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Financial Planning Perspectives

To B or not to B: Making sense of Medicare's alphabet soup

Many of us find the process of signing up for Medicare coverage confusing. However, we also know that the choices we make could make a big difference in both how much we spend on medical care during our lifetime and what options will be available to us along the way. Partnering with an advisor to better understand your health care priorities and match them to appropriate coverage types can strengthen both your financial and emotional well-being. This conversation should start with a look at what you value when it comes to health insurance coverage. After all, you need to have a strong sense of your personal preferences and health concerns before you can really identify the policy types whose features best meet your needs. Advisors can also add value by ensuring that you have a strong grasp of the logistics and timelines associated with Medicare enrollment. We believe that there are three key steps to choosing a Medicare coverage option:

■ **Prioritize your needs.**

When you reach Medicare eligibility, you will be faced with an alphabet soup of Medicare coverage options. Before trying to negotiate the array of choices, consider which elements of insurance coverage you think are the most important.

■ **Evaluate plan options based on how well they fit your priorities.**

No plan is perfect for everyone, so find the types of policies that come closest to aligning with your priorities. Why pay extra for features you don't care about?

■ **Once you know your best matches for plans, shop for specific policies.**

You will likely be able to choose from among several coverage providers. Shop for the best deal that's available where you live.

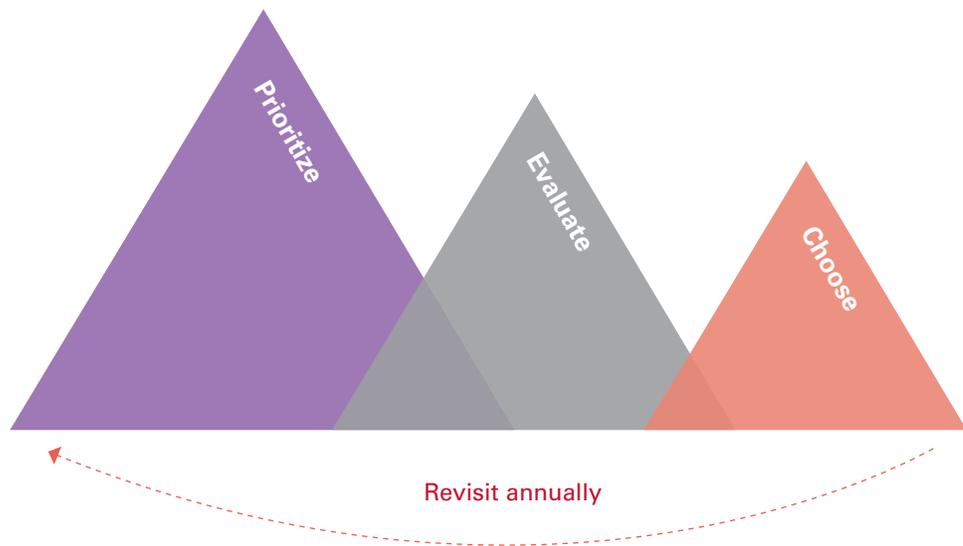
Look at yourself, then look at the coverage

It's hard to choose health insurance—especially when it comes to Medicare. Most of us are not experts on the topic; often the sheer number of options, and our resulting confusion, leads to bad choices. Research backs this up. Abaluck and Gruber (2011), for example, found that retirees frequently made objectively poor choices when enrolling in Medicare prescription drug coverage. Bhargava, Loewenstein, and Sydnor (2017) found that a *majority* of employees in one large employer-sponsored retirement plan chose a plan that had a clearly superior alternative. These choices could not be explained by enrollee preference; they could only be attributed to a lack of understanding of how health insurance works. Your risk of choosing poorly can be greatly reduced, however, if you follow a process designed to help you choose wisely.

Choosing a health insurance plan is difficult if you don't understand what you need.

Most approaches to plan choice focus on comparing the features of different insurance options. We think a better approach is to first take time to consider what insurance features are really important for you—that is, to decide what *you* believe is worth paying for. **Figure 1** presents a schematic of our suggested process.

Figure 1: A framework for choosing the right Medicare policy



Prioritize

Ask yourself: *What do I want out of my coverage?*

Consider the trade-offs between affordability, flexibility, cost certainty, and worst-case protection.

Evaluate

Map the features that you find most important to the strengths and weaknesses of different coverage types.

Choose

Research specific policies. Enroll on time to avoid penalties and coverage gaps.

Start by figuring out what's important to you

No one type of coverage is perfect for everyone, so you should think about which trade-offs between cost, convenience, and flexibility you're willing to make. Before diving into the details of Medicare, consider how you feel about each of the factors described below. Which ones are more important to you? Which are less important?



Overall affordability

You may just want the coverage that will most likely end up being the most affordable over your lifetime. Why pay more than you have to? Of course, what's most affordable over a lifetime might not be what's cheapest in any given year, and there could be dramatic spikes in costs during the years that you need more health care.

Prescription drug benefits and/or benefits for dental, vision, hearing, and/or gym memberships are provided by some coverage options. Having these benefits included as part of your coverage, instead of having to purchase them separately, is another way to enhance overall affordability.

Think about what you're willing to pay for.



