

## MODULE 15: OTHER HEALTH PROGRAMS AND SERVICES

### Objectives

HIICAP counselors will learn about employer retiree plans and how they work with Medicare. Additionally, counselors will learn about COBRA, the New York State Health Benefit Exchange, Veterans Administration healthcare benefits, and TRICARE for Life, and be provided with resources on other available services that may be useful to the uninsured or underinsured clients.

### What kind of health plans do employers offer to retirees?

- Some employers offer a Health Maintenance Organization (HMO) as an alternative to their fee-for-service health plans
- Some employers provide retiree plans that pay Medicare deductibles and coinsurance when they become eligible at age 65
- Other employers may offer a basic Medigap plan to their retirees

### What is COBRA?

COBRA is a federal program that allows former employees to keep their employer-sponsored group health plans under most circumstances

### What is the New York State Health Benefit Exchange?

- The New York State Health Benefit Exchange is a statewide marketplace for state residents to receive information about health insurance options and to enroll
- The Health Benefit Exchange will begin operations in January, 2014

### What insurance options are available to former military employees?

- Anyone who performed active duty military service and was not discharged dishonorably is eligible for healthcare through the Veterans Administration
- Former military personnel and their dependents are eligible for TRICARE for Life to supplement their Medicare

### What are the Pharmaceutical Manufacturers Association Prescription Drug Programs?

- Many major drug companies have programs that give prescription drugs to patients at low cost or no cost if they do not have prescription drug coverage or other means to pay;
- This is an important source of assistance for those who lack prescription drug coverage and are not eligible for EPIC.

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## RETIREE PLANS

Only about one-third of American retirees receive health insurance as a retiree benefit. Even fewer American workers can expect this benefit in the future. Employers, like consumers, are struggling with the skyrocketing costs of health insurance.

An individual whose former employer provides health benefits beyond age 65 may find their retiree plan to be a low-cost (sometimes a no-cost) way to cover some of Medicare's coverage gaps. However, retiree health benefits that continue beyond age 65 may be, but are not always, more comprehensive and less costly than privately purchased Medicare Supplement Insurance. Companies are constantly restructuring retiree health benefits, and only a yearly review will enable one to determine the value of their company's specific plan.

### **What kind of health plan can retirees expect?**

Retiree plans vary greatly. For retirees aged 65 and older, employers may offer a continuation of their regular company benefits with Medicare benefits carved out. In this situation, Medicare pays benefits first. The retiree plan then makes up the difference, if any, between what Medicare pays and the full cost of the service.

Some employers offer a Health Maintenance Organization (HMO) as an alternative to their fee-for-service health plan. The difference between HMO plans and fee-for-service plans is discussed below.

Other employers may provide a special plan for retirees once they become eligible for Medicare at age 65. It may be a plan that pays Medicare deductibles and coinsurance only after the retiree reaches a specific out-of-pocket dollar amount, or it may be a basic Medigap plan, paying Medicare deductibles and coinsurance, with or without extra benefits for non-covered Medicare services. Still other employers offer no company health insurance benefits to retirees, but instead provide an annual subsidy for retirees to buy private Medicare supplement policies.

The majority of employer sponsored retiree plans require that a retiree enroll in both Medicare Part A and Medicare Part B when they become eligible. Before age 65, an individual's retiree plan was probably their only health insurance payer. For most people, at age 65 Medicare steps in as first payer of health care costs and their employer sponsored retiree health plan becomes second payer. Retiree plans will usually pay health care costs only after Medicare has paid.



**Caution:** An individual's plan may require Medicare enrollment. If the retiree chooses not to enroll in Medicare Part B when eligible, they may be responsible for major health care costs as well as a Part B late enrollment penalty. Their retiree plan will deduct what Medicare would have paid from any payment they make or refuse to pay entirely.

### **Federal Employees Health Benefits (FEHB) Program**

Unlike most retiree plans that require enrollment in Medicare, the Federal Employees Health Benefits (FEHB) program will continue to pay as primary if the individual does not enroll in Medicare. FEHB members would probably want to enroll in Part A, but have to make a decision about whether to enroll in Part B. FEHB members basically have three choices:

- **FEHB and NO Part B.**  
They can continue with their FEHB coverage, and not sign up for Medicare. They would save the monthly Part B premium, but would have to wait until the next General Enrollment Period to sign up for Part B if they decide they want Part B later, and would be subject to a late enrollment penalty.
- **FEHB and Part B.**  
They can continue with their FEHB coverage and enroll in Part B also. FEHB plans may provide an incentive to enroll in Medicare, such as waiving FEHB plan co-payments, but they would be paying both the FEHB and Part B premiums.

