I. INTRODUCTION

“The Medicare Advantage program offers Medicare beneficiaries a wide range of health plan choices to meet their varying needs and circumstances. […] To date, approximately 8 million beneficiaries […] have enrolled in such plans and are receiving comprehensive, high quality, affordable coverage with benefits and innovative services that go well beyond the coverage offered by the Medicare FFS program.”

— America’s Health Insurance Plans¹
Despite the insurance industry’s and CMS’ insistence that Medicare Advantage (MA) plans are a good value for all beneficiaries, significant “gaps” created by the cost-sharing imposed by Medicare Advantage plans have led to the emergence of a new insurance product aimed at “filling” those gaps. This new insurance product, sometimes called “Advantage Plus,” is being marketed to insurance agents as a “wrap-around plan” that is “designed to fill in the gaps in Medicare Advantage Plans.” These new Advantage Plus plans pay cash benefits directly to enrollees of MA plans to cover out-of-pocket costs imposed by their MA plan. These plans (sometimes referred to as limited-benefit or mini med plans)² bundle a collection of insurance products, each providing coverage for a single benefit, into various packages that can be sold at an attractive cost to each Medicare Advantage member. Agents are marketed to and recruited by companies that make these products available, and these companies generate the leads that allow agents to identify and contact potential customers. The products marketed during the 2007 Annual Coordinated Election Period (AEP) – the time during which all Medicare beneficiaries can make a change to their Part D and Medicare Advantage insurance products – will undoubtedly include this new product aimed at addressing the failures of “Medicare approved” commercial insurance products sold under the Medicare Advantage banner.

The marketing problems we have seen since the inception of the Medicare Advantage and Part D program will now include the sale of these bundled “limited-benefit” insurance plans to Medicare beneficiaries. The current Medicare marketplace consisting of enormous numbers of MA and Part D plans with multiple complex and confusing plan designs, combined with the sale of specialized supplemental products, closely parallels the chaotic Medigap marketplace that existed prior to federal adoption of consumer protections and product standards for Medigap policies established in 1990. Now, similar to before the implementation of Medigap product standards, many consumers are unable to make intelligent and informed choices of health care benefits due to MA and Part D product designs that are tremendously convoluted and undecipherable to the average person. This complexity leaves people dependent on agents and companies with an economic interest in their decision to help them sort through the plethora of choices and buy a plan.

Further, from a public policy standpoint, the upsurge of these products aimed at filling in the gaps of Medicare Advantage plan packages – despite the overpayments that MA plans currently receive³ – underscores the failure of many MA plans to provide truly comprehensive benefits to their enrollees. It also further distances the MA program from the goal of creating an efficient, cost-effective means to access Medicare benefits.

II. “ADVANTAGE PLUS” & OTHER PLANS BEING SOLD TO FILL IN GAPS IN MEDICARE ADVANTAGE COVERAGE

Many Medicare Advantage plans charge significant cost-sharing for covered services, including the same amount(s) that someone in the Original Medicare program would pay for the same services, and in some cases, even more.⁴ For example, it is not uncommon for MA plans to charge the full 20% coinsurance for durable medical equipment, Part B covered drugs, including chemotherapy, and the full Part A first-day hospital deductible (or similar amounts). These significant out-of-pocket costs – often hidden to MA enrollees who believe they will receive “comprehensive benefits” through their private Medicare plan – frequently become unaffordable for plan enrollees who must use these services. True to Darwinian
New “Gap” Product Being Sold to Fill-in Medicare Advantage Deficiencies

theories of evolutionary adaptation, the insurance market has adapted to fill this void, or growth in deficiencies, in Medicare Advantage coverage by selling a new package of benefits – the “Advantage Plus” plans – that fill in some of these gaps, or otherwise “wrap around” the MA benefit. Advantage Plus plans, either in a specified benefit package or through defined benefits sold separately (such as individual hospital indemnity plans) pay a cash benefit directly to Medicare beneficiaries to cover the out-of-pocket costs they may face when obtaining certain services through their MA plan.

A number of companies are currently marketing to agents and promoting “Advantage Plus” products, including Senior Benefit Services, Inc., a “national insurance marketing company” based in Maryland, and Premier Senior Marketing, Inc., based in Nebraska. [see Attachment #1] In the section of Senior Benefit Services, Inc.’s website describing the Medicare Advantage products it sells, which include UnitedHealth Care, PacifiCare, Coventry, American Progressive, Pyramid Life and Humana, the following teaser for agents grabs the reader’s attention:

“If selling Medicare Advantage Plans, be sure to check out our Wrap Around product section. Easily add an additional 50%+ in commissions to each Medicare Advantage Sale. Plan can be sold all year long!!”

