Medicare Advantage Plans and Medicare Supplemental Insurance Plans

March 20, 2020

Overview

- The purpose of this document is to provide you with a better understanding of Medicare Advantage plans (MA plans) and Medicare Supplemental plans (Medigap plans). It is lengthy but, it should provide you a very complete understanding of these plans. The information has been reviewed for accuracy by our outside consultants and, represents the NCRO's Insurance Committees' goal of keeping you informed.

Medicare

- Before getting into a discussion of the plans, here's a brief overview in regard to Medicare. At age 65, retirees should sign up for Medicare. If you or your spouse are still working and you have health insurance coverage through an employer, then you can wait to sign up for Medicare Part B and not begin to pay the premium until you no longer have coverage (called creditable coverage). Even if you have not signed up for Social Security at age 65, you still should sign up for Medicare and then be billed monthly for the premium assuming you don't have creditable coverage as mentioned above. Medicare generally covers 80% of your Medicare approved costs, but you still will have a Part A (hospital) and Part B (doctor) annual deductible. Medicare has 20% copays, Part A & B deductibles, and no out-of-pocket limits. A serious illness can bankrupt a senior.
- For more information on Medicare and the timing, refer to the Social Security and Medicare Action Timeline presentation under the Healthcare/Medicare/Social Security tab on the NCRO website.

Medicare Advantage Plans, Medigap Plans, Medicare Part D Rx Plans

- The purpose of purchasing an Advantage plan or a Medigap plan is to supplement your Medicare coverage and with some plans cover both the Parts A and B deductibles.
- Also, unless you have Rx Drug coverage through an employer, you will need a Part D drug insurance plans. Most MA plans include drug coverage, Medigap plans do not.
- MA plans, Medigap plans and Part D Rx plans are purchased from private insurers and replace or supplement the Medicare coverage you receive when you turn 65 and or first enroll in Medicare.
- In the case of MA Plans you are enrolling in a private insurance plan, you still will have Medicare but you will get your Medicare Part A and Medicare Part B coverage from the

Medicare Advantage plan separate from the government's federally administered Medicare plan. Medicare Advantage plans often provide additional benefits not covered by Medicare such as limited dental and vision.

- With a Medigap plan, you have original Medicare plus supplemental coverage which fills some of the gaps in Medicare, such as the Medicare Part A deductible ($1,408 for 2020). A Medigap plan is also purchased from a private insurer.
- MA plans cannot deny you coverage for pre-existing conditions whether when first enrolling or later if changing MA Plans or insurers. Changing MA plans is allowable during the annual enrollment period October 15th to December 7th or during the Medicare Advantage open enrollment period January 1st to March 31st. However, with Medigap plans, unless you enroll at age 65 or when you are first eligible to enroll, the insurer may deny you coverage or charge a higher premium due to pre-existing conditions. There is a grace period of 3 months before and 3 month after age 65 to sign up for a Medigap plan.
- After your initial enrollment in either an MA Plan or a Medigap plan, if you want to change to a Medigap plan or change your Medigap plan, you will be subject to what's called medical underwriting. An exception to an insurance company's ability to impose pre-existing conditions is if you joined an MA plan when you were first eligible for Medicare and you aren't happy with the plan, you have special rights to buy a Medigap policy if you return to Original Medicare within 12 months of joining Medicare.

Underwriting

- **Underwriting is essentially a review of your medical history. You are required to answer a series of medical questions including a discussion of the prescription drugs you take and why. Certain conditions related to the heart, cancers, etc. and pending or recent surgeries can disqualify you from changing to a Medigap plan from an MA plan or from your current Medigap plan to another Medigap carrier and/or plan after initial enrollment eligibility. That's why it is so important to make the best choice for yourself when first eligible to enroll. The discussion in this document is intended to help you make that choice. Some states have different rules in regard to underwriting and may not require it under some circumstances. Check with a consultant.**
- Never cancel your existing plan until you have written confirmation of your new plan.

