Chapter 3
Health Insurance Beyond Medicare

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SYNOPSIS

3-1. Know Medicare Gaps

Although most retired Americans over age 65 are covered by Medicare, many are not familiar with its benefits and shortcomings. The following is a list of some of the major gaps left by Parts A and B of Medicare coverage that an individual must pay for:

- The inpatient hospital deductible for each benefit period[1] ($1,736 for 2026);
- Daily co-insurance for long inpatient hospital stays (over 60 days) per benefit period ($434 per day for days 61-90 and $868 for each lifetime reserve days used in 2026);
- Inpatient psychiatric care beyond 190 lifetime days;
- 20 percent of the Medicare-approved amounts for mental health services from doctors and providers during inpatient psychiatric hospitalization;

[1] A "benefit period" for Medicare Parts A and B starts upon admission as an inpatient in a hospital or skilled nursing facility (SNF) and ends if 60 consecutive days pass without receiving inpatient care or up to 100 days in an SNF. A new period begins with each new admission, and there are no limits on the number of benefit periods.

- Daily co-insurance for Medicare-certified skilled nursing beyond 20 days per benefit period ($217.00 per day for 2026);
- All nursing home care exceeding Medicare's 100-day limit for skilled services;
- Home health care for services that are not covered;
- The annual deductible for outpatient services ($283 Part B deductible for 2026);
- Co-insurance of 20 percent for outpatient hospital, doctors', and suppliers' services;
- Up to 115 percent of amounts in excess of Medicare-approved charges;
- Medical expenses while traveling abroad;
- Nonprescription drugs;
- Dental exams;
- Eyeglasses and Hearing aids;
- Equipment that is considered non-medical or custodial; and
- Physical, occupational, or speech therapy after a maintenance level is attained and skilled therapy services are no longer indicated. However, improvement is not required.

3-2. Options for Supplemental Medicare

To fill these gaps, many retirees obtain additional insurance coverage. Options include:

- Purchasing Medicare supplemental (Medigap) insurance;
- Enrolling in a Medicare Advantage plan (Medicare C), such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan;
- Continuing coverage under an employer's group retirement plan;
- Applying for federal or state assistance programs, if eligible. Colorado has four different "Medicare Savings Programs" (MSP). These include Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiary, Qualifying Individual 1, and Qualified Disabled and Working Individuals, as well as standard Medicaid programs (for more information, visit https://hcpf.colorado.gov/medicare-savings-programs-msp);
- Using military or veterans' hospitals and TRICARE for Life, if eligible;
- Purchasing long-term care insurance for nursing home and home health care costs; or
- Paying expenses out-of-pocket.

Some of these options are considered in more detail in the material that follows. State assistance programs are covered in Chapter 4, "Medicaid," and federal programs are covered in Chapter 2, "Medicare."

3-3. Supplemental Insurance

Standardized Plans

Medigap, or Medicare supplemental insurance, is a specialized type of insurance that coordinates benefits with original Medicare. It specifically fills some of the gaps left by Medicare, such as deductible and co-insurance, and, in some cases, may provide additional benefits.

In Colorado, several companies market these plans. There are Medicare Advantage (health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plans) or other Medicare health plans that provide prescription drug coverage with health coverage. Federal law mandates that each state adopt standardized Medigap benefit packages. Colorado permits the sale of standardized plans that must be labeled Plan A through Plan N (see Exhibit 3A of this chapter). Any company selling Medigap is required to offer Plan A. Other plans are marketed at the company's option.

Effective January 1, 2006, new Medigap policies may no longer provide prescription drug coverage, and seniors need to obtain drug benefit coverage. (See Chapter 2, "Medicare," for information on Medicare Part D.) Effective January 1, 2020, Plans C and F are no longer offered for enrollment for individuals who are newly eligible for Medicare.

3-4. Protecting Customers

Colorado has regulations that govern Medigap policies, including:

- Each applicant must receive an outline of coverage.
- A free-look period of 30 days is provided, during which time the applicant may cancel the policy and receive a full refund.
- The maximum pre-existing medical condition waiting period is six months from the date the policy is in force.
- If the applicant is replacing a Medicare supplement policy, no pre-existing medical condition waiting period by the replacement insurer is allowed if it has already been met.
- Medicare supplement policies are guaranteed renewable for life. Companies cannot cancel or fail to renew a policy for any reason other than failure to pay premiums or misrepresentation.
- Agents are prohibited from selling duplicative insurance, using high-pressure tactics, and pressuring consumers to switch policies.
- A six-month open enrollment period exists when an individual first signs up for Medicare Part B (including disabled individuals under age 65), during which time Medigap coverage cannot be denied because of pre-existing conditions. Disabled individuals have a second open enrollment period when they turn age 65.

3-5. How to Compare Policies

When comparing Medigap policies, consider the following:

- **Cost.** Premiums can differ among companies for the same benefits. Most companies increase premiums at some defined anniversary as the policyholder ages.
- **Financial stability of the company.** You can contact rating companies such as Weiss Research Inc. (www.weissratings.com, (877) 934-7778), Standard & Poor's (www.spglobal.com/ratings), or Moody's (www.moodys.com, (212) 553-1653), to check the financial rating of a company.
- **Waiting period.** By law, the maximum waiting period for pre-existing conditions is six months. Some companies have shorter waiting periods; others have none.

- **Health underwriting standards.** A company may refuse to issue a policy because of a pre-existing health condition, except during the open enrollment period (and in some other limited situations).

