

Freight Drivers Local 557 Health and Welfare Fund

Agenda

- Review some historical points of interest
- Explain the moving parts of the Health Care Industry – focused on Medicare and making sure you understand important timelines.
- Allow you to collect information from the vendors present
- Encourage you to check other sources – **make an informed decision**

Historical Points of Interest

- 557 Actives were moved to NY State Teamsters Fund September 1, 2003. Remaining assets in the Fund were earmarked to help offset costs of retiree H&W coverage provided assets have not been depleted.
- December 31, 2004 = \$4,755,776
- December 31, 2005 = \$3,487,382
- December 31, 2006 = \$2,639,162
- December 31, 2007 = \$1,871,121
- December 31, 2008 = \$1,035,536

Historical Points of Interest

- Participation in the Retiree Fund was limited to those who retired before September 1, 2003.
- Aetna - Effective January 1, 2005, if you reside in the Aetna Service Area and are Medicare qualified (Part A&B), you must take Aetna as your coverage. (283)
- Basic Retiree Plan (\$2,500 lifetime benefit - \$5,000 family max annual drug card) (194)
- Medicare Wrap Plan – (\$25,000 lifetime benefit - \$5,000 family max annual drug card) (62)

Current Costs or Subsidies

Retirement date	prior to 01/01/1998	on or after 01/01/1998
• Subsidy to offset Aetna costs	\$150	\$75
• Actual costs for Aetna have been significantly higher and are based upon where you reside and the coverage level you have chosen. For single retirees costs have ranged from \$94.59 to \$276.26 , and for couples costs have ranged from \$323.74 to \$639.62 per month (after the subsidy).		
• 557 Basic Retiree Plan - if you retired prior to Jan 1, 1998 you pay \$75 plus \$25 for your spouse. If you retired on or after Jan 1, 1998, you pay \$150, plus \$50 for your spouse.		
• 557 Medicare Wrap if you are retired prior to Jan 1, 1998 you pay \$145 plus \$95 for your spouse. If you retired on or after Jan 1, 1998 you pay \$220 plus \$120 for your spouse.		

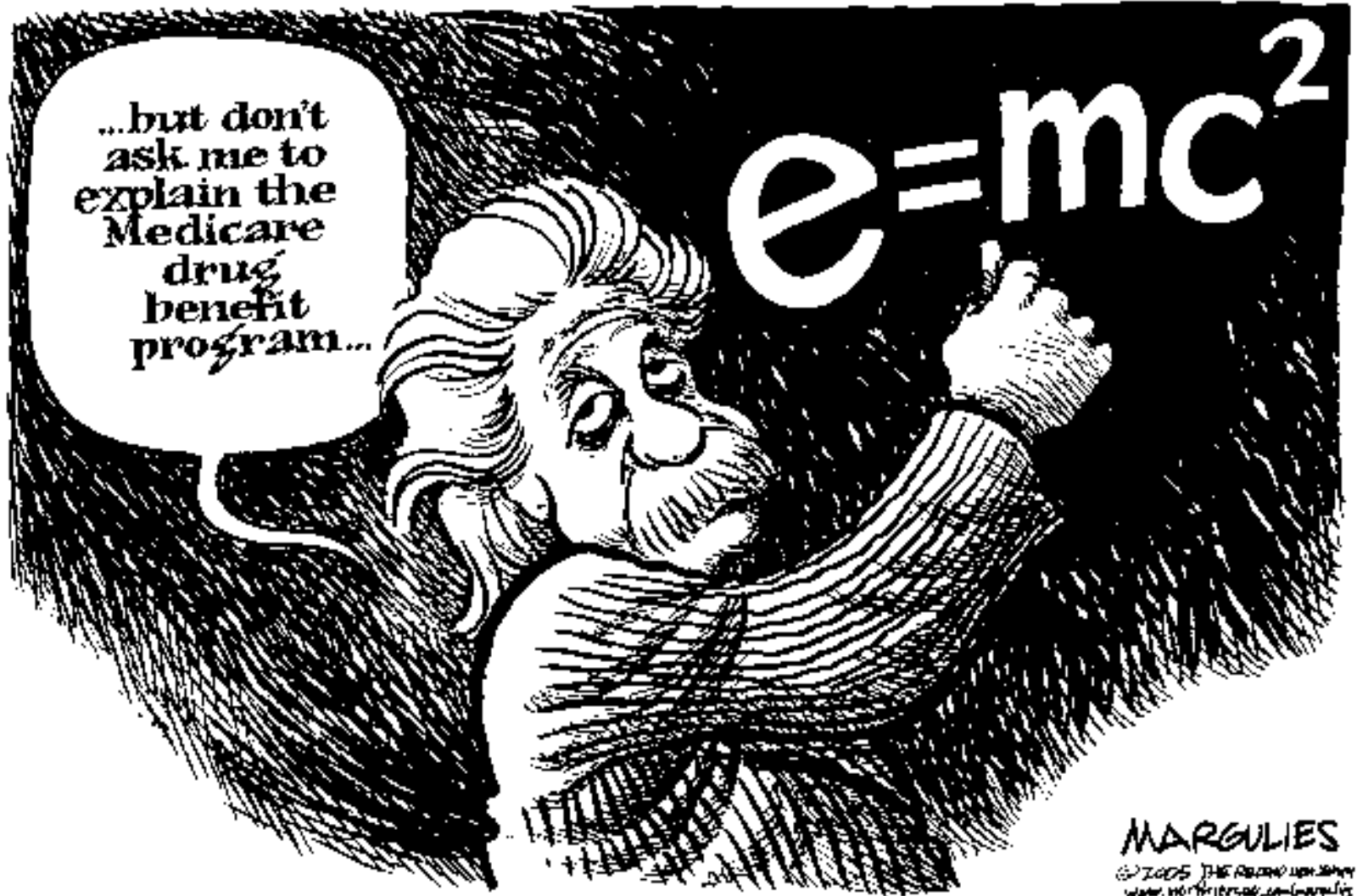
The Fund will “close its doors”

