

MODULE 15: OTHER SOURCES OF HEALTH INSURANCE AND PRESCRIPTION DRUG COVERAGE

Objectives

HIICAP counselors will learn about employer retiree plans and how they work with Medicare. Additionally, counselors will learn about COBRA, New York State of Health, Veterans Administration Health Benefits, and TRICARE for Life, and be provided with resources on other available services that may be useful to 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 employees 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 New York State of Health: The Official Health Plan Marketplace?

- New York State of Health (NYSOH) is a statewide online marketplace for state residents to receive information about health insurance options. Through NYSOH, consumers can enroll in subsidized or unsubsidized Qualified Health Plans (QHPs) as well as public insurance programs like Medicaid, Child Health Plus, and Essential Plans (EPs).
- Most Medicare enrollees are not eligible to purchase QHPs or EPs. Medicare enrollees can be eligible for Medicaid but will need to enroll through their Local Department of Social Services (LDSS). Current Medicaid beneficiaries insured through NYSOH who become eligible for Medicare will need to have their Medicaid cases transferred to the LDSS.

What insurance options are available to former military employees?

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

What are the Pharmaceutical Research and Manufacturers of America 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.

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 his or her retiree plan to be a low-cost (sometimes a no-cost) way to cover some of Medicare's coverage gaps. 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 policies, or Medigap policies. However, companies are constantly restructuring retiree health benefits, and only a yearly review will enable retirees to determine the value of their company's specific plan.

What kind of health plan can retirees expect?

Retiree plans vary greatly. For retirees age 65 and older, employers may offer a continuation of their regular company benefits with Medicare benefits carved out. In this situation, Medicare pays for 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 coverage for services outside the scope of the Medicare benefit. 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 s/he becomes eligible. Before age 65, an individual's retiree plan is often his or her only health insurance. For most people, at age 65, Medicare steps in as first payer of health care costs, and the 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, he or she may be responsible for major health care costs as well as a Part B late enrollment penalty. The retiree plan may deduct what Medicare would have paid from any payment it makes or may 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 should enroll in Part A to cover some of the costs that the FEHB plan may not cover, but can make a decision about whether to enroll in Part B. FEHB members have three choices:

- **FEHB and NO Part B.**

Members can continue with their FEHB coverage without signing up for Medicare, which will save them the cost of the monthly Part B premium. If these members later decide they want Part B, they will need to wait until the next General Enrollment Period to sign up for Part B and will be subject to a late enrollment penalty in the form of a higher monthly Part B premium.

- **FEHB and Part B.**

Members can continue with their FEHB coverage and enroll in Part B also. Some FEHB plans may provide an incentive to enroll in Medicare, such as reducing out-of-pocket costs and waiving FEHB plan co-payments, deductibles, and coinsurance. Members electing to participate in both Medicare and FEHB will need to pay both the FEHB and Part B premiums.

- **Part B and NO FEHB.**

Unlike most retirees, Federal retirees can SUSPEND (not cancel) their retiree coverage to enroll in a Medicare Advantage plan, which may have a lower monthly premium or no added premium at all. Individuals choosing this option will still need to enroll in Part B in order to enroll in a Medicare Advantage plan, but they will avoid the higher cost of the FEHB premium. Additionally, they may elect to return to FEHB coverage during the next FEHB Open Enrollment period.

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>, <http://www.opm.gov/healthcare-insurance/fastfacts/fehbmedicare.pdf>, and <http://www.opm.gov/healthcare-insurance/healthcare/medicare/75-12-final.pdf>.

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

If you're retired and have Medicare and group health plan (retiree) coverage from a former employer, generally Medicare pays first for your health care bills and your group health plan coverage pays second. How your retiree group health plan coverage works depends on the terms of your specific plan.

An employer may offer retirees a choice between a fee-for-service retiree health care plan and an HMO. Fee-for-service plans cover services from the retirees' providers of choice. Retirees are responsible for paying deductibles, coinsurance, and the costs of non-covered services. By contrast, an HMO plan limits retirees 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. Enrollees are required to choose a primary care physician who will be responsible for coordinating care and providing referrals.

HMOs differ in the degree of choice the enrollee 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. HMO enrollees will usually pay a co-payment, 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.

Regardless of whether retirees elect an HMO or fee-for-service insurance from their former employer, individuals planning to use this coverage in conjunction with Medicare will need to make sure that the doctors they see and prescriptions they take are covered under both Medicare and their retiree insurance.

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 the retiree's 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 the retiree's 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?

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 cost and benefits of both options including the coverage of spouses and dependents.

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 inpatient 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. However, 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 a 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?

