Congressional Research Service
Informing the legislative debate since 1914

Medigap: A Primer

Updated June 24, 2015

Congressional Research Service
https://crsreports.congress.gov
R42745

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Medicare is a nationwide health insurance program for individuals aged 65 and over and certain disabled individuals. The basic Medicare benefit package (termed "original Medicare" in this report) provides broad protection against the costs of many health care services. However, Medicare beneficiaries may still have significant additional costs, including co-payments, coinsurance, deductibles, and the full cost of services that are not covered by Medicare. To decrease their potential financial liability, some Medicare beneficiaries enroll in employer-sponsored insurance, Medicare Advantage, or Medicaid. This report focuses on another option. In 2010, about 22% of Medicare beneficiaries purchased the private supplemental insurance known as Medigap to fill some of the cost gaps left by original Medicare.

All Medigap plans cover some percentage of Medicare's cost sharing. Some plans offer additions to these basics, including various combinations of greater coverage of Medicare cost sharing, and care associated with foreign travel emergencies. The most popular plans are the most comprehensive, and cover all deductibles, co-payments, and coinsurance not covered by Medicare. Medigap generally does not cover medical treatments not covered by Medicare, although it does extend coverage for certain covered services, such as coverage for additional hospital days beyond the Medicare benefit limit. Medigap is financed through beneficiary payments to private insurance firms.

Federal law requires that Medigap insurers observe many consumer protections. Consumer protections are especially strong during open enrollment, which is a six month period that begins for most individuals during the month they turn 65. During this period, individuals are protected against

- insurers refusing to sell them any Medigap policy that the insurer offers,
- insurers setting premiums based on the individual's health, and
- insurers imposing waiting times on the start of the policy, other than a maximum of a six-month waiting period for preexisting conditions.

Following the open-enrollment period, beneficiaries have other rights in limited situations, such as when they move to a different state. Guaranteed issue (or the right to buy a plan, to have the plan's premium not depend on health status, and in some cases to have the plan start coverage of preexisting conditions immediately) is one such right. The right of guaranteed renewability is available in a wide variety of situations, and genetic discrimination is forbidden. Moreover, Medigap insurers must pay out at least 65% (and sometimes 75%) of total premiums as claims to the beneficiaries.

Recent data show that Medigap premiums vary by states and other factors. Medigap beneficiaries are concentrated in certain areas of the country and are more likely to have lower incomes than those holding employer-sponsored retiree health insurance. A relatively small number of insurance firms sell Medigap plans.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended by P.L. 111-152) requested that the Secretary of Health and Human Services ask the National Association of Insurance Commissioners (NAIC) to review and revise existing standards to examine the feasibility of requiring greater cost sharing for Medigap beneficiaries. The NAIC did so, and recommended that the current cost sharing not be changed. The Secretary accepted this recommendation.

This report provides a broad overview of Medigap insurance. It covers the history of Medigap legislation, the various types of Medigap plans, consumer protections awarded to Medigap

beneficiaries, and the requirements facing the insurance providers and the NAIC. The report ends with an empirical description of Medigap markets.

Contents

Introduction 1
Medicare Coverage 2
Supplementing Medicare 4
Medigap Plans 5
History of Medigap Statutes 6
During the 1980s 6
During the 1990s 7
During the 2000s 8
Coordination of Payment Between Medicare and Medigap 9
Plan Characteristics 9
Standardized Plans 9
Pre-standardized Plans 11
Older Standardized Plans Available for Renewal Only 11
Medigap Plans for States with Waivers 12
SELECT Plans 12
High-Deductible Plans 12
Plan Enrollment 12
Consumer Protections 14
During the Open Enrollment Period 14
After the Open Enrollment Period 15
Guaranteed Issue 15
Guaranteed Renewal 17
Genetic Nondiscrimination 17
Switching Medigap Plans 17
Medigap for Individuals Under the Age of 65 17
Insurers' Requirements 18
Required Plans 18
Premiums 18
Medical Loss Ratios 19
The Role of the National Association of Insurance Commissioners 20
Descriptions of Medigap Markets 20
Medigap Premiums and Plan Choice 21
Medigap Market Participation by Individuals Across States 21
Medigap Markets by Characteristics of Enrollees 23

Figures

Figure 1. Sources of Supplemental Coverage Among Medicare Beneficiaries, 2012 5
Figure 2. Distribution of Current Medigap Plans, All Medigap Beneficiaries, 2013 13
Figure 3. Medigap Enrollment by State, 2013 22
Figure 4. Percentage of Medicare Enrollees with Medigap Coverage by State, 2012 23

Tables

Table 1. Selected Original Medicare Cost-Sharing Levels, 2015 3
Table 2. Standard Medigap Plans, Effective On or After June 1, 2010 10

Contacts

Author Information 24
Acknowledgments 24

Introduction

Medicare is a nationwide health insurance program for individuals aged 65 and over and certain younger disabled individuals. The basic Medicare benefit package (termed "original Medicare" in this report) provides broad protection against the costs of many health care services. However, Medicare beneficiaries may still have significant additional costs. Medicare requires beneficiaries to pay part of the cost for most covered services, provides only limited protection for some services (e.g., medical costs incurred outside of the United States), and provides no protection for other services (e.g., custodial long-term care, hearing aids, and dentures). Furthermore, unlike most large group health insurance policies, original Medicare contains no upper ("catastrophic") limit on out-of-pocket expenses. As a result, Medicare beneficiaries have the potential to incur high out-of-pocket costs for their health care.

Most Medicare beneficiaries therefore have some form of (private or public) additional coverage to pay for some or all of their out-of-pocket costs for Medicare benefits. *Medigap* is one form of private supplemental coverage; Medigap fills some of the cost gaps left by Medicare, such as deductibles, coinsurance, and co-payments.[1] In order to be eligible to purchase Medigap, individuals must be

- enrolled in both Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) of original Medicare, and
- not enrolled in Medicare Advantage (an HMO-type plan).

Medigap is financed through beneficiary payments to private insurance firms, although retirees may have premiums paid on their behalf by their former employers. There are no government contributions toward Medigap premiums.

This report provides an overview of Medigap, which is also known as *Medicare Supplement* insurance. After a review of Medicare coverage, the report covers the ways in which Medicare is supplemented. A discussion of the Medigap plans includes standardized plans, pre-standardized plans, older standardized plans available for renewal only, plans in states with Medigap waivers, SELECT plans, and high-deductible plans. The analysis then covers various consumer protections, and the requirements for the insurance companies that offer Medigap. Next, the role of the National Association of Insurance Commissioners (NAIC), a nongovernmental advisory body, is discussed. The report then provides an empirical picture of Medigap markets.

The report concludes with a brief discussion of several current policy issues. First, how much of the total collected premiums might each insurer be expected to return to its beneficiaries as payment for claims? Second, what is the potential effect on Medicare spending of increasing the share of health care costs that the individual must pay out of his or her own pocket? This second question relates to the recent prohibition against Medigap insurers from covering the deductible for Medicare outpatient services.[2]

[1] Cost sharing refers to the amount paid by the individual for Medicare-allowable goods and services (excluding premiums). Cost sharing includes a *deductible*, or a set dollar amount the beneficiary must pay before Medicare provides any reimbursement for most services. Cost sharing also includes *co-payments* and/or *coinsurance*, with Medicare paying the remaining (allowable) costs. In general usage, co-payment refers to a flat amount (e.g., $30 per visit), whereas coinsurance refers to a percentage (e.g., 20% of the total visit charge).

[2] Medicare Access and CHIP Reauthorization Act of 2015, P.L. 114-10.

Medicare Coverage

Medicare consists of four parts:[3]

- Part A, Hospital Insurance (HI), covers inpatient hospital services, skilled nursing care, some home health care, and hospice care.
- Part B, Supplementary Medical Insurance (SMI), covers physician and non-physician practitioner services, outpatient services, some home health care, durable medical equipment, clinical laboratory and other diagnostic tests, preventive services, Part B drugs and biologics, and other medical services.
- Part C, Medicare Advantage (MA, a private plan option for beneficiaries) covers all Part A and Part B services, except hospice care.
- Part D covers prescription drug benefits.

Together, Part A and Part B of Medicare comprise original Medicare, which covers benefits on a fee-for-service (FFS) basis. Currently most Medicare beneficiaries choose original Medicare, obtaining covered services through the providers of their choice with Medicare paying its share of the bill for each rendered service.