When describing “Wrap Around Plans” to agents, the company asks: “When selling Medicare Advantage plans to your clients are you thinking about how they will pay the hospital, skilled nursing, ambulance and other co-payments” that the plan charges? The pitch then proceeds to describe a “scenario that could be quite frightening to a Medicare Advantage consumer.” The description posits a 65 year old, “on a very limited income” who “could not afford a traditional Medicare Supplement,” so instead s/he enrolls in a $0 premium Medicare Advantage Private Fee-for-Service (PFFS) plan with a $3,000 maximum out of pocket limit, a hospital co-payment of $150 per day for 4 days and an ambulance co-payment of $150. The scenario continues:

“Your client has been enjoying the benefits of a $0 premium PFFS plan, but a few months into the plan, they have an illness strike that causes them to be rushed to the hospital by ambulance and they spend 6 nights in the hospital. Just the ambulance trip and hospital stay will equal $750 … [t]he question is, how are they going to afford a minimum of $750 during a one month period. That’s where our Advantage Plus plan comes into play. For a small monthly premium of just $21.44 you could provide that same client with $150 daily hospitalization coverage and a $200 ambulance benefit. In the same scenario, your client would have had $1100.00 paid to them directly by the insurance company, which would have been plenty to offset the large bill they received.” [emphasis in original].

Similarly, an advertisement geared towards agents by Premier Senior Marketing, Inc., states: “Selling Medicare Advantage Plans? FILL the GAPS with Medicare Advantage Plus.” [see Attachment #2] The ad continues:

“SAVE your clients out-of-pocket expenses such as co-pays, deductibles and coverage gaps with Medicare Advantage Plus. Now you can offer them coverage that pays above and beyond what Medicare Advantage, Medicare Supplements and other retiree health plans fail to cover. … We are so confident in Senior’s interest in this product we will give you 500 leads, just for contracting!” [emphasis in original]

Potential benefits and products built-in to the “Advantage Plus” package include: a hospital indemnity plan paying a daily cash benefit

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chosen at time of purchase or a fixed “admittance benefit” payment; riders for skilled nursing care and durable medical equipment; riders for ambulance services; and lump sum critical illness plans. Also available for sale are annuities, final expense plans, and life insurance coverage designed for the over-65 market.

A damning indictment of the deficiencies in many Medicare Advantage plans comes in a one-page flyer from Senior Benefit Services, Inc., with the headline: “Medicare Supplements were designed to fill the gaps in Medicare. Advantage Plus was designed to fill the gaps in Medicare Advantage Plans!” [See Attachment #3] The flyer then outlines “Common co-pays Clients Pay on Advantage Plans” including: “From $125 per day or an admittance fee from $400 to $900” for inpatient hospital care; “Up to $115 per day, Usually staring with Days 11-100” for skilled nursing facility days; “20% to 30%” for durable medical equipment; and “Varies by carrier – Often 20% or higher” for “Cancer/chemotherapy.”

Guaranteed Trust and Life (GTL) Advantage Plus

While the agent solicitations above do not name the insurance company(ies) selling the “Advantage Plus” product, other agency websites name a plan sponsor: Guaranteed Trust and Life Insurance Company (GTL), based in Illinois. National Insurance Markets, Inc., a Pittsburg-based insurance firm, advertises on its website the “Medicare Advantage Copay Gap Insurance - from GTL.” Similarly, Senior Marketing Specialists, a firm based in Columbia, Missouri, advertises the “GTL Advantage Plus” product that, among other things, “Helps out with Medicare Advantage co-pays & deductibles.”

According to a brochure describing the plan, Guaranteed Trust and Life Insurance Company offers the “GTL Advantage Plus” as “Affordable Insurance Designed to Supplement Your Primary Health Plan.” The plan provides indemnity or lump sum benefits for daily hospital confinement, ambulance trips, durable medical equipment, and skilled nursing care, and also offers a “Supplemental Solutions Lump Sum Cancer Plan.” A prominent heading in the brochure states: “Chances are, your health insurance plan leaves you with out-of-pocket medical costs. Here’s an innovative solution to help cover these expenses.” Although the plan brochure itself does not reference the word “Medicare,” the brochure only lists premium prices and benefits for people aged 64 1/2 through 85. In addition, the agencies selling the product clearly link it to Medicare Advantage, and GTL’s website lists it among its products for seniors.