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law requiring that workers who would otherwise lose their employer-sponsored coverage due to specified “qualifying events” have the option of purchasing their employer’s group health insurance for themselves and their family members for a limited time. Under COBRA, qualified beneficiaries can purchase their employer’s group health insurance at the same group rate as when they were employed, but they are responsible for the entire premium plus a 2% administrative fee. Typically, COBRA coverage lasts for up to 18 months, with the possibility of extending coverage if the qualified beneficiary is disabled or if additional qualifying events occur. Plans can charge a higher rate if the extension is due to disability.

COBRA covers employers with 20 or more employees. New York State has a “mini-COBRA” law that covers employers with 2-19 employees 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.



Caution: Delaying Medicare enrollment to preserve COBRA coverage is not advisable. As a reminder, only clients who work beyond age 65 and remain enrolled in their Employer Group Health Plan (EGHP) as an active employee may postpone their Medicare Part B coverage until retirement without penalty. If an individual works beyond age 65 and subsequently enrolls in COBRA, their COBRA coverage will not qualify as active employer group health plan (EGHP) coverage. Individuals without Medicare in this situation must sign up for Part B within an eight-month Special Enrollment Period following the termination of their active EGHP coverage or face a penalty for late enrollment. If they do not sign up for Part B within eight months of losing coverage as an active employee and beginning COBRA, they will have to wait for the annual January to March General Enrollment Period, with Medicare Part B coverage beginning on July 1, and they will be subject to a Part B late enrollment penalty. If a client delayed Part B enrollment due to EGHP coverage but knows they will retire soon, they may want to enroll in Part B while still employed so that their Part B coverage starts by the time their employment ends.

If the worker was already covered by Medicare when first becoming eligible for COBRA, the worker may elect COBRA coverage. In this situation, the worker should not drop their Medicare coverage because COBRA will be billed secondary to Medicare. The worker will be responsible for paying their COBRA premiums in addition to their existing Medicare premiums. COBRA may offer extra benefits that are not available with Original Medicare, such as dental coverage. Clients should consider the cost of maintaining COBRA as secondary coverage and counseled on other alternatives for any benefits they will lose when their COBRA coverage ends.



Caution: Clients may also be subject to Part D late enrollment penalty if their COBRA drug coverage is not considered “creditable.” Clients should consider Part D enrollment within 63 days of losing creditable drug coverage.

COBRA coverage will typically end once a beneficiary enrolls in Medicare. Family members may be able to maintain COBRA coverage for a period of time even after the worker enrolls in Medicare. Clients should speak to their employer about ongoing coverage for family members in this situation.

WHAT IS NEW YORK STATE OF HEALTH?

New York State of Health: the Official Health Plan Marketplace (also known as “the Exchange”) is a statewide marketplace mandated by the Affordable Care Act that provides health insurance information and enrollment assistance to state residents.

The Exchange serves several purposes for individuals and families. First, it helps them determine if they are eligible for public programs such as Medicaid or the Essential Plan. Second, it assists them in determining their eligibility for financial assistance to pay the health insurance premiums for private Qualified Health Plans (QHPs) in the form of tax credits. The Exchange also helps compare the costs and benefits of private insurance options. Most importantly, the Exchange enrolls individuals and families in Medicaid, the Essential Plan, and QHPs. Additionally, small businesses may purchase health plans for their employees on the Exchange.

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



Caution: QHP coverage will not extend the time an individual has to enroll in Part B or waive late enrollment penalties. QHP enrollees who become eligible for Medicare will lose their tax credits and cost sharing reductions. QHPs may stop paying altogether for the cost of care of recipients eligible for Medicare who have elected to delay Medicare enrollment. However, if a QHP enrollee signs up for Medicare at any point during their Initial Enrollment Period (IEP), their QHP should continue to pay primary until their Medicare coverage goes into effect. Clients should contact the Department of Financial Services if their QHP stops paying for services before the end of their Medicare IEP.

Medicaid applications can be processed through the Exchange at any time of year. For other health insurance sold through the Exchange, there is an annual open enrollment period from November 15 through February 15. In certain circumstances such as the loss of other insurance, there are special enrollment periods allowing enrollment in non-Medicaid coverage outside of the open enrollment period. New York State residents eligible for QHP, Medicaid, or Essential Plan coverage through the Exchange are authorized to use the Exchange regardless of their immigration status. For example, undocumented immigrants can use the Exchange to apply for Emergency Medicaid (coverage for emergency medical conditions).

Note: Most Medicare recipients are not eligible to purchase a QHP on the Exchange. Medicare enrollees who pay premiums for Part A can enroll in a QHP.

