



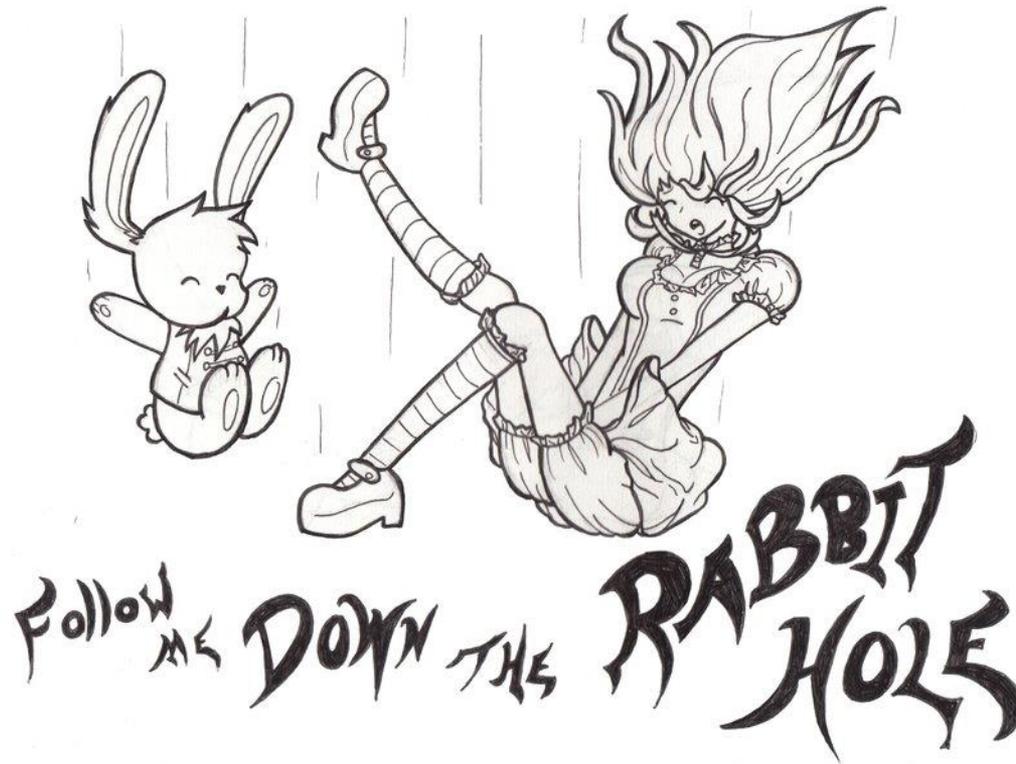
2019 SMP/SHIP NATIONAL CONFERENCE

The Subterranean World of Medigap

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The Subterranean *World* of Medigap



Into federal legislation



Federal Law (MACRA)

- MACRA enacted in 2015 (effective 2020)
 - Medicare Access and CHIP Reauthorization Act
 - Prohibited sale of benefit for Medicare Part B deductible to **newly eligible** for Medicare Part A on or after 1/1/20
- NAIC adopted changes to the NAIC Model Medigap Regulation
 - Subsequently incorporated into federal law
- States must enact changes to continue authority to regulate Medigap insurance
 - Adoption still pending in a few states

Beginning January 1, 2020

- Anyone “newly eligible” for Medicare Part A
 - Can’t be sold or issued any benefit for Medicare Part B deductible
 - Plans C and F, and high deductible F
 - Needs “Skin in the Game”
- “**Newly eligible**” means:
 - 65th birthday occurred on or after 1/1/20, or
 - *Deemed eligible* for Part A
 - Due to disability or ESRD *effective* on or after January 1, 2020
- **Date of eligibility for Part A by age or disability determines which Medigap plans a beneficiary can buy in 2020**



Part A Entitlement

- Eligible for Part A **before** January 1, 2020
 - By **age** (65), **disability**, or **ESRD**
 - Even if **didn't apply for Medicare** at the time
 - Even if **didn't sign up for Part B**
 - Can still buy **C** and **F** **after** January 1, 2020
 - **Effective date of Medicare A or B shown on Medicare card may not be date of entitlement**
 - **Delayed or retroactive enrollment**
 - **Drivers license or other legal source includes birthdate**

So, Who Can Buy What?