- The choice between an MA plan and a Medigap plan depends upon several factors all of which should be considered. Some of these factors are: your budget for healthcare, your

current and anticipated health, family health history as well as what you expect your insurance premiums to cover.

- For example, how do you want the following items covered by your plan: medical deductibles, co pays, prescriptions, dental, vision and hearing covered. Neither MA plans nor Medigap plans provide coverage for Assisted Living or Long-Term Care with the exception of very limited home health care for Medicare approved services.

Highly Recommend You Use A Consultant

- Most retirees choose to use an insurance consultant or agent to help them understand and choose the right plan for their healthcare needs. These consultants are licensed with multiple insurers and they are commissioned by the insurer at no cost to you. They are in the best position to understand your healthcare needs and provide you all your options. The NCRO site in the Healthcare section has information on several consultants including their presentation of their services. We are confident in recommending them. As you will note from reading this document, it can be confusing to try and understand, on your own, the various choices available to you.
- However, it is still important that you take the time to learn the basics of Medicare coverage in order to be able make the best decision for you and or your spouse when speaking to a representative and asking questions.
- It is not possible to provide you cost comparisons because of all the variations in coverage that are available. Depending upon your zip code or Region rates will vary. For example, Southeast Michigan is more expensive than Northern Michigan. Other states may be more costly in their metropolitan areas as well. Always provide your zip code and county when checking rates.
- By understanding what's available and at what cost, you should be in a good position to make your decision.
- An MA plan or a Medigap plan policy only covers one person. If you or your spouse both want coverage, you'll each have to buy separate policies, although not necessarily from the same insurer or the same type of plan. Although, some carriers may offer additional household discounts. You must purchase your policy in the state where you are a legal resident, some insurers may allow you to change your residence and continue the same policy. Your policy cannot be cancelled for health reasons if you continue to pay your premiums.

- **Next is a further explanation of these 2 types of plans by reviewing the differences and the rules for each of them.**

Medicare Advantage Plans (MA Plans)

Types of MA Plans

- There are varying types of plans within MA plans and that's where it can be very confusing, but it can make a difference in terms of coverage and costs. MA plans will vary in terms of where you can obtain coverage based on the type of plan, HMO, HMO-POS, PPO or PFFS Plans you choose. There are also Medicare Advantage plans for specific medical conditions and Medicaid eligible beneficiaries, which will not be discussed in this document.

HMO Plan

- An HMO plan can be the least cost plan but limits you to only participating providers (exception is emergencies). Your preferred doctor may not be in the plan. You chose a preferred primary care physician in the carriers' network who works as your medical provider and coordinates your care. You may need to be referred by your primary care physician before you can be seen by a specialist. They refer you to trusted doctors and specialists, but you must verify those specialists also participate in the plans network. A specific doctor you prefer may not be available to you. Except for a specified emergency or urgent care, there are NO benefits available when non-HMO network healthcare providers are used in your home service area. Varying arrangements are typically made for emergency and/or urgent care, when members are out of state.

HMO-POS Plan

- An HMO-POS plan works like an HMO plan except you can be seen by doctors outside your network in some cases. Typically, you can use an HMO network or non-HMO network primary care physician for the same co-pay. However, if you use an HMO non-network specialist, hospital, or other provider it will cost you more than if you use an HMO network healthcare provider. The choice is up to the member. That's where the "POS," or "point of service" part comes in. A member makes a choice, whether to use an HMO network doctor and get full plan benefits or a non-network healthcare provider and receive lesser benefits, at the point of service. Each insurance company implements this a little differently. This means you can get routine health care when you travel

outside your plans service area but still within the U.S. if your insurer has a national network of doctors. The insurer makes a difference with this plan.