These plans may have been around for a while without attracting the attention of the authors of this brief or other advocates for people with Medicare. Indeed, many lay people might find these products a logical solution to the problem of increasing out of pocket costs. An online newsletter for agents that touts the benefits of the GTL Advantage Plus Plan states:

A few years ago when the Medicare Advantage market was in its infancy, GTL worked closely with its valued field partners to be the first to introduce a cutting edge and innovative product designed to fill a variety of the co-pays, deductibles and coverage gaps of Medicare Advantage Plans.

Today, because of your hard work, GTL’s Advantage Plus product has become the leader in the market. Based on your feedback, Advantage Plus has helped many of you solidify relationships with your clients, generate Medicare Advantage sales you would have otherwise lost, improve client loyalty and, of course, add commission dollars to your pockets.
Over the past year, there have been many attempts to copy our innovative plan, but with your help, Advantage Plus continues to stay ahead of the competition!

In fact, we are pleased to announce that in the next month, GTL will be releasing our second generation Advantage Plus Plan. […]\(^{16}\)

**Benefits Can be Sold Separately**

Not all limited-benefit insurance plans are being marketed to seniors in a package explicitly aimed at filling in the gaps of Medicare Advantage plans. Products that attempt to supplement or fill-in the gaps of Medicare coverage are also being sold to pay for single benefits, such as hospital stays. For example, Bankers Life and Casualty Company recently introduced a new hospital indemnity product for the senior market, the “Senior Hospital Indemnity Product.”

According to the president of Bankers Life, “Even with good health insurance coverage, today’s seniors are still faced with many out-of-pocket medical expenses.”\(^{17}\) He adds, “We’re pleased to be making this product more available to the senior market … It’s a valuable addition that can help ensure that seniors have a more comprehensive plan in place when it comes to managing their health care expenses.”

As discussed in the next section, similar limited-benefit products aimed at filling in deficiencies of existing insurance coverage were sold with abandon to Medicare beneficiaries before Medigap policies were standardized and benefits and costs made transparent. The fact that these products are once again being packaged and promoted for sale to Medicare beneficiaries enrolled in Medicare Advantage plans is extremely troubling, and may be the tip of an iceberg we have yet to see.

The authors of this brief do not know how these new “Medicare Advantage Plus” supplemental plans are designed, or whether they contain hidden limitations on promised benefits. We also don’t know how many people have purchased – or will purchase – these products, but it is clear that the offering of these products at all is a symptom of a much larger disease. It is increasingly apparent to beneficiaries and others that there are expensive gaps in MA plan coverage. Those gaps allow companies and agents to exploit MA plan deficiencies and sell additional coverage, using the same scare tactics about the high cost of receiving medical care, even when covered by an MA plan. As the out-of-pocket costs of Medicare Advantage plans become more obvious we expect to see more of these products being offered for sale, and more agents selling them as a way to extend their earning capacity beyond the truncated Annual Coordinated Election Period (AEP) selling season.
Limited-Benefit Policies Plague the Under-65 Market

While limited-benefit plans are making an appearance again in the Medicare market (after a brief hiatus due to increased Medigap protections, discussed below), this type of product has mostly thrived in the fragmented health insurance market of uninsured and under-insured individuals who are not yet eligible for Medicare.

For example, a recent *USA Today* article profiled problems surrounding “limited- or scheduled-benefit plans, a fast-growing but controversial type of coverage that sets tight limits on what an insurer will pay towards benefits” (see “Limited Health Policies Vex Some Buyers” by Julie Appleby, *USA Today*, 9/4/07). The article notes that insurers are “competing for a growing market: the 17-million-plus people who buy their own insurance because they are students, self-employed or aren’t offered coverage at work.”