2 Classes Of Beneficiaries

Entitlement Date Before 1/1/2020

- Date of Entitlement for Part A
 - Can buy C or F
 - Plus other available Medigap plans
 - Including HD F and HD G

- Guaranteed Issue
 - (state or federal rights)

 - Can buy C or F
 - Plus other available Medigap plans
 - **Including HD F and G**

Entitlement Date After 1/1/2020 (65th birthdate or deemed eligible)

- Date of Entitlement for Part A
 - Can **only** buy D or G
 - **Instead of C or F**
 - Plus other available plans
 - And HD G instead of HD F

- Guaranteed Issue
 - (state or federal rights)

 - Can **only** buy D or G
 - **Instead of C or F**
 - Plus other available plans
 - Including HD G

2020 Medigap Chart



Benefits	Plans Available to All Applicants								Medicare first eligible before	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays ³ apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
					[\$5120] ²	[\$2560] ²				

Federal Law

- D and G substitute for C and F for newly eligible beneficiaries;
 - ***Even if*** no changes are made to state law
 - Substitution is mandated in federal law
 - Applies to Initial Enrollment Period (IEP)
 - Applies to any guaranteed issue rights

OH, OH! POP.....



Medicare Trial Periods, down another rabbit hole.....

Medicare Trial Periods

- Enrolled in a MA plan and wants to leave
- 1st time in an MA plan
- Wants a Medigap
- What are the rules?
 - Is it age?
 - Is it Medicare eligibility?
 - Is it other coverage?



Two Medicare Trial Periods

1. Enrolls in MA plan* or PACE for the **very first time since being entitled to Medicare**, and disenrolls during the first 12 months
 - At **age 65** and was **first eligible for Medicare A**
 - Guaranteed issue in any Medigap 60 days before and 63 days after date of disenrollment from MA plan
2. Dropped a Medigap, enrolled in an MA plan for the 1st time since being entitled to Medicare
 - Can get original Medigap back, or if not available, guaranteed issue to A, B, C, F, K, L.

Definition of MA Plan

- * MA Plan.....any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy;

STANDARDIZED MEDIGAP BENEFIT PACKAGES

Ever wonder how this happened?

It wasn't always this way

A little history.....



The Old (Really Old) Days

- Medicare in the old days
 - Hospitals bills
 - Itemized hospital billing to patients
 - MSN didn't match itemized billing
 - Showed only what Medicare paid
 - Many providers didn't bill Medicare
 - Doctors, labs, ambulance, radiology
 - Beneficiaries
 - Billed Medigaps, needed to submit Medicare MSN and matching itemized provider bills

Medigaps In The Old Days

- Medigap designs of the past included:
 - Separate Medigaps for Medicare Parts A and B
 - Deductible for Medigap benefits
 - Partial payment of Medicare covered expenses
 - Annual limits on benefit payment
 - New 6 month pre-X with every new Medigap issued
 - Not guaranteed renewable
 - Additional costs for group membership coverage



Medigap Variations

- Separate Medigap for Part A and Part B
 - Part A coverage
 - Part A deductible, covered or not, or some percentage amount
 - Nursing home benefit covered or not
 - Only after 100 days and if skilled care
 - Part B
 - Annual deductible of \$200 annually, or various amounts
 - Part B deductible, covered or not, or percentage amount
 - Benefits limited to 50% of Part B benefit copay or coinsurance
 - Benefit payment based on UCR, not Medicare
 - Sometimes included excess charges, or not
 - Annual benefit cap of \$5,000
 - Combinations of some or all of the above
 - Pre-x period defined by company
 - New pre-x period with each new Medigap
 - Some policies not guaranteed renewable
 - Could be cancelled at will by company

