

# BROOKS INSURANCE SERVICES - HEALTH, LIFE, LONG-TERM CARE

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**SPECIAL  
POINTS OF  
INTEREST :**

- > Medicare Drug Plans
- > The Medicare Drug Plan Donut Hole
- > Family Health Plan Coverage
- > Update on agency offerings
- > Standardized benefit summary

## MEDICARE PRESCRIPTION DRUG PLANS

Medicare adjusts the basic criteria for the “standard” plan each year. Almost none of the carriers offer the standard plan, most offer plans that end up better for certain clients than the standard plan.

The standard plan design includes a deductible of \$325, 25% cost sharing thru \$2970 total drug costs, a coverage gap in which members are responsible for most costs, and then the catastrophic coverage. The plans, drug manufacture’s, and the beneficiary share some of the coverage gap costs, depending on if the medicine is a brand name or

generic. For generics the plan pays 21% and the member 79%. For the brand name drugs the insured pays 50% with the rest shared by the plan and manufacture.

The plans all employ various methods of pharmacy management. These can include step therapy, quantity limits, prior authorization, and different tiers of cost sharing. These tools are intended to control costs while still providing appropriate drugs as needed by the insured.

Pharmacy networks and more recently preferred pharmacies are a popular way to help control costs. The network pharmacies agree to specific

rates for the services and products provided. Preferred network providers provide even better rates to the insurer and members in exchange for the natural steering of members to their pharmacies. Additionally the networks typically include mail-order pharmacies.

Use of mail order pharmacies is useful for ongoing prescriptions, since many will allow automatic filling and mailing of the medicine every quarter. The mail order pharmacies also typically cost the insured less for each refill.

## THE DONUT HOLE IN MEDICARE DRUG PLANS

This concept confuses nearly everyone looking at Medicare Drug Plans. It’s one aspect of the plans changing year by year thru its elimination in 2020.

Each year beginning in 2012 the amount paid by the member in the donut hole decreases. The member’s savings is a cost split between the carrier and drug manufacture’s (as a discount). In 2012 the discounts were 14% on generic medicine and 50% on many brand name drugs.

For 2013 the discounts increase to 21% for generics and 52.5% for many brand name drugs. Some

plans however offer enhanced donut hole coverage.

Plan members who know they will end up in the donut hole and use many generic prescriptions will find several plans that do offer some generic coverage in the donut hole. Although most plans have no coverage in the donut hole the few that do offer the generics and even in some cases brand coverage in the donut hole may be worth considering. Pricing prescription drugs used on a regular basis, is the best way to evaluate if economically these plans are better than facing the standard donut hole costs.

If the donut hole is going to

affect one’s drug expenses consider consulting state pharmacy assistance programs, manufacture drug assistance programs, and even using alternate medicines. Alternate prescription drugs are often beneficial when costs are driven by brand name drugs where generic replacements are available.

Closing the donut hole by 2020 is part of the affordable care act. It’s possible further modifications may occur. As it stands now each year the donut hole costs will shrink for plan members until gone in 2020.

## DOES MY FAMILY GET COVERAGE WHEN I GO ON MEDICARE

Medicare is an individual insurance policy. There are specific requirements that must be met before the policy becomes active, and when they are and Medicare is active, other family members are not included.

Many families come into situations where one adult ages into Medicare ahead of the other adult, and may still even have children on the family health plan. Part of what dictates how ongoing coverage plays out is what kind of family coverage is in place at the time of age-in.

When someone ages into Medicare, and they are on group coverage thru work, the person aging-in, may or may not need to stay on group coverage for the benefit of the family. Employers cannot force someone to take Medicare and drop their group coverage.

Employer group plans have the option in some cases to allow the employee to take Medicare and keep the family on group coverage. This is not typical, but some large companies do offer the option.

Of course in some cases the benefits offered by the employer, especially when calculating the cost of the employer coverage versus cost of Medicare, supplement plan, and drug plan, may work out better to stay on group coverage. This is a calculation best taken ahead of making the choice to stay or leave group coverage.

Medicare with a supplement and drug plan can provide better benefits than just about any group plan. That is a big consideration if someone is receiving lots of care every year. Again doing the math is useful.

When the adult aging onto Medicare is a spouse on a group plan it is easy enough to drop them when their Medicare goes live. Of course they can stay on the group coverage and take Medicare when the employee retires.

If the family is on a family plan not part of a group benefit plan, dropping one person off the plan is not a big deal. When setting the plan up originally it often is useful for the youngest of the two adults to take the policy in their

name and adding the one nearer to Medicare as the spouse. This is administratively easier when Medicare does kick in.