The same article profiles HealthMarkets, an insurer “which sells policies with strict limits on what they pay toward medical care” and which since 2002 has been fined by seven states, faced lawsuits from dozens of policyholders and is now the focus of a probe by insurance regulators in 36 states (see “Limited Health Policies Vex Some Buyers” by Julie Appleby, *USA Today*, 9/4/07). Some complaints and lawsuits have targeted the company’s sales practices. It should be noted that HealthMarkets will be entering the Medicare market for the first time in 2008, and will be offering both Part D and Medicare Advantage Private Fee-for-Service plans staring in January 2008 (see: [http://www.hmcareassured.com](http://www.hmcareassured.com); also see press release at: [http://tinyurl.com/395ayt](http://tinyurl.com/395ayt))

III. PARALLELS with the MEDIGAP MARKET – PRE-STANDARDIZATION

From the very beginning of the Medicare program, the insurance industry recognized the opportunity to sell products that would cover the out-of-pocket costs created by Medicare’s benefit design. Those products were eventually bundled together and became known as Medicare Supplement or Medigap policies. As Medicare’s deductibles and copayments grew over time, having retiree benefits to fill those gaps in Medicare or buying a supplemental insurance product to cover those costs became less of a luxury and more of a necessity. Consumers could not easily quantify their annual liability for medical care, and insurance agents and companies were able to frighten them with the prospect of huge out-of-pocket costs. Trusted celebrities were hired for TV commercials to pitch the high cost of the gaps in Medicare and the critical need for a Medigap policy. In one notable commercial in the 1980’s, Lorne Greene, the beloved “Bonanza” star, stood beside a cash register ringing up the total out-of-pocket cost of a one year stay in a hospital. Seniors readily appreciated the enormity of the potential impact on their pocketbook, but failed to understand that few people would ever stay in a hospital long enough to incur such a cost. As a result agents were able to sell not only Medigap policies but also hospital indemnity policies to pay the cost of an improbably long hospital stay, along with coverage for private duty nursing.
Agents appeared on the doorsteps of people with Medicare with slick and frightening advertising, much of it sporting pictures of the same trusted celebrities citing the same fearful but improbable costs. In response to such fear tactics, many people bought more than one Medigap policy, hospital indemnity policies, cancer policies, private duty nursing benefits, and other bits and pieces of health care benefits to cover these improbable contingencies. What we see in the advertising for “Advantage Plus” products pitched at agents today is eerily reminiscent of the build-up to the full scale marketing blitz of Medigap and other fringe insurance products prior to Congressional rejection of these practices and the passage of the Omnibus Budget and Reconciliation Act (OBRA) of 1990 which standardized Medigap policies and strengthened consumer protections.

By 1989, insurance companies had learned to be unbelievably creative in designing their Medigap benefit packages, concentrating on insignificant details and variations in plan design to distinguish their product from the rest of the market, and heavily recruited agents to sell them. Because people with Medicare could not determine for themselves what each Medigap policy would pay, let alone compare one policy with another, they were forced to rely on agents for that information. That meant then, as it does today, that some agents would sell what was best for themselves, not necessarily what was best for the consumer. At that time agents were also able to sell additional, duplicative and unnecessary benefits, precisely because consumers had no way to evaluate their potential costs. That environment exactly mirrors the situation today with MA and Part D plans and the emergence of “Advantage Plus” products that simply bundle these fringe benefits into a package matched to the increasingly expensive out-of-pocket costs of an MA plan.

Duplication of Coverage?
Most of the products currently packaged as Advantage Plus products are “limited benefit” insurance products sold in most if not all states, with few standards for the benefits they contain. It appears that these insurance products do not technically violate federal law, as they are not specifically designed and marketed to cover a specific benefit of a Medicare Advantage plan. Rather, each of these products is designed to pay specific amounts when a person is admitted to a hospital, uses an ambulance, or receives services for a specific disease. These benefits are not designed to coordinate with Medicare’s benefits, but are designed to pay in addition to, and irrespective of, other coverage a person may have. Either separately, or bundled together, these products have so far attracted little regulatory attention. However, while policymakers consistently prohibit duplicate insurance coverage for medical care, and worry about people purchasing first dollar coverage while insulating themselves from the cost of medical care, similar concern has not been expressed about the sale of these products which in some circumstances allow a person to accidentally profit from the cost of their medical care by collecting benefits in excess of their actual out-of-pocket costs.

