Medicare Primer: An Employer Guide

MY BENEFIT ADVISOR

PERSPECTIVE

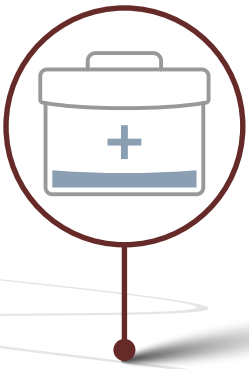
As the number of Americans working past the age of 65 continues to increase, business owners and their employees face the complexity of determining how medicare factors into their employer sponsored benefit programs.

With our aging population bringing greater numbers of people into Medicare eligibility status, there is a growing need for information regarding how employer-based coverage coordinates with Medicare.

At My Benefit Advisor, our specialists work with clients to help them make informed decisions and assist any Medicare beneficiaries with education and counseling.

1965

Medicare was created in 1965 as a federal health insurance program for people 65 years of age and older. It is intended to provide medical coverage for all eligible individuals, regardless of income, medical history or health status.

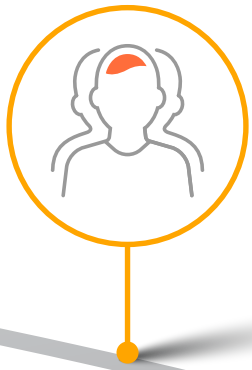


1972

In 1972 the program was expanded to provide benefits to people with long-term disabilities under age 65.

2019

In 2019, Medicare provides coverage to over 60 million people. With many of today's older Americans working well past normal retirement age, employers are increasingly likely to have Medicare-eligible employees on their payroll and participating in their benefit programs.



And with this swelling of over age 65 employees brings uncertainty regarding enrollment penalties, whether Medicare or the employer sponsored plan is the primary or secondary payor of claims and how Medicare eligibility impacts health savings accounts. As a result, it is important that employers and their human resource staff are knowledgeable in all matters regarding Medicare and have access to resources necessary for their employees to make sound, informed decisions.

A Brief Overview

When an individual turns 65, they become eligible for Medicare. From a practical perspective however, they need to apply for Medicare a few months prior to their 65th birthday. The program is financed by a portion of the payroll taxes paid by employees and their employers. Like the coverage provided by private insurance companies, Medicare pays part of the cost of medical care, subject to any applicable deductibles and co-insurance.

To be eligible for Medicare, a person must have:

- Entered the United States lawfully
- Lived in the U.S. for at least 5 years
- Attained the age of 65
- Certain disabilities or end-stage renal failure if they are younger than age 65

To understand how Medicare works, it is important to understand it's components:

PART A	PART B	PART D
Hospital Coverage	Physician Coverage	Prescription Coverage

The Part C that's missing from above is referred to as Medicare Advantage and provides all of the coverage under Medicare Part A, B and usually D as well as a few extra benefits. It is an option offered by private companies as an alternative to Parts A, B and D.

As a general rule of thumb, an individual can expect Medicare Parts A and B to cover roughly 50% of their medically necessary and preventative health care expenses. A Medicare Supplement policy (also known as a Medigap policy) is available for individuals to purchase to offset these out-of-pocket costs.

If an individual has Medicare and is actively at work with an employer who provides health insurance benefits, the employee has the right to remain on the company provided insurance and allow Medicare to coordinate with the employer sponsored program. The way Medicare coordinates with the employer coverage varies based on a few factors…their individual circumstance and the size of their employer.

Additionally, there are other complicating rules employers and their employees should be aware of and compliance failure with any of these could result in a fine or penalty being levied upon either the individual or the employer.

This paper, in addition to providing a general understanding of how Medicare works, will explain some of the rules regarding Medicare that directly affect an employer and their employees. The paper addresses issues facing both small and larger companies.

Medicare: Basic Composition

Medicare is composed of four basic parts, with each one covering different health care services. Each part also has certain costs that an individual may have to pay. The following represents a brief synopsis:

ORIGINAL MEDICARE

PART A

Part A is referred to as hospital insurance and covers inpatient care, including critical access and long-term care hospitals. There is no cost for this part for most people, as they have contributed to Medicare throughout their working years. If an individual isn't eligible to enroll in Part A premium-free, they may still be able to enroll and pay a premium.

PART B

Part B is referred to as medical coverage, covering services and supplies necessary to treat medical conditions as well as some preventative services. The individual must pay a premium for Part B, which is $135.50 per month in 2019, unless their modified adjusted gross income is greater than $85,000 for single filers or $170,000 for joint filers, which will require them to pay a higher amount.

PART C

Part C refers to Medicare Advantage Plans, which is private insurance that includes all of parts A and B in a single plan. It may also contain extra benefits as well, such as vision, dental and hearing services. The premiums for these plans vary.