Plan flexibility

Some coverage options use provider networks, which can limit your treatment options. With health maintenance organization (HMO)-style plans, coverage is limited to in-network providers; with preferred provider organization (PPO)-style plans, out-of-network providers may be available at additional cost or in certain circumstances. Coverage options that don't use a network provide access to any provider that accepts Medicare.

Most networks are limited to one geographic area, which can be a problem if you travel frequently or split your time between summer and winter homes. A network-based plan may also restrict your ability to see a "best in class" specialist who is not a member of its provider network; it may also require referrals to see any type of specialist. Preapprovals for some treatments may be required, and payment can be denied for treatments deemed "not medically necessary." If that happens, you may have to pay all the costs of the service, although you can appeal the denial.



Worst-case-scenario protection

With some options, there is no limit to the amount you could owe in a particular year if you experience a worst-case health scenario. Others put a cap on the amount you would owe. The lower that maximum amount, the higher your premiums are likely to be.



Cost predictability

For some of us, knowing that "everything will be covered" makes pricier coverage worth the expense. Sudden spikes in medical costs can be especially troublesome for people on a strict monthly budget. If unexpected medical bills would produce real financial or psychological hardship, the predictability of costs may be more important to you than saving money. Even if you are not on a strict monthly budget, it may be comforting to know that you will have fewer hassles dealing with specific medical bills along the way.

How Medicare works



Part A

The Medicare system consists of five distinct parts:

Part A (hospital coverage). Medicare Part A is the portion of Medicare that pays hospital costs. Part A also includes some benefits for skilled home care, hospice care, and the first 100 days of skilled nursing care.

You probably won't have to pay any premiums for Part A, because you already paid for it with payroll taxes while you were working.

In 2019, you have to pay the first \$1,364 of the cost of each hospital stay. Part A covers the rest for the first 60 days, and then you pay the first \$341 per day for days 61–90. After that, there are “lifetime reserve” days (you have a total of 60 days to use in your lifetime, and then they are done), for which you pay the first \$682 per day. You are responsible for the full cost of any additional days.



Part B

Part B (medical coverage). Medicare Part B is the portion of Medicare that covers outpatient health care visits such as doctors, outpatient surgery, diagnostic testing, durable medical equipment, and ambulance services. Part B is not free. You'll pay premiums (\$135.50 per month in 2019)—and if your income is over a certain amount, your premiums are subject to surcharges.¹

Under Part B, you are responsible for the first \$185 of covered medical services. Once that deductible is met each year, you will typically owe 20% of the cost of such services, although you may also owe “excess charges” for some providers.²



Part C

Part C (Medicare Advantage). Part C plans are private plans that contract with Medicare to provide Medicare A and B benefits. Many of these bundled plans are available for only the cost of the standard Part B premium. More than 60 percent of Medicare Advantage enrollees are in HMO plans, with the vast majority of the rest in PPO plans (The Henry J. Kaiser Family Foundation, 2019).



Part D

Part D (prescription drug coverage). Part D plans are optional prescription drug plans available to everyone who has Medicare. These private plans contract with Medicare to provide at least a standard level of prescription coverage. They are available both as stand-alone plans and as part of Part C (Medicare Advantage) plans. Premiums vary, and there are surcharges for those with higher incomes, but as of 2019, the national average is about \$40 per month (Cubanski, Damico, and Neuman, 2019).

Medigap



Medicare supplemental insurance (Medigap). Medigap policies are private policies designed to cover expenses not covered under Part A or Part B. They follow standardized forms, designated with letters A through N (see **Appendix B** for a rundown of the benefits offered by each policy). Medigap policies add to the “alphabet soup” confusion—Medicare Part A and Medigap Plan A are *not* the same thing! Any Medigap policy designated with a particular letter provides a specific set of benefits, regardless of which company issues it.³

¹ This surcharge is known as the income-related monthly adjustment amount (IRMAA) and in 2019 ranges from \$54.10 for an individual making over \$85,000 (\$170,000 for joint filers) to \$325 per month for individuals earning over \$500,000 (\$750,000 for joint filers).

² For a more complete description of what is and is not covered under Original Medicare, see *Medicare & You*, available at www.medicare.gov.

³ Massachusetts, Minnesota, and Wisconsin have their own standardized policy forms, distinct from the A–N standards.

Find plans that align with your priorities

The next step is to look for the types of coverage that dovetail as much as possible with your priorities. **Figure 2** presents some of the policy types you might choose or avoid, depending on what factors are most important to you.

Figure 2. Matching your priorities to Medicare policy types

| If this factor is important to you... |  Overall affordability |  Plan flexibility |  Worst-case-scenario protection |  Cost predictability |
|---------------------------------------|--|---|---|--|
| then consider these options... | <ul style="list-style-type: none"> • Medicare Advantage (HMO* or PPO^) • Medicare MSA† (if you are not in poor health) • Original Medicare with high-deductible Medigap Plan F or G • Original Medicare with Medigap Plan A or K • Original Medicare with Medigap Plan F or G (if you are in poor health) | <ul style="list-style-type: none"> • Original Medicare with any supplemental coverage | <ul style="list-style-type: none"> • Original Medicare with Medigap Plan F or G • Original Medicare with high-deductible Medigap Plan F or G • Original Medicare with Medigap Plan L | <ul style="list-style-type: none"> • Original Medicare with Medigap Plan F or G • Original Medicare with Medigap Plan B, C, D, M, or N |
| ...but avoid these options | <ul style="list-style-type: none"> • Original Medicare with Medigap Plan F or G (if you are not in poor health) | <ul style="list-style-type: none"> • Medicare Advantage (HMO or PPO) | <ul style="list-style-type: none"> • Original Medicare without Medigap | <ul style="list-style-type: none"> • Original Medicare without Medigap • Original Medicare with high-deductible Medigap F or G • Original Medicare with Medigap Plan K or L • Medicare MSA |

* Health maintenance organization.