Baucus Amendment of 1980

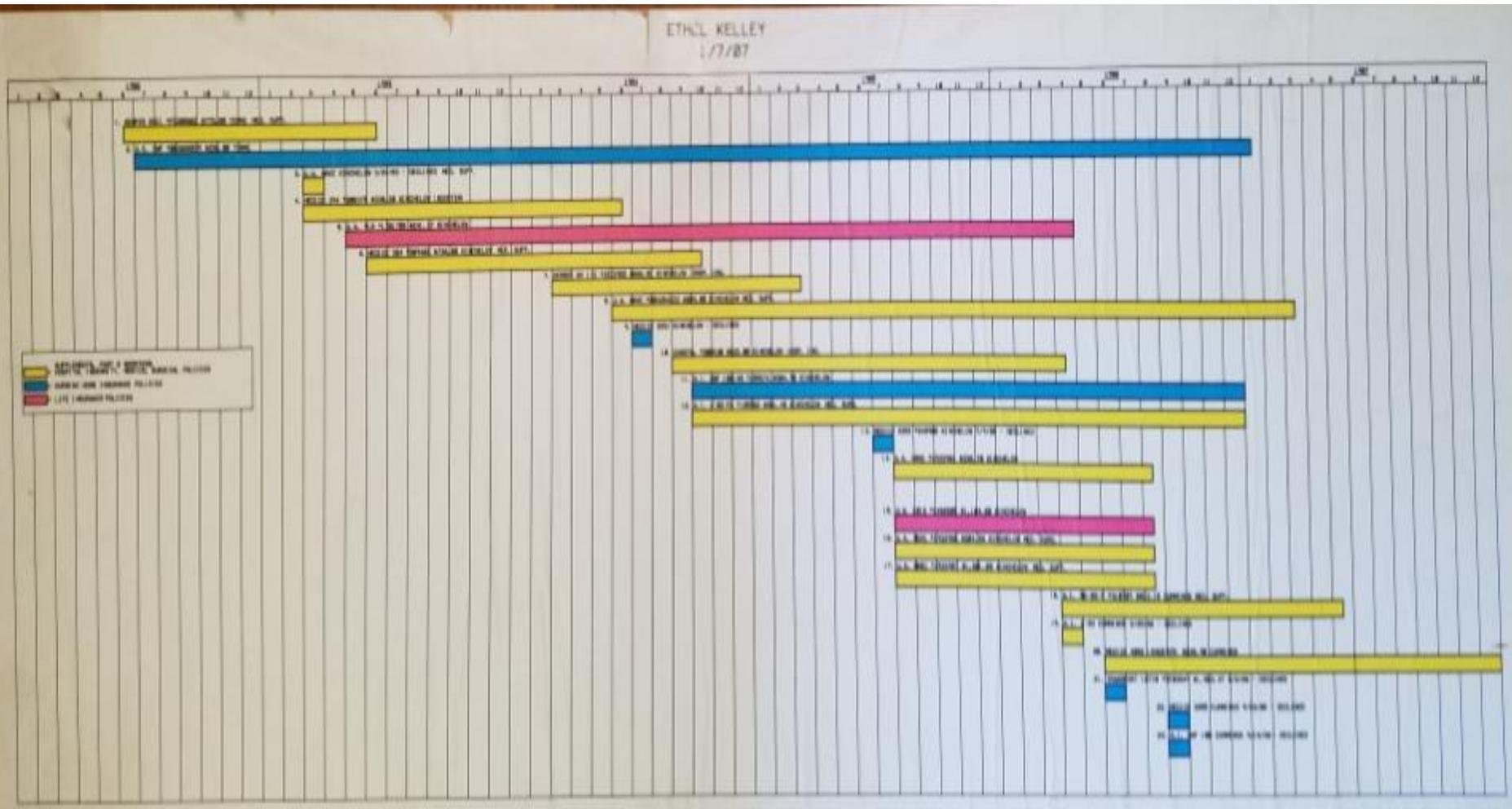
- Created federal voluntary standards for Medigaps
 - NAIC developed standards for states
 - **Minimum** benefit standards
 - \$200 maximum deductible for Part B eligible expenses
 - \$5,000 annual benefit cap
 - Limited pre-existing condition exclusions to six months before and after coverage
 - Medical loss ratio standards “encouraged”
 - 60% individual, 75% group
 - Encouraged standard outline of coverage and a buyer's guide
 - Required specific information to be disclosed to prospective purchasers
 - 30 day free look replaced 10 day
 - **Prohibited duplicative coverage, but no definition of “duplication”**
 - Sales of multiple Medigaps to the same individual continues (stacking)

