

# SHIBA



Senior

Health

Insurance

Benefits

Assistance

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## Section 3

Medigaps and  
Other Insurance  
to Supplement  
Medicare

# Section 3, Medigaps and Other Insurance to Supplement Medicare

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# Medigap Benefits 2009

2009 Medicare Supplement Benefit	A	B	C	D	E	F <sup>1</sup>	G	H	I	J <sup>1</sup>	K	L
Part A Hospital Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Blood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Hospice Care											50%	75%
Skilled Nursing			✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Part B deductible			✓			✓				✓		
Part B Excess Charges						✓	80%		✓	✓		
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓		
At-Home Recovery				✓			✓		✓	✓		
Preventive Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Preventive Care not covered by Medicare					✓					✓		
2009 out-of-pocket limit											\$4,620 <sup>2</sup>	\$2,310 <sup>2</sup>

<sup>1</sup> Plans F and J also offer a high-deductible option. You pay \$2,000 before your coverage begins.

<sup>2</sup> After the out-of-pocket limit is reached and the Part B deductible is met, plan pays 100%.

# 2009 Medicare Supplements (Medigaps)

## *Medigap Basic Benefits*

- ◆ Hospital coinsurance for days 61-90 (\$267 per day) and days 91-150 (\$534 per day while using your 60 lifetime reserve days)
- ◆ Payment in full for 365 additional hospital days
- ◆ 20 percent coinsurance for physician and other Medicare Part B services

## *Medicare Deductibles*

- ◆ Part A \$1,068 per benefit period
- ◆ Part B \$135 per year

## *Skilled Nursing Facility Coinsurance*

- ◆ \$133.50 per day for days 21-100

## *Medicare Part B Excess Charges*

- ◆ Up to 15 percent above the Medicare approved charge

## *Foreign Travel Emergency*

- ◆ Pays 80 percent of the cost of emergency care during the first two months of each trip after a \$250 deductible
- ◆ Lifetime maximum of \$50,000

## *At-Home Recovery*

- ◆ While receiving skilled home care, extra home health aide visits
- ◆ Home health aide up to 40 visits after skilled care is no longer needed
- ◆ Maximum of \$40 per visit to 40 visits per year, for total of \$1,600 per year

## *Preventive Care*

- ◆ Up to \$120 per year for preventive services ordered by a doctor

# Medigap Benefits 2010

2010 Medicare Supplement Benefit	A	B	C	D	E <sup>3</sup>	F <sup>1</sup>	G	H <sup>3</sup>	I <sup>3</sup>	J <sup>3</sup>	K	L	M	N
Part A Hospital Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓ <sup>2</sup>
Blood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice Benefit	✓	✓	✓	✓		✓	✓				50%	75%	✓	✓
Skilled Nursing			✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓			✓				✓				
Part B Excess Charges					✓	✓	✓		✓	✓				
Foreign Travel Emergency			✓	✓		✓	✓	✓	✓	✓			✓	✓
<b>2010 out-of-pocket limit</b>											<b>\$4,620*</b>	<b>\$2,310*</b>		

\*Once the out of pocket limit is reached plan pays 100% (Note: these are 2009 \$ amounts)

<sup>1</sup> Plans F and J also offer a high-deductible option. You pay \$2,000 (2009 amount) before your coverage begins.

<sup>2</sup> Plan N's Part B coinsurance: Beneficiary pays \$20 per physician visit & \$50 per Emergency Room visit, unless the patient is admitted, before coverage begins.

<sup>3</sup> Plans E, H, I and J will no longer be sold after June 1, 2010. Because Medigaps are guaranteed renewable, those who already have them may keep them.

***These changes are effective June 1, 2010.***

# 2010 Medicare Supplements (Medigaps)

## *Medigap Basic Benefits*

- ◆ Hospital coinsurance for days 61-90 (\$267\* per day) and days 91-150 (\$534\* per day)
- ◆ Payment in full for 365 additional hospital days
- ◆ 20 percent coinsurance for physician and other Medicare Part B services
- ◆ Hospice Benefit covers all Part A eligible hospice and respite care expenses

## *Medicare Deductibles*

- ◆ Part A \$1,068\* per benefit period
- ◆ Part B \$135\* per year

## *Skilled Nursing Facility Coinsurance*

- ◆ \$133.50\* a day for days 21-100

## *Medicare Part B Excess Charges*

- ◆ Up to 15 percent above the Medicare approved charge

## *Foreign Travel Emergency*

- ◆ Pays 80 percent of the cost of emergency care during the first two months of each trip after a \$250 deductible
- ◆ Lifetime maximum of \$50,000

## **June 1, 2010, changes:**

- ◆ Eliminates Plan E, H, I, and J (no sales of new policies)
- ◆ Creates Plans M and N (see graph for details)
- ◆ Adds Hospice coverage (see above for details) as a basic benefit
- ◆ Eliminates preventive services and at-home recovery benefits

*\*These numbers are 2009 amounts and may change depending on the 2010 amounts for Medicare.*

# Introduction To Medigap

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## Learning Objectives

Participants will possess thorough and accurate information about Medicare supplement insurance.