Most individuals aged 65 and over are automatically eligible for premium-free Part A based on either their own or their spouse's work history.[4] These individuals also are eligible for voluntary enrollment in Part B, which requires a premium of $104.90 a month for most individuals. Higher-income enrollees pay higher premiums. In 2015, individuals whose modified adjusted gross income exceeds $85,000 and each member of a couple filing jointly whose modified adjusted gross income exceeds $170,000 are subject to higher premium amounts.[5] Everyone enrolled in Part A and/or Part B can elect Part D, with premiums varying by the Part D plans. In 2015, about 54 million beneficiaries are enrolled in Medicare.[6]

Table 1 provides a brief overview of the coverage offered under Medicare Part A and Part B, along with the associated cost sharing.

[3] For more information on Medicare, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

[4] Some additional individuals are eligible for Medicare. Most individuals aged 65 and over do not pay a premium for Part A because they or their spouses paid at least 40 quarters of Medicare payroll taxes while working. For more information, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

[5] CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

[6] The Medicare Payment Advisory Commission, *Medicare and the Health Care Delivery System*, June 2015, p. xi, at http://www.medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0.

Table 1. Selected Original Medicare Cost-Sharing Levels, 2015

Benefits	Cost Sharing for Beneficiaries[a]
Medicare Part A	
Inpatient Hospital Stay, per Benefit Period[b]	
Days 1-60	$1,260 deductible
Days 61-90	$315 per day
Additional Days	100%
Lifetime Reserve Days (up to 60 lifetime)	$630 per day
Home Health Care	$0
Hospice Care	
Care	$0
Prescriptions	Up to $5
Inpatient Respite Care	5%
Skilled Nursing Facility Care, per Benefit Period	
Days 1-20	$0
Days 21-100	$157.50 per day
After Day 100	100%
Medicare Part B	
Medical and Other Services (includes physicians)[c]	20%
Excess Charges[d]	100%
Home Health Care	$0
Part B Deductible[e]	$147 per year
Blood	Varies by the treatment setting and other factors
Foreign Travel Emergency	No coverage of foreign travel emergencies
Out-of-Pocket Limit	No out-of-pocket limit

Sources: Centers for Medicare & Medicaid Services, Medicare 2015 Costs at a Glance, at http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.

a. Cost sharing is waived for certain screenings and preventive services. The deductible is waived for home health services, community health services, preventive services, and some other services.

b. A benefit period begins the day the beneficiary is admitted to a hospital or skilled nursing facility, and ends when the beneficiary has not received hospital or skilled nursing care for 60 consecutive days. There is a 190-day limit on lifetime inpatient mental health care days in a psychiatric hospital.

c. Part B also covers clinical laboratory and other diagnostic tests; durable medical equipment, prosthetics, orthotics, and supplies; certain specified outpatient prescriptions, drugs, and biologics; hospital outpatient department services; ambulatory surgical center services; ambulance; and rural health clinics and federally qualified health centers.

d. Excess charges are the difference between the Medicare approved amount and actual charges, subject to charge limitations set by Medicare or state law.

e. Home health services, community health services, some preventive services, and some other services are not subject to the Part B deductible.

Medicare does not cover all medical goods and services, including custodial long-term care, routine dental care, dentures, vision care, cosmetic surgery, acupuncture, most care received in other countries, charges above what Medicare reimburses, and hearing aids, among others. There is no out-of-pocket limit under original Medicare.

Alternatively, some beneficiaries are enrolled in Medicare Advantage (MA), which is also known as Part C. These beneficiaries obtain all covered Medicare services except hospice care through private insurers, such as health maintenance organizations (HMOs). Some Part C enrollees may be offered additional benefits beyond what is available in original Medicare; the scope of additional benefits varies by the health insurance plan. MA plans may include drugs through MA-PD (prescription drug) plans. Individuals who are enrolled in an MA plan may not be sold a Medigap plan.[7]

Supplementing Medicare

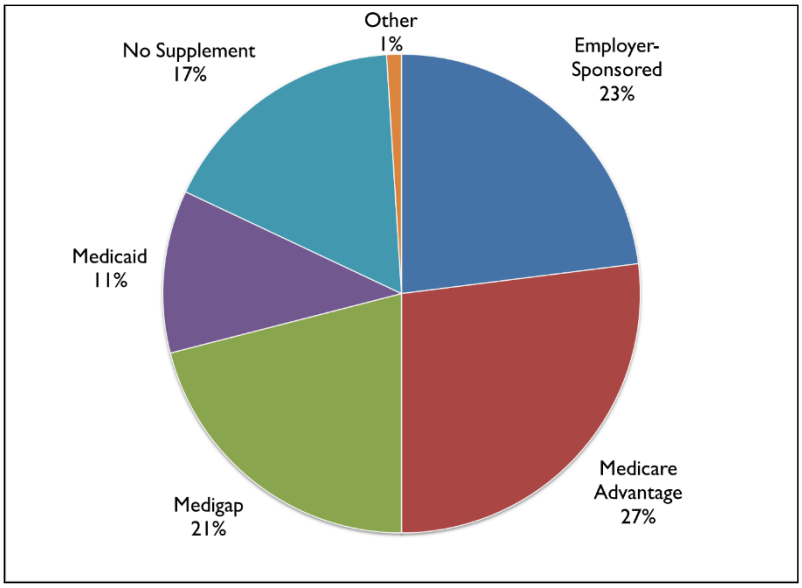
Many individuals have additional health insurance coverage to help pay for some of the costs that Medicare does not cover. **Figure 1** presents the breakdown across supplemental coverage types in 2012.[8]

[7] 42 U.S.C. §1395ss(d)(3)(A)(i).

[8] This report cites studies that generally use one of two data sources. The first data source is the National Association of Insurance Commissioners (NAIC). The NAIC is an association of insurance regulators from the 50 states, Washington, DC, and four U.S. territories. The NAIC collects financial information from insurance companies. Data collected by the NAIC is administrative data, and provides relatively more detailed information (than the MCBS data) on the characteristics of Medigap plans sold.

The second data source is the Medicare Current Beneficiary Survey (MCBS), which itself has two parts. The Access to Care MCBS file includes self-reported survey data on whether the individual holds a Medigap plan. This survey data provides detailed information on the characteristics of the Medigap plan beneficiaries. The Cost and Use MCBS file contains administrative data on the diagnoses, treatments, and costs to the individuals who were surveyed. This administrative data contains less information on personal characteristics of the survey participants and more financial information about their transactions with all health providers. The Cost and Use file and the Access to Care file are not necessarily compatible, and neither is necessarily compatible with the NAIC data. Moreover, estimates from different organizations may not be comparable even when the same data source is used. For example, one organization may have defined the participant having Medigap to mean the participant had Medigap for at least one day over the study year, a second organization may have defined the participant having Medigap to mean the participant had Medigap for more days than any other type of supplemental health insurance over the study year, and a third organization may have used a different definition that applies a rank-order to the various types of health insurance the participant had over the year.

Figure 1. Sources of Supplemental Coverage Among Medicare Beneficiaries, 2012



Source: America's Health Insurance Plans (AHIP) Center for Policy and Research, *Beneficiaries with Medigap Coverage*, April 2015, p. 2, at http://www.ahip.org/epub/MedigapBeneficiaries.

Notes: Data are from the Medicare Current Beneficiary Survey, Access to Care File. Individuals are assigned to the supplemental coverage category according to a hierarchy developed by AHIP used for the first time in this report. Therefore, these data are not comparable to data from earlier years, even if the earlier data were provided by AHIP.

Of all individuals enrolled in Medicare in 2012, 17% had no supplemental coverage; these individuals relied solely on original Medicare. The largest percentage of all Medicare beneficiaries with supplemental coverage (27%) was enrolled in Medicare Advantage. Beneficiaries in next-largest group of individuals (23%) received supplemental health insurance from their employer. Medigap (21%) and Medicaid (11%) were other sources of supplemental insurance.[9]

Nationally (but excluding California), 10.2 million policyholders had Medigap coverage in 2012.[10]

Medigap Plans

Medigap policies are sold in both the individual and the group health insurance markets. Whether purchased in the individual or the group market, each Medigap policy covers one individual.[11]

[9] The Medigap category includes any individuals with additional health insurance. *Medicaid* is a means-tested individual entitlement program that finances the delivery of primary care medical services, acute care medical services, and long-term care services and supports. Within broad federal guidelines, each state designs and administers its own program.

[10] Complete data for California are not available. California has both a Department of Insurance and a Department of Managed Care. These two departments are governed by different regulations, and only the former is required to file data with the NAIC. More information on the Department of Insurance is available at http://insurance.ca.gov. More information on the Department of Managed Care is available at http://www.dmhc.ca.gov. The Medigap coverage in 2012 data is from America's Health Insurance Plans (AHIP) Center for Policy and Research, *Beneficiaries with Medigap Coverage*, April 2015, p. 2, at http://www.ahip.org/epub/MedigapBeneficiaries.

