreign travel emergencies. It does not cover the Part B excess charge.
- Plan D covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, and an “at-home recovery” benefit that may help pay for some home care after Medicare’s home health coverage ends. Note that the at-home recovery benefit should not be confused with long-term care insurance.
- Plan E (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, and preventive services that Medicare Part B does not cover (e.g., an annual physical examination).
- Plan F covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the Part B deductible, and 100 percent of the Part B excess charge. Note that physicians in the United States accept assignment in 99 percent of the cases, meaning that very few doctors bill for the excess charge. Other Part B providers, such as medical equipment suppliers, may bill for excess charges more often. Some companies offer a high deductible Plan F with a \$2,000 annual deductible (2010).
- Plan G covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home recovery benefit, and 80 percent of the Part B excess charge. It does not cover the Part B deductible. After June 1, 2010, this plan must cover 100 percent of excess charges.

- Plan H (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge and foreign travel emergencies. It is almost identical to Plan D, except that it has no at-home recovery benefit. Before 2006, this policy had a limited prescription drug benefit.
- Plan I (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home recovery benefit, and 100 percent of the Part B excess charge. It does not cover the Part B deductible. Before 2006, this policy had a limited prescription drug benefit.
- Plan J (not sold after June 1, 2010) covers the basic benefit, the Part A inpatient hospital deductible, the Part A SNF daily coinsurance charge, foreign travel emergencies, the at-home recovery benefit, the preventive care benefit (e.g., for annual physical examinations), the Part B deductible, and 100 percent of the Part B excess charge. Before 2006, this policy had a limited prescription drug benefit. Some companies offer a high deductible Plan J with a \$2,000 annual deductible (2010).

Plans K and L joined the 10 original standard policies in 2006. K and L both pay a percentage of some Original Medicare cost-sharing gaps, and do not cover foreign travel emergencies or the Part B deductible. They also differ from the other standard policies in that they limit, or cap, annual out-of-pocket spending. After a beneficiary reaches the out-of-pocket cap the policies pay 100 percent of approved costs, but some costs like the Part B excess charge do not count toward the out-of-pocket limits.

- Plan K covers 100 percent of the Part A inpatient hospital coinsurance charges but it departs from the basic benefit by paying 50 percent (not 100 percent) of Part B coinsurance charges. It also covers 50 percent of the Part A inpatient hospital deductible and the SNF daily coinsurance charge. Its annual out-of-pocket cap is \$4,620 for 2010, and is adjusted each year for inflation.
- Plan L covers 100 percent of the Part A inpatient hospital coinsurance charges but it departs from the basic benefit by paying 75 percent (not 100 percent) of Part B coinsurance charges. It also covers 75 percent of the Part A inpatient hospital deductible and the SNF daily coinsurance charge. Its annual out-of-pocket spending cap is \$2,310 for 2010, and also is adjusted each year for inflation.

Plans M and N are the newest Medigap policies. Similar to Plans K and L, Plan M covers a percentage of the Part A deductible. Plan N differs from the other Medigap policies in that it covers the cost-sharing charges for physician office and emergency room visits after the policy holder pays a fixed copayment. While Plans M and N are similar in some respects to Plans K and L, they differ in that they fully cover the coinsurance charge for skilled nursing facility (SNF) stays, they cover foreign travel emergencies, and they do not have annual limits on out-of-pocket spending.

- Plan M covers 100 percent of the Part A inpatient hospital coinsurance charges and 50 percent of the Part A deductible. It also fully covers the SNF daily coinsurance charge.
- Plan N covers 100 percent of the Part A inpatient hospital coinsurance charges and 100 percent of the Part A deductible. It fully covers the SNF daily coinsurance charge. This plans covers the 20 percent coinsurance charge for most Part B services (e.g., ambulance and outpatient hospital services), except for physician office visits and emergency room (ER) visits. The policy holder is responsible for \$20 copayments for office visits and \$50 copayments for ER visits.

See the Health Assistance Partnership's Medigap Web page at <http://www.hapnet-work.org/medigap-coverage/> for additional background information and resources on Medicare Supplement Insurance.

## Other Policy Options

- **Medicare Select Policies:** Some insurance companies also offer “Medicare Select” policies for Medigap Plans A - J. Medicare Select policies cover the same gaps as regular plans A - J, except that they require beneficiaries to the use certain providers, typically hospitals, in non-emergency situations. Select policies usually cost less than regular policies.
- **High Deductible Plans F and J:** The law allows insurance companies to sell Medigap plans F and J with a high deductible option. After the beneficiary pays the first \$2,000 in covered costs (for 2009), the policies start to fill the same gaps as the regular plans F and J. CMS updates the deductible amount each year based on the consumer price index. The monthly premiums for high deductible policies are also usually less than those for regular policies.
- **Guaranteed Issue Policies:** Medigap insurers are not required to sell policies to applicants with pre-existing conditions unless the person has an enrollment right described below. State law sometimes requires a limited number of companies to sell “guaranteed issue” policies, meaning that the company issues a policy regardless of a person's health status. These policies usually cost more than regular policies.