- **Effective December 31, 2009 the coverage from the Freight Drivers Local 557 Health and Welfare Fund will stop and you must find an individual plan. Any portion of the cost currently deducted from your Pension, will be paid as part of your Pension effective January 1, 2010.**

What can you do going forward?

- The next few slides are intended to focus on Medicare and how the insurance market builds and offers Medicare products. Representatives from several insurers are here today to provide you with information regarding the coverage options they offer and what they cost. In addition, you are encouraged to contact outside parties in the Health Insurance Industry. Each of the insurers present today will have information for you to take with you. As you can appreciate, this is an important decision, but also a personal decision. We are trying to provide you with as much information to make an informed decision that fits your personal needs. You have time to consider your decision carefully. Don't rush, make sure you understand your options.

The Truth about Medicare...



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Understanding How You Are Currently Covered

- Aetna – Medicare Advantage Program – Part C (replaces Traditional Medicare with an insured product that includes Prescription coverage).
- Traditional Medicare (Part A & B) and the Freight Drivers Medicare Wrap Plan as a Medicare Supplement (Included a Drug Card that was creditable coverage.)
- Freight Drivers Basic Plan (Included a Drug Card that was creditable coverage)

For Those In Aetna or Traditional Medicare

- If you are currently covered under Aetna, you may chose to re-enroll in Traditional Medicare and purchase a Medicare Supplement and a Drug Plan.
- If you are in Traditional Medicare, you may remain there and purchase a Medicare Supplement and Drug Plan.
- Regardless of your current coverage, you may also chose to enroll in an individual Medicare Advantage Plan (this is an insured program that replaces Traditional Medicare and you get all services through one insurance product). You will still need to consider options for Prescription Coverage.