- **Part B and NO FEHB.**

Unlike most retirees, Federal retirees can SUSPEND (not cancel) their retiree coverage, and then return to it during the next FEHB Open Enrollment. Those choosing this option would enroll in Part B in order to enroll in a lower premium (or no premium) Medicare Advantage plan, and save the higher cost FEHB premium.

Check the Office of Personnel Management (OPM) website for more information about Medicare and FEHB at <http://www.opm.gov/insure/health/medicare/index.asp> and <http://www.opm.gov/healthcare-insurance/fastfacts/fehbmedicare.pdf>.

### **How does your client choose a retiree fee-for-service plan vs. an HMO?**

An employer may offer retirees the choice of a fee-for-service retiree health care plan or an HMO. Fee-for-service plans cover services from the client's provider of choice. The retiree would be responsible for paying deductibles, coinsurance, and the costs of non-covered services.

By contrast, an HMO plan limits the client to a specific group of doctors, hospitals and other health care providers (called an HMO provider network) in exchange for lower out-of-pocket costs. An employer-sponsored HMO option may cover a wider range of health care services at lower out-of-pocket cost to the retiree. HMOs use managed care to help keep down the costs of health care.

HMOs differ in the degree of choice that the person with Medicare will have in choosing a doctor. In most cases, prior authorization and referrals are needed to obtain specialty care. Emergency care provided by doctors outside the HMO's geographic area is usually covered after a telephone call confirms authorization for coverage. The costs for other services outside the HMO's geographic area will be the individual's responsibility. They will usually pay a co-payment of \$10 or more, or a co-insurance percentage, for each service received by an in-network provider. Paperwork is usually handled by the HMO. To be eligible to join, a person must live in the geographic area served by the HMO.

### **Are Medicare and an Employer-Provided Retiree Group Health Plan Enough?**

Medicare and a retiree health plan are often a comprehensive and cost effective health insurance combination. A health insurance plan from a former employer may cost less and cover more than a privately purchased Medigap policy. But only a thorough investigation of the specific employer's plan can help a retiree decide if this combination is more desirable than other alternatives. Consider the following:

- **The cost:** Companies may pay all or part of the health plan premium for their retirees. What part of the cost does a person's former employer pay? What is the retiree's share of the cost for health plan coverage? Is their share of the premium affordable? Is there a cost for one's spouse or other dependents? Will this cost increase should the retiree die before their spouse?
- **The benefits:** How much of your clients' health care costs not covered by Medicare will be paid by the retiree health plan? Does the plan cover costs that Medicare does not pay for, such as eyeglasses and dental care? Are extra preventive services covered?
- **The maximum lifetime benefit:** In the past, some retiree plans limited the amount that would be paid in benefits during a person's lifetime. As of 2010, insurance companies cannot sell policies with maximum lifetime benefits. If a retiree has already purchased a plan with maximum lifetime limits, determine the specific maximum lifetime benefit offered by a retiree plan. A low maximum

lifetime benefit may mean that the retiree will need to seek another option when that limit is met at some point in the future.

If a retiree health plan is available from one's former employer that is affordable and reasonably comprehensive, a Medicare supplement policy is not necessary. Educate clients to be cautious of advertisements, mailings, and insurance agent visits, which encourage people to buy more health insurance. An extra Medigap or hospital policy is usually not worth the annual premium that beneficiaries must pay.



**Caution:** Retirees who decide to drop their employer health plan because they find it unaffordable or of very little value should be aware that re-enrollment is not usually possible.

Consequently, the cost and benefits of a retiree plan should be very carefully considered and weighed against the cost and benefits of a privately purchased Medigap policy or Medicare Advantage plan.

The decision to drop an employer-provided retiree health plan should be made only after careful study of the costs/benefits and spousal/dependents inclusion of both options.

