

Oregon Medical Insurance Pool

OMIP
We're here for you!



PRODUCER GUIDE TO OMIP APPLICATIONS

WHAT IS OMIP?

OMIP is an acronym for the Oregon Medical Insurance Pool. OMIP was established in 1989 by the Legislature to provide health insurance to Oregonians who have been denied individual health coverage because of their medical conditions. In short, it is a safety net or last resort for people who cannot get individual health insurance coverage.

OMIP also provides health coverage in certain circumstances when an individual exhausts or is unable to obtain COBRA or portability coverage, and for individuals who are eligible for a health coverage tax credit through the federal government.

IMPORTANT FACTS TO REMEMBER WHEN HELPING A CLIENT APPLY FOR OMIP

- Applications may take up to 30 days for review and processing.
- There is a 10-day right-to-review period after the contract has been issued.
- If faxing an application, please do NOT mail the hard copy; this will only delay processing.
- OMIP has the right to refuse to pay the \$75 agent referral fee on incomplete applications. Examples of incomplete applications include:
 - Lack of required documentation as outlined on the *OMIP Application*
 - Missing signature and initials from applicant and/or dependents

- Failure to select one of the medical or portability plans
- Incomplete agent information

It is important that you help your clients complete their OMIP Application. They rely on your expertise.

HEALTH CONDITIONS

- Do not write in a diagnosis for a client. Only listed conditions are acceptable.
- “Prescreen” denials do not replace a formal letter of declination.

PROOF OF ELIGIBILITY

- Individuals are NOT eligible if they currently have any of the following coverages:
 - Medicare
 - Medicaid
 - Oregon Health Plan (OHP)
 - Any other health insurance with benefits *substantially equivalent* to OMIP coverage

- Acceptable forms of proof of Oregon residency are:
 - Current and valid Oregon Driver License
 - Current and valid Oregon Identification Card
 - Current utility bill (must have applicant’s name on bill and address listed on the application)
 - *FHIAP Certificate of Eligibility* (with applicant’s name, signature and effective date)
 - A dated, signed rental agreement showing applicant’s current Oregon address and applicant’s name

Please make sure proof of residency is legible and valid.

PORTABILITY PLAN

- OMIP portability plans offer continuous coverage, effective from the date previous coverage has been exhausted or terminated.
- Premium is due from the effective date of OMIP coverage.

ADDING DEPENDENTS TO CURRENT OMIP POLICIES

Medical Plans: A person who is already enrolled in OMIP can add an eligible dependent at any time by completing a *Dependent Application*. This is a new, abbreviated version of the regular *OMIP Application*. Dependents include a legal spouse, a domestic partner and any eligible children. New applicants who add dependents do not need to complete this form. The *Dependent Application* is available on the OMIP Web site at www.omip.state.or.us or by calling OMIP Customer Service at (800) 848-7280.

OMIP gives credits to dependents who provide a *Certificate of Coverage* showing that they had creditable coverage within 63 days of the mailing date on the *Dependent Application*.

Portability Plans: Dependents cannot be added to a portability policy unless they are added within 31 days of a qualified event. Qualifying events include: the birth of an eligible newborn child, a newly adopted child, a new spouse or a new domestic partner. New applicants can add dependents onto the portability plans if the dependents were covered under the previous group policy for at least 180 days without a break in coverage greater than 63 days from the mailing date on the *OMIP Application*.

CREDITS TOWARD PRE-EXISTING LIMITATION PERIOD

■ If the applicant and any dependents apply to OMIP within 63 days from the end date of their previous health benefit plan coverage, they may be eligible for credits toward the pre-existing limitation period.

■ *The applicant must mark the box in Section E of the application to qualify for credits.* If this box is not marked and there is no *Certificate of Coverage*, OMIP will not know to apply credits. Because these are deductible plans, enrollees may not understand or know that credits have not been applied.

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3. Federal Health Coverage Tax Credit Eligibility

The U.S. Department of Labor has certified me as being affected by competition from foreign trade, and I am eligible to receive a Federal Health Coverage Tax Credit (FHCTC) under Section 91 of the Internal Revenue Code. (Attach documentation from the federal government showing you are eligible for this program.)

E CREDIT TOWARD PRE-EXISTING LIMITATION PERIOD

OMIP will not pay benefits during the first six months of enrollment for coverage of expenses incurred for a pre-existing condition unless we grant you credits. A pre-existing condition is one for which professional medical advice, diagnosis, or treatment was recommended or received or a treatment plan was prescribed in the six months prior to your OMIP enrollment.