PPO Plan

- PPO plans have more flexibility but also higher costs than HMO plans or HMO-POS plans. You don't need a primary care physician and you can go directly to a specialist without a referral. You can see doctors inside or outside your network but, if you stay in network, you'll pay less. If you use non-network providers, you will pay more. PPO healthcare providers must bill you no more than PPO negotiated prices. These plans typically have a larger network of providers. The key here for you may be whether your preferred doctors are in your PPO network?

PFFS plan

- A Private Fee for Service, or PFFS plan, may cover medical care only or medical care and prescriptions. If the PFFS plan you choose does not offer prescription coverage you can join a Medicare prescription plan to get RX coverage. Benefits vary widely. There is also no network of providers for PFFS plans. You can go to any Medicare doctor in the country. However, the doctor or hospital must agree to accept PFFS guidelines and reimbursement or you will be responsible for the entire costs. The doctors and hospitals are not obligated to accept the PFFS terms and reimbursement and they are not obligated to accept PFFS terms and reimbursement for additional services, even if they had agreed to accept previous services.

Which one is right for you?

- If you want low monthly premiums and copays and you don't travel much, an HMO plan might be right for you.
- If you do a lot of traveling within the U.S. and you want the convenience of having one doctor coordinating all your care, an HMO-POS plan might be right for you.
- If you want to be able to coordinate your own health care and see specialists without a referral, a PPO plan might be right for you.
- Some plans are available with no monthly premiums, however deductibles, co pays and out of pocket expenses are generally higher. The plan may not pay your annual Part B deductible ($198 for 2020). All plans will have co pays and deductibles, but also out of pocket maximums.
- You can choose a plan based on the type of health care services you need and how often you need them. As a rule, higher premiums generally mean lower co pays and deductibles and out of pocket costs.

- Out of State for some plans can mean out of network and therefore higher costs for you.
- Almost all plans include a drug plan. You won't need to separately enroll in a Part D plan. MA plans follow the same rules as standalone Part D plans. However, it is very important that you consider what drugs you are taking when choosing a plan in order to minimize your drug costs as well as your medical costs. The NCRO website includes a complete tutorial in regard to Part D Rx plans.
- Most MA plans do not cover foreign travel medical costs, but some are beginning to offer this coverage.
- Premiums are generally less than a Medigap plan because you have deductibles, co pays and limited provider networks.
- Plans can include Dental, Vision and Hearing coverage at costs lower than purchasing as separate standalone coverage. **Please note that dental and vision plans offered by MA plans are very limited. For example, MA dental plans pay for annual x-rays and cleanings, but little else. Most MA plans will allow members to upgrade their dental plan at an additional cost.**
- Many plans include free wellness programs. Also, can include free in-home care and transportation (must meet certain requirements with doctor approval).

When You Can Change Plans

- After age 65 or when first eligible, you can only join or switch MA Plans during the Annual Election Period October 15th to December 7th of each year. Starting in 2020, you can now also change MA plans during the election period of January 1st to March 31st of each year and you can also dis-enroll from your MA plan if you want to move to a Medigap Plan (may be subject to medical underwriting) or you can change to no plan (dis-enroll).
- With MA plans, you will receive only one billing from the insurer, none from Medicare.

Medicare Supplemental Plans (Medigap Plans)

- Medigap is a private insurance plan to cover Medicare deductibles and co pays. Medicare pays approximately 80% of the approved amount for the service and your Medigap Plan covers the 20% balance subject to the level of plan coverage you have chosen.
- Unless you enroll at age 65 or when you are first eligible to enroll, the insurer may deny you coverage or charge a higher premium due to pre-existing conditions. After your initial enrollment in either an MA Plan or a Medigap Plan if you want to move to a Medigap Plan or change your Medigap Plan, you may be subject to what's called medical underwriting. This was explained earlier in this document.
- Most states allow you to enroll or change plans at any time, however if in a MA Plan switching to a Medigap Plan you are can only dis enroll from MA plan during time periods (mentioned previously). Therefore, if you have an MA plan, make sure you can leave the MA Plan before your Medigap policy begins.