### Limited Benefit Policies

Though federal law now prohibits the sale of a new health insurance policy to retirees that duplicates existing employer-provided health insurance benefits, many older adults have kept the limited benefit policies they bought several (or more!) years ago. Help your clients assess these situations, including what portion of their maximum benefits have already been reached, and what options may be available when their benefits have been exhausted under these limited plans.



**Caution:** Most of the limited benefit policies pay only in very special circumstances. Hospital indemnity policies, for example, pay a limited number of dollars per day—but only when an individual stays overnight in the hospital (this is referred to as in-patient care). Since many hospital services are now performed on an outpatient basis (i.e., no overnight stay required), no payment will be allowed from a hospital indemnity policy. Older adults may regard hospital indemnity policies as a great buy at a premium of only \$15 or \$30 per month for a \$50 per day inpatient hospital benefit. The \$50 per day benefit is a very small fixed amount with no relation to the actual cost of a hospital stay. In addition, many indemnity policies reduce benefits by as much as 50 percent after one reaches age 65.



**Caution:** Specific disease policies, another type of limited benefit policy, pay only if an individual contracts the disease (such as cancer) named in the policy. This type of plan does not provide basic coverage. Consumer advocates agree that these types of limited benefit policies are rarely a good choice.

### WHAT IS COBRA?

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COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law requiring that workers who would otherwise lose their employer-sponsored coverage for specified reasons have the option of purchasing their employer's group health insurance for themselves and their family members for a limited time.

COBRA covers employers with 20 or more employees. New York State has a "mini-COBRA" law that covers smaller employers and others left out of COBRA. New York provides a longer maximum coverage period than the federal law; most New York residents who qualify under either law can retain coverage for a maximum of 36 months. Individuals whose employers are self-insured, however, will only be eligible for the 18 months of COBRA coverage required by federal law.

COBRA coverage ends when the beneficiary becomes eligible for Medicare. Technically, a person is considered “eligible” for Medicare, in this case, only when the person actually enrolls in Medicare, not when they become eligible to enroll in Medicare. It is not advised that a person delay enrolling in Medicare, and incur the penalty for late enrollment, to preserve COBRA coverage. If the worker was already covered by Medicare when they became eligible for COBRA, however, they are still eligible to elect COBRA coverage.

Clients should be cautioned that those who work beyond age 65 may postpone their Medicare Part B coverage until retirement. However, COBRA beyond age 65 is not active employer group health plan (EGHP) coverage and therefore Medicare is primary. People with Medicare in this situation would need to sign up for Part B within the eight-month Special Enrollment Period following active EGHP coverage or face a penalty for late enrollment. If they do not sign up for Part B within eight months of beginning COBRA, they would have to wait for the January to March General Enrollment Period, with Medicare Part B eligibility on July 1, and a late enrollment penalty applied.

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### **WHAT IS THE NEW YORK STATE HEALTH BENEFIT EXCHANGE?**

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The New York State Health Benefit Exchange is a statewide marketplace mandated by the Affordable Care Act that provides health insurance information and enrollment assistance to state residents.

The Health Benefit Exchange will serve several purposes for individuals and families. First, it will help them determine if they are eligible for public programs such as Medicaid. Second, it will assist them in determining their eligibility for financial assistance in paying their health insurance premiums in the form of tax credits. Lastly, it will help them compare the costs and benefits of private insurance options. Additionally, small businesses can use the Exchange to learn more about their options for insuring their employees.

The Health Benefit Exchange will begin processing enrollment requests in October, 2013 for coverage starting on January 1, 2014.

State residents who are US citizens, legal permanent residents, or lawfully present non-citizens are authorized to use the Exchange. The Exchange will be available to provide support online, by telephone, in person or by mail.

Insurance plans sold through the Exchange will include a comprehensive set of benefits determined by federal law. While all plans will offer the same essential health benefits, there will be four levels of coverage (bronze, silver, gold and platinum) that differ primarily in the amount of cost-sharing for the enrollee. Individuals under thirty, and those who can show financial hardship, may instead purchase catastrophic coverage only.

**Note:** Individuals are eligible to purchase a Qualified Health Plan (QHP) on the Exchange if they have Medicare, but they are not eligible for premium tax credits or cost sharing relief because Medicare is considered to be minimum essential coverage. If the individual had no other coverage besides Medicare, Medicare would be primary and the QHP would be secondary coverage.