Note: Most Medicare recipients are not eligible to receive Medicaid on the Exchange. Unless a Medicare beneficiary is the parent or caretaker of a minor child, they can apply for Medicaid at their Local Department of Social Services (LDSS) instead of the Marketplace or Exchange.

The New York State of Health website can be found at <https://nystateofhealth.ny.gov/>
The New York State of Health phone helpline is 1-855-355-5777, TTY 1-800-662-1220.

Refer to The New York State of Health module (16) for more information.

MILITARY RETIREES – VETERANS ADMINISTRATION (VA)

Your client is eligible for Veterans Administration (VA) Health Benefits if he or she served active duty in the uniformed armed forces of the United States and was discharged from the military under any circumstance other than a dishonorable discharge. If a person has both VA and Medicare benefits, he or she must choose whether to use a Medicare provider or Veterans Health Administration facilities each time services are sought. VA Health Benefits and Medicare will not act as supplements to each other.

If eligible for VA Health 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 an illness rated by the VA as less than 50 percent service-connected, there is an \$8 or \$9 copayment for each 30-day 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.



Caution: Clients should not delay Medicare Part B enrollment because of VA Health Benefits. VA Health Benefits will not protect against late-enrollment penalties. Clients will have to wait for the annual January to March General Enrollment Period to sign up for Part B coverage effective the following July 1.

For more information, including enrollment information, see <http://www.va.gov/healthbenefits/> or call 1-877-222-8387.

The Department of Veterans Affairs also has a hotline specifically geared to providing information on all benefits, including, but not limited to, health care benefits, that are available to women veterans: 1-855-VA-WOMEN (1-855-829-6636).

TRICARE for Life

TRICARE (formerly known as Civilian Health and Medical Program of the Uniformed Services or “CHAMPUS”) is a health program for active duty and retired Uniformed Service members and National Guard/Reserve members and their families, including survivors and some former spouses as well as Medal of Honor recipients and their families, and others registered in the Defense Enrollment Eligibility Reporting System (“DEERS”).

TRICARE for Life (TFL) provides a Medicare wraparound for TRICARE-eligible individuals who are enrolled in Medicare Part A and Part B.

- Generally, Medicare will be the primary payer for Medicare-covered services. TRICARE will pay Medicare deductibles and co-insurance costs up to the Medicare allowed charge for those services that are also TRICARE-covered services.
- TRICARE will be the primary payer for services that are not Medicare-covered services but are TRICARE-covered services. TRICARE fiscal year deductibles and cost shares will apply.

TRICARE will not pay second to Medicare if a person has other health insurance, such as an employer-sponsored insurance plan. TRICARE pays after all other insurers except Medicaid. Medicare pays first, the other health insurance pays second and TRICARE pays third.

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 TRICARE and TFL call 1-877-874-2273 or visit 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 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 on active duty, in the line of duty and not due to misconduct, and not otherwise eligible for health benefits under TRICARE.

CHAMPVA is always secondary payor to Medicare.

For more information on CHAMPVA, see:

<http://www.va.gov/PURCHASEDCARE/programs/dependents/champva/index.asp>

GROUP HEALTH INSURANCE OPTIONS AND THE SELF-EMPLOYED

Group	Professions	Contact Info
Small Business Service Bureau	Small business employee	1-800-343-0939; www.sbsb.com
Graphic Artists Guild	Graphic Artists	1-212-791-3400; www.gag.org
National Writers Union	Writers	1-212-254-0279; www.nwu.org
Screen Actors Guild	Performers	1-212-944-1030; www.sag.org
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 www.freelancersunion.org

ADDITIONAL HEALTH PROGRAMS AND SERVICES

EyeCare America: Public service program that provides certain eye care services at no out-of-pocket cost to those who qualify. Contact 1-877-887-6327 or see www.eyecareamerica.org

Hear Now: Assistance to those needing a hearing aid who have no other resource available. Contact 1-800-328-8602 or see <https://www.starkeyhearingfoundation.org/hear-now>

NYS OVS Victim Compensation Program: The Office of Victim Services is a payor of last resort for medical and mental health bills for innocent victims of a crime as long as the illness or injury is related to the crime. Contact 1-800-247-8035 or see <https://ovs.ny.gov/help-crime-victims>

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. As of June 30, 2013, this program was transferred to the New York State Justice Center for the Protection of People with Special Needs. Contact 1-800-624-4143 or see <http://www.justicecenter.ny.gov/services-supports/assistive-technology-traid/traid-in-eeep>

RESOURCES FOR PRESCRIPTION MEDICATIONS AND COST-SHARING ASSISTANCE

AIDS Drug Assistance Program (ADAP): Clients must be low-income, uninsured or underinsured and living with HIV/AIDS. Clients with a Medicaid spend-down may be eligible. Call 1-800-542-2437 or see <http://www.health.state.ny.us/diseases/aids/resources/adap>.