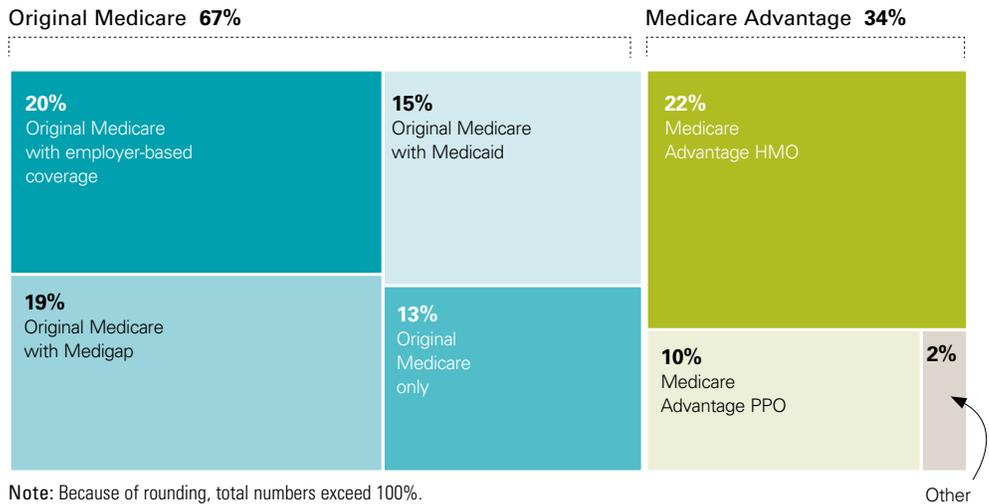
^ Preferred provider organization.

† Medical savings account.

Together, Part A and Part B are often referred to as Original Medicare, or traditional Medicare. There is no out-of-pocket maximum with Original Medicare, so a lengthy hospital stay may be catastrophically expensive. A true worst-case scenario could result in out-of-pocket costs in excess of \$20,000 per year (Weber et al., 2018). For this reason, only 13% of Medicare enrollees choose Original Medicare without additional coverage (Figure 3).

Figure 3. Distribution of Medicare insurance choices in 2016

You will probably want more coverage than just Original Medicare.



If you don't have supplemental coverage through an employer-based plan or Medicaid, you will probably want coverage that provides more benefits and limits out-of-pocket costs. This can be accomplished with any of the following options:

HMO and PPO Plans

| Available as part of: | Strong in: | Weak in: |
|-----------------------------|--|---|
| Medicare Advantage (Part C) | Overall affordability  | Plan flexibility  |

HMO and PPO plans are available through Medicare Advantage (also called Part C). Medicare Advantage plans are offered by private companies that contract with Medicare to provide Medicare A and B benefits; most also include prescription drug coverage. HMO and PPO plans often provide additional benefits, including dental, vision, and hearing coverage or even gym membership. A wide variety of Medicare Advantage plans are available. If you are considering this type of coverage, you should evaluate each plan individually, as many features vary dramatically from plan to plan.

With an HMO or a PPO, you will likely be constrained to a specific provider network. This means that not all doctors who take Medicare will be available to you. Most networks are regional, not national, so if you are a “snowbird” or travel frequently, it may be difficult to find covered services. Also, if you live in a more rural area or one with fewer hospitals, you are likely to have fewer Medicare Advantage plan options available—and the networks in those plans may include fewer first-rate hospitals you can use for specialized care.

Medicare Advantage plans are required to cover everything Original Medicare covers, but they are not required to cover care that is not “medically necessary.” Four in five Medicare Advantage enrollees are in a plan that requires prior authorization for services such as durable medical equipment, skilled nursing facility stays, inpatient hospital stays, or ambulance services (Jacobson and Neuman, 2018). When that authorization is not granted, you may find yourself uncovered for a needed treatment—or facing a long and complicated appeals process before you can get paid for it.

All Medicare Advantage plans have an out-of-pocket maximum for in-network services. The amount may vary, but for 2019, the highest maximum was \$6,700. Note that because the limit is only for services usually covered by Original Medicare, any expenses related to your covered extra benefits (prescription drugs or hearing aids, for example) won’t count toward it.

Supplemental plans
“First-dollar” plans

| Available as part of: | Strong in: | Weak in: |
|------------------------------|---|---|
| Standard Medigap Plan F or G | Cost predictability, worst-case-scenario protection | Overall affordability |
| |   |  |

The most popular Medicare supplement is standard Plan F, largely because it is the most comprehensive. Plan F policies provide “first-dollar” coverage, and they cover all of the expense categories that supplemental policies are permitted to provide.⁴ This means that virtually everything is paid for by your premiums (although you will still need to pay for other things like vision, dental, most long-term care, and Part D for prescription drugs). Plan F policies also tend to have the highest premiums—so unless you are in poor health, they are likely to prove to be the most expensive choice across your lifetime (Weber et al., 2018). However, they do provide a high degree of convenience and peace of mind.