These Abuses Flourished

- Rollover and “churning:” Medigaps and other coverage
 - First year commissions paid on each policy issued
 - Frequent and reckless sales
 - Medigap coverage replaced or added to existing coverage
 - Every year, or six months (to accommodate pre-x)
 - 6 month pre-x period in every Medigap
 - Policy “stacking”
 - Sale of multiple overlapping and unnecessary policies, including
 - Nursing home, dread disease, hospital indemnity, burial insurance
- Theft of premium payments

Ethel Kelly: 23 Policies (1982-86)

From Santa Cruz District Attorney lawsuit against insurance agency. One of 85 victims presented to the court – Part of federal hearings on Medigap abuse



And Then This Happened!

- **Federal hearings on Medigap abuses** (1988-89)
 - Medigap advertising appears as an official notice from the federal government
 - Bogus consumer organizations as fronts to solicit and sell Medigap and other insurance
 - Group association Medigaps
 - Membership and Medigap not guaranteed renewable
 - Could terminate group or coverage at will
 - Fees for membership in group added to premium
 - Fees for other group “services” added to premium
 - Churning, twisting, and stacking coverage

And Then OBRA 90 Happened

- **The Omnibus Budget Reconciliation Act of 1990**
 - (OBRA-90)
 - NAIC establishes a mandatory, standardized, set of Medigaps
 - 10 standardized, unchangeable benefit packages
 - Guaranteed renewability required
 - Federal penalties for agents and insurers who knowingly sell coverage that duplicates Medicare benefits, and
 - Can only replace Medigap coverage, not add Medigap to another Medigap
 - Other changes
 - Added 6 month open enrollment with no pre-x
 - Limits pre-x to 6 months prior to enrollment and after
 - Open enrollment exception
 - Limits commissions

Now....Ten Standard Medigaps

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	A	B	C	D	F*	G	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2017**			
							\$5,120	\$2,560		

* Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of \$2,200 in 2017 before your policy pays anything.

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$183 in 2017), the Medigap plan pays 100% of covered services for the rest of the calendar year.

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

I told you all of that so I could tell
you this!Say Hello To
Innovative Benefits!



Non-standard benefits added to a standardized benefit package

What Is An Innovative Benefits?

- Option as part of original standardization
 - **Congressional intent:**
 - **State's can experiment to develop future modification of standard benefits**
 - **Managed care and cost control features (Sen. Riegle, author of Senate Bill)**
 - **New or innovative benefits must be:**
 - New, innovative, cost effective
 - Not *otherwise available*
 - Not "*adversely affect the goal of simplification*"
 - Appropriate to Medigap coverage
 - "*.....may include cost controls or managed care **features***"
 -
 - **No definitions of "new, innovative, or features"**
 - **Statutory languages is permissive, CMS = state authority to decide**

- **Innovative benefits can't:**
 - Change, reduce, Medigap benefits, or cost sharing
 - Add Rx benefit (since Part D)
 - Be a *vendor discount or discounted cost*
 - *Must show separate premium cost*
- **Extra benefits without a premium are not innovative benefits**
 - Nurse line, Silver Sneakers, etc.

Innovative Benefits

- **Federal law** (Sec.1882 {42.U.S.C. 1395ss] (p)4(B))
 - **...not otherwise available?** (some benefits are often widely available)
 - Most benefits currently offered as innovative benefits are not new, and are widely available as separate insurance products available and marketed to older adults (vision, dental, hearing)
 - **...cost effective?** (adds value)
 - Depends on how each benefit is designed and priced
 - Premium vs actual benefit and amount
 - **...consistent with goal of simplification?** (ability to compare)
 - Inconsistent with standardized benefit packages
 - Benefits, and format of benefit descriptions not standardized