## Uncovered Gaps in Original Medicare

There are some gaps in Original Medicare that the twelve standard plans cannot fill. Foremost among the gaps is prescription drug coverage. Until 2005, insurers could sell three standard Medigap policies (H, I, and J) that contained a limited drug benefit. But with the start of the Medicare Part D prescription drug program in 2006, Medigap insurance companies no longer can issue or renew policies H, I, and J with a drug benefit.

Other gaps in Original Medicare include:

- SNF coverage after 100 days in a benefit period
- Private duty nursing
- Hearing aids
- Dentures and dental implants
- Eyeglasses (except for cataracts)
- Custodial care

Many people cover these additional gaps out-of-pocket. Some, however, purchase other types of insurance, such as long-term care insurance to help with the costs of custodial level care in nursing facilities and at home. Some buy dental insurance to help pay for dental care. These “other” gaps are among the main reasons that Medicare beneficiaries pay on average about 18 percent of their total health and long-term care costs out-of-pocket.

## The Cost of Medigap Insurance

Because each standard policy must cover the same benefits, the main point of comparison between one insurance company and another is price. Generally, Plan A is the least expensive plan among an insurance company’s array of Medigap insurance policies. Policies that fill more coverage gaps usually cost more. Policies with a guaranteed issue feature also tend to cost more. But insurers set their own prices for Medigap policies and monthly premiums vary from company to company, sometimes dramatically. The range in monthly premiums for Medigap insurance can be from as low as \$60 to more than \$400. It really pays to shop around.

A number of factors contribute to the difference in pricing among companies for the same insurance policy. One factor is the number of people the company insures. If it insures a large number of Medicare beneficiaries, it may be easier to spread the cost of insurance around. Another factor is the approach the company takes to marketing and customer service. Some use local agents for sales and service. Others rely on direct mail and toll-free customer service lines.

Insurance companies also use different methods to set or “rate” their prices. When buying a Medigap policy, it is good to know which method the company uses because it may have a big impact on future premium costs. The three most common rating methods are:

- Issue-age rating where the premium is based on the beneficiary’s age at the time the company issued the policy. Premiums generally are lowest for people in the 65 to 69 age group and will not increase as they get older, although premiums tend to rise due to inflation.



Some Medicare Supplement policies that pre-date 1992 cover medically necessary SNF care beyond 100 days in a benefit period.

When you are working with older clients who purchased their supplements in the 1980’s or earlier, keep in mind that the benefits will be a little different than those in the standard plans, and in some cases the benefits may be better.

- Attained-age rating where the premium is based on a beneficiary's current age and goes up with age. Premiums start out fairly low but increase over time.
- Community rating where the premium is the same for everyone who has the Medigap policy regardless of age.

Most insurance companies use one of the age-rating methods to set their premiums. Relatively few use the community rating method.

Community rating, though, can work to an older beneficiary's advantage when changing Medigap companies or when a retiree group plan becomes too costly or ceases to exist.

One important service that SHIP counselors provide is helping clients compare the cost of Medigap insurance with the cost of Medicare Advantage (MA) plans. Many MA plans have very low monthly premiums, including some with no premiums at all. But comparing Medigap insurance and MA plans on premium prices alone can lead to problems. It is also important for people to understand where the potential for out-of-pocket costs exists.

**EXAMPLE** *Glenn is new to Medicare. As he decides about enrolling in a Medicare Advantage plan, he asks about the difference in price between Medigap Plan C and a Medicare PPO. The monthly premium for the Medigap policy is \$170 (\$2,040 annually). The monthly premium for the Medicare PPO is \$50 (\$600 annually). Glenn wants to make sure, however, that he has good coverage for cancer care because the illness runs in his family. With Medigap Plan C, if he needs hospital outpatient services and chemotherapy drugs he would have no additional out-of-pocket costs. Plan C covers all the coinsurance charges. But with the Medicare PPO, he would owe 20 percent of the cost of chemotherapy drugs with the potential for many thousands of dollars in out-of-pocket costs that would add to the cost of the PPO's low premiums.*



Many states publish a Medigap insurance cost comparison guide. It's a great tool for evaluating insurance options. These guides enable your clients to compare the coverage and cost of different Medigap policies. If you're helping someone from another state, check the SHIP or insurance department website for state-specific guide premium comparisons.