Beginning in 2020, new Medicare enrollees will no longer be able to purchase Plan F. Fortunately, Medigap Plan G is almost identical, the only difference being that you are responsible for your Part B deductible (\$185 per year in 2019). That said, many people will find that the lower premiums for Plan G in their area offset most or all of that cost.

⁴ With first-dollar coverage, you do not have to deal with copayments or deductibles. Instead, depending on the type of policy you have, your plan pays for expenses starting with either the first dollar charged for health care or the first dollar charged for hospitalization.

High-deductible plans

| Available as part of: | Strong in: | Weak in: |
|--|---|---|
| High-deductible Medigap Plan F or G, MSA plans | Worst-case-scenario protection, overall affordability | Cost predictability |
| |  |  |

Accepting a higher deductible is often a good way to reduce your overall insurance costs.

High-deductible plans combine low monthly premiums with the requirement that you pay for some amount of care (up to the deductible). The Medigap plan that best fits this model is the high-deductible version of Plan F. These policies usually have the lowest premiums of any of the supplemental Medicare policies, mainly because typical retirees in good or average health wouldn't incur enough costs to collect benefits in most years. Once you meet the deductible (\$2,300 in 2019), the comprehensive coverage associated with Plan F kicks in. (Like its standard-version sibling, high-deductible Plan F will no longer be available to new enrollees beginning in 2020, but a high-deductible form of Plan G is expected to be available.)

In short, this option combines low overall costs with a reasonable out-of-pocket maximum to protect against worst-case-scenario years. The drawbacks: a lower level of convenience than seen in the more expensive first-dollar standard forms of Plan F and G, and possible underwriting requirements if you want to switch to another option later (you may have higher premiums, or not get coverage at all).

Another high-deductible option is the Medicare MSA plan. Similar in structure to the high-deductible insurance plans with health savings accounts (HSAs) that are becoming more prevalent as employer benefit options, this is a special type of Medicare Advantage plan that combines a high-deductible insurance plan with a medical savings account (MSA). Each year, the insurance provider puts money into your MSA. Once you reach your deductible, all Medicare costs are covered—but you are usually responsible for all costs before that. Tax-free withdrawals from the MSA can be used to pay these costs; you can also use MSA funds for some things that are not covered by Medicare, such as dental and vision care. Because any unused funds stay in your MSA, your balance can accumulate over time. Lastly, unlike most other types of Medicare Advantage plans, an MSA plan allows you to see any doctor or hospital that accepts Medicare.

This plan can be a great choice for healthy seniors who are willing to deal with paying the bulk of their medical costs out of pocket and seeking reimbursement later. However, there are only a limited number of providers of MSA plans, and they are not available in all states.

Other Medigap plans

The remaining standardized supplemental insurance plans fall along a spectrum between first-dollar and high-deductible coverage. Some of these coverages are close to first-dollar coverage but not quite as comprehensive as Plan F or G. For example, Plan N covers almost everything that Plan G covers, but you pay a copayment for some office and emergency room visits, and you are still on the hook if any providers bill you for excess charges. Other plans offer lower premiums with less coverage. Medigap Plan A for example, offers more "bare bones" protection—but it does cover most Medicare Parts A and B coinsurance, which is where most of the big, unpredictable expenses are likely to lie.

Enroll on time and find your policies

Enroll in Medicare *before* you turn 65

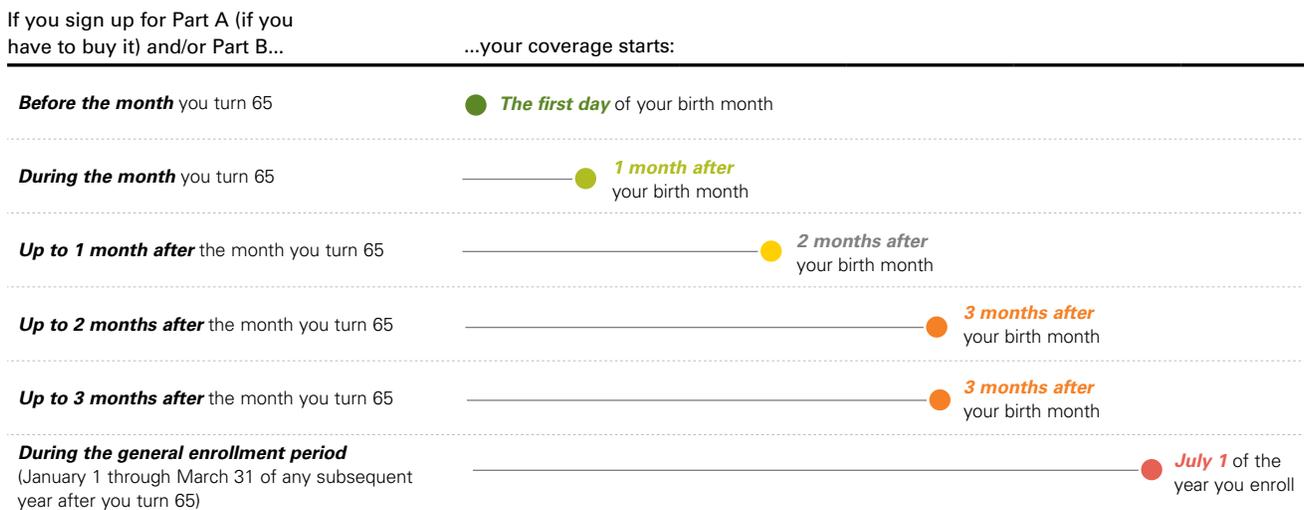
Regardless of which Medicare option you choose, you will need to make that choice in a timely manner. Otherwise, you could encounter periods of time when you don't have coverage, and you may face premium penalties that can last for your entire lifetime. Medicare eligibility begins at age 65, but in order to begin receiving benefits then, you need to enroll before you actually turn 65.