On completion of this section, the SHIBA counselor trainee will be able to:

- ◆ Understand Medicare choices and options available to beneficiaries.
- ◆ Describe the different ways to supplement Medicare coverage.
- ◆ Understand the benefits and limitations of various supplemental policies.
- ◆ Read, compare, and explain the differences between supplemental insurance plans, and how they function with Medicare.

## Health Insurance for People with Medicare

Medicare does not pay all costs of medical bills. Medicare's purpose is to increase access to health care and reduce its financial burden on elders, retired or disabled people.

Medicare offsets medical expenses by providing a basic foundation of benefits, leaving individuals responsible for some out-of-pocket expenses (called a "cost-share"). There are deductibles, coinsurance, and in some cases, charges over and above what Medicare will pay. These expenses are considered Medicare's *gaps*, and many beneficiaries find they need an insurance plan or program to fill them.

# Medigaps

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Medigap, also known as Medicare supplement insurance, is designed to help fill all or some of the gaps in Medicare by paying the Part A and Part B deductibles and coinsurance. Some supplement policies provide additional benefits.

## Standardization

In 1990, Congress enacted rules that made Medicare Supplement Insurance (Medigap) uniform in most states, including Oregon. (Minnesota, Massachusetts, and Wisconsin had already improved Medgiap coverage and were exempted from the national standardization requirements.) One of the most important changes resulting from the Omnibus Budget Reconciliation Act (OBRA) was the creation of ten standard Medicare supplement policy forms. At first the standard plans available were named A to J, more recently A to L, and effective 2010 some plans are eliminated while plans M and N are added. Insurers may market only the standard plans, making comparisons easier. While premium costs and customer service may vary, every Medigap policy offered in the United States is identical in coverage. For comparison of currently available plans, check the current *Oregon Guide to Medigap, Medicare Advantage & Prescription Drug Coverage*, which SHIBA produces. Plan A is the most basic. Benefits generally increase as plans go from A to N.



**Note:** Only policies issued since the federal standards were adopted by Oregon in 1990 must be in compliance with the standards. Medigap policies that were issued before 1990 may still be in effect for some beneficiaries and may provide different benefits than the 10 standardized plans. These old plans may or may not provide better benefits. These policies must be carefully reviewed before they are replaced.

## Core Benefits

See page 6 for this year's dollar amounts. Medicare supplement plans must provide the following *minimum* benefits:

- ◆ Coinsurance amount under Medicare Part A for days 61-90 of hospital confinement during a benefit period
- ◆ Coinsurance amount under Medicare Part A while using one's 60 nonrenewable lifetime reserve days of inpatient hospital care
- ◆ Payment in full for 365 additional lifetime reserve days
- ◆ Coinsurance for hospice care (added in 2010)
- ◆ First three pints of blood
- ◆ Coinsurance amount under Medicare Part B for eligible medical expenses

## Medigap Policy Requirements

All Medicare supplements must be **guaranteed renewable** regardless of the health of the policyholder. The insurer can only cancel a policy for nonpayment of premiums or if the policyholder gave false information in order to obtain the coverage.

Medicare supplement benefits must change automatically to coincide with changes in Medicare. The insurer may adjust premiums to reflect the increased cost of providing benefits after such changes.

At the point of sale, the insurer or its agent must provide an **outline of coverage**. This outline must clearly show the benefits paid by Medicare, the benefits paid by the policy, and all exclusions and limitations.

An insurer must assure that an applicant understands the hazards of replacing an existing policy. An insurer must provide a replacement form for the applicant to sign indicating that he or she understands these hazards.

The applicant must be allowed a **free-look period** of 30 days after the policy is received. During this period, the applicant may return the policy to the insurer for any reason and receive a full refund.

The **waiting period** on pre-existing conditions must be limited to a maximum of six months from the policy's effective date. A pre-existing condition is a condition which was diagnosed or for which medical advice or treatment was received within the **look back period** (also a maximum of six months) immediately preceding the effective date. Policies with a look back/waiting period do not pay for treatments for those pre-existing conditions during the waiting period, but do pay on all other Medicare-covered services.

If a Medicare supplement policy replaces another Medicare supplement policy and the waiting period on pre-existing conditions has been exhausted, then the new policy must waive any waiting period on pre-existing conditions.

An insurer may not offer a policy that limits or excludes coverage other than those specifically allowed by law. There can be no individual waivers or riders on specific health conditions. Medicare supplements must provide benefits for accident and sickness equally. Loss ratios, which indicate the percentage of premium dollars paid out as claims, must be at least 65 percent for individual Medicare supplements.

# Open Enrollment Period for Medigap Policies

Open Enrollment for Medigap policies **begins** on the day the applicant's Medicare Part B becomes effective and **ends** six months later.



Note: In Oregon, the Open Enrollment Period for Medigap policies applies to anyone – regardless of age – who enrolls in Medicare Part B. In many other states, beneficiaries under age 65 do not have the same rights to purchase a Medigap policy as those who are over 65.