- Plans are available where you incur only the Part B deductible and then no co pays or other deductibles, you choose the plan which then dictates the premium. Premiums are generally higher than MA plans. Insurer's rates are based on age and female vs male (higher rate), tobacco use, your health, zip code and county. Several cap their rates at a given older age. Most brokers/consultants can give you a general idea as to whether you will be able to pass medical underwriting by asking you some or all the questions you will need to answer if you apply.
- Group Insurers like Am WINS, sponsored by FCA, do not require underwriting, however the plan has a higher premium at age 65 than comparable plans. It is a fixed premium

for all ages and genders and includes a deductible. Worth considering if you cannot pass medical underwriting and prefer to not enroll in an MA Plan.

- **Medigap Plans do not cover Dental, Vision, Hearing, Assisted Living or Long-Term Care. They do cover skilled nursing if you meet certain requirements.**
- **Medigap Plans do not cover Part D (drugs), you will need a separate Part D policy.**

- You will receive one, two or three billings statements as follows:

1) One from Medicare if your Medicare payment is not deducted from your Social Security pension.
2) One from your Medigap insurer
3) One from your Part D Rx insurer, if you have a Medicare Part D Rx Plan.

<u>Plan Codes</u>

- Plan coverage is determined by the plan code (A,B,G,K,&N for example) which is standardized among insurers and therefore less confusing when choosing an insurer or specific coverage. This means every insurer's specific plan code has the exact same coverage, but the premium will vary. **Refer to the chart attached for more detail on the coverage provided by each plan code.**
- Plan F and C were very popular plans for many Medicare recipients for many years because, apart from paying the premium, all costs including the parts A and B deductibles and the 20% co pay were 100% covered.
- However, Medicare has discontinued plan F and C for anyone who turns 65 on or after January 1, 2020. Except, if you still have a Medicare Part A effective date prior to January 1, 2020 you will still be eligible to enroll for plan F or C. Also, if you turn 65 before January 1, 2020 you can enroll in plans F and C even after 2020 and can keep the plan as long as the participant chooses. Those already in plan F and C can continue with that plan (grandfathered) but, given that the plan will be limited for new enrollments the average age of those in the plan along with their higher usage, due to aging, is expected to increase the premiums for these plans to a higher degree than other plans available. Those in plan F and C that would like to move to a different plan will need to be able to pass medical underwriting which can be an issue for many older retirees.

- As a result of plan F and C being discontinued (except for those grandfathered) many insurers are offering a less expensive Plan G. The difference between Plan G and Plan F and C is that under Plan G you are required each year to pay the Medicare Part B

deductible before coverage of the 20% begins. The deductible for 2020 is $198 for the full year or the equivalent of $16.50 per month. You will find that plan G premium costs are more than $16.50 less than the former plan F premiums. You should be aware that the Medicare Part B upfront deductible will continue to rise. In 2020, it went from $185 in 2019 to $198. With plan G you receive the same coverage you would have received with plan F, 100% coverage of co pays after meeting the Part B deductible just mentioned.