Another alternative, and depending on employer contribution, possibly less expensive for a family as well, is dropping group coverage and taking coverage for the rest of the family on the individual market and Medicare for the person aging-in. This works well now when the family is in good health. In 2014, health status will no longer matter though, but that is still thirteen months away. When the employer does not pay any towards family coverage this is often a less expensive option for the family.

The overriding theme to remember is that Medicare is for the named individual only. Thus regardless of taking Medicare or not, the family needs to ensure they have other coverage. For families with no coverage Medicare at least gives some protection to the person aging-in.

## ANNUAL UPDATE ON OUR AGENCY

2013 is a year of continued growth for the agency. We continue to serve insurance needs of both group and individual clients. We help clients with health, life, long term care, disability, and Medicare related insurance products. We even assist with travel insurance since protecting the money invested in vacation is important to many families. The added medical evacuation and international health coverage is something most travelers want.

We expanded our travel insurance carriers to meet more travel needs. In addition we now work with a vendor providing medical evacuations. Anytime a client is more than 150 miles from home and need medical care requiring medical evacuation the company will fly them to the hospital of their choice at no cost. They even have a plan that will medically evacuate from your hometown to centers of excellence when special medical care is required.

This year we have expanded our reach for the life insurance market helping more people solve their various life insurance needs. Many clients have undertaken reviews of their current coverage to ensure survivors are provided adequate protection and estate tax needs are met. Some clients are even using life insurance to fund executive deferred compensation plans.

Long term care boomers see a high costs of care. As carriers are rushing to get cannot be carried even when carri-



insurance is a hotbed as baby need to protect assets against nursing home or in-home leave the market many people coverage since the policies celled and claims are paid ers stop selling new policies.

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### **Health, Life, Disability, and Long Term Care Experts**

Health Insurance in its various forms continues to change and that change is rapid. Thus it's good to have a knowledgeable broker on your side help you pick the plan best suited to your specific needs.

Although the need for Long Term Care is not necessarily something you want to think about, it's important to understand the need and plan accordingly. Life changing accidents and organic brain disease are two leading causes leading to long term care use. Preparing for this need with insurance is part of the overall plan to protect your family and assets.

Annual review of your life insurance plans vs. needs is another key to protecting your family and assets.

Brooks Insurance Services, can help you address all of the above needs, personally or for your company.

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## **STANDARDIZED SUMMARY OF BENEFIT DOCUMENTS**

One current benefit of healthcare reform is a new standardized summary of benefits document. The requirements are pretty specific about what must be displayed and how it's displayed. Further there are two required scenarios described to explain the sharing of costs between insurer and insured.

Beginning September 23, 2012 the requirement to use the standardized form went into effect. This date ensured annual renewals during the major renewal season around the end of the year will all use the new format.

The benefits summaries must be provided to all new enrollees as they enroll in the plan. Both fully insured and self insured plans must provide the summaries. All groups are being provided with the documents by the carriers so they can provide them to the enrollees.

The following elements must be included in each summary: glossary of terms; description of coverage, exceptions, cost sharing information to include all co-payments, co-insurance, and deductibles; information

about how the plan will renew or individuals can retain continuation coverage if needed; and any limitations or reductions in coverage. This will give everyone a pretty reasonable idea of what the plan covers. Of course for all the details the certificate of coverage should still be reviewed.

The two scenarios each carrier must use are treatment of a chronic disease, diabetes, and a normal birth. These two scenarios are used to represent how cost sharing are determined within each benefits plan. This allows the insured to better understand how much it will cost when they go to the doctor for care or into the hospital for care.

In areas where 10% or more of the households speak a foreign language the summary of benefits must be available in additional languages to meet the needs of these foreign speaking populations. Spanish and Mandarin are two we will see in the Houston area.

This is one provision in the healthcare reform act which carriers have indicated they will retain even if the law were repealed. Simplifying the explanation of how benefits work for the insured is useful. With all carriers using a single format to communicate the benefits it will be easier for everyone to better understand how the benefits work.

Individuals and groups will be able to better compare one plan with another since the format for these documents is required to be the same. It is eight double sided pages, and yes double sided is a requirement set forth in the affordable care act. The plans can be laid side by side and specifics can be reviewed for one and then the other based on common language use.

Previously different carriers used different view points for describing the same information making it difficult for some to understand. Also, they did not have to all provide in their summary the same information making comparison among various plans more difficult.