3-6. Medicare Advantage Plans

The annual open enrollment period is from October 15 through December 7 for Medicare beneficiaries to supplement Medicare through one of the Medicare Advantage plans. These plans require the beneficiary to assign his or her Medicare Parts A and B benefits to an insurance company and agree to receive all Medicare benefits, gap-filling benefits, and any extras such as prescription drugs from a network of providers set by the insurer. Check your plan for the level of skilled therapy rehabilitation services (physical, occupational, and speech therapy) provided. There may be a limit in the number of authorized home health visits for nursing; physical, occupational and speech therapy.

Currently in Colorado, the Medicare Advantage plans available can be HMO plans, preferred provider organization (PPO) plans, or private fee-for-service (PFFS) plans. However, only HMO plans will be discussed in this chapter.

Health Maintenance Organizations

HMOs provide or arrange for health services to the enrollee for a set monthly fee. Most Medicare Advantage HMOs have contractual arrangements under which the HMO agrees to provide Medicare and supplemental benefits in return for a fixed payment from the government.

Currently, most Medicare HMOs have a provision that if the patient goes to a non-HMO doctor or hospital, neither the HMO nor Medicare will pay the bills. Check your policy to see if it includes this feature.

To be eligible to enroll in an HMO, a Medicare beneficiary must meet the following requirements:

- Have Medicare Parts A and B,
- Live in an area served by the plan you want to join, and
- Not have end-stage kidney disease (ESRD).

To disenroll from an HMO and return to standard Medicare fee-for-service, the beneficiary must do so during the annual enrollment period of October 15 to December 7 or the Medicare Advantage Open Enrollment Period of January 1 to March 31.

3-7. Employer Group Health Plans

Many retired individuals who have Medicare also have additional health insurance coverage resulting from their own or their spouse's employment. These employer group health plans (EGHPs) are secondary to Medicare. That means that Medicare pays benefits first, and the EGHP pays what is not covered by Medicare. Unlike Medigap policies, EGHPs are not strictly regulated by the states. This means that EGHP benefits can differ from plan to plan and are not subject to minimum benefit requirements. An individual may be able to keep their EGHP for prescription drugs and dental care.

3-8. Long-Term Care Insurance

Long-term care can range from simple help with activities of daily living at home, such as bathing and dressing, to highly skilled nursing care. Though families continue to provide the majority of services to relatives in the home, long-term care also is provided by nursing homes, senior centers, home health agencies, adult day care centers, and assisted living facilities. It is estimated that more than 60 percent of those people who live to age 65 eventually will need some type of long-term care.

Current annual costs in a Colorado nursing home can exceed $100,000. Medicare pays only a small percentage of these costs since it only covers short-term skilled care, usually following hospitalization. Medigap insurance and employer plans seldom pay for nursing home care. Many nursing home residents eventually are covered by Medicaid when their assets have been spent down to the qualifying level (see Chapter 4, "Medicaid").

Long-term care insurance pays the policyholder a specified amount for each day that he or she qualifies for benefits. The policy may make payments when the individual needs home care, lives in an assisted living facility, attends adult day care, or resides in a nursing facility.

Some of the variables to consider when shopping for long-term care insurance are:

- **Age.** The risk of being admitted to a nursing home increases rapidly after age 75. Some insurance companies will not offer long-term coverage to persons older than 80 or 82.
- **How benefits are paid.** Most long-term care insurance pays a fixed daily amount rather than a percentage of the costs. Many policies pay actual costs up to the daily benefit selected by the policyholder, while other plans pay the full daily benefit selected.
- **Covered settings.** Companies generally offer coverage for home care, assisted living, and nursing home care. Check if your coverage covers all these living settings.
- **Benefit triggers.** Benefits are paid when care is considered medically necessary. This can include when the policyholder loses the ability to perform two or more activities of daily living: dressing, bathing, toileting, eating (including taking medications), transferring (in and out of a chair or bed), remaining continent, or if the person suffers cognitive impairment.
- **Length of coverage.** The insurance company pays the daily benefit for the number of years selected when the policyholder meets the requirements for services.
- **A "waiting" period.** This refers to the number of days the individual must qualify for benefits before the insurance will begin to pay benefits.
- **Health underwriting.** Companies ask detailed health questions before deciding to insure an applicant. Policies can be canceled if information is found to be inaccurate or fraudulent.
- **Renewability of policies and premiums.** Long-term care policies issued in Colorado beginning July 1, 1990, must be guaranteed renewable. This means the company will not cancel or fail to renew the policy as long as the insured pays the premiums on time.
- **Inflation protection.** Consumers can purchase benefit increase options to protect against the rising costs of long-term care.

3-9. Resources

Colorado Division of Insurance: *See* section 2-5, "Resources"

Colorado State Health Insurance Assistance Program (SHIP): *See* section 2-5, "Resources"

Exhibit 3A.
Benefits of the 10 Standardized Medicare Supplemental (Medigap) Insurance Plans

How do I compare Medigap plans?

The chart below shows basic information about the different benefits covered by Medicare Supplement Insurance (**Medigap**) in 2026. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest.

	Medigap standardized 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 benefit (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 2026**			
							$8,000	$4,000		

*Plans F and G also offer a high-deductible plan in some states. You must pay Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,950 in 2026 before your policy pays anything. **You can't buy Plans C and F if you were new to Medicare on or after January 1, 2020** (page 75).

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($283 in 2026), the Medigap plan pays 100% of covered services for the rest of the calendar year.

***Plan N pays 100% of the Part B coinsurance. You must pay 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.

Medicare & You 2026, p. 76, www.medicare.gov/publications/10050-medicare-and-you.pdf.