During the Open Enrollment Period (OEP), all Medicare supplement insurers must accept any applicant for any plan the insurer offers for sale in Oregon without regard to pre-existing health conditions. While the insurer cannot refuse to insure the applicant during the Open Enrollment Period, the insurer may restrict coverage on pre-existing conditions for up to six months if the applicant has not had at least six months of a **continuous period of creditable coverage**.

Creditable coverage means, with respect to an individual, coverage of the individual provided under any of the following:

- ◆ Group or individual healthcare program, including a COBRA policy
- ◆ Medicare or Medicaid
- ◆ Military-sponsored healthcare program
- ◆ Indian Health Service or tribal healthcare program
- ◆ State health benefits high-risk pool (OMIP)
- ◆ Certain public health plans
- ◆ Federal Employees Health Benefits program
- ◆ Peace Corps health benefit plan

Creditable coverage is “continuous” if the period during which an individual was covered had no break in coverage greater than 63 days. If the applicant has some creditable coverage, but less than six months, the new plan must give credit for the amount of creditable coverage the insured already had.

## **Coordination of Benefits**

Medicare is primary to a Medicare supplement. That is, Medicare benefits are applied and paid first before the Medigap insurer pays. Benefits paid by the supplement insurer are coordinated with Medicare. Medicare must first determine which expenses are eligible for payment by Medicare before the Medigap insurer pays on the Medicare eligible expenses. Some insurers require a denial from Medicare before paying on a Medicare non-covered service.

Most Medicare supplement policies are issued on an individual basis rather than group, and do not coordinate benefits with other individual insurance plans. This means that each individual policy will pay its full benefits regardless of any other coverage the insured may have. Group policies may coordinate with other group policies, depending on the policy provisions and state insurance law.

Those with insurance through a current or former employer may find that the employer’s plan fills Medicare’s gaps adequately. Retirees with employment-related benefits should review their options carefully before disenrolling, because they may not be able to get back into the employer’s plan.

# Medigap Claims Processing

Carriers forward claims to Medigap insurers to expedite the process for participating physicians. This process is commonly referred to as “crossover”.



Note: some Medigap policy carriers state they are not “crossover” claim participants.

The supplemental insurance company is required to make payment directly to the provider and send a copy of the payment to the beneficiary. This applies when the physician is participating and the patient agrees to assign any private insurance payments directly to the provider.

Medicare supplement insurers are to issue a card to each policyholder that lists policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent.

## Medigap Protections

### *Guaranteed Issue*

Under current federal and Oregon law, Medicare beneficiaries are awarded **Guaranteed Issue Rights**. In specific situations, beneficiaries are guaranteed the right to buy a Medigap policy *outside of their Open Enrollment Period but with Open Enrollment conditions*.

Medicare enrollees who have had additional health coverage that is going to end, or has ended, have Guaranteed Issue Rights under the following situations to purchase one of the corresponding Medigap plans sold in the state of Oregon. The chart below can be used as a reference to determine for which policy the beneficiaries are guaranteed approval under their specific situation. However, they must apply within 63 days of the termination of their prior coverage.

The authoritative description of Guaranteed Issue situations is found in the Oregon Administrative Rules, which can be located on <http://www.oregon.gov>. Look for OAR 836-052-0142.

See *Guaranteed Issue Situations* chart on next page.

### ***Plan Termination During Open Enrollment Period***

If a Medigap plan terminates its coverage and the beneficiary is still in the Open Enrollment Period (within 6 months of the Medicare Part B enrollment date) they are guaranteed issuance of any of the standardized plans offered in the State of Oregon.

**Example:** Susie's insurer terminates her Medigap Plan C. She has been enrolled in Medicare Part B for 5 months. Susie decides that she now needs a more comprehensive plan. She can choose any plan offered in the state. Even if her current insurer offers other plans, she can go to another insurer.

Guaranteed Issue Situations	Medicare Supplement Plan Choices (2009)
The beneficiary is in a MA plan that leaves Medicare or stops giving care in the service area, or the beneficiary moves out of the plan's service area.	A, B, C, F, K, or L
The beneficiary was covered by an employer group health plan (including retiree or COBRA or union) and that coverage ends.	A, B, C, F, K, or L
The beneficiary moves out of a Medicare SELECT policy service area.	A, B, C, F, K, or L
(Trial Right) The beneficiary joins a MA or a PACE plan when first eligible for Medicare, and within the first year of joining decides to end that coverage and switch to Original Medicare.	All plans
(Trial Right) The beneficiary drops a Medigap policy to join a MA plan or Medicare SELECT policy for the first time and has been out of the Medigap plan for less than a year, then chooses to switch back.	Original plan. If not available, then A, B, C, F, K or L
The Medigap plan goes bankrupt or has its certification terminated, or Medigap coverage is lost or ends through no fault of the beneficiary.	A, B, C, F, K, or L
The beneficiary leaves an MA plan or drops a Medigap policy because the company didn't follow the rules or was misleading.	A, B, C, F, K, or L

In these situations, an insurance company selling Medigap policies:

- ◆ Cannot charge more for a Medigap policy (underwrite) because of past or present health problems.
- ◆ Must cover all pre-existing conditions without limitation.
- ◆ Cannot deny or limit Medigap coverage to a beneficiary, provided the insurer is still selling that plan.