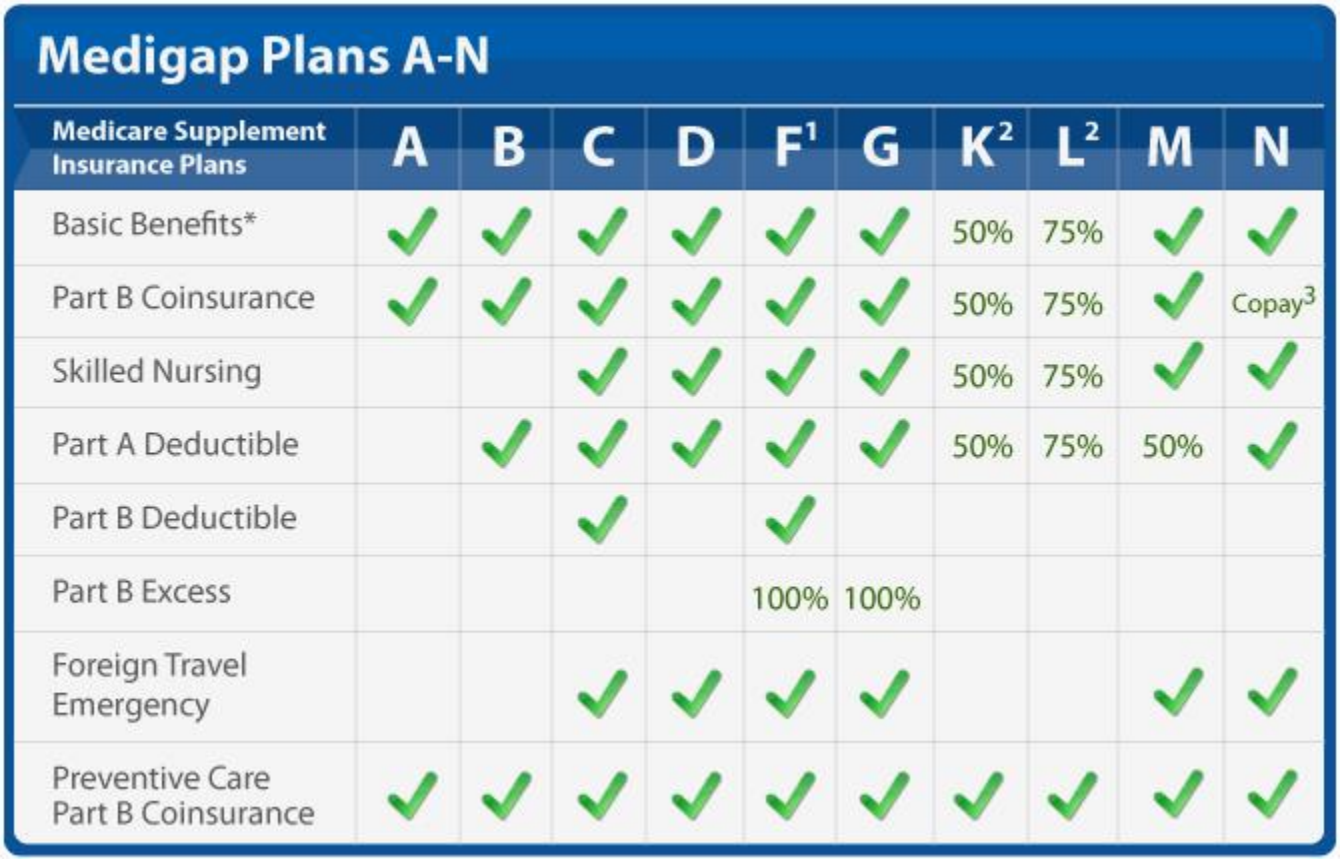
- Not all insurers offer a G Plan but, most are now that plan F and C are being discontinued. You can also consider plans K and N if available, they have higher copays but lower premiums. An N for example has a lower premium than G but, has the same coverage as the G plan except you pay a flat $20 copay for a doctor visit and a flat $50 copay for an emergency room visit. Your choice really depends on your anticipated usage.

- Several plans offer foreign travel coverage in emergency situations. After a $250 deductible, the plan pays 80% of your medical costs but, with a $50,000 cap.

- Several insurers will offer a household discount when both spouses are being insured.

- Most insurers require about 2 months to put your policy into effect. You may be required to pay the 1st month's premium upfront. October thru December is a very busy period for brokers and insurers.

Plan G offers the same coverage as F and C except for the requirement to pay the $198 Part B deductible each year.



Medigap Plans A-N

Medicare Supplement Insurance Plans	A	B	C	D	F[1]	G	K[2]	L[2]	M	N
Basic Benefits*	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	Copay[3]
Skilled Nursing			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess					100%	100%				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