A look at the history of federal Medigap regulation is illustrative for purposes of analyzing the current crop of products offered to fill-in the gaps of Medicare Advantage plans. Individual states were exclusively responsible for regulating Medigap plans until 1980, when federal legislation established voluntary state certification and standards for Medigap policies based on those developed by the National Association of Insurance Commissioners (NAIC). Among the standards outlined in the 1980 bill was a provision meant to prevent Medigap insurers from selling policies that duplicated coverage a Medicare beneficiary might already have. This anti-duplication provision, though, was
not all-encompassing; the definition of
“substantial duplication of health benefits for
a person eligible for Medicare Part A or
enrolled under Part B” excepted “...benefits
which are payable to or on behalf of an
individual without regard to other health
benefit coverage....” In effect, this exception
language allowed companies to continue
selling hospital indemnity, cancer policies and
other bits and pieces of health care benefits
to people with Medicare as long as these
policies did not coordinate its benefits with
Medicare.

Medigap protections contained in the
Omnibus Budget Reconciliation Act of 1990
(OBRA ’90), however, deleted the excepted
language above, which meant that (for a brief
time, at least) federal law prohibited agents
and insurance companies from selling these
limited benefit indemnity plans to people with
Medicare. Over the next few years, however,
the insurance industry successfully convinced
Congress to narrow existing anti-duplication
of coverage provisions, in part, by reinstating
this exception language in 1994 Amendments
to the Social Security Act. This once again
allowed the sale of limited benefit polices to
people with Medicare, and paved the way for
these new Advantage Plus plans.

Subsequent federal legislation amended the
anti-duplication provisions of OBRA ’90 so
that various types of insurance policies can
now be sold to Medicare beneficiaries – and
not be considered duplicative – as long as
insurance companies provide a disclosure
statement along with each application notifying
purchasers of the potential for duplicating
existing benefits. As a result, today
insurance companies are free to sell these
limited benefit products to people with
Medicare as long as they provide the
requisite disclosure notice.

Getting the exception language reinstated to
allow the sale of additional benefits for
medical care tesifies to the insurance
industry’s power, especially since this sale is
contrary to public policy for all other health
insurance products, and contrary to
Congressional concerns about the effect on
health care costs when people are insulated
from those costs by their first dollar benefits.

Unwary consumers can easily be convinced
to buy a high-cost cash benefit, or more than
one benefit or policy to cover the high out-of-
pocket costs in a Medicare Advantage plan
that can be made to seem even higher than
they actually are through frightening
advertising. As an accidental byproduct of
such a purchase, an individual could
potentially collect several hundred dollars for
each day spent in a hospital and receive
benefits far greater than the costs they would
actually be responsible for paying, depending
on how those supplemental benefits were
paid and whether they were payable from the
first day or required a deductible period of
one or more days before benefits were paid.

As these types of plans and benefits become
more visible and agents recognize the
potential for selling products year round to the
Medicare population, Advantage Plus and
similar supplemental products are likely to
become more pervasive. Agents will sell
these products to Medicare beneficiaries as
they did before 1990 without regard to the
actual need for these benefits, or the
restrictions on benefits that some products
will inevitably contain. Consumers will be
unable to refute information given to them by
agents selling these products as long as MA
plans are allowed to impose high out-of-
pocket costs and products are allowed to
proliferate based on insignificant differences.
The profit potential of these products will not
be ignored by companies that service this
market, and without a regulatory response
more companies will introduce these
products, bundle them, and entice agents to
sell them as a means of maintaining a year-
round income.
IV. CONCLUSION

The Medicare marketplace is confusing enough with the full range of Medicare Advantage and Part D plans being sold across the country. Medicare beneficiaries must sort through scores of Part D plans and additional Medicare Advantage plans available in their local area, and, depending upon what type of plan they enroll in, purchase additional coverage. This new type of product – designed to fill in the gaps of Medicare Advantage – is yet another form of insurance being marketed to seniors that can be sold in addition to their existing coverage. These limited benefit plans present an almost irresistible opportunity for agents to earn even more commissions on each Medicare Advantage sale, and to sell products year-round.

The promise of having private insurance companies involved in the provision of Medicare benefits did not include a marketplace frenzied at the prospect of maximizing profits, either through Medicare Advantage plans that are already overpaid, or additional limited benefit plans that are sold to fill gaps in coverage that MA plans are failing to fill themselves. As Mark Miller, Executive Director of the Medicare Payment Advisory Committee (MedPAC) notes:

Medicare’s private plan option was originally designed to produce efficiency in the delivery of health care, to the benefit of both the program and plan enrollees. Efficient plans would be able to provide extra benefits to enrollees, and greater efficiency would lead to higher plan enrollment. Competition among plans for enrollees would promote further efficiency.