**Note:**

*A great deal of confusion exists around the difference between Medigap policies and Medicare Advantage plans. Many beneficiaries do not understand the significant differences between the two programs. SHIP counselors can clear up confusion that comes from misinformation in the community about the distinct programs. For example, it is critical that beneficiaries understand that Medigap plans will not cover the out-of-pocket costs of Medicare Advantage plans.*

## Consumer Rights and Protections

Medicare beneficiaries have several important consumer rights when purchasing Medigap insurance. Some of the main protections are:

- **Open enrollment and guaranteed issue rights for new Medicare beneficiaries:** People aged 65 and older have a six-month Medigap open enrollment period after they become eligible for Medicare and enroll in Medicare Part B. This also protects older workers when they first enroll in Part B at a later date. A beneficiary has the right to purchase any Medigap policy during this frame. Insurance companies must issue the policy and cannot turn down the applicant on the basis of poor health status.
- **Guaranteed issue rights for those who lose coverage:** Medicare beneficiaries who lose their coverage from a Medicare Advantage plan when they move away from the plan's service area, or those who lose coverage when an employer or union group plan ends, have a right to enroll in one of six Medigap policies (A, B, C, F, K, or L) during a 63-day window after their previous coverage ends.
- **Guaranteed issue and open enrollment for people under 65:** Some states require insurance companies to sell at least one or two types of Medigap policies to Medicare beneficiaries who are under age 65, including those with disabilities. The companies must issue the policies regardless of age or health status.
- **Guaranteed Renewability:** Insurance companies cannot cancel Medigap insurance policies except for failure to pay premiums.
- **Annual switch period:** In some states, those who have a Medigap policy have a period of time (for example, 60 days) around their policy's anniversary date to switch companies. They can only switch, however, to a like policy. If, for example, a person has Medigap Plan F with Physicians Mutual, he can only switch to a different company's Plan F.
- **Six-month waiting period for pre-existing conditions:** For persons with pre-existing health conditions, Medigap insurers can limit payments related to the condition for no more than six months. Insurance companies must, however, reduce the six-month waiting period by the number of months that the person had health insurance coverage, called "creditable coverage."

**EXAMPLE** *Granite Insurance Company enrolled Gloria in a Medigap policy despite her pre-existing heart condition. Gloria had coverage through her employer plan for twenty years before applying for the Medigap insurance. Because Gloria has 240 months of creditable coverage, she will have no waiting period for coverage connected with her heart condition. She'll need a letter from her previous insurer to prove the creditable coverage.*

- Prohibited marketing practices: It is against the law for an insurance company or agent to sell duplicate Medigap policies, to sell a Medigap policy to someone who has Medicaid (with some exceptions), and to use high-pressure sales tactics.



If a client believes that a company or agent misrepresented an insurance policy or used illegal sales tactics, contact your state insurance department.

State insurance department investigate complaints against insurance companies and agents. To find the insurance department in your state, visit the NAIC website at [http://www.naic.org/state\\_web\\_map.html](http://www.naic.org/state_web_map.html).

## Medigap Modernization

Starting on June 1, 2010, insurance companies must offer Medigap policies that comply with a new set of Medigap standards. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes the states to adopt a revised NAIC model for Medigap modernization that has been in development since 2005. States will enact legislation or adopt regulations in 2009 to give effect to the revised model standards. Companies can sell policies that comply with the new standards in June 2010.

The revised model eliminates some policies altogether. After June 2010, companies will no longer sell Medigap Plans H, I, and high-deductible Plan J because, since they no longer offer the former limited prescription drug benefit, they now duplicate other plans. The new rules also eliminate Plan E because its 80 percent coverage of the Part B excess charge is not needed.

The revised model also eliminates some benefits from all Medigap plans. Companies will no longer offer the at-home recovery, preventive care, and 80 percent of excess charges benefit. Given changes in Medicare since 1990, these benefits are outdated and little used.

Two new Medigap policies – Plans M and N – will join Plans A, B, C, D, F, high deductible F, G, K, and L. Plan M will include the basic benefit, 50 percent coverage for the Part A deductible, full coverage for the Part B coinsurance charge, and foreign travel emergency coverage. Plan N will include the basic benefit, full coverage for the Part A deductible, coverage for the Part B coinsurance charge, except for a \$20 copayment for office visits and a \$50 copayment for emergency room visits, and foreign travel emergency coverage.

