SHIBA

Senior Health Insurance Benefits Assistance

Section 3

Medigaps and Other Insurance to Supplement Medicare

SHIBA Volunteer Training Program, April 2008

Section 3, Medigaps and Other Insurance to Supplement Medicare

Introduction to Supplemental Insurance Options (Medigaps)

Goals and objectives

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

On completion of this section, the SHIBA volunteer 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 on Medicare

Medicare does not pay 100% of all medical bills. Medicare's purpose is to increase access to health care and reduce its financial burden on older, retired or disabled people.

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

Medicare Supplements

Medicare supplement insurance, often called ***Medigap***, is designed to help fill all or some of the gaps in Medicare by paying the Part A and B deductibles and coinsurance. Some supplemental policies may provide additional benefits.

Standardization

In 1990, Congress enacted rules that made Medicare Supplement Insurance (Medigap) uniform in most states, including Oregon. One of the most important changes resulting from the Omnibus Budget Reconciliation Act (OBRA) was the creation of ten standard Medicare supplement policy forms. Insurers may market one or more of the standard plans A through L, making comparisons easier. While prices and company service may vary, every Medigap policy offered in the United States is identical in coverage. For comparison of plans A through L, check the *2008 Guide to Medigap, Medicare Advantage & Prescription Drug Coverage* by SHIBA. Plan A is the most basic. Plan J is the most comprehensive. Benefits generally increase as plans go from A to L.

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 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.

Benefits

Medicare supplement plans must provide the following *minimum* benefits:

- Either all or none of the Medicare Part A initial inpatient hospital deductible.
- The coinsurance amount under Medicare Part A for the days 61-90 of hospital confinement during a benefit period.
- The coinsurance amount under Medicare Part A while using its 60-day lifetime reserve of inpatient hospital care.
- 100% of Medicare Part A eligible expenses upon exhaustion of all Medicare inpatient coverage, with a maximum benefit of 365 additional days during the policyholder's lifetime.
- The first three pints of blood.
- The 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. A policy can be cancelled by the insurer only 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. Premiums may be adjusted by the insurer to reflect 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 for which medical advice or treatment was received within the six months immediately preceding the effective date.
- 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% for individual Medicare supplements and 75% for group.

Open enrollment period for Medigap policies

Open Enrollment for Medigap policies **begins** when the applicant first becomes enrolled in Medicare Part B and **ends** six months later.

During the Open Enrollment Period, 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 a *continuous period** of at least six months of *creditable** health insurance. If the applicant has less than 6 months of *creditable coverage*, the new plan must give credit for the amount of *creditable coverage* the insured already had. **This Open Enrollment Period for Medigap policies applies to anyone in Oregon – regardless of age – who enrolls in Medicare Part B.**

Continuous period of creditable coverage means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no break in coverage greater than 63 days.

Creditable coverage means, with respect to an individual, coverage of the individual provided under any of the following: A group health plan (including a governmental or church plan) health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program such as TRICARE, a program of the Indian Health Service, a state high-risk pool, the Federal Employees Health Benefit Program, a public health plan established or maintained by a state or local government, COBRA, and a health benefit plan provided for Peace Corps members.

Note: Medicare supplement plans "health underwrite" outside of open enrollment and *guaranteed issue* times.

Coordination of benefits

Medicare is primary to a Medicare supplement. Medicare benefits are applied and paid first before the Medicare supplement 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 Medicare supplement 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

- Effective 1989, carriers were to begin forwarding claims (called Medicare Summary Notices — MSNs) to Medigap insurers to expedite claims for participating physicians. In Oregon, this process is set up through the provider at a beneficiary's request. This process is commonly referred to as "crossover." (Note: some Medigap policies state they are not "crossover" companies.)
- 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 supposed 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.

Medicare enrollees who have had additional health coverage that is going to end, or has ended, would 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 you are guaranteed approval under your specific situation. However, you must apply within 63 days of the termination of your current coverage.

See "Guaranteed Issue Situations" chart on next page.

Plan termination during Open Enrollment Period

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

Example:

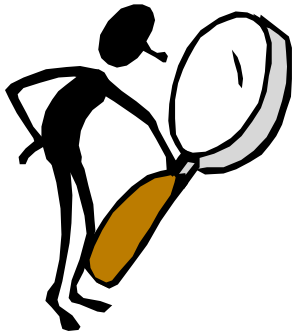
Susie's insurer terminates her Medigap Plan A. She has been enrolled in Medicare Part B for 5 months. Susie decides that she now needs a more comprehensive plan. She can choose any plan offered in the state. Even if her current insurer offers other plans, she can go to another insurer.