We will grant credits toward the pre-existing limitation period for each month of your creditable health coverage you or creditable coverage means prior to becoming insured by OMIP. To receive credits, your application must be received by OMIP no later than 63 days from the termination date of the prior creditable health coverage or coverage.

Creditable coverage means prior substantially equivalent health insurance coverage that reimburses for medical and hospital expenses without regard to a specific medical condition or disease and has comparable similar benefits and terms as your credit coverage for benefits and services that your previous health plan did not cover or credit benefits that had not been satisfied during the previous plan's exclusion period except portability.

I have credits toward the six-month pre-existing limitation period. (Attach a copy of your prior plan's benefits summary with a Certificate of Coverage stating your begin and end dates.)

F STATISTICAL & ELIGIBILITY INFORMATION

OMIP requires that you complete the following information. The program will use only information about other insurance or employer-based benefits to determine eligibility. OMIP also uses this data for evaluating future insurance market status.

1. Are you (check one) employee self-employed not employed retired

What is your occupation? _____

Does your employer offer health insurance to its employees? No Yes

If yes, are you currently, or have you ever been, covered under your employer's plan? No Yes

If yes, on what date did that coverage end and why? End date: _____ Reason: _____

If your employer offers health insurance to its employees and you are not covered under your employer's plan, why didn't you take your employer's insurance? _____

2. Have you ever been enrolled in OMIP? Yes No

If yes, what date did your coverage begin? _____ What date did your coverage end? _____

3. Have you ever received \$2 million in OMIP benefits? No Yes

4. In the last 6 months, have you applied for insurance through Medicaid/CHIP? No Yes

If so, were you eligible? Yes No

- OMIP will not apply credits for benefits that were not covered under prior coverage or for benefits that required a waiting period that the applicant has not already satisfied. An example is transplant services. If the previous policy required a 24-month waiting period and the enrollee satisfied only 12 months, OMIP will not give credits for that benefit.
- The six-month pre-existing limitation period starts on the original effective date of the OMIP policy.
- To expedite application processing, include the beginning and end dates of your client's prior coverage on the *OMIP Application*. Please note that OMIP:
 - Requires a *Certificate of Coverage*
 - May request a benefit summary (for medical plans only) to determine whether credit for prior coverage can be applied.
 - Requires a letter from previous insurer or employer indicating that the applicant has exhausted COBRA or is unable to obtain COBRA or commercial portability coverage.
- The applicant must exhaust or terminate any prior creditable coverage before OMIP coverage can begin.

DISCLOSURE AUTHORIZATION

- If you have a spouse or a domestic partner listed on the application, please make sure they initial and sign the application.

AGENT INFORMATION

- If more information is needed, you will be contacted by e-mail or phone.
- OMIP policies do not have an agent of record. Once the first month of premiums have been collected from your client, you will receive a \$75 agent fee. If you want access to information about the enrollee’s coverage the form “Authorization to Disclose Protected Health Information” must be completed and signed by the enrollee. This form is available on OMIP’s Web site under Producer/Agent Information.

OMIP FAQs

Q. *Is OMIP an insurance company?*

A. No. OMIP is a state program that works like an insurance company, but is exempt from many of the provisions under the Oregon Insurance Code. The premiums collected from enrollees cover only about one half of the total expenditures. Assessments charged to licensed Oregon medical insurance companies that insure Oregonians cover the other half. OMIP currently contracts with Regence BlueCross BlueShield of Oregon (RBCBSO) to administer the program for the State of Oregon. The OMIP Board of Directors approves any rate and/or benefit changes.

Q. *If an applicant qualifies for both medical and portability plans, what are the important considerations in deciding which way to apply?*

A. Once someone is enrolled in a medical plan, he or she can never switch to a portability plan. However, if a person enrolls in a portability plan, he or she can switch to a medical plan but only by re-applying and qualifying for medical eligibility.

There are only two portability plan options: \$750 deductible and/or \$1,500 deductible. Medical eligibles may choose from four different deductible plans: \$500, \$750, \$1,000 and \$1,500.

Premiums for the portability plans are set equal to the market average for similar portability plans. Premiums for the medical plans may be set up to 25 percent above the market average for similar commercial individual plans. The premiums for the \$750 and \$1,500 deductible *portability* plans are not the same as they are for the \$750 and \$1,500 deductible *medical* plans.

The effective date for enrollees who choose a portability plan is the day after their previous insurance ends. This means that they will be responsible for premiums back to their OMIP effective date.