The Health Benefit Exchange website can be found at <http://www.healthbenefitexchange.ny.gov/>.

## **MILITARY RETIREES – VETERANS ADMINISTRATION (VA)**

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Your client is eligible for VA healthcare benefits if they served active duty in the uniformed armed forces of the United States, and were discharged from the military under any circumstance other than a dishonorable discharge. If a person has both Veterans Administration (VA) and Medicare benefits, they must choose which coverage to use each time. Veteran's benefits and Medicare will not act as supplements to each other. And remember that if a client chooses to delay enrolling in Medicare Part B because they have VA benefits, they will face a premium penalty if they enroll in Part B later on.

If eligible for VA medical benefits, prescription drug coverage is available. If the veteran is being treated for a service-connected disability, there is no copayment for the prescription. If your client is being treated for a non-service connected illness or rated by the VA as less than 50 percent service-connected, there is an \$8 or \$9 copayment for each 30-day or less supply, depending on the veteran's income. In order to take advantage of the VA prescription benefit, your client must see a VA physician for treatment. For enrollment information, your client can call 1-877-222-8387. The VA has also launched a new hotline for information on health care benefits for female veterans: 1-855-829-6636.

### **TRICARE for Life**

TRICARE for Life (TFL) provides expanded medical coverage for former military personnel and dependents that are enrolled in Medicare Part B including:

- Medicare-eligible armed forces retirees, including National Guard members and military reservists;
- Medicare-eligible family members and widow/widowers of armed forces retirees;
- Certain former spouses of armed forces retirees if they were eligible for TRICARE before age 65.

Medicare will be the primary payer for Medicare-covered services provided by a Medicare provider and TRICARE will pay any remaining expenses including deductible or coinsurance amounts up to the Medicare allowed charge.

TRICARE will not automatically pay second to Medicare if a person has other health insurance. TRICARE pays after all other insurers except Medicaid. Medicare will pay first, the other health insurance will pay second and TRICARE will pay third. Examples of other health insurance include employer-sponsored insurance and Medigap policies. A TRICARE beneficiary needs to decide if a Medigap plan is necessary.

TRICARE also offers prescription drug benefits with co-payments. You are not required to enroll in a Medicare Part D prescription drug plan to keep your TRICARE drug benefits.

For more information on TFL call 1-877-874-2273 or visit [www.tricare.mil](http://www.tricare.mil).

### **CHAMPVA**

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries.

To be eligible for CHAMPVA, you cannot be eligible for TRICARE/CHAMPUS and you must be in one of these categories:

1. the spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office, or
2. the surviving spouse or child of a veteran who died from a VA-rated service connected disability, or
3. the surviving spouse or child of a veteran who was at the time of death rated permanently and totally disabled from a service connected disability, or
4. the surviving spouse or child of a military member who died in the line of duty, not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA).

CHAMPVA is always secondary payor to Medicare. For more information:

<http://www.va.gov/hac/forbeneficiaries/champva/champva.asp>.

### **GROUP HEALTH INSURANCE OPTIONS AND THE SELF-EMPLOYED**

<b>Group</b>	<b>Professions</b>	<b>Contact Info</b>
Small Business Service Bureau	Small business employee	1-800-343-0939; <a href="http://www.sbsb.com">www.sbsb.com</a>
Graphic Artists Guild	Graphic Artists	1-212-791-3400; <a href="http://www.gag.org">www.gag.org</a>
National Writers Union	Writers	1-212-254-0279; <a href="http://www.nwu.org">www.nwu.org</a>
Screen Actors Guild	Performers	1-212-944-1030; <a href="http://www.sag.org">www.sag.org</a>
Freelancer's Union	Financial Services Nonprofits Technology Media & Advertising Arts, Culture or Entertainment Domestic Child Care Giver Traditional or Alternative Health Care Provider Skilled Computer User	1-718-222-1099 <a href="http://www.freelancersunion.org">www.freelancersunion.org</a>

### **ADDITIONAL HEALTH PROGRAMS AND SERVICES**

**Eye Care America:** Not for profit that assists with finding eye care for those who need it. Will bill Medicare and waive any charges that are not covered by Medicare. Call 1-877-887-6327 or go online to [www.eyecareamerica.org](http://www.eyecareamerica.org)

**Hear Now:** Gives assistance to anyone needing a hearing aid. 1-800-648-4327

**NYS Crime Victims Board:** The Crime Victims Board pays, as a last resort, medical bills for crime victims for as long as the illness or injury is related to the crime (1-800-247-8035).

