

# Medicare Supplements

What is available on the Open Market in Minnesota to Supplement Medicare?

In Minnesota a Medicare participant can choose among five types of plans:

"Medigap" Insurance Policies

1. Basic Medicare Supplement (sold by 17 companies)
2. Extended Basic Medicare Supplement (sold by 17 companies)
3. Medicare Select Plans (sold by 4 companies)
4. Medicare Cost Plan (sold by 3 companies)
- 5a. Medicare Advantage HMO Plans (sold by 2 companies)
- 5b. Medicare Advantage Private-Fee-for-Service Plans (sold by 3 companies)

## **1) Basic Medicare Supplement With no riders**

This is the least expensive but also offers the least coverage.

### **Does Not Cover:**

- The \$912 Part A hospital deductible.
- The \$110 Part B annual deductible.
- Prescription drugs.
- Non-emergency medical care outside of the United States (with some exceptions for Mexico and Canada)

### **Does Cover:**

- All Part A co-insurance amounts and 100% of all eligible expenses for hospitalization not covered by Medicare (except the \$912 part A hospital deductible).
- The Part A \$114 co-payment for skilled nursing facility care, up to the 100th day.
- The Part A blood deductible of three pints.
- The Part B 20% co-payments.
- 100% of the costs of immunization and a routine cancer screening
- 80% of emergency foreign travel care.
- 50% of the approved amount for most outpatient mental health services.

PER PERSON MONTHLY COST RANGE:

\$74 - \$168

Basic Supplement with Riders

To cover the gaps in the Basic Medicare Supplement, the State of Minnesota allows the insurance company to offer the following additional coverage (riders) for added cost:

**RIDER 1** covers the \$912 Part A hospital deductible (per-person monthly cost range for Rider 1 only: \$19.42-\$53.58).

**RIDER 2** covers the \$110 Part B annual deductible (per-person monthly cost range for Rider 2 only: \$7.92-\$9.17).

**RIDER 3** covers the difference between the Medicare approved amount and the medical bill. Minnesota requires in-state providers (except ambulance services and medical supplies and equipment) to accept the Medicare approved amount, so this rider may not be needed unless you are outside of the state. Rider 3 has two options: either 100% coverage or 80% coverage of the difference. (Per person monthly cost range for Rider 3: 80% - \$3.42-\$10.08; 100% - \$3-\$36).

**RIDER 4** for at least 50% coverage for prescription drugs. No companies offer this rider in Minnesota.

**RIDER 5** covers up to \$120 per year for physicals, hearing tests, cholesterol and diabetes screening, and thyroid function tests (per person monthly cost range for Rider 5 only: \$3.58-\$16.33).

**RIDER 6** covers up to \$1,600 per year for short term, at-home assistance with activities of daily living, such as bathing, dressing, and personal hygiene. In order for this rider to apply, Medicare must cover skilled home care first (per person cost range for rider 6 only: \$4-\$23.17).

Medicare Supplements ("Medigap" policies) (Basic and Extended Basic)

Minnesota allows the sale by private insurance companies of two types of supplement policies (often called "Medigap"): Basic (optional riders may be added) and Extended Basic, which help cover some of the costs Medicare doesn't cover. Extended Basic offers the most comprehensive coverage, including 80% coverage of prescription drug costs. Note: In many other states, ten policy options, A through J, are available. Nevertheless, Minnesota's policies equal or exceed national standards. Medigap policies do not require you to receive services from a specified network of providers, but more paperwork may be needed.

Note: When shopping for a Basic or Extended Basic policy, you need only compare costs and the reliability of the insurance company. Minimum benefit levels are mandated by Minnesota law and do not differ among companies, although some companies may elect to offer higher benefit levels of certain state-mandated coverage. Call the company to ask about coverage of non-standard items.

## **2) Extended Basic Medicare Supplement**

These can be the most expensive policies of all supplement options.

In addition to the coverage offered by the Basic Plan with all the riders, the Extended Basic policies offer the following coverage:

- 80% of usual and customary fees not paid by Medicare, including foreign travel.
- 80% payment of prescription drugs. Note: This coverage can no longer be purchased as of January 1, 2006, but if you purchase it before that date, you may keep it indefinitely.
- 100% of the cost of immunization and routine cancer screening.

- 50% approved amount of most outpatient mental health services.
- \$1,000 annual limit on any money you pay out of your own pocket on covered medical expenses. Once you have reached this limit, the policy will pay 100% for all covered expenses including drugs

PER-PERSON MONTHLY COST RANGE: \$422 to \$915.

#### Medicare Supplement (Basic and Extended Basic)

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### **3) Medicare Select Plans**

(sold by four companies, Blue Cross Blue Shield of MN, HealthPartners, Medica and UCare)

These are a cross between a Basic Medicare Supplement with some riders, and a Health Maintenance Organization (HMO), since the plans include some preventative care and minimum or no paperwork. To receive the most coverage, there may be a requirement to use the network of health care providers within a service area.