Guaranteed Issue Situations	Medicare Supplement Plan Choices
Your Medicare Advantage (MA) plan or PACE program coverage ends due to the plan leaving the Medicare program, or stops giving care in your area.	A, B, C, or F
Your employer group health plan coverage ends.	A, B, C, or F
Your employer group health plan, MA MCO, PACE, Medigap, or Medicare Select health coverage ends because you move out of the plan's service area.	A, B, C, or F
You joined a MA plan or PACE program when you were first enrolled for Medicare. Within the first year of joining the plan, you want to leave.	All plans
You terminate a Medigap policy to enroll in a MA plan, Medicare SELECT policy, or PACE program for the first time and now you want to terminate that policy after no more than 12 months of enrollment.	Original plan. If not available, then A, B, C, or F
Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	A, B, C, or F
You leave your plan because your MA plan, MCO, PACE, Medicare SELECT, or Medigap insurance company has committed fraud. For example, the marketing materials were misleading, or quality standards were not met.	A, B, C, or F
Your Medicare Select insurer has had its certification terminated, the insurer has discontinued providing the plan in your area, has substantially violated a material provision of the organization's contract in relation to the individual (e.g., failure to provide the timely care) or the organization or agent materially misrepresents the plan's provisions, or you move out of the Medicare Select plan's covered area.	All plans

In these situations, an insurance company selling Medigap policies:

- Cannot charge more for a Medigap policy 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.

Medigap tips



- If more than one situation applies, you can choose the protection that gives you 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. You may need to provide these documents as prove of coverage that insures the Guaranteed Issue Rights.
- Medigap plans H, I and J offered some prescription drug coverage prior to January 1, 2006. By law those plans are guaranteed renewable with that drug coverage. It is not considered creditable, that is, as good as Medicare Part D coverage. Such plans with the drug coverage included have stopped being sold as of January 1, 2006. H, I and J *without* the drug benefits are still available.
- Summary statements on Medigap plans H, I, and J: **1)**Medigap policies with drug coverage are no longer being offered. **2)** Pre-January 1, 2006, Medigap policies that had drug coverage may be kept; however, their drug coverage does not count as creditable coverage. 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.

How to compare Medicare supplements

Applicants select a plan, A through L, that provides their desired benefits. The benefit chart of plans A through L in the *SHIBA Oregon Guide* shows how the plans compare. Applicants consider the premium charged for the plan and the service provided by the insurer.

(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 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*?
- What is the financial condition of the insurer? Will the insurer be able to honor its policies now and in the future?
- What is the insurer's standing with the Insurance Division?
- Does the applicant have current health concerns? Is the applicant anticipating medical treatments soon?

A good resource for checking out how an insurance company provides service is **Oregon Insurance Complaints**. This booklet lists insurance companies; shows the amount of premium earned, the number of complaints received, and gives a complaint index number. The complaint index shows how many complaints the Insurance Division processed in relation to how much business the company has. The full report is available at www.oregoninsurance.org.

To get a copy of the *2008 Guide to Medigap, Medicare Advantage & Prescription Drug Coverage* by SHIBA, or the Oregon Insurance Complaints Guide, call or write:

Oregon SHIBA
250 Church St SE, Suite 200
Salem, OR 97301-3921
(503) 378-2014 or 1-800-722-4134

E-mail: shiba.oregon@state.or.us
Web site: www.oregonshiba.org

How to Read a Health Insurance Policy

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 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 policy

Renewability

One of the most important policy provisions is the 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. However, policies issued prior to federal standardization in 1990 (see page 4 Standardization) did not have

to meet this requirement. 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. **Premiums may be changed due to changes in Medicare. As deductibles and coinsurance amounts increase every year**, the amount the insurer is liable to pay may increase.

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

- ***Attained age*** policies increase premiums when policyholders attain certain ages — often in five-year intervals, such as age 70, 75, 80, etc.
- ***Issue age*** policies do **not** have planned premium increases due to age. *Issue age* policies base premiums on the age of policyholders at the time their policy is issued. (Issue age policy premiums may increase for other reasons, though.)

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 conditions limitation

The pre-existing condition limitation clauses may differ, but an insurer may not have more than a six-month waiting period on pre-existing conditions. This clause may not be an issue 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 7 Creditable Coverage).

Consideration

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

Definitions

This section defines terms that are used in contracts. **The same term could be defined differently by two different policies.** The definitions should be read carefully with each definition applied only to the policy in which it is used.

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

Limitations and exclusions have been standardized by the Omnibus Budget Reconciliation Act (OBRA) of 1990. 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.

Other Health Insurance

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. (See page 19 for *More on EGHPs*.)

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).

Continuation of Group Health Insurance (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

All health carriers must offer, on a guarantee 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. Eligible individuals are:

- Those who have been continuously covered for 180 days or more under one or more group plans issued in Oregon for which they are no longer eligible.

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. Creditable coverage includes:
  - Group coverage (including FEHBP and Peace Corps)
  - Individual coverage (including student health plans)
  - Medicaid
  - Medicare
  - CHAMPUS
  - Indian Health Service or tribal organization coverage
  - State high-risk pool coverage and/or public health plans

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 indefinitely.

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.