As of July 1, 2009 Oregon law now extends Guaranteed Issue protection to people who lose their Medicaid eligibility. If your client lost Medicaid and has significant medical needs, especially ESRD, it would be in his or her best interest to consider a Medigap supplement.

## *Medigap Tips*

- ◆ If more than one situation applies, choose the protection that gives the best choice of policies.
- ◆ A copy of all letters, notices, and claim denials should be kept, as well as the postmarked envelopes that they came in.
  - Beneficiaries may need to provide these documents as proof of coverage for Guaranteed Issue rights.
- ◆ Medigap plans H, I and J sold before January 1, 2006, offered some prescription drug coverage.
  - These Medigap policies may be kept; however, their drug coverage does not count as creditable coverage—it is not considered to be as good as Medicare Part D plans. This means that should the beneficiary decide to enroll in a Medicare drug plan in the future, he or she would be subject to the premium penalty for delayed enrollment.
  - Such plans with the drug coverage included are no longer being offered.
  - H, I and J *without* the drug benefits, and Plan E, will be not be available for sale after June 1, 2010.



# How to Compare Medigaps

Applicants select a plan which provides their desired benefits. They should consider *the premium charged for the plan and the service provided by the insurer.*



Note: Comparison of plans issued *before 1990 standardization* is not as straightforward. Their benefits may differ substantially. For proper comparison, it may be necessary to list the specific Medicare benefit gaps and determine whether the older policy or policies provide benefits to fill the gaps.

## ***Other considerations:***

- ◆ Under what conditions may *the insurer* cancel the policy? (Important in comparing older plans)
- ◆ Will the premium fit into the applicant's budget now *and in the future*?
  - Medicare supplement premiums increase as Medicare increases deductibles and coinsurance.
- ◆ What type of service can the applicant expect from *the insurer's agent*?
- ◆ How large is the insured pool?
- ◆ What is the insurer's standing with the Insurance Division?
- ◆ Does the applicant have current health concerns? Is the applicant anticipating medical treatments soon?

Contact the Oregon Insurance Division for questions about the insurance company's complaint record (see page 35). They do not list separate complaints on Medigaps, only for the performance of the company as a whole.

# Reading A Medigap Policy

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An insurance policy is a contract between the insurer and the policyholder. The insurer promises to reimburse the policyholder under circumstances set out in the policy. The policyholder makes no promises. The policyholder pays a premium, but is not compelled to do so by the contract; however, the company does not have to pay benefits, and may cancel the policy if its premium is not paid.

Health insurance policies may at first seem complicated, but are relatively easy to read for comparison purposes, if one knows which parts differ from policy to policy and which parts remain the same.

## Elements of a Medigap Policy

### *Renewability*

One of the most important Medigap policy provisions is the guaranteed renewability clause. This clause is required to be prominently placed on the face page (front page) of the policy. All Medicare supplements must be issued as guaranteed renewable, which means that the elements of coverage cannot change, and that the policy can be cancelled only if the insured fails to pay the premiums or is found to have falsified the original application. However, policies issued prior to federal standardization in 1990 (see page 8 *Standardization*) did not have to meet this requirement. Have the beneficiary read the renewability clause carefully. It will state the conditions under which the policy may be cancelled or otherwise changed.

### *Premiums*

This section will state the reasons or conditions under which the insurer may raise premiums. As Medicare deductibles and coinsurance amounts increase every year, the amount the insurer is liable to pay also increases. Medigap insurers are allowed to raise premiums once every 12 months.

Premiums also may differ depending on the insurer's premium rating structure:

- ◆ *Attained age-rated* policies increase premiums as policyholders age as well as for increased costs.
- ◆ *Issue age-rated* policies do **not** have planned premium increases due to age.
  - Premiums are based on the age of policyholders at the time their policy is issued, but may increase due to inflation or other factors.
- ◆ *Community age-rated* policies are the same no matter how old the beneficiary is.
  - Premiums are the same for everyone who has the policy regardless of age, but may increase due to inflation or other factors.

### ***30-day free-look provision***

This provision is required by law. All Medicare supplements must allow an applicant to return the policy for any reason within 30 days of policy delivery for a full refund of premium.

### ***Pre-existing condition limitation***

While pre-existing condition limitation clauses may differ, an insurer may not have more than a six-month waiting period on pre-existing conditions. This clause may not be a consideration if the proposed policy is replacing an existing policy for which the waiting period has already been exhausted, or if the applicant has had six months of creditable coverage. See page 11 for more information on creditable coverage.

### ***Consideration***

Consideration is the value or exchange given for the agreement. The insured offers the application and first premium as consideration.

## ***Uniform provisions***

Uniform provisions are required by law. The wording varies little from policy to policy. While these provisions are important and should be read, they are not different enough to be a concern while comparing policies.