You have a seven-month initial enrollment period that extends from three months before your birth month to three months after it. As **Figure 4** shows, to begin Part A or Part B coverage in the month you turn 65, the best time to enroll is during the three months before your birth month. If you miss that window, there will be a delay before your coverage kicks in. If you then delay beyond the end of the third month after your birth month, you won't be able to enroll until the next general enrollment period for new enrollees (January 1 through March 31 each year), and your coverage will not take effect until July 1 of the year you enroll. Having a gap in coverage could prove very costly if something happens when you are uncovered.

Not signing up during the initial enrollment period triggers lifetime premium penalties. For Part B coverage, a penalty of 10% of premiums is charged for each year of delay. For Part D coverage, you face a penalty of 1% of premiums for each *month* of delay. These penalties are assessed for the rest of your life, for as long as you remain enrolled.

You are allowed to defer enrollment past age 65, but only if you or your spouse are still working and you have employer-provided health coverage. With a deferment, you are assigned a special enrollment period that continues while you work and extends for eight months after your employment or coverage ends. If you want to make sure that you don't have a gap in coverage, you will want to enroll *before* you leave your employer plan. Note that some company plans may require you to sign up for Medicare as your primary insurance (typically if your employer has fewer than 20 employees). Consult with your employer to find out the best way to coordinate your job-related benefits with Medicare.

Figure 4. To avoid gaps in coverage, enrollees should sign up before the month they turn 65



Source: www.medicare.gov.

Unless you are actively contributing to an HSA, you may choose to sign up for Part A at age 65 even if you are still employed (it's free for most enrollees anyway). If you participate in an HSA, you must stop contributing to it six months before your Medicare benefits become effective. You can still use your accumulated HSA balance to pay for qualifying expenses, including your Medicare premiums and expenses not covered by Medicare, such as long-term care or dental services. You cannot, however, use the balance to pay for Medigap policy premiums.

Medigap policies have a slightly different enrollment window. The initial enrollment period lasts for six months and begins once you are 65 and enrolled in Medicare Part B. As with Medicare, missing the enrollment window for buying Medigap policies can prove costly. That's because during your initial enrollment period, the companies that provide Medigap insurance are not allowed to use medical underwriting to determine whether to cover you or how much to charge for your coverage—but *after* that period, they can, in most states, deny coverage or charge a higher rate based on your health status.

Shop for the right policy

Once you have an idea of the types of policies that you are interested in, and you are approaching or in your initial enrollment period, you will need to choose the exact insurers you want to use and policies you want to buy. As you begin this process, keeping a few important points in mind will help you organize your tasks:



You need to have a full list of your current medications

Getting the right prescription drug plan, whether that is a separate Medicare Part D plan or a Medicare Advantage plan that includes prescription drug coverage, is crucial. Different insurers cover different drugs at different levels, so have an up-to-date list of your medications on hand as you shop.



Coverage choices vary by area

Medicare has a very useful [online tool](#) for finding the best Part D and Medicare Advantage coverages where you live, based on your current prescriptions.⁵ You enter your zip code, the drugs you take, and your pharmacy, and it lays out the costs you would face under different coverage options. The Medigap policy [search tool](#) can also help you understand the Medigap options and premiums in your area.⁶



Free help is available

Every state has a [State Health Insurance Assistance Program \(SHIP\)](#), which offers free, personalized counseling about Medicare options and rules, and can help you navigate other state-specific benefits you may be eligible for.⁷ You may also be able to find information from your state insurance department or your local [Area Agency on Aging](#).⁸

Revisit your choices every year

Each year, from October 15 through December 7, Medicare has an open enrollment period for current enrollees. Use this time to review your coverage and whether it still suits your needs. It's particularly important to look at your prescription drug coverage. Do you still have the best choices for prescription coverage given the drugs you take? Insurance carriers can and do change their formularies, preferred provider pharmacies, and prices each year.

It's also a good time to consider if any of your priorities have changed, making you prefer a different type of coverage. Maybe you thought you'd be okay with the limitations of a Medicare Advantage plan, but you found those limitations to be a bigger hindrance than

⁵ The tool can be found at www.medicare.gov/plan-compare/#/?year=2019/.

⁶ Visit www.medicare.gov/medigap-supplemental-insurance-plans/.

⁷ www.shiptacenter.org/.

⁸ www.n4a.org/.

expected and now know that you need more flexibility. If so, you may want to choose a different carrier or switch back to Original Medicare coverage. Or you may decide that you want to enroll in a Medicare Advantage plan for the first time.