Benefits Check Up: Helps people locate benefits and services available to them. See www.benefitscheckup.org.

CancerCare Co-Payment Assistance Foundation: Provides co-payment assistance for cancer patients that need help paying for their cancer-related medications. Call 1-866-55-COPAY (1-866-552-6729) or see www.cancercarecopay.org.

Caring Voice Coalition: Helps pay some of the cost of prescription drugs and provides other support for clients living with a life threatening chronic disease. Call 1-888-267-1440 or see www.caringvoice.org.

Good Days from CDF (formerly known as Chronic Disease Fund): Co-payment assistance for those clients with chronic diseases, cancer, or other life-altering conditions. Call 1-877-968-7233 or see www.cdfund.org.

The Health Well Foundation: Helps pay your clients' drug co-pays, deductibles or monthly premiums. Client must be diagnosed with certain conditions. Go online to www.healthwellfoundation.org or call 1-800-675-8416.

Be the Match Financial Assistance Fund: For people who will use or have used the Be The Match Registry. May help pay for some of the costs associated with a bone marrow or cord blood transplant, including prescription drugs. Go online to <http://bethematch.org/For-Patients-and-Families/Getting-a-transplant/Planning-for-transplant-costs> 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 have access to under their health insurance. See NORD's website <http://www.rarediseases.org/patients-and-families/patient-assistance> 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 or access their helpline at 1-800-503-6897.

New York State Department of Health (NYSDOH): Search prescription drug prices in New York State for the 150 most frequently prescribed drugs with a small number of surveyed pharmacies in an area. To search enter the zip code, city or county online at <https://apps.health.ny.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 or call 1-866-512-3861.

Patient Services Inc. (PSI): Provides premium and co-pay assistance for people with certain rare chronic diseases. Go online to 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 or call 1-888-4PPA-NOW (1-888-477-2669).

RX Hope: Help your clients apply for discounted and free medications directly through this website. Go online to <https://www.rxhope.com/Patient/AssistanceRequest.aspx> to request assistance.

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA PRESCRIPTION DRUG PROGRAMS

Most major drug companies have developed programs to give certain drugs at low or no cost to patients 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 costs associated with them by writing, calling, or going online. The pharmaceutical manufacturers will only accept applications from physicians, not from individual patients. If a doctor is unfamiliar with manufacturer aid programs, suggest that he or she call the Pharmaceutical Research and Manufacturers of America and ask for its guide to these programs. A list of programs can be found at www.rxassist.org or www.needymeds.com. 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 independent, chain, and supermarket drugstores.

Sources of Assistance

NYS OFA HIICAP Hotline	1-800-701-0501
1-800-MEDICAR(E) www.medicare.gov	1-800-633-4227
NYS Office for Aging Senior Hotline	1-800-342-9871
Pharmaceutical Research & Manufacturers of America 950 F St., NW, Suite 300 Washington, DC 20004 www.phrma.org	1-202-835-3400
Veterans Administration https://www.myhealth.va.gov	1-800-827-1000
New York State of Health: The Official Health Plan Marketplace http://www.nystateofhealth.ny.gov	1-855-355-5777
TRICARE www.tricare.mil	1-877-874-2273
Partnership for Prescription Assistance, PhRMA www.pparx.org	1-888-477-2669

Additional Resources

- Federal Benefits for Veterans and Dependents, Department of Veterans Affairs

STUDY GUIDE MODULE 15: Retiree Plans, Other Health Insurance, and Additional Assistance

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.

**3. INSURANCE THROUGH NEW YORK STATE OF HEALTH**

- How many levels of Qualified Health Plan coverage are available through the New York State of Health Marketplace and what are they called?
- Are these policies available to Medicare enrollees?

**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 his or her spouse
- If your client's retiree health plan is reasonable and comprehensive, he or she 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: Retiree Plans, Other Health Insurance, and Additional Assistance

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.



3. INSURANCE THROUGH NEW YORK STATE OF HEALTH

- While all Qualified Health Plans offer the same essential health benefits, there are four levels of coverage (bronze, silver, gold and platinum) that differ 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.
- Most Medicare enrollees cannot buy insurance through New York State of Health. Exceptions are those who are paying for Part A or who purchased insurance before becoming eligible for Medicare.



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 his or her spouse
- If your client's retiree health plan is reasonable and comprehensive, he or she will not need additional health insurance
- Heavily marketed limited benefit policies such as hospital and accident policies have very limited value