Traditional Medicare

- Closer look at Medicare Part A - Hospital
- Purpose: Provides **inpatient** insurance
 - Hospital, Skilled Nursing Facility (SNF), Hospice, Home Health
- Eligibility:
 - First day of the month that member or beneficiary turns 65
 - Two years after becoming disabled
 - Soon after renal dialysis begins
- Cost:
 - No premium if beneficiary or spouse have worked 40 quarters of Medicare-covered employment (40 quarters = 10 years)
 - If beneficiary worked less than 40 quarters, a monthly premium is set by Medicare formula

Traditional Medicare

- Closer look at Medicare Part B - Medical
- Purpose: Provides **outpatient** services
 - Physician services (inpatient and outpatient), outpatient surgery, lab, radiology, durable medical equipment (DME), dialysis, etc.
- Enrollment:
 - **Optional plan**: Individuals responsible for their own enrollment
 - Enroll with Social Security Administration
 - Individuals can enroll over a 7-month period that starts 3 months before their 65th birthday
 - Late Enrollment Penalty (LEP) if individual does not enroll in this 7-month window. If initial enrollment is missed, they can enroll during Medicare's Open Enrollment Period
 - Occurs every year from January 1 to March 31
 - Coverage effective July 1
 - Applies to Individual Plan members and retirees or group health plan with 20+ employees

Traditional Medicare

- Closer look at Medicare Part B - Medical, cont.
- Cost:
 - Monthly premium, usually deducted from Social Security
 - Premium goes up 10% for each 12-month period that individual declines coverage
 - Known as Late Enrollment Penalty (LEP)
 - Not imposed if individual continues to work for, **and receives** his or her health coverage from, a Group plan of 20 or more eligible employees
 - In 2009, Part B premium will range from \$96.40 to \$238.40*, depending on income
 - In 2010, new to Part B enrollees will pay \$110.50

*these amounts are updated every year by CMS

Summary of Part A and B

Part	Provides	Eligibility	Monthly Premium?
A	Inpatient Insurance <ul style="list-style-type: none"> ■ Hospital ■ Skilled Nursing Facility (SNF) ■ Home health visits after a hospital or SNF stay ■ Hospice care 	All individuals with 40 or more quarters of Social Security income	No
		Some individuals with less than 40 quarters of Social Security income	Yes
B	Outpatient Insurance <ul style="list-style-type: none"> ■ Doctor office visits ■ Outpatient hospital services ■ Services and supplies (Labs, Radiology, DME, etc.) 	All individuals who are 65, disabled, or with ESRD	Yes

Medicare Part C – Medicare Advantage

- Legislation: Balanced Budget Act (BBA) of 1997
- Purpose: Expanded the role of managed care plans
 - Created private plan options for how beneficiaries receive Medicare coverage
 - Option One: Original Medicare Plan through the Centers for Medicare & Medicaid Services (CMS)
 - Option Two (New): Medicare Advantage Plan - Through a private insurer plan, such as an HMO or PPO
 - » These plans were first known as Medicare Risk plans
 - » Then renamed Medicare + Choice plans
 - » Today they are known as Medicare Advantage plans

Medicare Part C: Relationship between CMS and Medicare Advantage (MA) plans

- MA plans are “at risk” plans, as opposed to “cost” (fee for service) plans that are guaranteed to be paid their costs
- CMS pays the insurer a monthly capitation
 - Based on the beneficiary’s county of residence
 - Amount is adjusted over time, based on:
 - “Fee-for-service” national per capita growth rates update the county rates
 - Payments to plans based on their bids relative to the county rates
- In order for the insurer to be paid capitation by CMS, the member must exclusively assign his or her benefits to the insurer
 - Member is locked into the plan’s providers. CMS will not pay any other provider for this member. The option you select from the insurer, may offer in and out of network coverage – you need to check on this.

Medicare Part D – Prescription Drugs

- Legislation: Medicare Modernization Act (MMA) of 2003
- Purpose: Provides outpatient prescription drug coverage
- Options for enrollment in Part D:
 - Prescription Drug Plan (PDP): A new plan type (created by the legislation) that offers prescription drugs only
 - Unlike Parts A and B of Traditional Medicare, members enroll in Part D directly with the an insurer, not CMS
 - Private insurers administer this benefit for the Federal Government.

Medicare Part D – Prescription Drugs, cont.