Unfortunately, this dream of market-driven solutions to enrich Medicare beneficiaries with broader coverage delivered more cheaply and efficiently through private plans has created an alarming number of plans, often with insignificant differences, providing too few benefits, at too much cost to the Medicare program and taxpayers. In this environment, new insurance products have arisen to capitalize both on the inefficiencies of private MA plan benefit packages as well as beneficiaries’ fears driven by the cost shifting imposed by these plans.

Similar to consumer protections that were implemented in OBRA ’90, which largely eliminated most abuses surrounding the sale of Medigap plans, Congress must act to better protect Medicare beneficiaries from similar abuses around the sale of Medicare Advantage and Part D plans. This includes creating a limited number of standard Medicare Advantage and Part D benefit packages that any company can sell, and creating several modest deductibles and annual out-of-pocket limits that apply to all covered services, thus eliminating the need to purchase additional insurance. In addition, strengthened consumer protections should truly limit the duplication of Medicare covered services, which would prevent insurance companies and agents from potentially preying upon vulnerable Medicare beneficiaries by offering “Advantage Plus” and other limited benefit products.

# # #
New “Gap” Product Being Sold to Fill in Medicare Advantage Deficiencies

Attachment 1

Products: Wrap Around Plans

When selling Medicare Advantage plans to your clients are you thinking about how they will pay the hospital, skilled nursing, ambulance and other co-payments.

These numbers can add up quickly and could cause your client to have a very large bill to pay in just a short period of time. Here is an example of what can happen.

Your client is 65 years old, on a very limited income, and could not afford a traditional Medicare Supplement plan for $100 per month. Let's say you sell your client a PFFS plan that has:

- An annual maximum out of pocket limit of $3000
- A hospital co-payment of $150 per day for 4 days
- And an ambulance co-payment of $150

Your client has been enjoying the benefits of a $0 premium PFFS plan, but a few months into the plan, they have an illness strike that causes them to be rushed to the hospital by ambulance and they spend 6 nights in the hospital.

Just the ambulance trip and hospital stay will equal $750 that will likely be due during just one month. Now remember, your client could not afford a $100 monthly premium for a Medicare Supplement. The question is, how are they going to afford a minimum of $750 during a one month period.

That's where our Advantage Plus plan comes into play.

For a small monthly premium of just $21.44 you could provide that same client with $150 daily hospitalization coverage and a $200 ambulance benefit. In the same scenario, your client would have had $1100.00 paid to them directly by the insurance company, which would have been plenty to offset the large bill they received.

Just look at how many benefits your client can get from an Advantage Plus plan!
Attachment 2

Selling Medicare Advantage Plans?
FILL the GAPS with Medicare Advantage Plus

SAVE your clients out-of-pocket expenses such as co-pays, deductibles and coverage gaps with Medicare Advantage Plus. Now you can offer them coverage that pays above and beyond what Medicare Advantage, Medicare Supplements and other retiree health plans fail to cover.

Medicare Advantage Plus is EASY to sell with inexpensive rates, simplified underwriting, jet issues and FAST Commissions.

Offer your clients these benefits and more:
- Daily Hospital Confinement
- Skilled Nursing Home Care
- Ambulance Benefit
- Durable Medical Equipment
- Accidental Death and Dismemberment
- Lump Sum Hospital Confinement

Learn how Premier Senior Marketing can show you how to easily open doors and close more sales with a product your clients want and need. We are so confident in Senior’s interest in this product we will give you 500 leads, just for contracting!

With over 45 years of industry-leading expertise and a large support staff dedicated to quality producers like you, we are your source for insurance products for the Senior Market.

For more information and to receive your 500 FREE LEADS, please Complete the Form Below.

800-365-8208

Contact Information
First Name:*  Last Name:*  Company:
Address:  
City:  State:  Zip:
E-mail:*  Phone:*  Comments:

*REQUIRED  Submit

Want innovative insurance industry offers delivered to your inbox? Visit InsuranceMail and subscribe today!

Manage my InsuranceMail subscription

Interested in reaching more insurance professionals? InsuranceNewsletter can help!  http://www.insurancenewsletter.com
### Medicare Supplements were designed to fill the gaps in Medicare.

