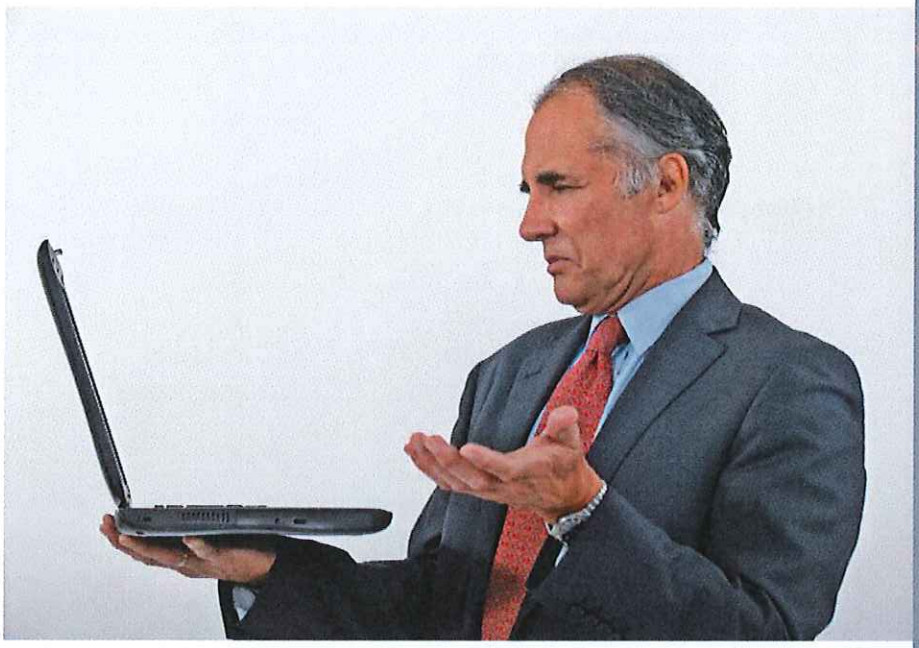
MEDICARE VERSUS PPACA VERSUS OTHER INSURANCE... KNOW THE OPTIONS!



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A recent news article ("Don't Confuse Medicare with Obamacare" in the September 7 *Wall Street Journal*) cautioned readers not to confuse the annual Medicare open-enrollment period (aka, "open season") with the PPACA marketplace enrollment period. Since the two programs will have overlapping enrollment periods during the last quarter of the year, there is bound to be confusion, if not opportunistic hustlers looking to exploit unsuspecting enrollees.

CMS spokesman Richard Olague indicated in the article, "We want to reassure Medicare beneficiaries that they are already covered, that their benefits aren't changing and that the Marketplace doesn't require them to do anything different. Specifically, they do not have to change their Medicare coverage or enroll in any Marketplace plan." Just what Medicare beneficiaries didn't need—more confusion!

This got me thinking about other aspects of Medicare that confuse, confound and challenge program beneficiaries and employers/HR managers alike. As an employee benefits broker/consultant, I answer a lot of questions relating to Medicare and its impact on employer-sponsored health insurance. So this is dedicated to clarifying some key aspects of the transecting of Medicare (and its various parts) and employer-sponsored health insurance.

POINT 1: MEDICARE ELIGIBLE EMPLOYEES HAVE A CHOICE FOR COVERAGE. WHICH IS BETTER?

I always remind and encourage benefits eligible employees to evaluate ALL of their health insurance coverage options (e.g., employer coverage, spouse's employer coverage, individual major medical, Medicare, Tri-Care, VA, etc.), and compare coverage AND out-of-pocket costs. This can be a daunting task, and may be an opportunity for employers to conduct thorough "employee-engagement" sessions to better acquaint employees with their coverage options. In some cases, the coverage available from an employee's employer is NOT the best option.

For many Medicare beneficiaries, the four-part Medicare coverage package (i.e., Parts A, B, D and a Medigap policy) is a far superior alternative to the employer offering. Regrettably, many Medicare-eligible employees feel a sense of entitlement to their employer's benefit offering, even if it's not their best option. In many cases, the four-Part Medicare coverage package provides vastly superior coverage relative to the available employer offering. In fact, this package can provide a nearly 100% coverage benefit design (with the exception of the copays associated with prescription drugs on Part D), compared with the ever growing high-deductible, high out-of-pocket plan that the employer may be offering/funding. In some cases, the cost of coverage may be less for the Medicare package versus the available employer plan offering.

POINT 2: HOW DOES THE MEDICARE ENROLLMENT WINDOW OF ELIGIBILITY WORK?