PART D

Part D includes Prescription Drug coverage, available as a standalone plan to be added along with Parts A and B or as part of Medicare Advantage. There are several different options to choose from and as a standalone plan, there is a premium required. As part of Medicare Advantage, the premium may be included in the cost of the overall program.

Some Choices Available to a Medicare Eligible Individual

A Medicare eligible individual has a few choices to make. Although it is not the intent of this paper to explore them all in great detail, the following represents a basic rundown of the some of the options available to them.

Original Medicare

An individual can choose to just take the free Part A (assuming they qualify), but that would leave them with a large financial exposure due to unpaid medical service costs, deductibles, copays, coinsurance and prescription drug expenses that are left behind after Medicare Part A pays. A better option would be to pair Part A with Part B, together known as Original Medicare. This would cover a good deal of hospital and medical costs, but still leave deductibles, copays, coinsurance and prescription costs.

Original Medicare Can Be Paired With a Medigap Policy

Medigap refers to a type of health insurance policy that offers standardized benefits for individuals who are enrolled in Original Medicare, Parts A and B. Offered through private insurance carriers, these policies (which are not available to those enrolled in a Medicare Advantage Plan) are designed to “fill the gap”, or in other words, pay for part or all the costs after Original Medicare pays. The costs uncovered by Medicare might include deductibles, copayments, coinsurance and even other costs that Medicare does not cover, such as healthcare received when travelling abroad.

There are 10 standardized plans that exist in most states, labeled with letters from A through N, each of which cover a different range of Medicare cost sharing. Each policy that goes by the same letter must offer the same basic benefits. Plan F offers the most comprehensive coverage and the prices of these policies will vary based on the carrier and coverage level.

Part D Can Be Added

Part D provides outpatient prescription drug benefits to Medicare recipients, supplementing their coverage in Medicare Parts A and B. Part D is provided through private insurance companies that have contracts with the federal government. Enrollment is only allowed during approved enrollment periods. Although the program is optional, enrollment is highly recommended since failure to sign up when an individual is first eligible for Medicare could result in a future enrollment penalty.

By combining Parts A, B, D and a Medigap Policy, the Medicare beneficiary has a comprehensive package of benefits that can be designed to fit their needs and budget.

The Individual Could Enroll in A Medicare Advantage Plan

Medicare Advantage Plans are offered through private insurance companies that contract with the federal government to provide Medicare Benefits. These plans must provide the same benefits offered by Original Medicare but may apply different rules, costs and restrictions. They may also cover certain benefits that Medicare doesn't cover. Typically, these plans are in the design of a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or a Private Fee-For-Service (PFFS) plan. If someone signs up for this type of plan and later wants to switch to Original Medicare, or vice versa, it must be done only during certain designated enrollment periods.

If the Medicare Eligible Person is Employed

Individuals over the age of 65 who are actively employed at a company with 20 or more employees where health benefits are offered can delay enrolling in Medicare and enroll in the company's health plan instead. When employment ends or the coverage stops, the individual is entitled to a special enrollment period of up to eight months to sign up for Medicare (but only 63 days to add a drug plan) without incurring any late penalties. The law requires such a large employer to offer someone over 65 the same benefits that it offers to those under age 65.

So, in this situation, the employee can:

- Accept the employer health plan and delay Medicare, or
- Decline the employer program and enroll only in Medicare (and optional Supplemental Insurance or Medicare Advantage), or
- Enroll in both the employer program and Medicare at the same time with the employer plan as primary (although it is not cost effective for the employee to pay for Part B and use it as secondary coverage).

If the individual's employer has less than 20 employees, unlike for larger groups, Medicare is primary and the employer plan pays second. As a result, the individual generally must sign up for Medicare Parts A and B. If the employer negotiates with their insurer that its plan will pay first, it is important to get that in writing.

There is a tremendous complexity inherent in the options available to the typical Medicare enrollee and as a result, it is important that they seek professional, sound guidance prior to making a decision!

Medicare as Primary vs. Secondary Payor

Employers that offer group health insurance to their employees should understand how their employee's eligibility for Medicare coverage coordinates with the company plan. Coordination of Medicare with employer sponsored health plans is governed by rules that apply based on a variety of factors and the size of the company providing benefits.

Generally speaking, for employers with 20 or more employees, the group health plan is primary for Medicare eligible employees and Medicare is the secondary payor. In situations where Medicare is the secondary payor, the individual has a choice whether to enroll in Medicare or not. If they do enroll in Medicare, then any benefits that are not reimbursable under the company plan can be submitted to Medicare.

Deferring Medicare Coverage

Should an actively employed individual decide to defer enrollment in Medicare in its entirety, the person must:

- Have health insurance from their employer or their spouse's employer of 20 or more employees, and
- Have creditable prescription drug coverage with their employer plan

When is Medicare the Primary Payor?