[11] A group health policy is defined in Section 5000(a)(1) of the Internal Revenue Code to mean "a plan (including a

Plans are identified by letter, and each plan is associated with a specific benefit package. For example, all Plan As have the same benefit package. The term *plan* refers to all the Medigap insurance contracts with a common benefit package (e.g., Plan A), and the term *policy* refers to an insurance contract sold by an insurer to a beneficiary (e.g., United Healthcare's Plan A).

Federal law governing the sale of Medigap plans is contained in Section 1882 of the Social Security Act. This section of the report first provides a history of Medigap legislation, and then characterizes the various Medigap plans.

History of Medigap Statutes

Health insurance regulation largely has been and continues to be the province of the states; Medigap is a partial exception.[12] Congressional changes to Medigap over the years can be characterized along several dimensions. What began as voluntary standards governing the behavior of insurers increasingly became requirements. Consumer protections were continuously strengthened, and there was a trend toward the simplification of Medigap reimbursements whenever possible.

During the 1980s

The federal government first provided a *voluntary* certification option for Medigap insurers in Section 507 of the Social Security Disability Amendments of 1980 (P.L. 96-265), commonly known as the "Baucus Amendment." To meet the Baucus Amendment's *voluntary* minimum standards, the Medigap plan was required to

- meet or exceed the NAIC model standards for such plans, and
- return to policyholders as aggregate benefits at least 75% of the aggregate amount of premiums collected in group policies and at least 60% of the aggregate amount collected in individual policies.

Whether or not the insurers met these voluntary standards, the Secretary of Health, Education, and Welfare (now Health and Human Services, HHS) was required to

- make information available to Medicare beneficiaries about the value of Medigap policies,
- study the methods the states used to regulate Medigap plans, and
- report to Congress, at least once every two years, on the effectiveness of the certification procedure.

The move toward increased consumer protections was evident beginning in the late 1980s. The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) provided that individuals who knowingly and willfully make a false statement or misrepresent a medical fact in the sale of Medigap are guilty of a felony. The Omnibus Budget Reconciliation Act of 1987 (OBRA87; P.L. 100-203) permitted the participating physicians or suppliers to be paid directly by the Medigap plans.

---

self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families."

[12] For information on the federal regulation of pension plans, health plans, and other employee benefit plans, see CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*, by Patrick Purcell and Jennifer A. Staman.

The Medicare Catastrophic Coverage Act of 1988 (MCCA; P.L. 100-360) improved the information available to potential Medigap purchasers by directing the Secretary of HHS to inform them about sales abuses, publish a toll-free phone number to report such abuses, and inform potential beneficiaries of the addresses and telephone numbers of state and federal offices that provide information and assistance. MCCA also *required* that Medigap plans offered in a state meet or exceed the NAIC guidelines; if this requirement was not met, federal model standards would be established for that state.

Several provisions in MCAA would have made additional changes to Medicare, but they were repealed (before they went into effect) by the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234). The changes included

- expanding Medicare Part B benefits;
- imposing an annual supplemental Medicare premium on Part A beneficiaries whose tax liability equaled or exceed $150; and
- imposing an out-of-pocket maximum on Part B expenditures.

These changes would generally have lowered the Medicare beneficiary's level of cost sharing, and therefore interact with Medigap.

During the 1990s

The Omnibus Budget Reconciliation Act of 1990 (OBRA90; P.L. 101-508) replaced some voluntary guidelines with federal standards. In particular, OBRA90

- provided for the sale of only 10 standardized Medigap plans (in all but three states) known as Plan A through Plan J;
- guaranteed plan renewability (with rare exceptions);
- prohibited the selling of policies that duplicated certain health insurance provisions to which a beneficiary was entitled, for instance through a retiree health plan;
- curtailed the use of preexisting condition limitations and other forms of health-based pricing;
- required that insurers return to policyholders as aggregate benefits at least 75% of the aggregate amount of premiums collected in group policies and at least 65% of the aggregate amount collected in individual policiesl and
- introduced Medigap SELECT plans in 15 states, where SELECT plans provided a managed-care option for beneficiaries with reimbursement within a limited network.

The Act to Amend the Omnibus Budget Reconciliation Act of 1990, which was passed in 1995 (P.L. 104-18), extended the 15-state Medicare SELECT demonstration program to every state, at state option.

Two of the statutes enacted during the 1990s continued to emphasize consumer protections. The Balanced Budget Act of 1997 (BBA97; P.L. 105-33) imposed restrictions on preexisting condition exclusions during the initial Medigap open enrollment period when the plan purchaser is at least age 65 and meets a requirement for previous health insurance coverage. In addition, the BBA97 required that the Secretary of HHS ask the NAIC to develop two high-deductible Medigap plans, which became known as Plan F—High Deductible Version and Plan J. The Ticket to Work and

Work Incentives Improvement Act of 1999 (P.L. 106-170) permitted disabled Medicare beneficiaries more flexibility in moving into and out of a Medigap policy.

A few Medigap statutes passed in the 1990s primarily affected the insurance firms. The Social Security Act Amendments of 1994 (SSAA94; P.L. 103-432) modified the OBRA90. As listed above, the OBRA90 barred the sale of policies that duplicated other (non-Medigap) coverage to which a beneficiary was entitled. The OBRA90 therefore had the unintended consequence of insurers refusing to sell Medigap policies to beneficiaries who had any other type of private coverage, however limited. SSAA94 amended the OBRA90 requirements by narrowing the anti-duplication provisions and clarifying the circumstances under which insurers could sell health insurance policies with duplicative (non-Medigap) coverage.

The Omnibus Consolidation and Emergency Supplemental Appropriation Act of 1999 (P.L. 105-277) required that providers or facilities that paid Medigap premiums for beneficiaries be subject to civil penalties. This legislation attempted to avoid conflicts of interest created when providers or facilities first paid premiums and then self-referred patients.

During the 2000s

The Consolidated Appropriations Act, 2001 (P.L. 106-554) specified various anti-discrimination provisions. In particular, individuals who experienced certain changes in their health insurance status (e.g., involuntary termination of a Medigap plan) were guaranteed the right to purchase a new Medigap plan and were protected against preexisting conditions exclusions.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108-173, MMA) included various changes in Medigap plans. Because the MMA added the Medicare Part D drug provisions, Medigap plans containing drug benefits could no longer be sold to those who did not already have them. Those whose Medigap policies were issued before January 1, 2006, and did contain drug coverage were allowed to keep their existing Medigap policy as is, in some cases keep their existing policy minus the drug benefit, or purchase Medicare Part D together with either their old Medigap plan minus the drug benefit or certain new Medigap plans. In particular, individuals with Medigap Plan H, Plan I, and Plan J were guaranteed the right to purchase any of Plan A, Plan B, Plan C, and Plan F with the same insurance carrier.[13] Moreover, the carrier could not use the individual's health status, claims experience, receipt of health care, or medical condition to determine the premium. Excluding preexisting conditions from these policies was also prohibited.

The MMA also requested that the Secretary of HHS request the NAIC to develop additional Medigap plans. Two plans were to incorporate coinsurance and a maximum out-of-pocket limit; no plans available in 2003 had these features. These two plans became Plan K and Plan L. Any other Medigap plans developed by the NAIC did not have to incorporate these features, but were required to exclude prescription drug benefits; Plan M and Plan N fell into this category. In some instances, the MMA changes created two identical plans; existing Medigap Plan E, Plan H, Plan I, and Plan J were eliminated because they duplicated other plans.[14]

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275) set standards for which plans insurers must offer. In particular, insurers who wanted to offer plans beyond the basic least comprehensive plan (Plan A) were required to offer at least one of the most comprehensive plans (Plan C or Plan F). The Genetic Information Nondiscrimination Act of 2008

[13] These Medigap plans are characterized in **Table 2**.

[14] Centers for Medicare & Medicaid Services, "Medicare Program: Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance," 74 *Federal Register* 18810, April 24, 2009.