Medicare beneficiaries actually have a variety of enrollment periods within

which they can enroll in Medicare (e.g., initial, open and special). Unless otherwise requested, an eligible individual is automatically enrolled in Medicare Part A (hospital/facility-only coverage), effective the first day of the month he turns 65. During the three-month period prior to the birth month, the birth month and the three-month period following the birth month, beneficiaries can evaluate/enroll in the other three parts, without providing any evidence of insurability.

If a Medicare beneficiary is working and has employer-sponsored health coverage as of the time of initial Medicare eligibility, his "eligibility window" is preserved until such time as he stops working and/or otherwise loses his employer coverage.

POINT 3: WHAT ARE THE OTHER THREE PARTS OF THE FOUR-PART MEDICARE PACKAGE?

Part B: coverage for physician-provided care, ambulance, mental health, durable medical equipment; income means tested, but generally costing around $105 per month

Part D: prescription drug coverage, generally requiring copays associated with various tiers of drugs – preferred generic, non-preferred generic, preferred brand, non-preferred brand, specialty (and sometimes an up front deductible); costing in the range of $35 - $50 per month, and income means affected

Medigap/Medicare Supplement coverage: provides coverage for the various "gaps" or out-of-pocket requirements associated with Parts A and B. These policies are strictly regulated by the federal government, and provide a range of coverage options at various premium levels. Some plans can be purchased for as little as $50 per month.

Since Part A is funded through a payroll-related tax that is collected during the beneficiary's working life, the approximate sum total cost for the four-part Medicare package can be around $200 per month. Again, in many cases, such coverage provides far superior benefits than an alternative employer offering.

POINT 4: DOES A MEDICARE-ELIGIBLE EMPLOYEE HAVE TO MAKE A DECISION WITHIN THE INITIAL SEVEN-MONTH ENROLLMENT PERIOD?

If a Medicare-eligible employee ops to remain on his employer's group health plan, his guaranteed-issue enrollment window moves with him in time. In effect, as long as the Medicare beneficiary remains enrolled in the employer's plan, he does NOT forfeit his eligibility to enroll in Parts B and D. More important, he retains the right to purchase a Medigap policy on a guaranteed-issue basis, without having to provide evidence of insurability, provided he elects Part B within eight months of the loss/termination of employer coverage, and enrolls in a Medigap policy within 63 days of the loss of employer coverage.

POINT 5: IS THERE ANY DOWN SIDE TO REMAINING ON EMPLOYER COVERAGE VERSUS ELECTING THE MEDICARE PACKAGE AT INITIAL ELIGIBILITY?

Aside from comparing both the cost and coverage, and making the best decision, there are a couple of very important considerations facing employees that have consumer-driven health plan coverage. In particular, CDH plans that are coupled with Health Savings Accounts pose unique considerations for Medicare beneficiaries. And those are:

- If your employer-based plan is considered "non-creditable" for Medicare Part D purposes, you may incur a premium penalty associated with future Medicare Part D coverage. Some, but not necessarily all, of the higher-deductible plans coupled with HSAs are considered non-creditable. In short, if your employer plan is considered non-creditable, and you elect to remain enrolled in it instead of enrolling in Part D, you may incur a premium penalty of one percent of the cost of Medicare Part D premium times the number of months you had non-creditable drug coverage. Each October, employers are required to provide eligible plan participants who are Medicare-eligible with a notice that indicates whether the offered plan is "creditable" or "non-creditable." This is a very important indication to Medicare-eligible employees, and should be given careful and thorough consideration at enrollment time.
- Once an employee is enrolled in Medicare Part A (as previously mentioned, this generally happens in conjunction with turning 65, with Part A coverage taking effect the first day of the month this occurs), he can no longer contribute to his HSA. In addition, the employer can no longer contribute tax-preferred funds to the employee's HSA. Without the ability to contribute to their HSA, the resultant employer-based CDH plan is essentially a high-deductible plan with no funding offset. It is possible (although not easy) to dis-enroll in Medicare Part A by contacting the Social Security Administration and making the request.

An important clarification that is often miscommunicated: Turning age 65 does not, in and of itself, disqualify an individual from making and accepting HSA contributions. Rather, it is enrollment in Medicare Part A that creates the disqualification.

Each of these considerations is of particular importance to Medicare-eligible employees who have CDH coverage through their employer.

Hopefully, this helps to clarify some of the many confusing issues facing Medicare beneficiaries (including a brand-new one associated with the PPACA marketplaces). To summarize, beneficiaries are advised to understand all their coverage options, including cost, coverage, penalties and timing. HIU