Note, however, that if you want to make a switch that involves new Medigap coverage, you may have to go through underwriting to purchase the Medigap policy. This means that insurance providers may be able to charge higher premiums or deny you coverage entirely.⁹ To avoid gaps, it's a good idea to apply for a Medigap policy before your current coverage has ended; that way, you can start using your Medigap coverage the day after your current coverage ends, and you won't have let one coverage lapse before knowing you had other coverage.

Conclusion

Choosing your Medicare coverage is a daunting task. You can, however, quickly pare down the multitude of options to a select few by deciding how much importance you place on affordability, flexibility, worst-case-scenario coverage, and cost predictability. No plan will be the best for everyone, and the best plan for you may not be the one you think of first.

Once you've narrowed your choices, shop carefully for the policies that make the most sense for you—and then enroll on time. Revisit your choices annually to ensure that your priorities and your coverage are always in line with each other.

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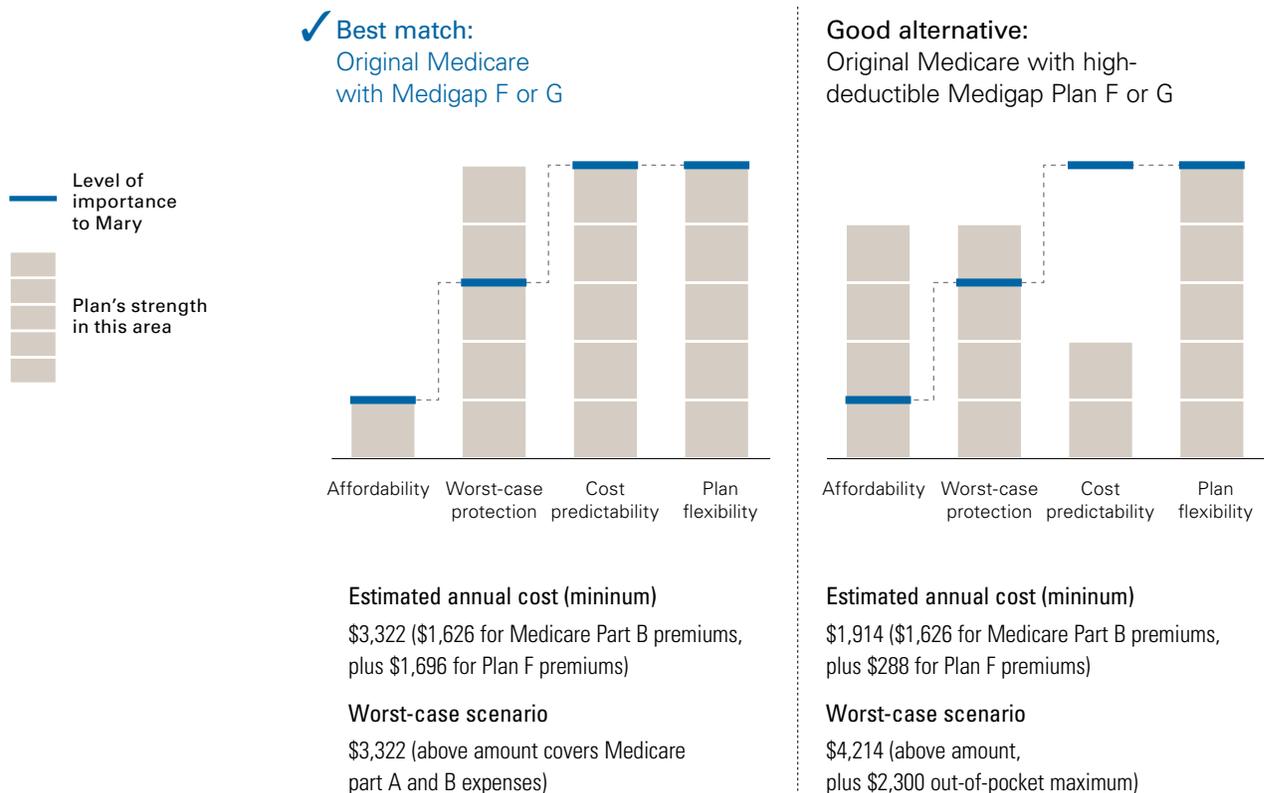
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⁹ In some situations, you may have guaranteed issue rights, which allows you to purchase certain supplemental plans without medical underwriting. These situations usually occur because you lose your current coverage because of a situation that is beyond your control. There is also a special "trial period" provision for Medicare Advantage plans that provides guaranteed issue rights. Some states also provide additional circumstances when these rights apply.

Appendix A. Case studies¹⁰

Mary: Health concerns and a desire for convenience

Mary has a chronic medical condition. While it's usually under control, there are stretches of time during which she does not feel well and has to visit the doctor frequently. She and her doctor are keeping their eyes open for innovative treatments that may help her in the future. Mary is not very concerned about cost, as long as she knows there is some reasonable limit if things get worse. Rather, her biggest priority is to make sure that when she needs to, she can see whomever she needs to see, for whatever treatment she needs, with the least amount of hassle.



Note: The case study presented is hypothetical and for illustrative purposes only.

Source: Vanguard.