- Enrollment:
 - Periods when members are eligible for initial enrollment:
 - Age-in: When member turns 65 (7-month period)
 - Annual Election or Enrollment Period (AEP): Nov. 15 – Dec. 31
 - After losing employer group coverage (terminated active employment)
 - Late Enrollment Penalty (LEP):
 - Like Part B, beneficiaries must obtain Part D as soon as they are eligible or they will be charged a penalty
 - LEP is 1% penalty (based on Part D national average cost)
 - Members who continue to work past age 65 and have employer sponsored coverage with “creditable coverage” will not be assessed a penalty, but must enroll in Part D if they lose employer coverage to avoid penalty
 - Periods when members can change their enrollment:
 - **Annual Enrollment Period (AEP): November 15 – December 31**
 - **Special Enrollment Period (SEP): (e.g., termination of a group plan)**
 - Open Enrollment Period (OEP): January 1 – March 31

Medicare Enrollment Periods

- Initial Coverage Election Period (ICEP) - can happen anytime through out the year depending on when the individual becomes eligible for Medicare. This is the 7 month window (3 months before birth date, month of birth, 3 months after).
- **Annual Election Period (AEP)**
The annual election period for Part C and D occurs from November 15 through December 31. During this period, an individual may elect to join or drop Part D, may change from an MA plan to original Medicare, or to a different MA plan, or from original Medicare to an MA plan. Most election changes made during this time period will become effective the first of January.
- **Special Enrollment Periods (SEP)**
In certain situations, a person may be able to join, switch, or drop their Medicare Advantage plan — such as when they move out of a service area, have both Medicare and Medicaid, or are leaving their group insurance.

Medicare Enrollment Continued

- **Open Enrollment Period (OEP):** This is the time frame where a Medicare Advantage member may make one change to their plan. Members may not add or drop Part D during the OEP, therefore, members may not disenroll from a Part D Plan (MA-PD or PDP) during the OEP. Members may move between Part D Plans or between Original Medicare and non-Part D Plans (Jan 1-Mar 31).
- **Fee for Service, Medicare Open Enrollment Period (MOEP) –** This is the time period where individuals who were Medicare Eligible but did not pick up their Medicare Part B during their Initial Coverage Election Period (ICEP) can elect to purchase Part B. The time period to do this is January 1 through March 31st for coverage effective July 1 of the year they enroll. For all individuals who have to purchase Part B during Medicare's Open Enrollment Period (MOEP) they will be assessed a 10% Late Enrollment Penalty (LEP) for each year they did not pick up Part B. This penalty is based upon the current years Part B premium and will be assessed to the individual for their lifetime.

Medicare Disenrollment

- There are different allowances for the number of times a member can enroll / disenroll during different enrollment periods, so you need to clarify this.
 - AEP: Annual Election Period - Multiple elections OK
 - ICEP: Initial Coverage Election - One election only
 - OEP: Open Enrollment Period - One election only
 - SEP: Special Election Period - Depends on the terms of the SEP
- **Disenrollment from one plan with immediate enrollment in another is considered one election.**
- In most cases, Medicare recipients may make only one change during each enrollment period. This one choice will either be an enrollment or a disenrollment.

Medicare Disenrollment Cont.

- **Involuntary Disenrollments from Medicare Advantage**
 - Plan must disenroll the beneficiary if:
 - Member no longer resides in the plan's service area
 - Member loses eligibility for Part B of Medicare
 - Death of member
 - Insurer's contract with CMS is terminated
 - Other reasons (non-payment of premium, member acts in disruptive manner, fraud)
- **Voluntary Disenrollments from Medicare Advantage**
 - A member may disenroll from a plan with Part D *only* during one of the election periods.
 - The member may disenroll by: Enrolling in another plan (during a valid enrollment period); Giving or faxing a signed written notice to the organization where they are currently covered, or through his/her employer or union, where applicable; or Calling 1-800-MEDICARE.

Medicare Disenrollment Cont.

- Members may travel outside of the service area for up to 90 days without being disenrolled.
 - If a member permanently moves out of the service area they will be disenrolled on 1st of the month from point of discovery.

Visiting Member Benefit

- Check the provisions for the Plan you are considering and how it manages out of area claims.

Medicare Part C

- How does it work financially?
- You must continue to pay Part B premium through Social Security Deductions.
- The Insurer will get paid by CMS a monthly capitated amount for each person selecting their Medicare Advantage Product. In addition, the insurer gets paid by CMS for providing Part B services. Plus, you will pay premium to the insurer based on the level of benefits selected.