Uniform provisions include:

- ◆ Entire contract
- ◆ Coverage for alcoholism treatment
- ◆ Time limit on certain defenses
- ◆ Grace period
- ◆ Reinstatement
- ◆ Notice of claim
- ◆ Claim forms
- ◆ Proof of loss
- ◆ Time of payment of claims
- ◆ Payment of claims
- ◆ Physical examinations and autopsy
- ◆ Legal actions

## ***Limitations and exclusions***

The Omnibus Budget Reconciliation Act (OBRA) of 1990 standardized limitations and exclusions. A Medicare supplement policy issued since OBRA may not have any limitations or exclusions not specifically allowed by OBRA. Limitations and exclusions on older policies require careful reading.



See CMS publication 02110, *Choosing a Medigap* for additional information.

# Other Health Insurance

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**Note:** There are two types of health insurance – Group and Individual.

## Employer Group Health Plans (EGHPs)

Most people with health insurance are covered by group plans, which issue a master policy to members of a group. The group owns the policy and policyholders receive certificates indicating they are members of the group. Certificates usually outline the coverage, but the master policy is the actual contract of insurance.

The group may be an employer, union, association, or other entity, but it must have been formed for reasons other than obtaining insurance. The purpose of group insurance is to take advantage of cooperative purchasing power, allowing the group to negotiate and have a measure of control over the plan. Also, it is easier for an insurer to predict the potential claims experience of larger groups, which allows it to set rates more accurately, reflecting actual loss ratios. Consumers should beware of one-member groups, and/or associations that appear to have no other purpose than to provide insurance to members. Smaller groups and trusts are often subject to control by the agent or administrator.

The most common form of group insurance is employer group health (EGHP) insurance offered as an employment benefit. The employer is the master policy owner and certificates are issued and delivered to employees by employers. An insured group policy must comply with federal law, as well as the laws of the state in which it is issued. If an Oregon employee is covered under a group policy issued to an employer in Texas, the insurance regulatory agency in Texas has jurisdiction over that policy and the policy must conform to the Texas insurance code.

Some types of out-of-state group insurance sponsored by trusts or associations, for which certificates are marketed to Oregon residents, are subject to the Oregon Insurance Code. One feature that may be offered by group insurance is an open enrollment period. Enrollment during this period may offer members advantages not available at other times. During an open enrollment period, the insurer will accept a member without proof of insurability (or evidence of good health).



See CMS publication 02179, *Medicare and Other Health Benefits: Your Guide to Who Pays First* for additional information.

## **COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that EGHPs covering 20 or more employees must allow continuation of the EGHP for employees and their dependents. Employees and dependents can get an 18-month continuation of the EGHP in the event of job termination or a reduction in hours that would otherwise result in a loss of benefits. Dependents can get a 36-month continuation in the event of employee death, divorce, legal separation, or the loss of a child's dependent status.

The employee or the dependent(s) are usually required to pay premiums for extended COBRA benefits.

The employee or the dependent(s) has the responsibility to notify the employer within 60 days of the qualifying event in order to request EGHP continuation.

# Portability Plans

Portability makes ongoing health insurance coverage available if you were enrolled in an employer-sponsored group health plan for at least six months immediately before your coverage ended. All health carriers must offer, on a guaranteed basis, two types of portability plans – prevailing and low-cost – to all eligible individuals who leave group coverage and apply for portability coverage within 63 days. Carriers may offer additional portability plans that have been filed and approved.

## *Oregon portability applicants:*

- ◆ Are NOT currently eligible for, nor enrolled in, group health benefits, Medicare, Medicaid, or an individual health benefit plan, and
- ◆ Must submit a portability application within 63 days of the date of receiving “NOTICE OF TERMINATION OF GROUP BENEFITS” and
- ◆ Are residents of Oregon, and
- ◆ Must have been continuously covered by Oregon-based group health benefits for 180 days or more, or
- ◆ Have been covered for at least 18 months of continuous creditable coverage, which may include another carrier.
- ◆ If prior coverage was through a self-funded group plan or if the terminated member resides outside the State of Oregon, the options for continued coverage are different.

Eligible individuals may enroll in portability coverage before, during, or at the end of their COBRA or state continuation coverage. All portability plans must be offered on a guaranteed issue basis. No portability plans may contain pre-existing condition provisions, exclusion periods, waiting periods, or other similar limitations on coverage.

If an eligible individual did not complete an exclusion period applicable under the prior group coverage, the remaining portion of the exclusion period may carry over to the portability coverage. Portability coverage must be guaranteed renewable and may be retained as long as the individual is eligible.

Eligible individuals who lose group coverage because they move out of the carrier's service area, and individuals who lose self-insured group coverage may purchase portability coverage through the Oregon Medical Insurance Pool (OMIP) with no high-risk premium surcharge. Individuals who lose self-insured coverage must exhaust their COBRA coverage before enrolling in portability coverage via OMIP. For more on OMIP, see page 31.

**COBRA and portability rules do not apply to self-insured companies.**

## Individual Policies

An individual health insurance policy is a contract between an individual and an insurer. The individual is the policyholder and usually must present evidence of insurability in the form of a written application or health questionnaire. The insurer may investigate the applicant's medical history and may deny coverage. This process of deciding whether an applicant qualifies as an acceptable risk is called *underwriting*.