- Covers 100% of the \$912 Part A hospital deductible as long as you use the providers stipulated in the plan.
- Covers 100% of the \$110 annual Part B deductible as long as you use the providers stipulated in the plan.
- Covers 100% of physician charges as long as you use the providers stipulated in the plan.
- Offers options, at higher premiums, to obtain either 50% or 80% prescription drug coverage.
- If out-of-network providers are used in a non-emergency, Medicare will pay their portion of the approved charges, but most Medicare Select Plans will probably not pay anything. Check with the individual company.

## **4) Medicare Cost Plans**

(sold by three companies, HealthPartners, Blue Cross Blue Shield and Medica)

To receive the most coverage, Medicare Cost Plans require you to receive your care through a network of health care providers.

- a. Cost plans are HMOs, but they do not “lock” your Medicare coverage into the HMO, as do the Medicare Advantage plans. To get the most coverage from the Cost plan you must use providers in the plan’s network
- b. Covers 100% of the \$912 Part A hospital deductible as long as you use the network of providers, but some plans may require a co-pay.
- c. Covers 100% of the \$110 annual Part B deductible as long as you use the network.
- d. Covers 100% of physician charges as long as you use the network of providers, but some plans may require a co-pay.
- e. Offers options or riders, at higher premiums to obtain various levels of prescription drug coverage.
- f. Some plans may offer a Medicare-approved drug discount card to help you save on your outpatient prescription drug costs. There may be an enrollment fee of up to \$30 per year.
- g. If out-of-network providers are used in a non-emergency, Medicare will pay their portion of the approved charges, but the Medicare Cost plan will probably not pay anything (unless your plan offers an Extended Absence Option. Contact plan for more information).

## **5a) Medicare Advantage HMO Plans**

Formerly known as Medicare+Choice Plans. (sold by two companies, HealthPartners and UCare)

Note: If you are eligible for coverage through your former employer, benefits and rates may be different than those listed here.

Medicare Advantage Plans "lock in" your Medicare coverage to the plan. You sign your Medicare benefits over to the plan and agree to receive all of your health care through the plan. The only payer of any of your health care bills can be the Medicare Advantage plan, not Medicare. To receive payment for Medicare services, you must use the plan's network of providers. The Medicare Advantage Plan should cover out-of-network emergency care.

- a. Covers 100% of the \$912 Part A hospital deductible as long as you use network of providers, but some plans may require a co-pay.
- b. Covers 100% of the \$110 annual Part B deductible as long as you use network of providers.
- c. Covers 100% of physician charges as long as you use network of providers, but some plans may require a co-pay.

d. These plans offer a Medicare-approved drug discount card to help you save on your out-patient prescription drug costs.

e. If out-of-network providers are used in a non-emergency, and a point of service option is not part of the plan, you will probably be responsible for all charges. Some plans do have a travel benefit, which allows for some out-of-network services.

f. Medicare Advantage Plans cannot health screen at any time. If diagnosed with End Stage Renal Disease (ESRD), check with your health plan.

g. Beneficiaries typically can enroll and disenroll from Medicare Advantage plans at any time. The annual election period in 2005 is extended and will run from Nov. 15, 2005 to May 15, 2006.

### **5b) Medicare Advantage Private Fee-For-Service Plans**

(sold by three companies: Sterling Life Insurance Company, Humana Insurance Company and UniCare Life and Health Insurance Company)

A Private Fee-For-Service (PFFS) plan is a Medicare Advantage Plan offered by a private insurance company. Medicare pays a set amount of money monthly to the insurance company to provide health care coverage to enrollees on a pay-per-visit arrangement. Although costs for services may not be the same as original Medicare, you get all services covered under Medicare Parts A and B. The plan may also offer additional benefits.

Monthly premiums vary by company and you must be told what premiums will be for the coming year before enrolling. You must continue to pay your Medicare Part B premiums in addition to the PFFS premium.

PFFS plans reimburse doctors and hospitals based on Medicare-approved amounts under original Medicare. Beneficiaries may have out-of-pocket costs including co-insurance, co-pays and deductibles, but these may not exceed the actuarial equivalent of the "average amount" you would pay for original Medicare fee-for-service. In addition:

a. You are not restricted to a provider network

b. A PFFS may be attractive in rural areas where there are few health plan choices

c. PFFS plans are required to pay only for medically necessary services that are covered by the plan.

d. Enrollees may obtain care from any licensed physician or provider in the U.S. who can be paid by Medicare and who accepts the plan's terms of payment. Provider participation is entirely voluntary.

e. Enrollees cannot be balance-billed by providers (unless permitted by the plan).

f. Enrollees typically can enroll and disenroll at any time.

Information in this guide is intended only to help you compare different health plans. For specific coverage, rates and terms of any plan, contact the company that sells it or the Minnesota Department of Commerce.