

Retiree Health Benefits

State of Idaho
Department of Administration
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Retiree Health Benefits

- In 2009, HB 173 was introduced and passed by the Idaho Legislature
- HB 173 changed eligibility requirements to no longer provide a retiree medical plan for eligible retirees and eligible dependents aged 65 and older.

[House Bill 173 Impacts]

- Under 65 retirees
 - Guaranteed subsidy
 - Guaranteed joint rating with active plan
 - Expect annual premium increases of 12-15%
 - While retirees have been receiving the benefit of a state subsidy and joint rating, there was nothing in statute that requires it.
 - Without the benefit of joint rating, the retiree plan would have increased 74% in FY 2008

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[House Bill 173 Impacts]

- Over 65 retirees
 - Eliminates the statutory requirement for coverage of eligible retirees and eligible dependents age 65 and older.
 - Provide assistance in transition to Medicare supplement plans by identifying available resources
 - Ability to use sick-leave funds to pay premiums with major vendors
 - Dependents under 65 would remain on the state plan and receive the state subsidy

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[Effects on Retirees]

- Under 65
 - Financial impact
- Over 65
 - Substantial changes

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[Coverage Options for Over 65 Retirees]

- Includes:
 - Medicare Part A – Hospital Insurance
 - No monthly premium
 - \$1,068 deductible for hospital stays up to 60 days, additional costs after 60 days
 - Medicare Part B – Medical Insurance
 - \$ 96.40 monthly premium
 - \$135 annual deductible
 - 20% co-insurance for my Part B services
 - Medicare Part C – Medicare Advantage Plan
 - Takes the place of original Medicare Part A & B
 - Medicare Part D – Prescription Drugs

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[Medigap Plans]

- Health insurance plans sold by private companies to fill “gaps” in the original Medicare plan (Parts A & B) coverage
 - Gaps may include deductibles, co-insurance, co-payments, etc
 - Does NOT work with Medicare Advantage plans
 - Up to 12 standardized plans available (Plans A – L)

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[Medigap Plans]

- Plans available for purchase
 - Enrollment
 - Initial eligibility within 6 months of enrolling in Part B
 - Must be age 65 or over
 - Enrollment after initial eligibility
 - If they lose certain kinds of health insurance through no fault of their own
 - If they leave Medicare Advantage plans under certain circumstances
 - Whenever a vendor is willing to sell them one
 - Monthly premiums
 - Generally able to go to any Doctor or specialist

[Medicare Advantage Plans]

- There are four types of Medicare Advantage plans
 - Health Maintenance Organization (HMO) Plans
 - Preferred Provider Organization (PPO) Plans
 - Private Fee for Service Plans
 - Medicare Medical Savings Account (MSA) Plans

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[Eligibility for Medicare Advantage Plans]

- Must live in the plan service area
- Entitled to Medicare Part A
- Enrolled in Medicare Part B
 - Continue to pay Part B premium
 - May also pay monthly premium to plan
- May not have End Stage Renal Disease (ESRD) at enrollment
 - Some exceptions

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[Medicare Advantage Plan]

- Typically get all Part A and B services through the plan
 - May have to use providers in plan network
 - Typically must still pay Part B premium
 - May include Part D prescription coverage
 - May get extra benefits such as vision, hearing, dental and prescription drug coverage
- Still in Medicare program
 - Entitled to all Part A and B services
 - Continued Medicare rights and protections

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[Medicare Prescription Drug Coverage]

- Available to all people with Medicare
- Provided through
 - Medicare Prescription Drug plans
 - Medicare Advantage and other Medicare plans

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Comparison of State Plan and Market Plans

	FY2010 State Traditional Medical Plan	Blue Cross True Blue (HMO)	Regence Blue Shield MedAdvantage + Rx (PPO)	Blue Cross Classic Blue Plan "J"	Regence Blue Shield Senior Selection Plan "F"
Annual Deductible Individual Family	\$ 350 \$1,050	No Deductible No Deductible	No Deductible No Deductible	No Deductible No Deductible	No Deductible No Deductible
Co-Insurance/Co-payments	Member pays 20% after deductible is met	Member pays varying co-payment amount	Member pays varying co-payment amount	Member generally pays \$0	Member generally pays \$0
Dental	Not a benefit	Some Coverage	Some Coverage	Optional Plan available	Some preventive benefits
Vision	Not a benefit	Some Vision Coverage	Some Vision Coverage	Treatment of illness/injury only	Treatment of illness/ injury only
Prescription	No Deductible 30 day supply for \$10 to \$50 co-payment	No Deductible 30 day supply for \$6 to \$40 co-payment up to \$2,700; Member pays 100% thereafter until out-of-pocket = \$4,350	\$295 Deductible 30 day supply for \$4 to \$40 co-payment up to \$2,700; Member pays 100% thereafter until out-of-pocket = \$4,350	No Coverage Member must purchase Medicare Part D Plan for prescription coverage.	No Coverage Member must purchase Medicare Part D Plan for prescription coverage.

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Comparison of Costs

	FY2010 State Traditional Medical Plan	Blue Cross True Blue (HMO)	Regence Blue Shield MedAdvantage + Rx (PPO)	Blue Cross Classic Blue Plan "J"	Regence Blue Shield Senior Selection Plan "F"
Monthly Premium (2008)	\$231.00	\$94.00	\$107.00	\$165 - \$190.00	\$187 - \$221.00
Medicare Part D (2008)	N/A	N/A	N/A	\$40.00	\$40.00
Premium Impact -vs- State Plan*	N/A	Savings of \$137.00	Savings of \$124.00	Savings of \$26 to an increase of \$1.00	Savings of \$4 to an increase of \$30.00

* These savings are based on a premium-to-premium only and do not include additional savings retirees may experience in deductible, co-insurance, prescription, dental and vision coverage.

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[Prescription Drug Costs]

- Help available to those with limited income and resources
 - Income limit in 2008
 - \$1,300 month / individual, \$1,750 month / married
 - Resource limit
 - \$11,990 individual, \$23,970 married
- Those with lowest income and resources pay no premiums or deductibles and have small or no co-payments
- Those with slightly higher income and resources pay reduced premium and deductible and pay slightly more out of pocket.

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[Prescription Drug Reimbursement – Temporary Rule]

- Effective January 1, 2010 through December 31, 2011
- Offered to any retired personnel or dependent who is no longer eligible for the state health care coverage due to age.
- \$2000.00 per year limit for two years (2010 and 2011)

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[Prescription Drug Reimbursement – Temporary Rule Guidelines]

- Currently participating in State retiree medical plan
- Have met the initial Part D coverage limit for prescription drug costs (\$2700)
- Have paid \$2000 out of pocket for prescription drug costs under the available Medicare supplement plan
- Total out of pocket costs have **not** yet exceeded the “coverage gap”.
- Available for reimbursement of “gap” costs as noted or for any prescription drug not covered by Medicare supplement plans, or that the plan has denied the request for a formulary exception for such drug.

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[Questions?]

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