**TRAID-IN Equipment Exchange Program:** Connects people who have assistive devices they no longer need with people with disabilities who could use those devices. The program is available to New York State residents only, and is free of charge. 1-800-624-4143 or <http://cqcy.ny.gov/advocacy/assistive-technology/traid-in-equipment-exchange-program>

## RESOURCES FOR PRESCRIPTION MEDICATIONS AND ASSISTANCE WITH COST-SHARING

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**AIDS Drug Assistance Program (ADAP):** Clients must be low income, uninsured or underinsured and living with HIV/AIDS. Call 1-800-542-2437 or go online to <http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm> .

**Benefits Check Up:** Helps people locate benefits and services available to them. Go online to [www.benefitscheckup.org](http://www.benefitscheckup.org) .

**CancerCare Co-Payment Assistance Foundation:** Provides co-payment assistance only for cancer patients that need help paying for their cancer-related medications. Go online to [www.cancercarecopay.org](http://www.cancercarecopay.org) or call 1-866-55-COPAY (1-866-552-6729).

**Caring Voice Coalition:** Helps pay some of the cost of your clients' prescription drugs for certain medical conditions. Go online to [www.caringvoice.org](http://www.caringvoice.org) or call 1-888-267-1440.

**Chronic Disease Fund:** Co-payment assistance for those clients with chronic diseases. Go online to [www.cdfund.org](http://www.cdfund.org) or call 1-877-968-7233.

**The Health Well Foundation:** Helps pay your clients' drug co pays or monthly premium. Client must be diagnosed with Acute Porphyries, Anemia associated with Chronic Renal Insufficiency/Chronic Renal Failure, Chemotherapy Induced Anemia/Chemotherapy Induced Neutrogena and other systems. Go online to [www.healthwellfoundation.org](http://www.healthwellfoundation.org) or call 1-800-675-8416 .

**National Marrow Patient Assistance Program and Financial Assistance Fund:** For people who used the National Marrow Patient Assistance Program's donor registry. May help pay for some costs of prescription drugs when recovering from a marrow transplant. Go online to [http://marrow.org/Patient/Transplant\\_Planning/Planning\\_for\\_Transplant\\_Costs/Financial\\_Assistance\\_for\\_Transplant\\_Patients.aspx](http://marrow.org/Patient/Transplant_Planning/Planning_for_Transplant_Costs/Financial_Assistance_for_Transplant_Patients.aspx) or call 1-888-999-6743.

**National Organization for Rare Disorders (NORD):** Medication Assistance program helps people obtain prescription drugs they could not otherwise afford or that are not yet on the market. Over 1,100 rare diseases are listed on NORD's website. Go online to [www.rarediseases.org](http://www.rarediseases.org) or call 1-800-999-6673.

**NeedyMeds.com:** Provides information on medications and patient programs explaining how to apply for each one. Go online to [www.needymeds.com](http://www.needymeds.com) .

**New York State Attorney General's Office:** The Attorney General has a website that shows the value comparison for 150 commonly prescribed drugs with a small number of surveyed pharmacies in an area. To search enter the zip-code, city or county Online at <http://rx.nyhealth.gov/pdpw/>.

**Patient Advocate Foundation Co-Pay Relief:** Provides clients with direct financial support so long as they are insured patients, including Medicare Part D beneficiaries, who must financially and medically qualify to access pharmaceutical co-payment assistance program. Go online to [www.copays.org](http://www.copays.org) or call 1-866-512-3861.

**Patient Services Inc. (PSI):** Provides premium and co-pay assistance for people with certain chronic conditions. Go online to [www.patientservicesinc.org](http://www.patientservicesinc.org) or call 1-800-366-7741.

**Partnership for Prescription Assistance:** Helps people access free or low-cost prescription medications. Also provides links for programs that assist with paying co-payments. Go online to [www.pparx.org](http://www.pparx.org) or call 1-888-4PPA-NOW.