In the following situations, Medicare is the Primary Payor:

For Individuals Over Age 65 Working for a Small Company

For an individual 65 and over who works at a small company with less than 20 employees, Medicare is the primary payor. This means that Medicare would pay benefits for any claims before the company plan could pay. It is important that these individuals are enrolled in both Medicare parts A and B. (Enrollment in Medicare Part D is optional for these individuals if the company medical plan has prescription drug coverage. In this situation, it would be best for the employee to compare costs to determine the best approach). If they don't enroll in Medicare parts A and B, they will most likely have to pay for anything Medicare would have covered out of their own pockets. Once benefits are exhausted or any maximum coverage limits are reached with Medicare, the individual could submit a claim for any remaining costs to the secondary payor.

For Those on Medicare Under Age 65 Due to Disability at a Mid-Sized Company

For anyone who is under age 65 but qualifies for Medicare coverage due to a disability and works at a company with less than 100 employees, Medicare is primary.

For Those Who Have Retiree Coverage or are on COBRA

If a former employee receives retiree coverage through a company plan, Medicare will typically be the primary payor. However, if an employee's spouse receives coverage through the employee's plan as a dependent and the spouse retires but the employee remains actively at work, Medicare will be the secondary payor for the employee but will be the primary payor for the spouse.

For those individuals enrolled on coverage through COBRA, Medicare will also be primary. These individuals must enroll in Part B coverage within the first 8 months and prescription coverage within 63 days of COBRA or they will be subject to a late enrollment penalty.

For Someone with End-Stage Renal Disease

Anyone with End-Stage Renal Disease (ESRD) with employer based coverage will have the company plan as primary for the first 30 months, but then will automatically transition to Medicare as primary after the 30th month (subject to change if the employee goes on dialysis).

For Individuals with Medicaid

Anyone on Medicaid will never see Medicaid pay first. Medicaid will only pay after Medicare or employer sponsored health coverage pays first.

Medicare and HSA Plans

Health Savings Accounts (HSAs) are accounts used by enrollees in a high-deductible health plan (HDHP). The funds contributed to an HSA are used to pay for qualified medical expenses. These funds are given favorable tax treatment; the funds are contributed pre-tax and the withdrawals are not taxed, as long as they are used for qualified expenses.

However, if an individual is enrolled in Medicare Part A and/or B , they can no longer contribute pre-tax dollars to their HSA account. This is because Medicare is not considered an HDHP and the only permissible health insurance pairing for an HSA is a HDHP.

The employee should have their HSA contribution changed to zero dollars per month the month their Medicare coverage begins.

The employee may, however, continue to withdraw any funds accumulated in their HSA account for qualified expenses and the funds will continue to be tax-free.

If the individual decides to delay enrollment in Medicare, they can continue contributing money pre-tax into their HSA account. But the decision to delay enrollment should be carefully evaluated, as there are several factors that should be considered.

Employer Reporting and Medicare

Business owners who include prescription drug coverage in their health plans for active employees or retirees who are Medicare eligible must notify those individuals no later than October 15 of each year whether the prescription drug benefit is “creditable coverage.” For the coverage to be creditable, it must cover, on average, as much as the standard Medicare Part D prescription drug plan.

Employers also must report whether their prescription drug program is creditable to the Federal Centers For Medicare and Medicaid Services (CMS) within 60 days after the beginning of each plan year, i.e., by March 1 for calendar-year plans. The submission must be done electronically on an annual basis and the form, called the Creditable Coverage Disclosure Form, can be found on the CMS Creditable Coverage website.

Case Study: A Better Solution For Medicare Eligible Employees

The Issue

A mid-sized client with 125 employees located in the suburbs of Philadelphia, PA. came to us recently with a dilemma. Several Medicare eligible employees had come to the HR department complaining of the high cost of their medical coverage through the group health plan. The corporate plan was a high deductible health plan (HDHP) with a $2500 deductible and single employee monthly contribution rate of $ 340.00

Our Solution

Our Medicare Solution Team performed an analysis and suggested that each Medicare eligible enrollee enroll in Medicare Part A (free) and Part B ($135/mo.), along with a Medigap plan ($160/mo) and Part D ($35/mo). This would provide comparable coverage to the group program at a more affordable premium of $330 per month.

Impact/Result

Fourteen employees decided to heed our advice and enroll in the package we recommended. Instead of paying $340 per month for the employer sponsored health program, they took the Medicare package and paid just $330/month each for comparable coverage to the group health plan but reduced their medical deductible to just $185. The total savings for each employee came in at an average of just over $2400 annually, assuming each met their deductible.

MY BENEFIT ADVISOR

About My Benefit Advisor

My Benefit Advisor (MBA) is an employee benefits platform designed to guide employers through the complexity of planning, communicating and managing a successful employee benefits program.

To learn more about My Benefit Advisor, visit us online at

www.mybenefitadvisor.com