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 Employer Group Health Plans (EGHPs)

Some employers offer continuation or conversion as a ***retirement benefit,*** allowing retirees to continue group coverage or convert to a plan acting like a Medicare supplement. Such plans are not subject to minimum standards for Medicare supplements

and may provide more benefits or less 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.

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 is no health underwriting or waiting periods.
- 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.
- 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.
- Company may cancel policy or change benefits as they deem necessary.
- Medicare regulation allows EGHPs for fewer than 20 employees to pay as a secondary payer. This means that if you are eligible for and do not enroll in Medicare Part B, the EGHP may pay as though you are enrolled and pay only the excess beyond what Medicare would not cover.

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 none to $10,000 or higher. After the deductible, the insurer usually pays a percentage (usually 80%) 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%.

Advantages

- Coverage keeps pace with inflation.
- Deductible and coinsurance allows 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.

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

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.

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.

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.

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.

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.

The 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

The plan is administered by Blue Cross/Blue Shield of Oregon. Questions about claims should be addressed to:

Oregon Medical Insurance Pool
c/o Blue Cross and Blue Shield of Oregon
100 SW Market St.
PO Box 1271
Portland, OR 97207
(503) 220-6363 or 1-800-777-3168
TTD (503) 225-6780

When individuals who have been enrolled in OMIP insurance become eligible for Medicare, 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 for Purchasing Health Insurance

Health insurance *Dos* & *Don'ts*

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 if the applicant's doctor will accept assignment* before purchasing a policy. This information will help in comparing the benefits of various plans.

  **Assignment* of Benefits – A method under which a claimant requests that his or her benefits under a claim be paid to some designated person or institution, usually a physician or hospital.

- 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. 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.

Do not:

- Do not believe a Medicare supplement policy pays for everything that Medicare doesn't pay. **No such policy exists.**
- Do not 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.
- Do not purchase more than one Medicare supplement policy or Medicare Advantage plan.
- Do not pay cash for insurance. Use a check or money order payable only to the company, not the agent.

How do I choose a trustworthy insurance agent?

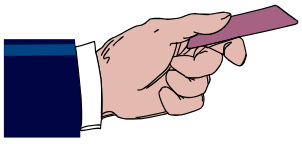
Your agent can be as important as your doctor or lawyer. Choose carefully.

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

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

√ ***Third - Ask the agent*** *what kind of service you can expect from them.* Will they regularly evaluate your 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.



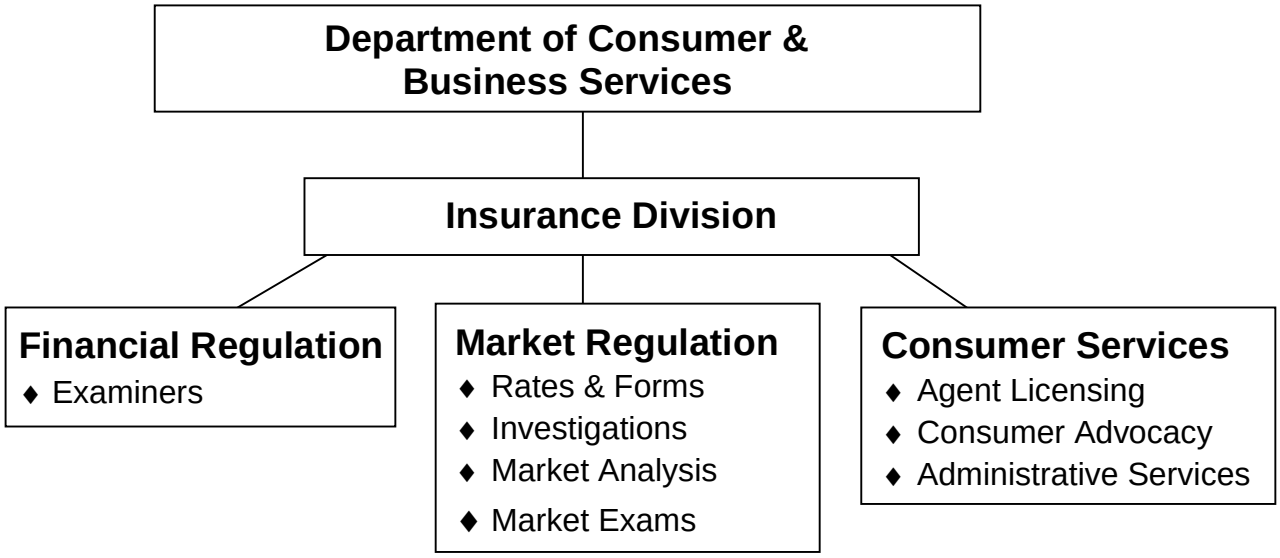
Avoid an agent who uses any of these questionable or illegal tactics:

- 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
PO Box 14480
Salem, OR 97309-0405
(503) 947-7984 or 1-888-877-4894