For Mary, the best fit is a first-dollar coverage plan, such as that found with Original Medicare, paired with a comprehensive supplemental insurance like Plan F or G. These standard supplemental plans are generally expensive, but they cover every issue that she prioritizes. If she has a choice between the two plans, she might prefer Plan F, because she values convenience over cost and would likely be willing to pay more in premiums to avoid the hassle of being billed for her first \$185 of physician costs each year. She will also need to be careful to find a Part D prescription drug plan that adequately covers her medications.

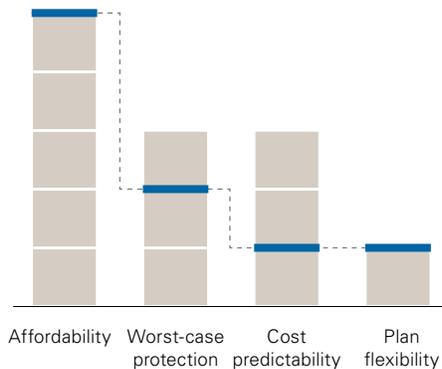
If Mary is willing to deal with paying some costs out of pocket, she could choose Original Medicare with high-deductible Plan F or G instead, as that would save her more than \$1,200 per year in premiums.

¹⁰ Dollar amounts are based on values from www.medicare.gov for someone living in Lafayette, Indiana, an area where premiums for Plan F are near the national median. Typical costs are likely to be fall somewhere between premium costs and out-of-pocket maximums, depending on health care services used in a given year. Premiums and out-of-pocket costs for prescription drugs and dental, vision, and hearing costs are not included in these examples.

Ben: Healthy and unworried

Ben is in great health, doesn't take any medications regularly, and generally sees a doctor only for his annual checkup or when something happens, like the time he injured his knee at the gym. He is aware that he is lucky in this respect, and wants to be protected if something happens, but mostly he just wants to spend as little as possible on health insurance he doesn't really use much. The idea of extra benefits, such as gym membership and dental, vision, and hearing coverage, appeals to him, because those are things he can use, and why pay extra for them if they can be included? He is willing to be part of a health care network; after all, he was part of one when he was working and never had a problem with it.

✓ **Best match:**
Medicare Advantage
HMO or PPO plan



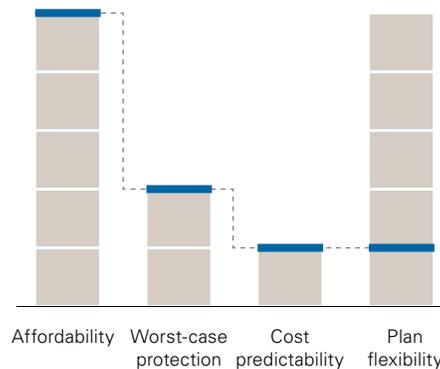
Estimated annual cost (minimum)

\$1,626 (for plan premiums)

Worst-case scenario

\$8,326 (above amount, plus \$6,700 out-of-pocket maximum)

Good alternative:
MSA plan



Estimated annual cost (minimum)

-\$894 (\$1,626 for Medicare Part B premiums, less \$2,520 MSA deposit)

Worst-case scenario

\$5,806 (above amount, plus \$6,700 deductible)¹¹

Note: The case study presented is hypothetical and for illustrative purposes only.

Source: Vanguard.

Ben is likely to be well-served by a Medicare Advantage plan. His primary concern is cost, and there are many plans that can be had with no premiums (other than Part B premiums). For Ben, this is a particularly good option from a cost standpoint, as it also provides prescription drug coverage that he might not want to pay for otherwise—and *not* having that coverage would subject him to penalties that would make future benefits more expensive. The possibility of additional coverage for dental, vision, and hearing is also a bonus. Finally, Medicare Advantage plans also have an out-of-pocket maximum, so he knows that there is a limit to what he would owe if the worst ever happened.

Ben might also consider choosing an MSA plan, if there is one available where he lives. As someone with low health care cost risk, he is a perfect candidate for this type of plan. Because he spends little on health care, he is likely to be able to build up his MSA against future years when his health care costs may go up.¹² He would, however, need to purchase a separate Part D policy if he goes this route.

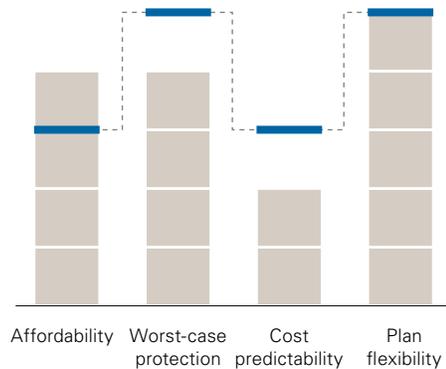
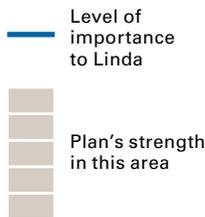
¹¹ Deductibles and deposits may vary by MSA plan.

¹² MSA contributions are not forfeited if they are not used in the year they are made; instead, they remain in the account. In addition, the unspent balance of an MSA can be invested in mutual funds.