**RX Hope:** Help your clients apply for discounted and free medications directly through this website and phone number. Go online to [www.rxhope.com](http://www.rxhope.com) or call 1-877-979-4673.

**Together Rx Access:** A prescription drug discount card program available to people whose incomes meet the guidelines and who are not on Medicare and have no other prescription drug coverage. Go online to [www.togetherrxaccess.com](http://www.togetherrxaccess.com).

## **PHARMACEUTICAL MANUFACTURERS ASSOCIATION PRESCRIPTION DRUG PROGRAMS**

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Most major drug companies have developed programs to give certain drugs to patients at low cost or no cost who have neither insurance nor the means to pay. The programs are targeted at people with very low incomes, but if a drug is very expensive, middle-income people may also be eligible. The details of the programs vary widely; some companies offer only one or two drugs, while others offer their entire product line.

**Note:** Since prescription drug coverage became available under Medicare Part D, people with Medicare may no longer be eligible for many of the drug manufacturer programs. You should check with the individual drug manufacturers to confirm eligibility.

Your client can receive further information, a directory of participating manufacturers, the list of drugs included in their programs, and any cost associated with them by writing, calling, or going online to them. The pharmaceutical manufacturers will accept applications only from physicians, not from individual patients. If your doctor is unfamiliar with manufacturer aid programs, suggest that he or she call the Pharmaceutical Research Manufacturers of America and ask for its guide to these programs. Or better yet, check [www.rxassist.org](http://www.rxassist.org) or [www.needymeds.com](http://www.needymeds.com) for a list of programs. Many of these programs provide prescription medications at no cost or for a modest fee, usually no more than \$5 per 30 day supply for even the most expensive medications.

Other cost control tactics for prescription drugs include generic substitution, mail order pharmacy purchase, and comparison-shopping. Studies reveal substantial price differences between pharmacies, including independents, chains, and supermarket drugstores.

## Sources of Assistance

**NYS OFA HIICAP Hotline** **1-800-701-0501**

**1-800-MEDICAR(E)** **1-800-633-4227**  
[www.medicare.gov](http://www.medicare.gov)

**NYS Office for Aging Senior Hotline** **1-800-342-9871**

**Pharmaceutical Research & Manufacturers of America** **1-202-835-3400**  
1100 Fifteenth Street NW  
Washington, DC 20005  
[www.phrma.org](http://www.phrma.org)

**Veterans Administration** **1-800-827-1000**  
<https://www.myhealth.va.gov>

**NYS Health Benefit Exchange**  
<http://www.healthbenefitexchange.ny.gov/>

**TRICARE** **1-877-874-2273**  
[www.tricare.mil](http://www.tricare.mil)

### **Additional Resources**

- Directory of Prescription Drug Patient Assistance Program, PhRMA
- Federal Benefits for Veterans and Dependents, Department of Veterans Affairs

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## STUDY GUIDE MODULE 15: OTHER HEALTH PROGRAMS AND SERVICES

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If your client's former employer offers a retiree health insurance plan after 65, it may pay some of the gaps in coverage left by Medicare. Limited benefit health insurance policies should be considered with great caution.



Read your *HIICAP Notebook*, and the *Medicare & You Handbook* for information on retiree, and other health programs and services.

Use the information from your HIICAP Notebook and the Medicare & You Handbook for the following lessons regarding retiree health plans and other health programs and services.



### 1. CONSIDERING A RETIREE HEALTH PLAN FROM YOUR FORMER EMPLOYER

#### Group Activity:

Recruit one member from your group who is very familiar with his or her own post-65 retiree health plan to act as a resource for the group's discussion of how a retiree health insurance plan works with Medicare.



### 2. LIMITED BENEFIT POLICIES

Though federal law now prohibits the sale of a new health insurance policy that duplicates current health insurance benefits, many older adults have kept the limited benefit policies they bought several (or more!) years ago.



#### In Summary: Review these basic concepts of Retiree Plans.

- If your client's former employer offers retiree health insurance after 65, they should investigate its cost, benefits, maximum lifetime benefit and coverage for their spouse
- If your client's retiree health plan is reasonable and comprehensive, they will not need additional health insurance
- Heavily marketed limited benefit policies such as hospital and accident policies have very limited value

## ANSWER KEY MODULE 15: OTHER HEALTH PROGRAMS AND SERVICES

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