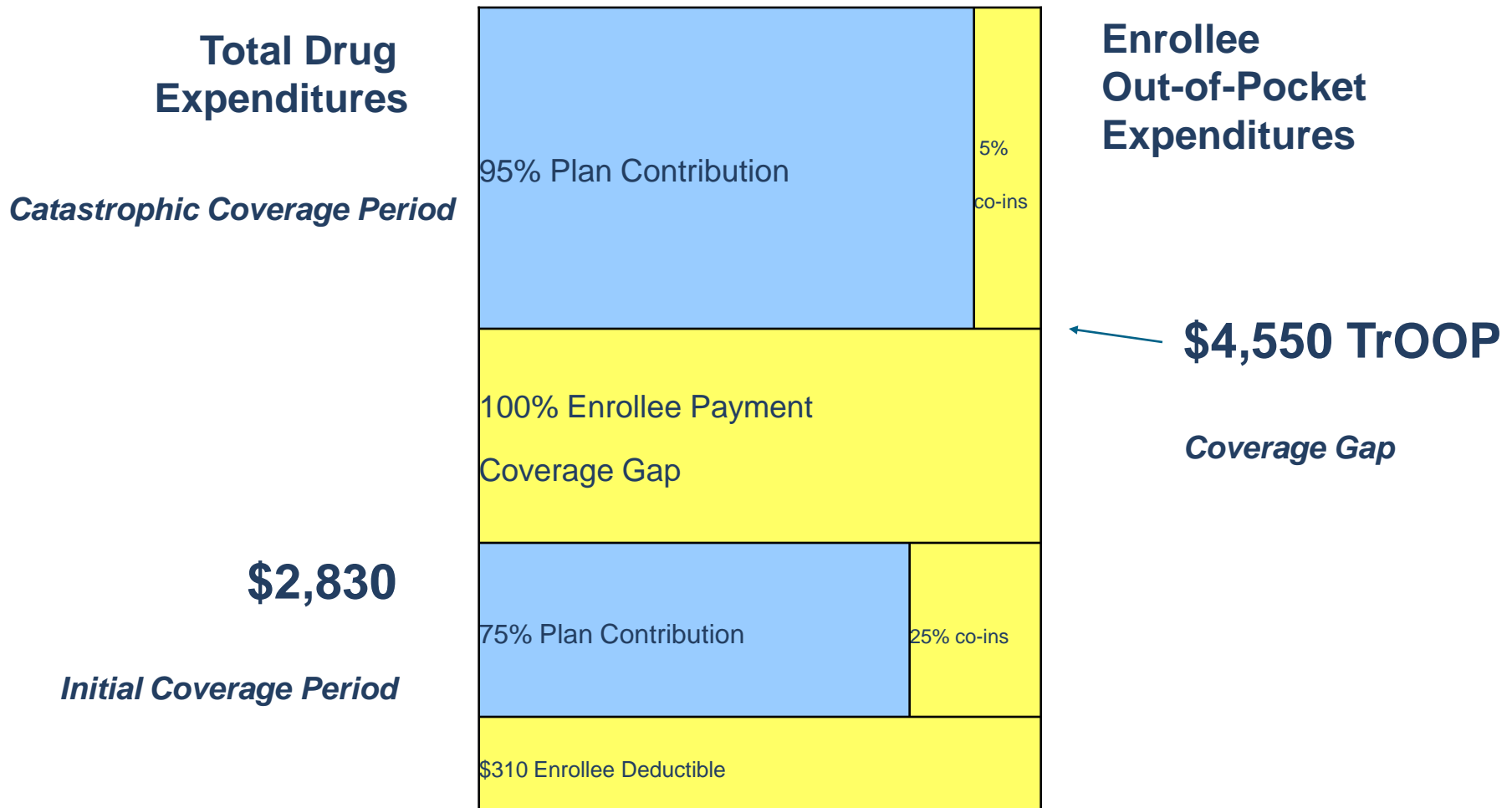
Medicare Part D – Prescription Drug Coverage

- **Most Individual Plans have a three-tier Part D drug benefit:**
 - Tier 1 = Generic drugs
 - Tier 2 = Brand-name drugs
 - Tier 3 = Specialty drugs
- Specialty drugs are defined as high-cost medications (\$600 or more for up to a 30-day supply) that generally come from biotechnology to treat many conditions.
- Medicare drug plans cover generic and brand-name drugs. All plans must cover the same categories of drugs, but plans can choose what specific drugs are covered in each drug category. If you are taking specific medications, you may want to review the drug list from a Drug Plan you are considering.