Linda: Cautious, but looking for a good deal

Linda is in average health (generally about as healthy as her peers) and takes two medications on a regular basis. Her primary concern is to be well-protected in a worst-case scenario. She spends her winters in Florida and her summers in Ohio, so she needs to be able to see doctors in both places. She doesn't mind having copayments, but the idea of paying the whole cost of a doctor's appointment or treatment makes her uncomfortable.

✓ **Best match:**
Original Medicare with high-deductible Medigap Plan F or G



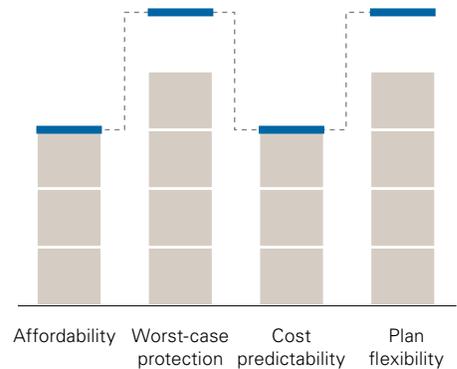
Estimated annual cost (minimum)

\$1,914 (\$1,626 for Medicare Part B premiums, plus \$288 for Supplemental Plan F premiums)

Worst-case scenario

\$4,214 (above amount, plus \$2,300 out-of-pocket maximum)

Good alternative:
Original Medicare with Medigap Plan L



Estimated annual cost (minimum)

\$2,589 (\$1,626 for Medicare Part B premiums, plus \$963 for Supplemental Plan L premiums)

Worst-case scenario

\$5,369 (above amount, plus \$2,780 out-of-pocket maximum)

Note: The case study presented is hypothetical and for illustrative purposes only.

Source: Vanguard.

Linda could likely benefit from looking at high-deductible plans. These generally have the lowest premiums of the supplemental plans, but they do provide good worst-case protection, as they offer comprehensive coverage once the deductible of \$2,300 has been met. Until she meets that deductible, she will still be covered under Original Medicare. She will also need to buy Part D prescription drug coverage, and she should make sure that her policy has good coverage for the drugs she takes.

Linda could also consider Original Medicare with Medigap Plan L. Plan L has higher premiums and a slightly higher out-of-pocket maximum—but it also offers her a little more cost predictability, as she would have to cover only 25% of uncovered expenses before hitting her out-of-pocket maximum. Plan L does not, however, cover Part B excess charges or non-U.S. costs.

Appendix B. Medigap coverages

Most people who choose Original Medicare coverage (Part A and B) also want to have some coverage to pay for expenses that aren't covered under Original Medicare. When that coverage isn't provided through Medicaid or some type of employer benefit, people often turn to standardized supplemental insurance policies called Medigap plans. These standardized policy types are also identified using letters for different coverages. Note that if you live in Massachusetts, Minnesota, or Wisconsin, different Medigap policies apply and the classification system is different.

The chart below shows basic information about the benefits covered by Medigap policies.

Figure B-1. Medigap plans and what they cover

| Medigap benefits | Medigap plans | | | | | | | | | |
|---|---------------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|
| | A | B | C* | D | F*,^ | G*,^ | K | L | M | N |
| Part A coinsurance; 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 B coinsurance or copayment | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | 50% ■ | 75% ■ | Yes ■ | Yes† ■ |
| Blood (first three pints) | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | 50% ■ | 75% ■ | Yes ■ | Yes ■ |
| Part A hospice care coinsurance or copayment | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | 50% ■ | 75% ■ | Yes ■ | Yes ■ |
| Skilled nursing facility care coinsurance | No □ | No □ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | 50% ■ | 75% ■ | Yes ■ | Yes ■ |
| Part A deductible | No □ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | Yes ■ | 50% ■ | 75% ■ | 50% ■ | Yes ■ |
| Part B deductible | No □ | No □ | Yes ■ | No □ | Yes ■ | No □ | No □ | No □ | No □ | No □ |
| Part B excess charge | No □ | No □ | No □ | No □ | Yes ■ | Yes ■ | No □ | No □ | No □ | No □ |
| Foreign travel exchange (up to plan limits) | No □ | No □ | 80% ■ | 80% ■ | 80% ■ | 80% ■ | No □ | No □ | 80% ■ | 80% ■ |
| Out-of-pocket limit | NA | NA | NA | NA | NA | NA | \$5,560‡ | \$2,780‡ | NA | NA |

■ Yes = The plan covers 100% of this benefit □ No = The policy doesn't cover this benefit ■ % = Percentage of benefit covered by plan NA = Not applicable

* Starting January 1, 2020, Medigap plans sold to people with Medicare will not be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people who are new to Medicare as of January 1, 2020. If you already have Plan C, Plan F, or the high-deductible version of Plan F, or you are covered by one of them before January 1, 2020, you will be able to keep your plan. If you are eligible for Medicare before January 1, 2020, but have not enrolled by then, you may still be able to buy one of these plans.

^ Plan F also offers a high-deductible plan. If you choose this option, you must pay for Medicare-covered costs up to the deductible amount of \$2,300 before your Medigap plan pays anything. A high-deductible Plan G will be available starting in 2020.

† Plan N pays 100% of the Part B coinsurance, aside from copayments of up to \$20 for some office visits and copayments of up to \$50 for emergency room visits that do not result in inpatient admission.

‡ Each year, after you meet your out-of-pocket limit and your Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

Sources: Vanguard, based on a table available at www.medicare.gov.

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