Individual policies may be guaranteed renewable, but the majority are issued as renewable or alterable at the discretion of the insurer by policy form number. This means that an individual policy may not be changed or cancelled by the insurer unless all policies sharing the same form number are changed or cancelled. The grouping of policyholders by policy form numbers creates a block of business for actuarial purposes, or establishing loss ratios and appropriate premiums.

Loss ratio is the ratio of benefits paid out to premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars was paid out in benefits, whereas high loss ratios indicate that a high percentage of the premium dollars was paid out in benefits.

## More on EGHPs

Some employers offer continuation or conversion as a *retirement benefit*, allowing retirees to continue group coverage or convert to an insurance plan that acts like a Medicare supplement. Such plans are not subject to minimum standards for Medicare supplements and may provide more benefits or fewer benefits. *These plans are secondary to Medicare benefits.*

An employee may **continue working** past age 65. If the employer has 20 or more employees and provides an EGHP, the worker older-than-65 must be covered under the same EGHP with the same benefits as employees younger than age 65. *In this case, the EGHP is primary to Medicare, providing full benefits before the Medicare benefits are applied.* Workers older than 65 and covered under EGHPs may postpone enrollment in Medicare Part B without paying the penalty for late enrollment, until their EGHP is no longer available. If beneficiaries are eligible for and do not enroll in Medicare Part B, the EGHP may pay as though they are enrolled and pay only the excess beyond what Medicare would not cover.

### ***Advantages:***

- ◆ Coverage may provide benefits beyond Medicare approved amounts and for services not provided by Medicare Parts A and B, such as prescription drugs.
- ◆ There are no waiting periods or health underwriting.
- ◆ Coverage may provide for the retiree's spouse or dependents.
- ◆ The employer may pay all or a portion of the premium.

### ***Limitations:***

- ◆ Premium may be high if the retiree is responsible for paying all of it.
- ◆ The term of coverage may be limited.
- ◆ If the employer employs fewer than 20 employees, benefits may be limited depending on how the plan coordinates benefits with Medicare.
  - Medicare regulation allows EGHPs for fewer than 20 employees to pay as a secondary payer.

- The company may cancel a policy or change benefits as it deems necessary.

## Medical-Surgical Expense Plans

Medical-surgical expense plans provide for physician and medical expenses based on a percentage of covered expenses. Reimbursement is generally based on usual and customary charges, as determined by the insurer. Surgical expenses are generally based on a surgical schedule. The schedule is a list of specific surgical procedures and provides a maximum amount to be paid for each procedure.

### *Advantages:*

- ◆ Coverage is available to people younger than 65.
- ◆ Premiums tend to be more stable over time if benefits are fixed by schedule.
- ◆ Reimbursement is not based on Medicare payments or approved charges.

### *Limitations:*

- ◆ Coverage is for medical or surgical expenses only, *not for hospital* or skilled nursing facility.
- ◆ Premiums tend to be high for older ages.
- ◆ Underwriting tends to be strict.
- ◆ Scheduled benefits do not keep pace with inflation.

## Major Medical Plans

Major medical plans provide for hospital, medical, and surgical services, subject to policy limitations. They usually have deductibles from \$0 to \$10,000 or higher. After the deductible, the insurer usually pays a percentage (usually 80 percent) up to the policy maximum, which may be from \$10,000 to \$1,000,000 or higher. Some major medical plans have stop-loss provisions in which their percentage eventually becomes 100 percent.

### *Advantages:*

- ◆ Coverage keeps pace with inflation.
- ◆ Deductible and coinsurance allow the insured to accept a small amount of risk and transfer the larger portion of risk to the insurer.
- ◆ Premiums decrease with choices of larger deductibles.

### *Limitations:*

- ◆ Premiums increase due to inflation of medical service fees.
- ◆ Coverage often ends at age 65.

## **Hospital Indemnity Plans**

Hospital indemnity plans pay a fixed dollar amount for hospital expenses covered by the policy. Most require that the beneficiary be confined as an inpatient in the hospital before benefits are paid, and pay a fixed number of dollars per day of hospital confinement. Benefits are often paid directly to the beneficiary, but may be assigned to the hospital.



**Note:** Variations of Individual and Group health plans may involve combining characteristics of hospital indemnity, medical-surgical, and major medical plans into one policy.

### *Advantages:*

- ◆ Coverage is easy to understand.
- ◆ Coverage is available to people younger than 65.
- ◆ Premiums tend to be more stable over time as benefits are fixed.
- ◆ Proceeds may be used as the beneficiary chooses.

### ***Limitations:***

- ◆ Not a comprehensive health plan
- ◆ Outpatient services or other medical services are not provided.
- ◆ Benefits may be reduced after age 65.
- ◆ Benefits fail to keep pace with inflation.
- ◆ Not designed to cover gaps or changes in Medicare.

## **Specified-Disease or Accident Plans**

Specified-disease or accident plans cover expenses due to a specific disease diagnosis or accidental injury. The most common types are cancer insurance and accident insurance.