## EMPLOYER AND UNION GROUP PLANS FOR RETIREES

Many employers and unions offer some form of health insurance for their retirees. In 2006, 35 percent of Medicare beneficiaries nationwide had some type of supplemental coverage through employer-sponsored health plans. That percentage tends to be higher in states where many retirees worked for large companies with a unionized work force.

Group plans for retirees vary as much as the employers and unions who sponsor them. Some plans are designed to “wrap around” Original Medicare and they may fill the gaps in Original Medicare better than Medigap insurance does. Other plans complement Medicare by paying a percentage of uncovered costs and covering some excluded services. At the same time, some plans do not mesh well at all with Original Medicare or they may have other limits that reduce their value.

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*One Medicare trainer offers this quip about employer and union sponsored plans for retirees, “If you’ve seen one, you’ve seen one!”*

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## Retiree Group Plans: The Positives

Retiree plans often cover services and benefits that Original Medicare excludes from coverage. Prescription drug coverage is the prime example. About one-fourth of Medicare beneficiaries receive prescription drug benefits through a retiree group plan. Some companies also pay a share of the plan premiums for their retirees keeping the costs low in contrast to Medigap insurance, although this benefit is becoming less common.

Retiree plans often offer the same coverage for spouses. The combined cost of covering both the retiree and spouse may be much less than the cost of buying two Medigap insurance policies.

## Retiree Group Plans: The Concerns

One concern about group health plans for retirees often leads people to meet with SHIP counselors. That feature is the fact that the group plans may change dramatically in any year. Plans can change the covered benefits, deductibles, co-payment amounts, and premiums regularly. In recent years, many companies have shifted a greater share of plan costs to retirees, creating a financial burden for some beneficiaries. Thus, the cost of some retiree plans is very high compared to Medigap insurance. Retirees want to know how their group plan coverage compares to other health insurance options including Medigap insurance and Medicare Advantage plans.

Some retiree group plans limit their coverage through lifetime or annual payment caps. Some

**SHIP TIP**

As retiree group plans cost more and cover less, people may ask you if they should drop these plans and buy a Medigap policy or join a Medicare Advantage plan. It is impossible to make “apples to apples” comparisons between group plans, Medigap policies, and Medicare Advantage plans. To help your clients, you must review the group plan’s coverage outline carefully. Call the plan’s benefits office to ask questions. Ask about out-of-pocket costs for hospital, physician, and other services. Test some scenarios that show how the plan’s out-of-pocket might work. Keep in mind that a plan’s prescription drug coverage could be well worth the cost. On the other hand, some plans are a waste of money. Because clients may not be able to return to a group plan if they drop it, this decision can cause anxiety. Take care in counseling them.

plans may limit lifetime payments to \$1 million or more while others limit annual payments to \$100,000. A plan that pays, for example, only \$100,000 in a lifetime may not last through three hospital stays. Retirees whose plans limit payments in this way must weigh carefully whether or not to buy Medigap insurance or enroll in a Medicare Advantage plan instead. Note that a retiree can have a Medigap policy and employer coverage at the same time. The restriction against selling duplicate insurance applies only to Medicare supplement (Medigap) insurance policies.

A final concern is that plan sponsors can discontinue retiree group plans. It happens with bankruptcies, mergers, and during downturns in business cycles. In these cases, retirees want to know about their insurance options and their rights.

## COBRA CONTINUATION PLANS

### Qualifying for COBRA Continuation

COBRA stands for the Consolidated Omnibus Budget and Reconciliation Act of 1986. This law protects those who would otherwise lose group health plan coverage through the termination of employment or reduced hours of work. COBRA requires employers with 20 or more employees to offer continuation of group health plan coverage to employees, spouses and other dependents following a “qualifying event,” at the person’s expense.

Here is a list of COBRA-qualifying events. The length of continued group plan benefits is tied to the type of event that qualifies a person for COBRA continuation rights.

- Reduction in hours of work; 18 months of COBRA benefits
- Termination of work (with no gross misconduct); 18 months
- Loss of job due to disability; 18 months with an extension to 29 months if qualified for Social Security Disability benefits.
- Divorce/legal separation from employee; 36 months
- Death of insured employee; 36 months
- Employee enrolls in Medicare; 36 months for spouse not yet eligible for Medicare
- Loss of dependent status; 36 months

### COBRA Counseling Issues

COBRA plans generally pay second to Medicare. For those with Medicare and a COBRA plan, a key question is whether the plan will pay for services in addition to Medicare coverage. Does it cover Medicare’s deductibles and coinsurance charges, or do the plan’s own high deductibles and provider payment rates make it of little value as a Medicare wrap-around?

