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Page 1 of 2
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A Communication from the National Association of State Farm Agents, Inc.

Follow-Up #2 on the State Farm Group Health Plan "Roll Out"

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While awaiting the contact by Aon Hewitt's licensed insurance salespersons with their recommendations for the replacement of our State Farm Group Health Plan with an **individually-issued and age-rated** Medicare Supplement Policy and a Prescription Drug Plan, I thought it best to bring you up to date with what I have learned since the announcement of our upcoming expulsion from the State Farm Group Health Plan.

Perhaps the most important thing I learned is the condition that applies to Medicare eligible persons, who are being denied continued coverage from a current policy in force, be it a group or individual policy. And, generally speaking, it is that **your acceptance and eligibility for a Medicare Supplement policy is guaranteed** so long as you make application within the prescribed enrollment period and before your present coverage expires. There will be no individual health condition ratings and there will be no pre-existing condition exclusions. I say "generally speaking" because the literature you get from the various sources uses the word "may" as opposed to "will" or "shall," but nonetheless, it appears to be pretty certain.

For those of you who might be considering a Medicare Advantage Plan, consider these five conditions that may affect your thinking. When purchasing a Medicare Advantage Plan, you are taken out of original Medicare and are provided the Medicare Part A & Part B coverage in an individual policy by a Medicare-approved private insurance company. They may require you to use network doctors and hospitals. They may restrict specialist visits to network only providers and require a referral. Only certain types of care will be covered while traveling in the U.S. and out of network. And there are specific enrollment periods during the year when you may change to another Medicare advantage plan. Apparently, none of these restrictions will apply to the purchase of a Medicare Supplement Plan.

Because it was not completely vetted in the materials provided to us by State Farm, I called Human Resources to get clarification on the subject of eligibility for reimbursement from the Health Reimbursement Account being set up for us by State Farm. Of course, as indicated in the brochures, if you buy your policy through one of the Aon Hewitt recommended companies, and you pay your premium first out of pocket to Aon Hewitt, the process for your reimbursement will be automatically handled by Aon Hewitt. And, as indicated in one of the brochures, you would also be eligible for reimbursement if you purchased your policy through your State Farm agent, but you and your agent would have to apply for the reimbursement. What was not clear was if you chose to make your purchase elsewhere, from say someone like AARP's health carrier, would you be eligible for reimbursement from your Health Reimbursement Account. The answer was YES, but again you would have to provide proof that your premium was paid by you, when you apply yourself for reimbursement from your HRA account.

And, because I assumed that most of us are probably members of AARP as well, that brings me to my inquiries to AARP. AARP uses an outside carrier, the United Healthcare Insurance Company. Any AARP member can call them and ask for the package of information on the Medicare Supplement Plans and the Prescription Drug Plans they offer. In my telephone inquiries to AARP I was advised that Medicare eligible applicants would be getting coverage through a bona fide "community rated group" with an age rated policy. If you are losing coverage from a currently in force policy (which all State Farm Retirees are), there will be no health questions to answer, no question of acceptance or eligibility, and no pre-existing condition exclusions. They will send you materials which include your actual costs for

your age on the plan of your choice. In the application included in the package you would skip from question Section 3, question 3D, to Section 7 (which eliminates providing ANY medical information due to the guaranteed acceptance condition).

To give you an idea of comparative costs, here is my present situation. My monthly costs, as an individual, with no spouse and no dependents, and with Medicare being my primary coverage, with Blue Cross/Blue Shield of Illinois as my secondary group carrier, and State Farm's monthly contributions (the latter taxed to me as income on my 1099 each year) over the last seven years were as follows:

Year	State Farm's Contribution	My Cost	Total Monthly Cost*
2005	$225.23	$56.31	$281.54
2006	$211.56	$58.28	$269.84
2007	$214.44	$58.28	$272.72
2008	$240.98	$64.10	$305.08
2009	$198.30	$70.52	$268.82
2010	$199.72	$81.10	$280.82
2011	$168.48	$93.26	$261.74

***These total monthly costs include the Prescription Drug Plan costs.**

You will note that these monthly costs for the past seven years have exceeded the $200 per month contribution to the Health Reimbursement Account that State Farm has indicated it will be making for the 2012 policy year, and which they indicate may be reduced in the future.

In the two Medicare Supplement Plans that AARP seems to be touting (Plan C and Plan F), which are community group rated and age rated plans, the Medicare Supplement monthly premiums for me, at my current age 74, are $235.67 and $236.77 respectively. That is their Level 1 rates. It is not clear when and if their Level 2 rates would apply but it looks like that would be a different situation for an applicant NOT coming out of a current in force plan, but I am not sure of that. So for $1.10 more difference per month Plan F includes payment of any Part B Excess Charges above Medicare-approved Charges, so Plan F looks like the better deal than Plan C. I don't know what the AARP Prescription Drug Plans monthly premiums are yet as I am still awaiting those materials.

To further my cost comparisons, I also checked with Blue Cross/Blue Shield of New Jersey, and found that they appear to be touting Plans F & G. (These letter identified plans may differ from state to state.) The difference in New Jersey between Plan F and Plan G appears to be that Plan F pays the $162 Medicare Part B deductible, where Plan G does not. However, the additional annual premium difference between Plan F and Plan G at my age rate is $298.32. So if you chose Plan F you would pay $298.32 more per year to eliminate a $162 deductible. Not such a good deal, so Plan G would look like the best choice in New Jersey for me. Blue Cross and Blue Shield of New Jersey offers two Prescription Drug Plans, a Standard and an Enhanced. The Standard costs $45 per month and the Enhanced costs $82.10 per month. The only differences that are clear in the literature is that the Standard has a $310 yearly deductible, and a $9 co-pay for a monthly supply of a drug, and a $27 co-pay on a 90-day supply of a drug, while the Enhanced had NO deductible and an $8 and $24 co-pay respectively. Depending on your drug needs you would have to make the determination if the additional $445.20 in premiums per year between the Standard and the Enhanced plans are worth the additional costs to you up front. So, in my case, if I chose their Medicare Supplement Plan G to avoid the extra $298.32 more in annual premiums for Plan F, and I chose the Standard Prescription Drug Plan to avoid the $445.20 of additional annual premium for the Enhanced Prescription Drug Plan, my monthly costs for both the Medicare Supplement Plan and the Prescription Drug Plan would be **$224.95**.

Please understand that, as a retired layperson, I make no recommendations for anyone for any specific company or plan, I'm just sharing my own comparative shopper experiences with you, and I hope you find them of some value.

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