Examples of Innovative Benefits

- **Dental, vision, hearing benefits** (filed as innovative benefit)
- **High Deductible F and disappearing high deductible**
 - Converts to Plan F after 3 years with same premium as HD F (filed as innovative benefit)
- **Part A deductible waiver**
 - \$100 premium deduction for use of preferred hospital waives Part A deductible (filing status unknown)
- **Innovative benefit can't be vendor discount**
 - “Benefits such as discounts for eyeglasses or frames, discounts for hearing aids, membership in health clubs, or other types of ancillary services or programs should not be considered new or innovative benefits.” (NAIC Compliance Manual)

Non-standard Innovative Benefits

- No standards exist for these benefits
 - Coverage (what's included or excluded)
 - Annual limit for each benefit
 - Annual deductibles
 - Network or sole source provider
 - Amount of copayment for each benefit
 - In and out of a network, or contracted provider
 - Premium
 - Format, benefit design, and description
 - Non-standard benefits inside a standardized plan

Insurance and Vulnerable Elders

- When products are so complicated that people can't decipher the benefits it makes them vulnerable to fraud, or to being sold excessive or unnecessary benefits
 - Buying products that don't fit their needs but reward the seller with lucrative commissions
 - Misleading sales and advertising
 - Higher premiums
 - Difficulty using benefits
 - See: Annuity sales and suitability issues

The Role Of The NAIC

- The National Association of Insurance Commissioners (NAIC)
 - Delegated to create 10 standard plans (1990 federal law)
 - Appointed a workgroup of regulators, industry and consumer groups
 - Designed 10 standard Medigap benefit packages
 - Reconstitutes workgroup when federal law changes
 - Makes revisions to the NAIC Model Act and Regulation
 - States must adopt changes to retain regulatory authority of of Medigaps..... or regulation reverts to federal government

- Monitors Medigap market for changes (Compliance Manual)
 - States should report new or innovative benefits to the Senior Issues Task Force (SITF)
 - NAIC maintains a record of all new or innovative benefits approved throughout the country
- SITF required to periodically review:
 - In collaboration with: CMS and other interested parties, whether any of the new or innovative benefits approved for use in the states should be made part of the standard benefit designs and benefit plan designs contained in the Medicare Supplement Model Regulation.
- Availability of new or innovative benefits:
 - Each state should consider publishing all the new or innovative benefits it has approved so that the benefits will be available to all insurers in the marketplace
- Ease of filing with states:
 - Medicare supplement carriers could certify that the benefit they are filing for approval are *exactly the same* as a previously approved new or innovative benefit

And then this happened!

- Congressman Neal
 - Chair of House Ways and Means
 - Letter to the NAIC
 - LTSS in Medigaps?
 - New Medigap or Medigap like product with front end benefits for LTSS?
 - 90 days to respond
- NAIC working to respond
- Stay Tuned!



When Is COBRA Not a Reptile?



Working Past Age 65

- The number of people working past age 65 today is the highest it has been in 55 years.
- By 2024 **36%** of people between the ages of 65 and 69 projected to be in the labor force

Source: The Bureau of Labor Statistics

- Many have EGHP health coverage
 - EGHP is primary coverage while working
 - Age 65 = 20+ employees
 - Disabled = 100+ employees
 - Many don't enroll in Medicare
 - More premium, secondary coverage

Eligibility and Benefit Payments

- Entitled to Medicare first, before eligible for COBRA
 - **Can have both Medicare and COBRA**
- Enrolled in COBRA first and later entitled to Medicare
 - **Will lose COBRA immediately**
 - Employer can extend COBRA
 - Few choose to do so
- Little known fact:
 - Once on COBRA, order of payment changes
 - Medicare becomes primary, COBRA is secondary, even if not enrolled, and even if they didn't know this
 - Medicare is secondary **only** while someone is actively employed, bene or dependent (IRS rules)
 - Except during 30 month coordination period for people with ESRD when COBRA is primary