People who elect COBRA coverage and miss Medicare's Initial Enrollment Period (IEP) may owe a late enrollment penalty on their Part B premium. Because COBRA coverage is not tied to "current employment," those who elect COBRA coverage do not have a Special Enrollment Period to enter Medicare Part B after age 65, as they would if they continued to work with employer group plan coverage. In addition, the six-month Medigap open enrollment period could end for persons who enroll in Part B and continue their employer group health plan coverage through COBRA.

Another important counseling issue involves those who leave employment because of a disability. They have a right to extend COBRA coverage from 18 to 29 months if they qualify for Social Security Disability payments. This enables people with disabilities to continue their COBRA benefits until Medicare coverage begins. But they must inform the COBRA plan administrator of their eligibility for Social Security Disability benefits within a time period (not less than 60 days) of receiving the award notice from Social Security. Otherwise, they may lose the right to the 11-month extension.

The Department of Labor's Employee Benefits Security Administration (EBSA) oversees compliance with the COBRA law and rules. For more information, go to EBSA's website at <http://www.dol.gov/ebsa>.

## TRICARE FOR LIFE

TRICARE for Life (TFL) is a health insurance plan for military retirees and their spouses who have Medicare. In effect, the program supplements Original Medicare by covering the deductibles, coinsurance charges, prescription drugs, and other Medicare-related costs. TRICARE for Life is an outstanding benefit for those who qualify. Unless Congress makes major changes to the TFL program, those who are eligible for its benefits do not need to concern themselves with Medigap insurance.

For information on TRICARE for Life, call 1-888-874-9378 or visit <http://www.tricare.mil/mybenefit/home/overview/Plans/ForLife?>

## INDEMNITY INSURANCE POLICIES

Indemnity policies are a type of insurance that pay a fixed dollar amount when the insured person meets certain conditions of coverage, such as a hospital stay or the onset of a specific disease like cancer. Typically, they make cash payments to the insured person for each day she is hospitalized or under care for the specific disease. Indemnity policies pay regardless of other health insurance coverage and Medicare does not coordinate benefits with them.

## Indemnity Insurance: The Positives

Some of the key selling points for indemnity policies are:

- They are easy to understand.
- They cover people under 65 who may have few affordable insurance options otherwise.
- They pay cash benefits directly to an insured person that she can use as she sees fit, including paying for services like private duty nursing or Medicare Advantage plan copayments.

## Indemnity Policies: The Concerns

- They are not comprehensive health care policies and are not designed to fill Original Medicare's gaps.
- Their payments are structured to supplement lost income, not to cover the daily rate for inpatient hospital care.
- They may not keep pace with inflation.
- They may cap payments.

## DEPARTMENT OF VETERANS AFFAIRS (VA) BENEFITS

The Department of Veterans Affairs (VA) provides several health care services, including hospitalization and pharmacy benefits, to those who served in the military and are eligible for benefits.

Many veterans are eligible for both VA benefits and Medicare. Medicare does not pay for services received in a VA hospital or other health care facility. Generally, the VA does not pay for services a veteran receives outside the VA, except when the VA authorizes a service from a non-VA health care provider. In such cases, the VA is the primary payer to Medicare.

Veterans with prescription drug coverage through the VA may not need to enroll in a Medicare Part D prescription drug plan. The VA program offers coverage that is at least as good as (actuarially equivalent to) the standard Medicare prescription drug plan.

For information on VA benefits call 1-800-827-1000 or visit <http://www1.va.gov/health/index.asp>. Also keep in mind that the VA hospitals have benefit counselors on their staffs. They may be good information resources for you and your clients.



As people shop for Medigap insurance or any of the other private plans, what is your role as a counselor? Will you recommend a certain type of policy, or recommend one company instead of another? Will you suggest something because, “This is what I’d do?” Take care to provide objective information based on resources from your state insurance department and nationally recognized insurance rating services like Best’s.

## WHERE TO LEARN MORE

For general information on Medicare Supplement insurance, visit <http://www.medicare.gov> to find these and other resources:

- *2009 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, a booklet with information on choosing a Medigap policy, including information on enrollment rights. Go to the “Find a Publication” link on Medicare’s website.
- The “Plan Compare” page on Medicare’s website, available at <http://www.medicare.gov/MPPF/Include/DataSection/Questions/SearchOptions.asp>, describes Medigap options in your area along with some price information.

For general information on COBRA, see:

- *The Employee Benefit Security Administration’s Frequently Asked Questions about COBRA Continuation Health Coverage and An Employee’s Guide to Health Benefits Under COBRA*, both found on the EBSA website at <http://www.dol.gov/ebsa>.

