

## **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.

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- This is an important source of assistance for those who lack prescription drug coverage and are not eligible for EPIC.

## RETIREE PLANS

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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 copayments, 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 copayment, or a coinsurance percentage, for each service rendered 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 select 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.

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## 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 the cost of services that Medicare does not pay for, such as eyeglasses and dental care? Are extra preventive services covered?

If the retiree health plan available from one's former employer 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 believe it to be 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 Medigap policy or Medicare Advantage plan.

The decision to drop an employer-provided retiree health plan should be made only after careful study of all options available, including the coverage of spouses and dependents.

### Limited Benefit Policies

Although 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 determining 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 with no overnight stay required, no payment will be allowed from a hospital indemnity policy under these circumstances. 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.

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## 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 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.

Under federal law, COBRA coverage is available through employers with 20 or more employees and can last for up to 18 months, with the possibility of extending coverage to up to 36 months 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. New York State law provides COBRA-like benefits to cover employers with 2-19 employees and others left out of COBRA. In addition, most New York residents who qualify under either law can retain coverage for a maximum of 36 months without needing to apply for an extension, and qualifying disabled beneficiaries cannot see their premiums increase above 102%. Individuals whose employers are self-insured, however, will only be eligible for the 18 months of COBRA coverage required by federal law. Finally, while COBRA coverage is sometimes available to individuals who were also first eligible for Medicare, New York law will not cover such individuals. If these individuals would only have been eligible for COBRA-like benefits under New York law, Medicare eligibility will preclude them from participating.



**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 vision or dental coverage. Clients should consider the cost of maintaining COBRA as secondary coverage and should be counseled on other alternatives to 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.

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## WHAT IS NEW YORK STATE OF HEALTH?

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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.

Medicaid and Essential Plan applications can be processed through the Exchange at any time of year. For QHPs sold through the Exchange, there is an annual open enrollment period. New federal regulations have shortened the open enrollment period which now lasts from November 1 through December 15. However, last year, New York State extended the open enrollment period through January 31, 2019. In certain circumstances such as the loss of other insurance, there are special enrollment periods allowing enrollment in a QHP 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. Although undocumented immigrants are ineligible for QHPs, regular Medicaid, and the Essential Plan, they are eligible for Emergency Medicaid which provides coverage for emergency medical conditions; these individuals can use the Exchange to apply for Emergency Medicaid.

### Transitioning from the Marketplace to Medicare

Transitioning from the Exchange to Medicare can be complicated. What follows is a brief overview of the process. For more comprehensive information, see the Medicare Rights Center’s Medicare Interactive article entitled “Moving from the Marketplace to Medicare in New York State” at [https://www.medicareinteractive.org/learning-center/toolkits/moving-from-the-marketplace-to-medicare-in-new-york-state?utm\\_source=professionals&utm\\_medium=Email&utm\\_campaign=mi-outreach](https://www.medicareinteractive.org/learning-center/toolkits/moving-from-the-marketplace-to-medicare-in-new-york-state?utm_source=professionals&utm_medium=Email&utm_campaign=mi-outreach) (If viewing in PDF format, copy and paste link in browser.)

In addition, Module 16 (*Medicare and the Health Insurance Marketplaces*) also includes information regarding transition from a QHP to Medicare.

<https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod16.pdf>

### Qualified Health Plan Recipients

Clients enrolled in a QHP should be sure to enroll in Medicare during their Initial Enrollment Period (IEP). 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, unless such individuals would have to pay a premium for Part A and do not

enroll in Medicare. However, penalties will still apply if such individuals later enroll in Medicare. 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 recipient signs up for Medicare at any point during their Initial Enrollment Period (IEP), the QHP should continue to pay primary until the 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.

Thus, generally, it is best to timely disenroll from your QHP. To do so, you may call the Exchange or your QHP. Note that if you contact the Exchange to disenroll, the disenrollment may take place immediately. If you call the plan, you should call at least 14 days in advance of the Medicare effective date.

### **Medicaid Recipients**

Individuals receiving Medicaid on the Exchange prior to eligibility for Medicare should be evaluated for Medicaid eligibility by the Local Department of Social Services (LDSS). In general, Medicaid financial eligibility rules are different for those receiving Medicare than for those who are not receiving Medicare. For example, there are asset limits for those receiving Medicare and seeking Medicaid as a secondary payer while there are no asset limits for many Medicaid applicants who are not receiving Medicare.