(GINA; P.L. 110-343) prohibited discrimination by health insurers and employers based on genetic information. Finally, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) prohibits Medigap policies from covering the Part B deductibles for beneficiaries newly eligible for Medicare on or after January 1, 2020. These beneficiaries may be newly eligible because they have turned 65 or because they qualify under disability provisions. This prohibition also applies to policies issued in waiver states.[15]

Coordination of Payment Between Medicare and Medigap

The rules governing coordination of the health insurance payments from the insurers to the Medicare service providers for services covered by Medicare Part B are mandated by Section 1842(h)(3)(B) of the Social Security Act.[16] In most cases, when a beneficiary receives care covered by Medicare Part B, the Medicare contractor pays the provider its portion of the bill. The claim is automatically forwarded to the Medigap insurer, and the Medigap insurer pays the provider its portion of the bill. Some insurers also provide this service for Medicare Part A.[17]

Plan Characteristics

This section first describes the 10 (current) standardized Medigap plans that differ in their deductibles, co-payments, coinsurance, and covered services. The section then describes the nonstandard plans: pre-standardized plans, older standardized plans available for renewal only, plans in states with Medigap waivers, SELECT plans, and high-deductible plans. Unless otherwise noted, the text refers to those who qualify for Medicare because they are at least age 65; Medigap options for those who qualify for Medicare because they are under age 65 and disabled are discussed later in the report.

The current standardized plans are the third generation of Medigap plans included in statute. The first group of plans predated the plan standardization mandated by the OBRA90. The second group of plans (labeled Plan A through Plan J) were standardized and became effective in a state when the terms of the OBRA90 were adopted by the state. Many states adopted these terms in 1992.

Standardized Plans

Table 2 provides information on the 10 current, standardized Medigap plans. These plans became effective on June 1, 2010, and an individual purchasing a Medigap policy for the first time (in a state without a waiver) must choose among these plans. However, not every Medigap plan is offered in each state.

[15] The states with waivers are Massachusetts, Minnesota, and Wisconsin. More information is given below in "Medigap Plans for States with Waivers."

[16] No comparable statute exists for Part A.

[17] Centers for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, 2015, p. 20, at http://www.medicare.gov/pubs/pdf/02110.pdf.

Table 2. Standard Medigap Plans, Effective On or After June 1, 2010

Medigap Benefits	Medigap Plans[a]									
	A	B	C	D	F[b]	G	K[c]	L[c]	M	N
Medicare 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 A Hospice care coinsurance or co-payment	yes	yes	yes	yes	yes	yes	50%	75%	yes	yes
Skilled nursing facility care coinsurance			yes	yes	yes	yes	50%	75%	yes	yes
Medicare Part A deductible		yes	yes	yes	yes	yes	50%	75%	50%	yes
Medicare Part B coinsurance or co-payment	yes	yes	yes	yes	yes	yes	50%	75%	yes	d
Medicare Part B excess charge					yes	yes				
Medicare Part B deductible			yes		yes					
Blood	yes	yes	yes	yes	yes	yes	50%	75%	yes	yes
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-pocket limit in 2015							$4,940	$2,470		

Sources: Centers for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, 2015, p. 11, at http://www.medicare.gov/pubs/pdf/02110.pdf and Centers for Medicare & Medicaid Services, *K & L Out-of-Pocket Limits Announcements*, September 2014, at https://www.cms.gov/Medicare/Health-Plans/Medigap/KandL.html.

Notes: This table lists plans available for purchase by new Medigap enrollees as of June 1, 2010**.** Some of the plans had different benefits before this time. For example, the pre-June 1, 2010, Plan G contained an 80% Medicare Part B excess charge benefit and an at-home recovery benefit, while the post-June 1, 2010, Plan G contained a 100% Medicare Part B excess charge benefit and no at-home recovery benefit.

A "yes" in a cell indicates that Medigap covers 100% of the cost of the benefit. A percentage in a cell gives the percentage of the cost that Medigap covers.

a. Plan E, Plan H, Plan I, and Plan J are no longer offered for sale to new beneficiaries.

b. Plan F also is available with a high-deductible option, where the deductible is $2,180 in 2015. Excess charges are the difference between Medicare's recognized amount and actual charges, subject to charge limitations set by Medicare and state law.

c. Plan K and Plan L pay 100% of covered services after the Medigap out-of-pocket limit is met.

d. Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to $50 for emergency room visits that do not result in an inpatient admission.

These 10 plans differ with respect to generosity of benefits, cost-sharing provisions, deductibles, and other features. Plan A provides a basic set of benefits, and Plan F has the most generous benefits. Plan C and Plan F cover all Medicare co-payments and deductibles, and therefore provide "first dollar" or "wraparound" coverage for all covered services.[18]

Plan K and Plan L represent a move away from first dollar coverage. In addition to their outpatient co-payments, these plans have "catastrophic coverage" in that, once the beneficiary has

[18] First dollar coverage of a good or service means that the insurance plan covers 100% of the cost of the good or service (up to any maximum). All plans have first-dollar coverage for preventive care and certain other services.

exceeded an annual out-of-pocket spending limit, Medigap pays 100% of the covered costs for the remainder of the insurance year.

Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to $50 for an emergency room visit that does not result in an inpatient admission.

It should be noted that standardization is not absolute; rather, it serves as a national benefit floor within each plan. In each state, Medigap insurers are permitted, with the prior approval of the state insurance commissioner, to offer plans with new or innovative benefits.[19] For example, a version of Plan F offered by Regence Blue Shield of Idaho offers preventive dental benefits.[20] New or innovative benefits, however, may not be used to reduce standardized benefits.

Pre-standardized Plans

Medigap plans offered before the OBRA90 became effective are known as pre-standardized plans. Although these plans cannot be sold to new beneficiaries, individuals who already have them may keep them. In other words, pre-standardized plans are grandfathered as long as the insurer continues to offer them. About 5% of Medigap plans were pre-standardized in 2013.[21]

Older Standardized Plans Available for Renewal Only

Older standardized Medigap plans that were once available for purchase but are now only available for renewal are Plan E, Plan H, Plan I, and Plan J. An individual who purchased one of these plans may continue to renew his or her plan provided the insurer keeps offering the plan.[22] However, the insurer may not sell these plans to new enrollees. As with pre-standardized plans, older standardized plans are grandfathered.

There is considerable variation among the benefit packages offered by these older plans. Some benefits no longer offered to new beneficiaries may be covered in these plans. For example, Plan H, Plan I, and Plan J can include drug coverage (as long as the beneficiary is not enrolled in Medicare Part D). Those who did not elect Part D may keep the drug benefits in their Medigap plans.[23] A second example of variation is the at-home recovery benefit, which is currently available in Plan D, Plan G, Plan I, and Plan J if the plans were originally sold before May 31, 2010.[24]

---

[19] 74 *Federal Register* 18823.

[20] Regence BlueShield of Idaho, "Regence Bridge Medigap (Medicare Supplement) Plans," p. 7, at http://www.assets.regence.com/docs/ID/medigap/medigap-sales-brochure.pdf.

[21] America's Health Insurance Plans, Center for Policy and Research, *Trends in Medigap Enrollment and Coverage Options*, 2013, November 2014, p. 7, at http://www.ahip.org/AHIPResearch. The underlying data are from the NAIC.

[22] Centers for Medicare & Medicaid Services, "Medicare Program: Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance," 74 *Federal Register* 18825, April 24, 2009.

[23] For information on the conditions under which Medigap with drug benefits and Part D could be exchanged, see Center for Medicare & Medicaid Services, *Your Guide to Medicare Prescription Drug Coverage*, revised June 2014, pp. 44-46, at http://www.medicare.gov/Publications/Pubs/pdf/11109.pdf.

[24] Medicare Interactive, at http://www.medicarerights.org/pdf/Pre-2010Medigap-Benefits-National-2012update.pdf. The at-home recovery benefit covers short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

Medigap Plans for States with Waivers

The standardized Medigap plans do not apply to residents of Massachusetts, Minnesota, and Wisconsin.[25] These states had their own standardized Medigap plans prior to the enactment of the federal standardization requirements. The insurance carriers were permitted to continue existing state standardized plans. The states, however, were required to modify their regulatory requirements to comply with the MMA requirements (e.g., the prohibition against renewing Medigap policies with prescription drug coverage for those enrolled in Medicare Part D). The Medigap plans themselves are broadly similar to the nationally standardized plans, although they differ in their details. For example, at the time these states were granted waivers, their mandated benefits differed. In addition, Wisconsin covers 40 visits of home health care in addition to those covered by Medicare.[26]

SELECT Plans

Medicare SELECT plans are Medigap plans that provide beneficiaries with a managed-care option with reimbursement for medical goods and services received within a limited network.[27] Purchasers of SELECT plans are required (except in emergencies) to obtain care through specified hospitals and, in some cases, doctors in order to have the SELECT plans pay for services rendered.[28] The beneficiaries' premiums are generally lower in SELECT plans in exchange for the restrictions in provider choice.