**Important:** Medicare beneficiaries should think twice before buying a *limited benefit policy*, such as *hospital indemnity* or *specified disease plans*. These policies may provide less coverage than Medicare with a Medicare supplement. And, because there is only a small chance of meeting the criteria for receiving the benefits offered, *these policies usually cost more in premiums than they ever pay in benefits*.

### ***Advantages:***

- ◆ Benefits are paid directly to the beneficiary.
- ◆ Premiums are lower than more comprehensive plans.

### ***Limitations:***

- ◆ No coverage is provided for diseases or accidents not specified in the policy.
- ◆ Coverage generally does not keep pace with inflation.
- ◆ Coverage is usually limited.

# Travel Insurance

Travel insurance is insurance that is intended to cover medical expenses and financial and other losses incurred (such as money invested in nonrefundable pre-payments) while traveling, either within one's own country, or internationally.

Temporary travel insurance can usually be arranged at the time of the booking of a trip to cover exactly the duration of that trip, or a more extensive, continuous insurance can be purchased from travel insurance companies, travel agents or directly from travel suppliers such as cruiselines or tour operators. However, travel insurance purchased from travel suppliers tends to be less inclusive than insurance offered by insurance companies.

Travel insurance often offers coverage for a variety of travelers. Student travel, business travel, leisure travel, adventure travel, cruise travel, and international travel are all various options that can be insured. The most common risks that are covered by travel insurance are:

- ◆ Medical expenses
- ◆ Emergency evacuation/repatriation (returning to one's country)
- ◆ Overseas funeral expenses
- ◆ Accidental death, injury or disablement benefit
- ◆ Cancellation
- ◆ Curtailment (cutting the trip short)
- ◆ Delayed departure
- ◆ Loss, theft or damage to personal possessions and money (including travel documents)
- ◆ Delayed baggage (and emergency replacement of essential items)
- ◆ Legal assistance
- ◆ Personal liability and rental car damage excess

Some travel policies will also provide cover for additional costs, although these vary widely between providers. In addition, separate insurance can be purchased for specific costs such as:

- ◆ Pre-existing medical conditions (e.g. asthma, diabetes)
- ◆ Sports with an element of risk (e.g. skiing, scuba-diving)
- ◆ Travel to high risk countries (e.g. due to war or natural disasters or acts of terrorism)

***Common exclusions:***

- ◆ Pre-existing medical conditions
- ◆ War or terrorism - but some plans may cover this risk
- ◆ Injury or illness caused by alcohol or drug use

Travel insurance can also provide helpful services, often 24 hours a day, 7 days a week, that can include concierge services and emergency travel assistance. Typically, travel insurance for the duration of the journey costs approximately 5-7% of the cost of the trip.

# Oregon Medical Insurance Pool (OMIP)

For individuals younger than 65 who are unable to obtain health insurance due to health conditions, and not eligible for Medicare, the Oregon State Legislature created the Oregon Medical Insurance Pool (OMIP). For questions about eligibility, write or call:

**Oregon Medical Insurance Pool**

250 Church St. SE, Suite 200

Salem, OR 97301-3921

**1-800-848-7280**

Web site: <http://www.omip.state.or.us>

When individuals who have been enrolled in OMIP insurance become eligible for Medicare, typically their OMIP coverage ends.

Then their options are the same as any other person starting Medicare:

- ◆ Original Medicare Part A and Part B, with or without a Medigap plan, and/or a Part D prescription plan, or
- ◆ A Medicare Advantage plan, with or without drug coverage

# Consumer Tips

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## Health Insurance “Do”s & “Don’t”s

### *Do:*

- ◆ Insist on a simple outline of the policy that describes the benefits offered.
  - Under law, this outline must be given to an applicant at the time of application or when the applicant receives the policy if purchased through the mail.
  - Read the outline carefully.
- ◆ Compare the benefits and premiums of plans offered by several insurance companies or agents before buying any health insurance policy.
- ◆ Find out which insurance the applicant’s doctor will accept before purchasing a policy.
  - This information will help in comparing the benefits of various plans.
- ◆ Be careful about buying a policy on the basis of its skilled nursing home coverage.
  - Few policies cover the custodial care most older persons receive in nursing homes.
- ◆ Read the policy carefully after it is received.
  - Make sure it provides the benefits that were represented by the agent.
  - Use a check or money order payable only to the company, not the agent.
  - If for any reason the policyholder wishes to cancel the policy, it may be returned to the company within 30 days of receipt for a full refund.
- ◆ If covered under an Employer Group Health Plan (EGHP) understand how the EGHP will supplement Medicare.
  - Try to find out if the employer has plans to drop health coverage for retirees.

### ***Don't:***

- ◆ Believe a Medicare supplement policy pays for everything that Medicare doesn't pay. **NO such policy exists.**
- ◆ Purchase a policy that pays only daily indemnity or *per-day* benefits (or a policy that pays only for accidents or a specific disease) before considering a comprehensive plan to supplement Medicare coverage, like a Medicare supplement or Medicare Advantage plan.
- ◆ Purchase more than one Medicare supplement policy or Medicare Advantage plan.
- ◆ Pay cash for insurance.