Individuals receiving Medicaid on the Exchange who become eligible for Medicare should complete any Medicaid renewal form that is sent to them so that the LDSS can evaluate their eligibility for Medicaid. In addition, whether or not these individuals are eligible for Medicaid through the LDSS, they may be eligible for a Medicare Savings Program (MSP) which pays their Part B premium. The LDSS should evaluate all Medicaid renewals for MSP eligibility.

The one exception to the above is for those individuals receiving Medicare who are also the parent or caretaker relative of a minor child (a child under 21). These individuals may continue to be eligible to receive Medicaid with Exchange Medicaid financial eligibility rules. (See Medicaid Alert/MAP-3097 using the following link: <http://www.wnyc.com/health/file/516/?f=1>.) They may also be eligible to receive an MSP through the LDSS.

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.

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

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Clients are eligible for Veterans Health Administration benefits (VA Health Benefits) through the U.S. Department of Veterans Affairs if they served active duty in the uniformed armed forces of the United States and did not receive a dishonorable discharge. If a person has both VA Health Benefits and Medicare, they must choose whether to use a Medicare provider or Veterans Health Administration facility 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 has a VA service-connected disability that is 50% or more disabling or is being treated for a service-connected disability, there is no copayment for the prescription (these are veterans in Priority Group 1).

There is also no copayment for medications:

- For veterans who are former Prisoners of War (POWs);

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- For Vietnam-era herbicide-exposed, radiation-exposed, combat or Camp Lejeune Veterans, as authorized under 38 U.S.C. 1710(e);
  - For treatment of military sexual trauma, as authorized under 38 U.S.C. 1720D;
  - For treatment of cancer of the head or neck, as authorized under 38 U.S.C. 1720E;
  - Provided as part of a VA-approved research project, as authorized by 38 U.S.C. 7303;
  - For veterans with a low income (annual income lower than the applicable VA pension);
  - For veterans who VA determines to be catastrophically disabled, as defined in 38 C.F.R. 17.36(e);
  - For veterans receiving care for psychosis or a mental illness other than psychosis pursuant to §17.110.

Unless otherwise exempt, veterans must pay a copayment of \$5, \$8, or \$11 for each 30-day or less supply of medication for a nonservice-connected condition, depending on the tier of the prescribed medication. In order to take advantage of the VA prescription benefit, the veteran 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. The penalty increases each year the client delays signing up. 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 care program for active duty and retired Uniformed Service members, retirees, and their families 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 beneficiaries 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, coinsurance, and copayment 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 for Medicaid, TRICARE supplements, State Victims of Crime Compensation Programs, other federal government programs identified by the directors, and Defense Health Agency (i.e., Indian Health Service). In general, Medicare pays first, the other health insurance pays second and TRICARE pays third.

TRICARE also offers prescription drug benefits with copayments. 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 1-866-773-0404 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 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.
2. The surviving spouse or child of a veteran who died from a VA-rated service connected disability.
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.
4. The surviving spouse or child of a military member who died in the line of duty and not due to misconduct (in most of these cases, these family members are eligible for TRICARE, not CHAMPVA).

CHAMPVA is always secondary payer to Medicare.

For more information on CHAMPVA, see: <https://nvf.org/champva-civilian-health-and-medical-program/>

## GROUP HEALTH INSURANCE OPTIONS AND THE SELF-EMPLOYED

Group	Professions	Contact Info
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.graphicartistsguild.org">www.graphicartistsguild.org</a>
National Writers Union	Writers	1-212-254-0279; <a href="http://www.nwu.org">www.nwu.org</a>
Screen Actors Guild – American Federation of Television and Radio Artists	Performers	1-855-724-2387; <a href="http://www.sagaftra.org">www.sagaftra.org</a> <a href="http://www.sag.org/">http://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	<a href="http://www.freelancersunion.org">www.freelancersunion.org</a>
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## ADDITIONAL HEALTH PROGRAMS AND SERVICES