Employer Coverage and COBRA

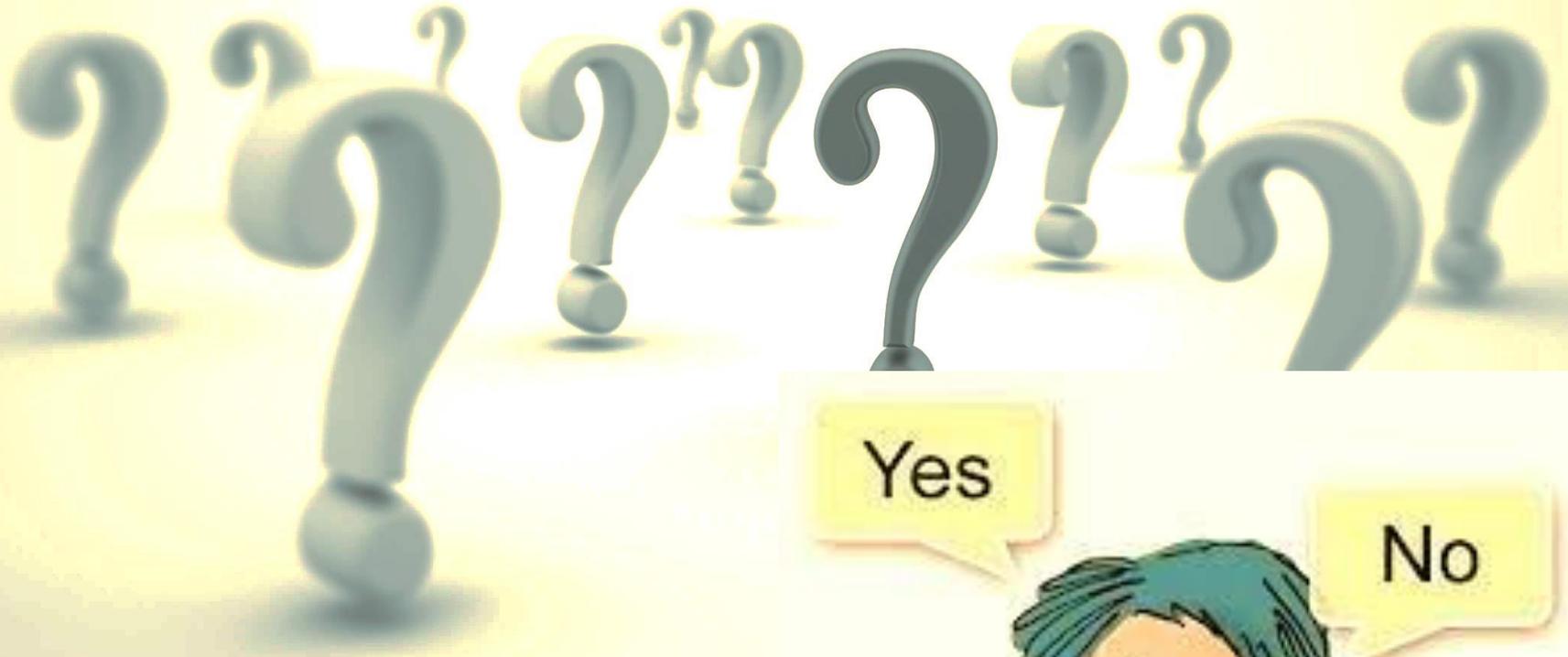
- Working and entitled to Medicare
 - Employer group is primary
 - Or during 30 month coordination for ESRD
 - **Employment stops*** (or coordination period ends)
 - Individual doesn't sign up for Medicare
 - Reasoning?
 - COBRA is same benefits as when working
 - Part B adds additional premium cost
 - Provides similar benefits as employer plan
 - **But, Medicare automatically becomes primary**
 - Regardless of actual enrollment in Medicare

When Things Go Horribly Wrong

- Medicare should automatically be primary, but **mistakes happen** and COBRA may pay primary
 - Carrier can recoup all primary benefits paid
 - Providers must bill Medicare as primary, and
 - Limit, one year post claim for recovery at 100%
 - Bill COBRA for secondary benefits
 - COBRA premiums are **not** reduced
- Medicare late enrollment penalties
 - Premium penalty (lifelong) (760,000 currently)
 - Medicare Part B (10% every 12 months)
 - Medicare Part D (potentially, depends on credible coverage)
 - Benefits delayed, depending on enrollment date

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Questions?



Answers



Yes

No



...maybe