High-Deductible Plans

A second version of Medigap Plan F has a high deductible.[29] In a high-deductible Plan F, all co-payments are paid for after the deductible is met. The premium for this plan should be less expensive than the standard (no-deductible) Plan F because a high deductible often increases the beneficiary's out-of-pocket expenses, all else equal. The 2015 high deductible is $2,180. In addition, a second version of older Medigap Plan J is a grandfathered high-deductible plan.

Plan Enrollment

About two-thirds of Medigap beneficiaries are enrolled in one of two plans. **Figure 2** provides the distribution of Medigap participants across all current plans. In 2013, about 55% of beneficiaries purchased Plan F. This plan is the most comprehensive available and covers, in addition to the basic services covered in Plan A, all Medicare deductibles, co-payments, and excess charges. An additional 11% of beneficiaries purchased Plan C, which includes the same benefits as Plan F, except it does not cover excess charges. In other words, the two most popular benefit plans cover all deductibles and co-payments.

---

[25] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicare Program: Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance, 74 *Federal Register* 18809, April 24, 2009.

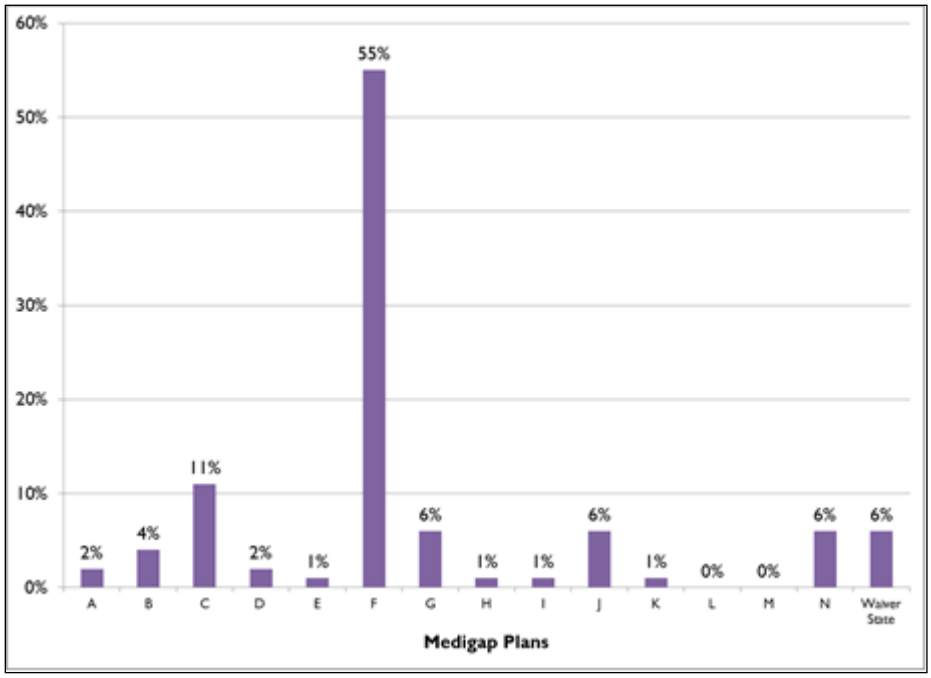
[26] Center for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, 2015, p. 44, at http://www.medicare.gov/pubs/pdf/02110.pdf and Medicare & Medicaid Services, *Medicare and Home Health Care*, May 2010, at http://www.medicare.gov/Pubs/pdf/10969.pdf.

[27] 74 *Federal Register* 18823. The insurance contracts for these *Medigap* plans are known as *Medicare* SELECT.

[28] Medicare always pays its share for services whether or not the provider is a SELECT provider.

[29] 74 *Federal Register* 18809.

Figure 2. Distribution of Current Medigap Plans, All Medigap Beneficiaries, 2013



Sources: America's Health Insurance Plans, Center for Policy and Research, *Trends in Medigap Enrollment and Coverage Options, 2013*, November 2014, p. 7, at http://www.ahip.org/AHIPResearch. The underlying data are from the NAIC.

Notes: Note that some of the plans were available for renewal only to longtime policyholders and could not be purchased by other individuals. Totals may not add to 100% because of rounding. Plan L and Plan M each account for less than 0.5% of Medigap plans. Each state with a waiver (Massachusetts, Minnesota, and Wisconsin) offers its own standardized Medigap plans.

Five plans have entered the Medigap market since 2006.[30] Sales of high-deductible Plan F, Plan K, and Plan L began in 2006, and sales of Plan M and Plan N began in 2010. These new plans have different types of cost sharing.[31] Plan K and Plan L were the first plans to cover less than 100% of the cost of certain benefits including the Medicare Part A deductible and the Part B coinsurance and co-payment. Plan K and Plan L cap out-of-pocket spending to compensate for the potentially large costs of these excluded benefits. Plan M covers 50% of the Part A deductible, and does not have a cap on out-of-pocket spending. For these three plans, beneficiaries might have a relatively hard time predicting their annual costs because their costs depend on the amount and total cost of the medical services they use. On the other hand, Plan N imposes a $20 co-payment for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission. Under Plan N, beneficiaries might have a relatively easier time predicting their annual costs because, while the individual's cost sharing will vary depending on the number of visits they have, the cost sharing does not depend on the total costs of the medical services provided. In short, Medigap plans with co-payments may have

[30] The five plans are Plan K and Plan L (whose development by the NAIC was requested by the MMA), high-deductible Plan F (which was described in the BBA97), and Plan M and Plan N,

[31] All information in this paragraph is from American's Health Insurance Plans, *Trends in Medigap Coverage and Enrollment Options, 2013*, November 2014, at http://www.ahip.org/Epub/Trends-in-Medigap-Enrollment-2013. Data on Plan F include its high-deductible version; however, earlier research concluded that there were relatively few high-deductible F policyholders.

more predictable costs than plans with coinsurance, all else equal. Thus, Plan N's cost sharing may be more predictable than Plan K's, Plan L's, or Plan M's cost sharing.

Over the past few years, Plan N has been one of the fastest-growing plans in percentage terms; for example, total enrollment in Plan N grew by about 116% between 2011 and 2013 (from 265,854 policies to 573,243 policies.) In contrast, total enrollment in Plan F, the most popular plan, grew by about 20% between 2011 and 2013 (from 4,604,164 policies to 5,510,183 policies).[32] Turning to the corresponding insurers, in 2013, about 45% of insurers offered Plan N, but fewer insurers offered the other new plans—15% of insurers offered Plan K, 16% offered Plan L, and 9% offered Plan M.[33]

Consumer Protections

This section summarizes the protections accorded to purchasers of Medigap insurance plans who are at least age 65. Consumer protections are strongest during the initial open-enrollment period, and are also strong in some circumstances discussed below. The section ends with a discussion of the protections accorded to disabled beneficiaries under the age of 65.

During the Open Enrollment Period

Federal law establishes an initial, one-time six-month Medigap open enrollment period for the aged that begins on the first day of the first month the individual both is at least 65 years old and is enrolled in Medicare Part B.[34] Individuals who are receiving Social Security benefits are automatically enrolled in Medicare Part B at the age of 65.[35]

During the open enrollment period, the individual is protected in three ways. First, insurers cannot refuse to sell the individual any Medigap policy that the insurer offers. Second, an insurer cannot set an individual's policy premiums based on the individual's health (i.e., medical underwriting). Third, insurers cannot impose a waiting period before the individual's policy can start. This third prohibition refers to the start of the entire Medigap policy, and is different from a prohibition against the coverage of preexisting conditions.

For the purposes of Medigap, *preexisting conditions* are defined as those conditions diagnosed or treated during the six months immediately preceding the individual's enrollment in a Medigap policy.[36] During open enrollment, individuals may be subject to no more than a six-month preexisting exclusion period. However, preexisting condition limitations may not be imposed at all in certain cases:[37]

---

[32] Total Medigap enrollment increased by 10.1%, from 9.2 million to 10.1 million between 2011 and 2013.

[33] Plan A is offered by 84% of Medigap insurers. American's Health Insurance Plans, *Trends in Medigap Coverage and Enrollment Options, 2013*, November 2014, at http://www.ahip.org/Epub/Trends-in-Medigap-Enrollment-2013.

[34] 74 *Federal Register* 18825.

[35] Individuals who are covered by employer-sponsored health insurance (ESI), based on either their own on their spouse's active employment, when they turn 65, however, may delay purchasing Part B at that time because they would have to pay a premium for benefits that are (usually) already covered by ESI. The six-month Medigap open enrollment period for these individuals begins when they purchase Part B, usually when they are no longer covered through ESI based on active employment. Some states have additional open enrollment periods.

[36] 74 *Federal Register* 18818.

[37] Broad limits on the use of preexisting conditions were imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191).