Q. *How does someone prove Oregon residency?*

A. An individual can provide a copy of one of the following: A current and valid Oregon Driver License or Oregon Identification Card, an Oregon income tax return, a dated rental agreement showing residence, a current utility bill with his or her name and address on it (matching the address listed on the application), a *FHIAP Certificate of Eligibility* or any other documentation that may be deemed appropriate by the Administering Insurer, Regence BlueCross BlueShield of Oregon (RBCBSO).

Q. *If a person is a resident of Oregon, but not a U.S. citizen, can he or she still apply to OMIP?*

A. Yes, the statutes do not require that OMIP enrollees be U.S. citizens. An individual does have to be an Oregon resident. This means they must permanently reside in Oregon at least 180 days per benefit enrollment year once enrolled in OMIP. Individuals do not have to live in Oregon 180 days prior to applying to OMIP.

Q. *Can OMIP help a person now who currently lives out of state, but plans to move to Oregon?*

A. The person may apply to OMIP up to 90 days before the requested effective date. However, the application may be pended until OMIP can ascertain that he or she has established permanent residency in Oregon. See *“How does someone prove Oregon residency?”* above for the kinds of documentation individuals can submit to demonstrate that they are residents.

Q. *How does an individual add a newborn to an OMIP policy?*

A. An enrollee must complete a *Status Change Form* within 31 days following the birth of the baby. This form is available online at www.omip.state.or.us or by calling OMIP Customer Service at (800) 848-7280.

Q. *Where does an individual get an application?*

A. Applications are available online at www.omip.state.or.us or an application can be mailed to your office. Call our administrator, RBCBSO, and request an OMIP packet at (800) 848-7280. The applicant must complete the application in full and attach proof of Oregon residency.

Q. *How long does it take to process an application?*

A. If the application is complete and all required documentation is attached, please allow up to 30 days for processing.

Q. *When does coverage become effective?*

A. If applying for a medical plan, coverage can generally begin on the first of the month following the date RBCBSO receives the completed application. Even though it could take up to 30 days for processing, applicants will still get the effective date on the first of the month following receipt of their completed application.

Example: An application that is complete and received by RBCBSO on October 10 would normally allow a November 1 effective date. If RBCBSO completes its review and processing of the application on November 3, the effective date would still be November 1. However, the member wouldn't receive the contract and eligibility letter until after BCBSO completed its processing review.

If the applicant had previous insurance that was terminated in the middle of the month that their OMIP effective date would normally begin, then the OMIP coverage would not begin until the day after the prior coverage terminates.

Example: An application is complete and received by RBCBSO on October 19, allowing a November 1 effective date. However, the previous coverage ends November 15. The OMIP effective date is November 16 and the premium for November is prorated.

For a portability plan, OMIP coverage begins the day following the termination date for the previous coverage.

Example: An applicant exhausted COBRA coverage on August 31 and OMIP received her application on October 9, (within 63 days of termination). She is eligible for a portability plan, so her effective date would be September 1. She is responsible for premiums beginning September 1.

Q. *What happens when an OMIP member begins receiving Medicare?*

A. The enrollee's OMIP policy would terminate the month after he/she began receiving any Medicare benefits. It is the enrollee's responsibility to inform OMIP when he/she becomes eligible for Medicare, and to enroll in a Medicare policy. If the member is under 65, he or she becomes ineligible for OMIP when he or she becomes eligible for Medicare.

Q. *Can someone have OMIP and Medicaid (OHP) coverage at the same time?*

A. No. If it is discovered that an OMIP member is receiving both types of coverage, OMIP will terminate coverage retroactively as far back as the original effective date of Medicaid coverage. The member will be responsible for any claim payments made on his or her behalf including prescription drugs. Medicaid will not reimburse members for these costs.

Q. *Does OMIP recognize domestic partners?*

A. Yes. A domestic partner, regardless of gender is considered an eligible dependent. However, OMIP requires the domestic partner and contract holder to complete an *Affidavit*, which can be found at www.omip.state.or.us.

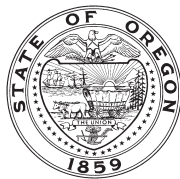
OMIP CONTACT INFORMATION

OMIP Customer Service at Regence (800) 848-7280

OMIP Fax Number for Applications (503) 225-5474

OMIP Administrative Office (800) 542-3104

- OMIP Web Site: www.omip.state.or.us
- Regence Web Site: www.or.regence.com
- Web address for ordering OMIP Materials:
<http://web.regence.com/Apps/ORMktSupplyReq.nsf/fsIndSupply>



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