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**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.aaio.org/eyecare-america](http://www.aaio.org/eyecare-america)

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

**NYS Office of Victim Services:** The Office of Victim Services is a payer 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>

**Technology-Related Assistance for Individuals with Disabilities (TRAID) Program / getATstuff: Assistive Technology Exchange in New England & New York:** The TRAIID Program coordinates statewide activities to increase access to assistive technology. It is administered by the New York State Justice Center for the Protection of People with Special Needs. The program supports 12 Regional TRAIID Centers that allow for information, training, reuse of devices, exchange, and loans. Contact 1-800-624-4143 or see <http://www.justicecenter.ny.gov/services-supports/assistive-technology-traid>.

**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 <https://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm>.

**BenefitsCheckUp:** Helps people locate benefits and services available to them. See [www.benefitscheckup.org](http://www.benefitscheckup.org).

**CancerCare Co-Payment Assistance Foundation:** Provides copayment assistance for cancer patients that need help paying for their cancer-related medications. Call 1-866-55-COPAY (1-866-552-6729) or see <https://www.cancercare.org/copayfoundation>.

**Good Days:** Financial assistance for clients with chronic diseases who need medications. Call 1-877-968-7233 or see [www.mygooddays.org](http://www.mygooddays.org).

**HealthWell Foundation:** Helps pay your clients' drug copays, deductibles, or monthly premiums. Client must be diagnosed with certain conditions. Go online to [www.healthwellfoundation.org](http://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 <https://rarediseases.org/for-patients-and-families/help-access-medications/patient-assistance-programs-2/> 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 <http://www.needymeds.org/> or access their helpline at 1-800-503-6897.

**New York State Department of Health (NYSDOH) – Search Drug Prices:** Search prescription drug prices in New York State for the 150 most frequently prescribed drugs from pharmacies that participate in Medicaid and pharmacies that submit their price information to NYSDOH. 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 copayment assistance programs. Go online to [www.copays.org](http://www.copays.org) or call 1-866-512-3861.

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

**Pharmaceutical Research and Manufacturers of America (PhRMA):** Created the Medicine Assistance Tool (MAT) to provide a dedicated search engine that allows users to search for financial assistance resources available to them, their loved ones or patients in their lives through the various biopharmaceutical industry programs available for patients who are eligible. Building upon the Partnership for Prescription Assistance (PPA), MAT gives patients, loved ones and health care providers a single point of access to hundreds of public and private assistance programs, as well as connecting them with more transparent information about the cost of medicine. <https://medicineassistancetool.org/>

**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.

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## PRESCRIPTION DRUG ASSISTANCE PROGRAMS

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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.

A list of programs can be found at [www.rxassist.org](http://www.rxassist.org), [www.needymeds.org](http://www.needymeds.org), and <https://medicineassistancetool.org/>. 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

<b>NYS OFA HIICAP Hotline</b>	<b>1-800-701-0501</b>
<b>1-800-MEDICAR(E)</b> <a href="http://www.medicare.gov">www.medicare.gov</a>	<b>1-800-633-4227</b>
<b>NY Connects</b>	<b>1-800-342-9871</b>
<b>Pharmaceutical Research &amp; Manufacturers of America</b> 950 F St., NW, Suite 300 Washington, DC 20004 <a href="http://www.phrma.org">www.phrma.org</a>	<b>1-202-835-3400</b>
<b>U.S. Department of Veterans Affairs</b> <a href="https://www.myhealth.va.gov">https://www.myhealth.va.gov</a>	<b>1-877-327-0022</b>
<b>New York State of Health: The Official Health Plan Marketplace</b> <a href="http://www.nystateofhealth.ny.gov">http://www.nystateofhealth.ny.gov</a>	<b>1-855-355-5777</b>
<b>TRICARE</b> <a href="http://www.tricare.mil">www.tricare.mil</a>	<b>1-866-773-0404</b>
<b>Pharmaceutical Research and Manufacturers of America, PhRMA, Medicine Assistance Tool (MAT)</b> <a href="https://medicineassistancetool.org/">https://medicineassistancetool.org/</a>	<b>1-888-477-2669</b>

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

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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 health plans 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**

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- 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 or that Marketplace or job-based insurance are unaffordable, 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.



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