- If on the date of application, the individual is in the first six-month enrollment period, and has had at least six months of health insurance coverage meeting the definition of "creditable coverage" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191), he or she cannot have preexisting condition limitations.[38] If the individual has less than six months of creditable coverage, the waiting period for the preexisting conditions is reduced by the number of months of creditable coverage.[39]
- An individual who met the exception for preexisting condition limitations in one Medigap plan does not have to meet the exception under a new plan for previously covered benefits.[40]

After the Open Enrollment Period

If an individual applies for a Medigap policy after the open enrollment period, the insurer is sometimes permitted to use medical underwriting. *Medical underwriting* is the use of an individual's health history to decide whether to accept the health insurance application, whether to add a waiting period for preexisting conditions (if permitted by state law), and how much to charge the individual for his or her Medigap policy.

Guaranteed Issue

Even after the open enrollment period has passed, however, the individual may have other consumer protections when purchasing a Medigap policy in limited situations. Medigap g*uaranteed issue* rights are the rights to buy a Medigap plan, have all preexisting conditions covered, and not be charged more for past or present health conditions.[41] There are four broad classes of guaranteed issue rights: rights following a change in residence or employment, rights associated with sampling a Medicare Advantage or Medicare SELECT plan (trial rights), rights triggered by certain actions by the insurer (no fault rights), and other rights.

Rights After Changes in Residence or Employment

If the individual is covered by Medicare, and his or her place of residence or labor force status changes, the individual may have guaranteed issue rights for Plan A, Plan B, Plan C, Plan F, Plan K, and Plan L. In general, to preserve these rights, the individual must apply for the Medigap plan no later than 63 calendar days after the previous health insurance coverage ends. The rights are available for the following reasons:

- An individual is enrolled in a Medicare Advantage plan and moves out of the geographic area. The individual must switch to original Medicare before the Medigap purchase.
- An individual has original Medicare and
  1. an employer group health policy (including retiree or COBRA coverage), or
  2. union coverage that is a secondary payer to Medicare, and

[38] Creditable coverage generally requires that there has not been a break in health insurance coverage for more than 63 days.

[39] The insurer may impose a preexisting exclusion limitation if the individual did not have creditable coverage.

[40] An insurer could impose exclusions for newly covered benefits.

[41] 74 *Federal Register* 18825-18826.

3. the individual's policy ends. If the individual has COBRA coverage, guaranteed issue extends to the end of COBRA.[42] The individual may have additional rights under state law.

- An individual has Medicare SELECT and moves out of the SELECT plan's service area.

Trial Rights

Some individuals enrolled in original Medicare may want to try out different Medicare alternatives such as Medicare Advantage or Medicare SELECT. These individuals may switch from original Medicare to MA or Medicare SELECT, and can try out that policy for up to one year. If these individuals decide to switch back to original Medicare within that initial year, they are guaranteed the right to enroll in a Medigap policy at that time. These rights operate as follows:

- If the individual joined MA when he or she was first eligible for Medicare Part A at age 65, within the first year of joining the individual may switch to original Medicare and have guaranteed issue rights for any standardized Medigap plan sold in the state.[43]
- If the individual dropped a Medigap policy to join an MA or Medicare SELECT plan for the first time, and the individual has been in the new plan for less than a year, the individual has guaranteed issue rights for the original Medigap plan if the former insurer still sells it. If the former plan is not available, the individual has guaranteed issue rights for any of Medigap Plan A, Plan B, Plan C, Plan F, Plan K, or Plan L that is sold in the state.

These rights generally last for 63 days after coverage of the forfeited MA or SELECT plan ends, although they might last for an extra 12 months under certain circumstances.

No Fault Rights

If an insurer is no longer able to sell the Medigap plan, or has not followed the requirements for Medigap insurers, or has misled the individual, the individual's purchase of Medigap Plan A, Plan B, Plan C, Plan F, Plan K, or Plan L from any insurance carrier is guaranteed as follows:[44]

- If the individual's insurer goes bankrupt or a Medigap policy ends through no fault of the individual, the individual has guaranteed issue rights.
- If the Medigap insurer commits fraud, and the individual then drops the insurer's business, the individual has guaranteed issue rights.

---

[42]COBRA coverage takes its name from the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). COBRA requires employers with 20 or more employees to provide employees and their families the right to continue participation in the employer's group health policy in case of certain events, one of which is involuntary dismissal. For more information on COBRA, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer.

[43] The guaranteed issue right also holds if the individual joins the Programs of All-Inclusive Care For the Elderly (PACE). PACE is a capitated benefit permanently authorized by the BBA97 with a comprehensive service delivery system and integrated Medicare and Medicaid financing.

[44] 74 *Federal Register* 18826.

Other Rights

If the individual is enrolled in an MA plan and the insurer sponsoring the plan stops participating in Medicare or if the MA plan leaves the geographic area, the individual has guaranteed issue rights to purchase any of Medigap Plan A, Plan B, Plan C, Plan F, Plan K, and Plan L that is sold in the state by any insurance carrier. The individual must be enrolled in original Medicare before purchasing Medigap.

Guaranteed Renewal

Standardized Medigap policies are guaranteed renewable so long as the plan remains for sale in the market.[45] A Medigap insurer may only terminate a beneficiary's standardized plan if that beneficiary commits fraud, makes an untrue statement, or fails to pay the premium.

Genetic Nondiscrimination

Section 104 of the Genetic Information Nondiscrimination Act (GINA; P.L. 110-343) prohibits Medigap insurers from[46]

- using genetic information about an individual to deny coverage, adjust premiums, or impose preexisting condition exclusions;
- requiring or requesting genetic testing; and
- requesting, requiring, or purchasing genetic information for underwriting purposes.

Switching Medigap Plans

A beneficiary might want to switch Medigap plans to reduce or increase the benefit levels, change the insurance firm, or move to a less expensive plan. To purchase a new Medigap plan, the beneficiary must notify the first Medigap insurer that he or she is going to cancel that insurer's plan as of a certain date. If the new Medigap plan starts one month before the coverage from the old Medigap plan ends, the beneficiary has 30 days to decide whether to keep the new Medigap plan. The beneficiary must pay premiums for both the old and new Medigap plans during these 30 days.[47]

Even though a beneficiary may be able to switch Medigap plans, he or she might not want to. In particular, the consumer rights discussed above do not apply outside of the circumstances listed above. At other times, the insurer might refuse to sell the individual a policy, or increase the premium if the individual is in poor health.

Medigap for Individuals Under the Age of 65

To be covered under Medicare before the age of 65, individuals must qualify for Medicare based on disability. In particular, individuals under the age of 65 who received cash disability benefits

[45] 74 *Federal Register* 18818.

[46] For additional information on GINA, see CRS Report RL34584, *The Genetic Information Nondiscrimination Act of 2008 (GINA)*, by Amanda K. Sarata and Jody Feder.

[47] Centers for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, 2015, pp. 32-33, at http://www.medicare.gov/pubs/pdf/02110.pdf.

from Social Security or the Railroad Retirement systems for at least 24 months are entitled to Medicare Part A.[48] While there is no federal requirement that insurers sell Medigap plans to disabled individuals, some states require that Medigap plans be available to some or all of these individuals.[49] In other states, insurers choose to sell Medigap plans even though there is no requirement that they do so. If permitted by state law, insurers can use medical underwriting and charge higher premiums for the standardized plans when selling to those under the age of 65.

Those under the age of 65 covered by Medigap are entitled to all open enrollment rights upon turning 65. Because medical underwriting is forbidden during the initial open enrollment period, the beneficiary's premium might drop at the age of 65 because the beneficiary's health status can no longer affect the premium. In addition, for those who have had Medicare for at least six months immediately before turning 65, there is no preexisting condition waiting period because the beneficiaries have met the creditable coverage requirement.

Insurers' Requirements

In addition to fulfilling these consumer protection requirements, insurers must offer certain plans, set premiums for their Medigap plans, and ensure the plans return a certain amount of the dollar value of claims as benefits to the policyholders.