Medicare Part D

- Standard Part D Plan for 2010
 - Individual deductible - \$310 paid by you
 - Plan pay 75%, you pay 25% until total paid by both is \$2830 ($\$2830 - \$310 = \$2520 * 75\% =$ Plan pay \$1890.00 you pay 25% or \$630.00)
 - Then there is a coverage gap where you pay the next \$3610.00 out of pocket. ($\$3610 + \$630 + \$310 = \4550)
 - Plan pays 95% you pay 5% of all additional costs.

2010 Part D Prescription Plan



TrOOP: True Out of Pocket

About AEP and Other Medicare Enrollment Periods

The Centers for Medicare & Medicaid Services (CMS) allows Medicare-eligible people to enroll in a Medicare Advantage/Cost plan, depending on their age and circumstances, during specific times of the year, as follows:

- **Annual Election Period (AEP): November 15 to December 31**

The Medicare Annual Election Period (AEP) is the time of year when most beneficiaries can switch plans. Enrollment changes take effect on January 1. (Note: According to CMS rules, health plans may begin to market and sell Medicare plans to beneficiaries beginning October 1 of any plan year.)

- **Special Enrollment Periods (SEP)**

In certain situations, a person may be able to join, switch, or drop their Medicare Advantage plan — such as when they move out of a service area, have both Medicare and Medicaid, or are leaving their group insurance.

- **Open Enrollment Period (OEP): January 1 to March 31**

During the Open Enrollment Period, individuals enrolled in Medicare may choose to switch from their current plan to a different plan. They may switch one time during this period. However, they cannot add or drop prescription drug coverage during this time.

- **Lock-in: April 1 to November 14**

People with Medicare Advantage/Cost and prescription drug plans are “locked-in,” meaning they can only switch Medicare plans during certain times of the year unless they qualify for special circumstances or are newly eligible for Medicare.

Contact Information

- Medicare – www.medicare.gov 1-800-medicare
 - Part A (Hospitalization) and Part B (Outpatient services)
 - Part D - Prescription Drug Coverage (watch out for the doughnut hole)
- Teamstar – www.teamstar.com 1-800-808-3239
 - Early Retiree Coverage (age 0 – 64)
 - Medicare Supplement (United American)
 - Part D – Prescription Drug Options
- Aetna – www.aetna.com 1-800-MY-Health
 - Under 65 coverage
 - Medicare Coverage

Contact Information

- Kaiser – www.kp.org – 1-800-368-5784 x 5690
- CareFirst – www.carefirst.com – 1-800-619-1419
- Bravo Health, Inc. www.mybravohealth.com 1-800-821-7513

Medicare only - since 1996 offering Medicare HMO and PPO options.

Brokers offering assistance

- Senior Benefit Services – Karen Simundson

www.srbenefit.com 1-800-924-4727

Items to make sure you understand

- 1st decision
 - Traditional Medicare with a wrap plan (to cover medicare deductibles and out of pockets) and a separate Prescription Drug Plan.
 - OR Medicare Advantage Plan where you are “opting” for all coverage to be coordinated through an insurer, and you will still need to make a decision on a Prescription Drug Plan (usually integrated by insurer).

Medicare Advantage

- Is the Plan a HMO or PPO? Does it have a network of physicians, pharmacies and hospitals that you MUST use OR do you have the option to go out of network?
- If an HMO – are your current doctors in the Plan – look them up on-line or in a directory and call them and ask the physician's office.
- If you can go out of network, what is the difference in out of pocket costs to you.

Drug Plan Selection

- Ask for the participating pharmacy listing
- Ask for the covered drug list (see if your medications are covered – possibly discuss with your physician).
- Determine from the available options, what level of coverage works for you based on costs (both out of pocket and premium).

Questions???

Thank you for your attention