## **How To Choose A Trustworthy Insurance Agent**

An agent can be as important as a doctor or lawyer. Choose carefully. Have the beneficiary take the following steps:



***First - Is the agent licensed?*** Check with the Insurance Division's Agent Licensing Unit at (503) 947-7981.



***Second - Ask around.*** Has the local Better Business Bureau received complaints about a particular agent? Ask the agent for recommendations from some other clients.



***Third - Ask agents what kind of service the beneficiary can expect from them.*** Will they regularly evaluate the insurance needs? Will they help when it's time to make a claim?



***Remember whom agents work for.*** Agents work on a commission basis for their company. Legally, they do not work for consumers.

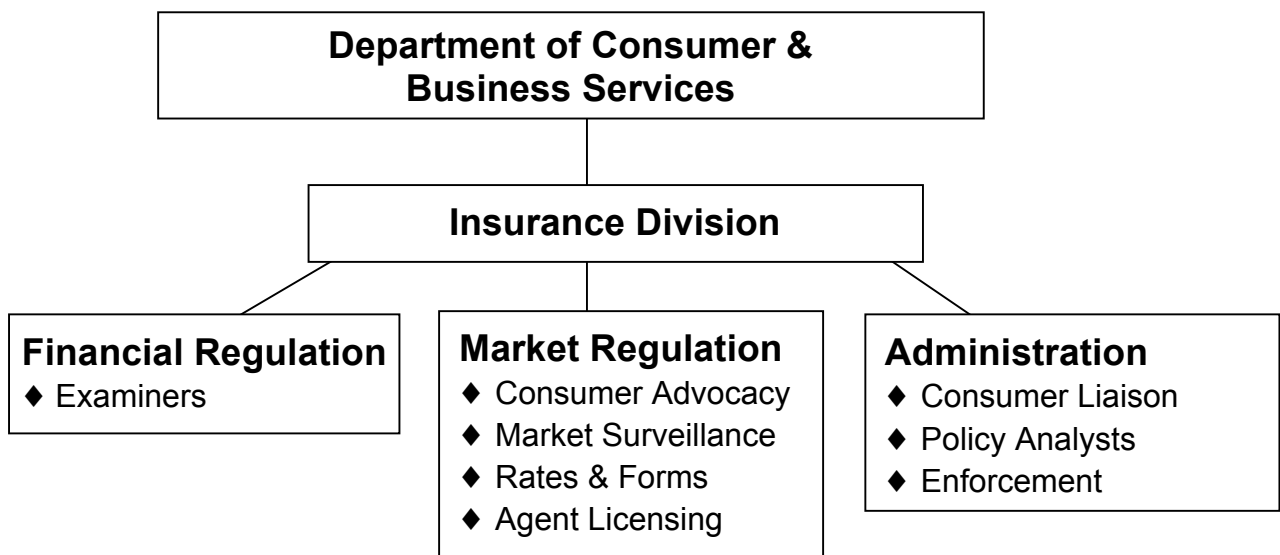
***Avoid an agent who uses any of these questionable or illegal tactics:***

- ◆ Fails on initial contact with clients to disclose that they represent a ***for-profit*** insurance company
  - Agents may say they are “from Medicare” and want to “help” seniors with policy problems.
- ◆ Encourages the client to cancel or add to a satisfactory existing policy in order to seek a new policy that gives the agent additional commission
  - The agent might even try to sell the applicant additional policies that duplicate the coverage of existing policies.
- ◆ Misrepresents an existing policy or a proposed policy in order to gain a sale
  - The agent misrepresents policy content with words like *no waiting period or this policy will pay for everything*.
  - Do not believe an agent who states that a particular item is covered if it is not in the outline of coverage.
- ◆ Asks the applicant to make the check out to him or her
  - If the agent cashes the check and doesn’t report the transaction to the insurance company then no policy would be issued.
- ◆ Uses language intended to frighten potential customers into buying, such as, “buy now because you may not qualify later or you’ll pay a higher rate if you buy later”
- ◆ Fails to complete health questions on the application or otherwise fails to report pre-existing health conditions of the applicant to the company
  - This may lead to the policy being rescinded by the insurer due to misrepresentation of pre-existing health conditions of the applicant and accusations of applicant misrepresentation.

# Regulation

The insurance industry is regulated in Oregon by the Department of Consumer and Business Services, Insurance Division, which does the following:

- ◆ Licenses agents
- ◆ Monitors insurer solvency
- ◆ Authorizes insurers to transact insurance
- ◆ Reviews and approves policy language
- ◆ Reviews and approves premium rates
- ◆ Investigates potential violations of insurance law
- ◆ Answers consumer questions and investigates complaints



Questions, complaints, or reports of illegal activity or sales practices should be directed to:

**DCBS - Insurance Division-2**

P.O. Box 14480

Salem, OR 97309-0405

**1-888-877-4894 or 503-947-7984**

<http://www.insurance.oregon.gov>

[cp.ins@state.or.us](mailto:cp.ins@state.or.us)