**Advantage Plus was designed to fill the gaps in Medicare Advantage Plans!**

<table>
<thead>
<tr>
<th>Services with Gaps</th>
<th>Common Co-pays Clients Pay on Advantage Plans</th>
<th><strong>Advantage Plus</strong> (Cash directly to your clients)</th>
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<tbody>
<tr>
<td>Inpatient Hospital Care</td>
<td>From $125 per day or an admittance fee from $400 to $900</td>
<td>Daily Benefit-$100 to $600</td>
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<td></td>
<td></td>
<td>Lump Sum Rider—If elected adds an additional payment of $250/$500 or $750.</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>Up to $115 per day. Usually starting with Days 11-100</td>
<td>If this rider is elected: $120 per day</td>
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<td></td>
<td></td>
<td>Days 21-100</td>
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<tr>
<td>Durable Medical Equipment</td>
<td>20% to 30%</td>
<td>If this rider is elected: 30% of first $1000</td>
</tr>
<tr>
<td>Ambulance Benefit</td>
<td>$100 to $150 per service</td>
<td>$200 per service</td>
</tr>
<tr>
<td>Cancer/ Chemotherapy</td>
<td>Varies by carrier</td>
<td>Lump Sum: Cancer Coverage available through additional plan that pays $5000 / $10,000 / $15,000</td>
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<td></td>
<td>Often 20% or higher</td>
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Advantage Plus benefits are paid directly to the client in addition to any other insurance plans they might have. This money can be used to cover co-pays and other expenses not covered by their Private Fee for Service (PF/S) plan or any other health plan they might have. The benefits even restore every 60 days of not being confined to a hospital.
Endnotes

1. See AHIP’s website at: http://www.ahip.org/content/default.aspx?bc=39|341|321

2. Plans of this type may be regulated as “limited benefit” health plans under state insurance law, and are sometimes referred to as “mini med” policies by agents and brokers.


5. Among the products Senior Benefits Services sells that are listed on its website are “Gap Plans for Medicare Advantage Products.” See http://www.srbenefit.com/about-senior-benefit-services.shtml


7. See http://www.srbenefit.com/medicare-advantage.shtml

8. In this example, an accidental result of a Medicare Advantage member buying this product would be $1,100 paid by an Advantage Plus plan, which exceeds by $200 the actual out-of-pocket costs of the MA plan. In other words, the beneficiary is actually receiving a profit when using medical services.

9. See http://www.insurance-mail.net/PremierPlan.asp

10. The website describes the skilled nursing benefit as “usually starting from days 11-100” a period clearly tailored to the cost-sharing requirements of some Medicare Advantage plans.


14. Also see, e.g., S. A. Nichols Brokerage website, which states: “GTL’s ‘Advantage Plus’ plan is affordable supplemental insurance designed to cover the ever increasing daily co-pays many of the new Medicare Advantages plans are offering today. Cover the gaps left over by the MA plans and increase your commissions with ‘Advantage Plus!’” (see: http://www.sanb.net/index_files/Page2143.html)

15. See: http://www.gtlic.com/products_services/healthins.html#ap


19. OBRA ’90 – Public Law 101-508


21. OBRA ’90 – Public Law 101-508
New “Gap” Product Being Sold to Fill-in Medicare Advantage Deficiencies

22 Public Law 103-432; note that language narrowing the anti-duplication provision was originally inserted into a 1991 Technical Corrections Act, but was not adopted until 1994 when it was included in Social Security Act amendments clarifying the interaction of long term care insurance with Medicare.

23 Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 8.21.96. See also NAIC Model Regulation for Medicare Supplement Insurance, Appendix C and prescribed disclosure statements for specific benefits sold to someone with Medicare.

24 For an example of a disclosure notice re: duplication of coverage relating to a hospital indemnity policy, see: [http://www.nimbroker.com/pics/ContentPics/MEDDUP-5.pdf](http://www.nimbroker.com/pics/ContentPics/MEDDUP-5.pdf)

25 For example, many MA Private Fee-for-Service (PFFS) plans do not offer Part D prescription drug coverage, forcing many enrollees to purchase a separate, stand-alone PDP in addition to their MA plan; in addition, some MA plans are selling one or more “supplemental packages” in order to access more services for an additional premium.


27 For further recommendations re: improving both consumer protections and the Medicare Advantage program in general, see the series of joint issue briefs written by California Health Advocates and the Medicare Rights Center available at: [http://www.cahealthadvocates.org/advocacy/index.html](http://www.cahealthadvocates.org/advocacy/index.html)