Required Plans

If an insurer wishes to offer any Medigap plans, the insurer must offer the basic plan (i.e., Plan A). If the insurer wishes to offer any plan(s) in addition to Plan A, the insurer must then offer at least Plan C or Plan F, before it can offer any other plan.[50]

Premiums

A *rating option* is the method by which the insurer sets premiums for health insurance policies. There are three rating options in the Medigap market. Premiums may increase over time under all three ratings options; the options differ in the conditions under which premiums may increase based on the ratings option. For example, all options allow premiums to vary with the inflation rate in the beneficiary's community, but not all options allow premiums to vary with the beneficiary's age. Depending on the state, premiums may also vary with gender, smoking status, and perhaps other variables. The three rating options are as follows:

- Under the *community rating* option, the premium does not depend on the beneficiary's age. Therefore all individuals enrolled in a particular plan pay the same premium and it does not increase with the individual's age.
- Under the *issue-age rating* option, the premium is based on the beneficiary's age when the Medigap policy was first purchased. For example, if Plan A is sold by an insurer, that insurer would charge a lower premium for a 65-year-old new

[48] Centers for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, 2015, pp. 39-40, at http://www.medicare.gov/pubs/pdf/02110.pdf. Many disabilities qualify. In addition, a few specific illnesses/diseases have special provisions for Medicare enrollment; examples include End-Stage Renal Disease (ESRD, or permanent kidney failure requiring dialysis or a kidney transplant) and Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease).

[49] 74 *Federal Register* 18829.

[50] 74 *Federal Register* 18823. See also Centers for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, 2015, p. 12, at http://www.medicare.gov/pubs/pdf/02110.pdf.

enrollee than for a 75-year-old enrollee. However, for any given individual, the premium may not increase as the individual grows older. Premiums are therefore relatively high (when compared to premiums that are adjusted each plan year for an individual's attained age) at the time of initial purchase, but do not increase as the beneficiary ages.

- Under the *attained-age rating* option, the premium is based on the beneficiary's current (attained) age. Premiums are relatively low when the individual first purchases the policy (i.e., those who are 65 years old), but as the individual ages, the premiums will increase.

The greatest difference between the ratings options, therefore, is the way premiums increase (or do not increase) over time. From a beneficiary's perspective, the least expensive option for any given policy at the date of purchase may not be the least expensive option over the lifetime of the policy. When comparing premiums across insurance companies, therefore, individuals need to consider the premiums (or expected premiums) over the lifetime of the policy.

Medical Loss Ratios

The *medical loss ratio* (MLR) measures the extent to which an insurance company uses the premiums it receives to cover the claims of its beneficiaries. More precisely, the MLR is the percentage of the total premiums received that the insurance company spends on health care benefits. Thus, if a plan received $100 in premiums and spent $85 on medical claims, its MLR would be 85%. A relatively high MLR suggests that the policyholders are receiving value because they are receiving relatively more benefits, and the insurance company is retaining relatively less in administrative costs and profits. The actual process by which individual insurers calculate their respective MLRs involves more details and assumptions.[51]

The required Medigap medical loss ratios are at least 75% for group plans and at least 65% for individual plans.[52] Should a Medigap insurer fail to meet the required ratios, the insurer is required to reimburse the beneficiaries by offering refunds or credits in order to meet the Medigap plan MLR requirement. It should be noted that the MLRs for comprehensive health insurance policies were defined in ACA, and are higher than those for Medigap. In addition, the methodologies for calculating MLRs differ between comprehensive health insurance and Medigap.

The required MLR is lower for individual policies than for group policies because an insurance firm's administrative costs tend to be higher for individual plans. For example, it is more expensive (per beneficiary) to market plans to individuals one at a time than it is to market to one employer (or one union or one retiree group) on behalf of multiple individuals.

[51] U.S. General Accounting Office (now called the Government Accountability Office), *Medigap Insurance: Compliance With Federal Standards Has Increased*, HEHS-98-66, March 1998, at http://www.gao.gov/archive/1998/he98066.pdf.

[52] In this context, policies issued as a result of the solicitation of individuals through mail or by mass media advertising are considered individual policies. The calculation requirement for Medigap MLRs predates ACA and differs from the calculation of comprehensive health insurance MLRs. For information on the comprehensive health insurance MLR calculation, see CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by Suzanne M. Kirchhoff.

The Role of the National Association of Insurance Commissioners

NAIC is an association of insurance regulators from the 50 states, Washington DC, and four U.S. territories.[53] One of the Association's stated goals is to make state regulation more consistent and uniform.[54] The NAIC also collects financial information from insurance companies; some of the data presented in this report were collected by the NAIC.[55]

The specific provisions (e.g., levels of cost sharing and types of coverage) of all Medigap plans (excluding those in waiver states) are formulated by the NAIC. Once finalized, the standardized plans are known as *NAIC model standards* for Medigap plans. The NAIC, however, has no authority to monitor whether the states comply with its model standards. Instead, states retain regulatory authority. States must either

- adopt the NAIC model standards and any subsequent revisions, or
- enact regulatory provisions that are more stringent that those in the NAIC model standards or in the regulatory requirements.[56]

If a state fails to adopt the NAIC model standards, the state will be considered out of compliance with federal requirements and will not be permitted to regulate its Medigap market.[57] In this case, the Centers for Medicare & Medicaid Services of HHS would regulate the sale of Medigap plans.

The NAIC has been actively involved in the evolution of the standardized Medigap plans. Changes are made over time to reflect changing health care statutes and practices. For example, a Medigap "preventive care" benefit was eliminated in 2010 because expanded Medicare Part B benefits under ACA made the Medigap preventive care benefit unnecessary.

Descriptions of Medigap Markets

This section discusses Medigap premiums, the level of participation in Medigap across states, and the socio-demographic characteristics of the Medigap beneficiaries. Because Medigap is sold and regulated by states, each state is its own Medigap market.

[53] More formally, the NAIC is a private Internal Revenue Code Section 501(c)(3) nonprofit association. The NAIC members are the elected or appointed state government officials who, along with their departments and staff, regulate the conduct of insurance companies and agents in their respective state or territory.

[54] For additional goals, see *About the NAIC*, NAIC, at http://www.naic.org/index_about.htm.

[55] In some states, not all insurers report to the state insurance commissions and therefore not all insurers report to the NAIC. For example, health insurance issuers regulated by California's Department of Managed Health Care are not required by state regulators to submit data to the NAIC.

[56] 74 *Federal Register* 18809.

[57] Implementation Materials for Revisions to Medigap Model, NAIC, at http://www.naic.org/documents/committees_b_senior_issues_medigap_impl_guide.pdf, p.1.

Medigap Premiums and Plan Choice

Medigap premiums for the same standardized plan, for example Plan F, may not be the same across any or all insurers offering that plan in a state. In fact, there is wide variation in Medigap premiums for each plan nationwide.[58]

This variation reflects the geographic variations in the price levels, state regulations, smoking, gender, and possibly other discounts, and the rating structure used. Even controlling for these differences, however, variations in premiums remain.[59] Individuals do not always purchase the least expensive version of their chosen plan. There are a number of hypotheses concerning this behavior:[60]

- Many of the price comparisons are available on the Internet (at the state insurance websites), and some of the elderly are not Internet savvy.
- There may be cognitive impairment in this age group.
- The large number of choices associated with selecting a Medigap plan could prove daunting.
- Potential Medigap beneficiaries may prefer to remain with their existing (pre-Medicare) insurance agent, even though the existing agent may not sell what would be the best plans for these beneficiaries.
- Certain insurers attract individuals through name recognition.[61]

Medigap Market Participation by Individuals Across States

Figure 3 provides the number of Medigap enrollees in 2013 by state. Enrollment varies from a low of 5,215 individuals in Hawaii to a high of 682,913 individuals in Florida. Other states with a high Medigap enrollment include Texas, Pennsylvania, and Illinois.[62] **Figure 3** is informative from a financial perspective in that it indicates which states have relatively more dollars in the Medigap market. However, the map does not provide any information about whether Ohio has a higher Medigap enrollment than North Dakota because a larger number of those eligible for Medigap actually enroll or simply because Ohio has more residents than North Dakota.

[58] Jennifer T. Huang, Gretchen A. Jacobson, and Tricia Neuman, et al., *Medigap: Spotlight on Enrollment, Premiums, and Recent Trends*, The Henry J. Kaiser Family Foundation, April 2013, p. 27, at http://kff.org/medicare/report/medigap-enrollment-premiums-and-recent-trends/.

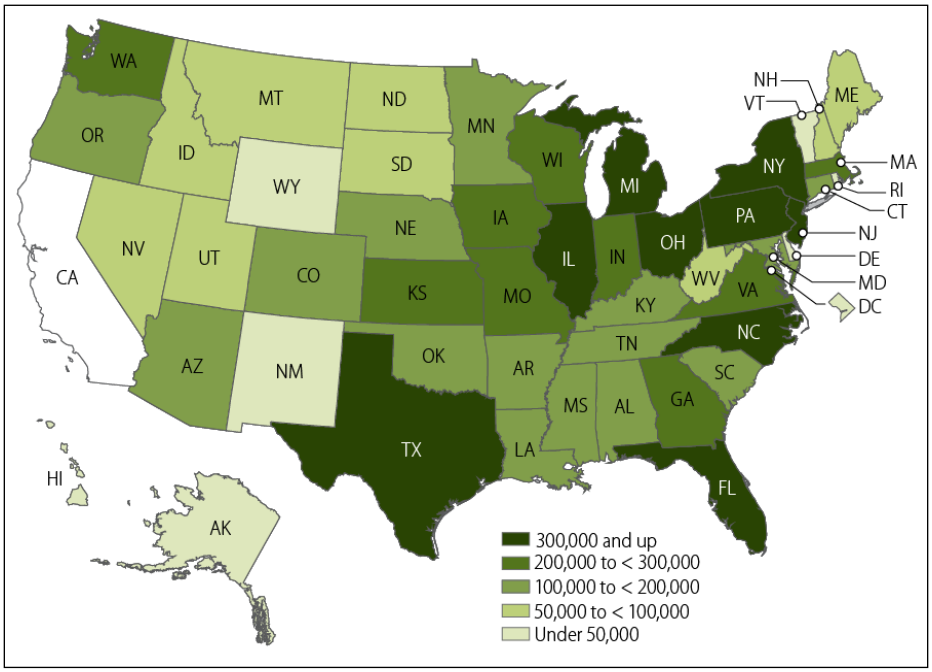
[59] Nicole Maestas, Mathis Schroeder, and Dana Goldman, *Price Variation in Markets with Homogeneous Goods: The Case of Medigap*, NBER, Working Paper 14679, January 2009, pp. 1-6, at http://www.nber.org/papers/w14679.

[60] Ibid.

[61] For example, most individuals have heard of the Blue Cross/Blue Shield insurers. In addition, many individual policies are purchased in conjunction with the AARP. Individuals who contact the AARP about Medigap are referred to United Healthcare and may then go on to purchase individual Medigap policies from this insurance firm. The AARP markets the plans, and United Healthcare is the insurer who bears the risk associated with that insurance. At the national level, United had a national market share of about 46% between 2004 and 2008; see Amanda Starc, *Insurer Pricing and Consumer Welfare: Evidence from Medigap*, Harvard Business School, Working Paper, November 29, 2010, pp. 5-9 for details.

[62] The four states with the greatest population are California, Texas, New York, and Florida.

Figure 3. Medigap Enrollment by State, 2013



Source: Created by CRS, based on the NAIC data contained in America's Health Insurance Plans, *Trends in Medigap Coverage and Enrollment Options*, 2013, November 2014, p. 10, at http://www.ahip.org/Epub/Trends-in-Medigap-Enrollment—and-Coverage-Options-2013/Trends-in-Medigap-Enrollment—and-Coverage-Options,-2013.aspx.

Notes: Complete data for California are not available. California has both a Department of Insurance and a Department of Managed Care. These two departments are governed by different regulations, and only the former is required to file data with the NAIC. More information on the Department of Insurance is available at http://insurance.ca.gov. More information on the Department of Managed Care is available at http://www.dmhc.ca.gov.

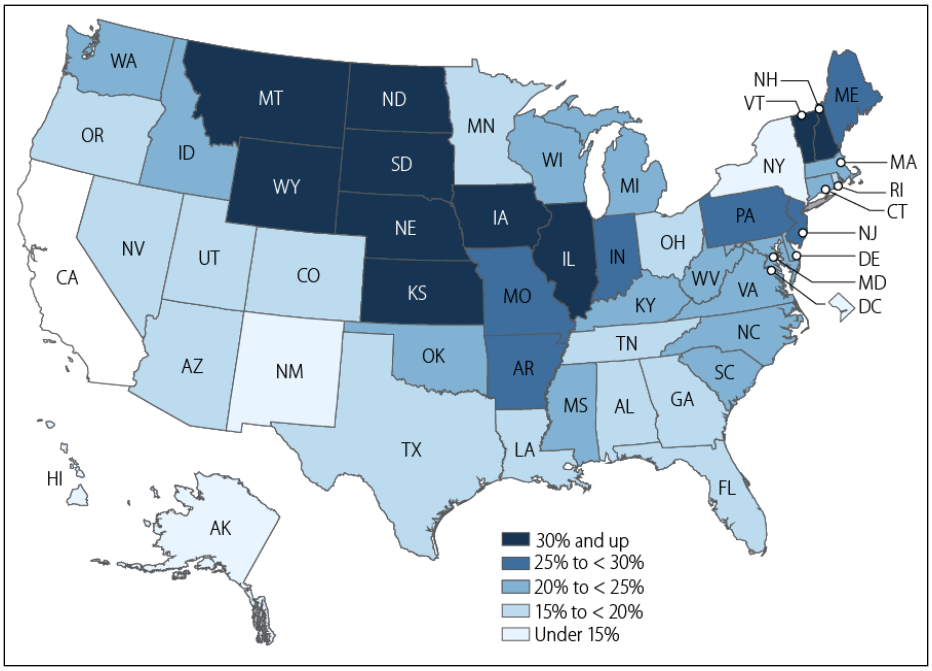
Figure 4 shows the percentage of those enrolled in Medicare who purchased Medigap plans in 2012, and it presents a different picture than **Figure 3**.[63] The share of those enrolled in Medicare who purchased Medigap varies from a low of 2.2% in Hawaii to a high of 48.8% in Iowa.

On average, participation in Medigap is relatively lower in those states where participation in Medicare Advantage is relatively high. In 2012, the percentage of Medigap enrollees of those with Medicare was relatively higher in parts of the Midwest and mountain states than in other areas of the country. The participation rate in Medicare Advantage was relatively lower in parts of the Midwest and mountain states than in other areas of the country.[64] Similarly, the participation rate in Medigap plans was relatively lower in parts of the Southwest and the participation rate in Medicare Advantage was relatively higher.

[63] Consistent data are not available for both Medigap and Medicare Advantage for 2013. Instead, the report presents the most recent available data for each concept. **Figure 3** is broadly similar when depicted with either 2012 or 2013 data.

[64] The Henry J. Kaiser Family Foundation, *Medicare Advantage Fact Sheet*, May 1, 2014, at http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet. This paragraph compares data from 2012 with data from 2014. There are not consistent data for a single year comparison.

Figure 4. Percentage of Medicare Enrollees with Medigap Coverage by State, 2012



Sources: CRS calculations using two data sources. The total Medicare data cover July 2012, and are from Table 2.8 of the Medicare & Medicaid Statistical Supplement, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013.html. The Medigap data cover December 2012, and are based on NAIC data contained in *Trends in Medigap Coverage and Enrollment, 2012*, May 2013, pp. 7-9, at http://www.ahip.org/Trends-Medigap-Coverage-Enroll2012.

Notes: Complete data for California are not available. California has both a Department of Insurance and a Department of Managed Care. These two departments are governed by different regulations, and only the former is required to file data with the NAIC. More information on the Department of Insurance is available at http://insurance.ca.gov. More information on the Department of Managed Care is available at http://www.dmhc.ca.gov.

Medigap Markets by Characteristics of Enrollees

Limited public information is available on the socioeconomic characteristics of those individuals who participate in Medigap. The information reported here comes from various components and years of the Medicare Current Beneficiary Survey. A report by America's Health Insurance Plans (AHIP, a trade group) found differences in take-up rates and socioeconomic characteristics between rural and urban beneficiaries in 2012.[65] AHIP concluded that 29% of Medigap beneficiaries lived in rural areas, whereas 23% of all Medicare beneficiaries did so. AHIP also observed that Medigap holders in rural areas were more likely to have lower incomes than their urban peers.

The Medicare Payment Advisory Commission (MedPAC) reported the relationships between Medigap status and income class and health for 2010. Of Medicare beneficiaries with an income of less than $10,000, 8% were covered by Medigap, 8% were covered by employer-sponsored insurance, and 57% were covered by Medicaid. Of those Medicare beneficiaries in poor health,

[65] America's Health Insurance Plans, Beneficiaries with Medigap Coverage, April 2015, p. 4, at http://www.ahip.org/epub/MedigapBeneficiaries. The underlying data come from the Medicare Current Beneficiary Survey Access to Care files.

16% were covered by Medigap. But of those in excellent or very good health, 24% were covered by Medigap.[66]

Author Information

Patricia A. Davis
Specialist in Health Care Financing

Acknowledgments

This report was written by Carol Rapaport, a former CRS analyst.

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

[66] MedPAC, *Healthcare Spending and the Medicare Program*, June 2014, p. 28, at http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf?sfvrsn=1. The underlying data come from the Medicare Current Beneficiary Survey Access to Care files.