Medicare Basics for Human Resources

Provided By Haylor Freyer & Coon Medicare Advisors

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This contents of this booklet are intended to provide a basic overview of Medicare for Human Resources Personnel, Administrators, and/or Staff. This document was created as an educational resource and is not intended as a legal document. Please refer all questions to your company’s benefits advisor or a Haylor, Freyer & Coon Benefits specialist.
The Human Resource Department is the root of internal support in an organization or company. They are expected to be responsible for many tasks and hold expertise in a multitude of topics, including health benefits such as Medicare. This is a growing challenge as there are many complexities and exceptions in the Medicare world. There are the different parts - and each having varying coverage, and employers are also required to give notice of coverage options and deadlines. This booklet is a quick overview of what employers and their Human Resource personnel need to know about Medicare and their Medicare-aged employees.
What is Medicare?

Medicare is a federal program that provides health coverage to individuals:

- who are over the age of 65

  OR

- who are disabled and receiving Social Security Disability Insurance

  OR

- who have End-Stage Renal Disease

The program is funded by beneficiary premiums, taxpayers through Social Security and Medicare taxes, and the federal budget.

Medicare is considered an entitlement program, meaning that most citizens earn the right to enroll after working and paying taxes for a minimum period. There are many parts and coverage options, and not everyone will receive the same type of benefits. Out-of-pocket costs can vary, including deductibles and copays. Medicare is not to be confused with Medicaid, which is based on income-based federal program.
# The Parts of Medicare

## Quick Overview

<table>
<thead>
<tr>
<th></th>
<th>Part A</th>
<th>Part B</th>
<th>Part C</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>You are eligible when you turn 65 if you/your spouse has paid into Social Security for a minimum of 10 years</td>
<td>You are eligible when you turn 65 and are enrolling/enrolled in Part A</td>
<td>You must be eligible for Part A and enrolled in Part B</td>
<td>You are eligible if you are entitled to Medicare Part A or enrolled in Part B</td>
</tr>
<tr>
<td><strong>Premium</strong></td>
<td>Most people receiving Social Security benefits will not pay a premium</td>
<td>Monthly premium set by Medicare each year</td>
<td>There may or may not be a premium payment</td>
<td>There may or may not be a premium payment</td>
</tr>
<tr>
<td><strong>Copayment/Coinsurance/Deductible</strong></td>
<td>Copayments, coinsurance and/or deductibles may apply</td>
<td>Copayments, coinsurance and/or deductibles may apply</td>
<td>Copayments, coinsurance and/or deductibles may apply</td>
<td>Copayments, coinsurance and/or deductibles may apply</td>
</tr>
</tbody>
</table>
| **Overview of Coverage** | • Inpatient hospital care  
• Skilled nursing facilities  
• Helps cover hospice & home health care | • Physician Services  
• Outpatient treatment  
• Other services not covered by Part A  
• Some preventative services | Provides all Part A and B benefit coverage plus additional coverage not offered by Medicare | Outpatient prescription drugs |

## Key Terms

- Medicare Part A & Part B are known as “Original Medicare”
- Medicare Part C is referred to as “Medicare Advantage” or “MA Plans”
- Medicare Part D is Prescription Drug Coverage
  - When combined into a Medicare Advantage Plan (Part C) it creates a Medicare Advantage Prescription Drug (MA-PD) Plan
The Parts of Medicare (cont.)

Explore the differences between Medicare Parts A, B, C & D

All the Parts of Medicare
Learn the differences of Medicare Part A, B, C, and D & which parts you need to have

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B</th>
<th>Part C</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Coverage</td>
<td>Medical Coverage</td>
<td>Hospital &amp; Medical</td>
<td>Prescription Drug</td>
</tr>
<tr>
<td>What this covers:</td>
<td>What this covers:</td>
<td>What this covers:</td>
<td>What this covers:</td>
</tr>
<tr>
<td>- Hospital stays</td>
<td>- Doctor services</td>
<td>- Combination of</td>
<td>- Covers prescription</td>
</tr>
<tr>
<td>- Emergency Services</td>
<td>- Medical Equipment</td>
<td>Medicare Parts A &amp; B*</td>
<td>drugs</td>
</tr>
<tr>
<td>- Surgery</td>
<td>- Outpatient &amp;</td>
<td>+ Vision, Dental, Hearing</td>
<td>- Vaccine Drugs</td>
</tr>
<tr>
<td>- In-home hospice</td>
<td>Preventative services</td>
<td>+ Some prescription drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Tests</td>
<td>coverage</td>
<td></td>
</tr>
</tbody>
</table>

Generally, Original Medicare plans are associated with higher copayments, coinsurance, and deductibles. Because Medicare Advantage Plans can vary, it is best to review available options in your plan service area.

There are also plans called Medicare Supplement Insurance, also known as Medigap. These are plans that help cover or pay for deductibles, coinsurance and out-of-pocket costs that original Medicare does not cover.

What Medicare Doesn’t Cover
Learn the where the coverage stops so you know what Medicare parts you should have

A
What it doesn’t cover:
- Hospital stays < 60 days
- Long Term Care

B
What it doesn’t cover:
- Alternative Medicine
- Cosmetic Surgery
- Vision or Dental

C
What it doesn’t cover:
- Hospice & Long-Term Care*
- Routine Dental*
- Cosmetic Surgery

D
What it doesn’t cover:
- Weight loss/gain drugs
- Fertility & sexual performance drugs
- Compound drugs**

*verify with your insurance provider
**Dose higher than standard dosage
Some Medicare Part D plans have a coverage gap. This means that when your individual plan’s drug costs reach a certain limit, prescription drugs will hit a gap in coverage where they generally cost more.

**Prescription Drug (Part D) Coverage Gap - 2020**

1. **Initial Coverage Stage**
   - During this initial stage, you pay your copay/coinsurance for your covered medication. Your Medicare Part D plan pays the rest.
   - You are in the initial coverage stage until you and the plan contributions have reached $4,020 total drug costs.
   - For coinsurance/copay amounts that you pay during this stage, refer to your plan benefits.

2. **Coverage Gap**
   - When you’re in the coverage gap, you pay for 25 percent of generic medication & 25 percent for covered brand name medications. You stay in this stage until your true-out-of-pocket costs reach $6,350.

3. **Catastrophic Stage**
   - When you’re in the catastrophic stage, you pay either 5 percent coinsurance or $3.60 for generic drugs - whichever is greater.
   - For all other prescription drugs, you pay the greater of either 5 percent or $8.95. Your Medicare Part D plan pays for most of the cost for your covered medication.

*Medicare Part D stages run on a calendar year cycle*
Medicare Eligibility – Enrollment

When wanting to enroll or make changes in Medicare coverage, there are certain times when to do so.

**Medicare Enrollment Periods**

- **IEP** (Initial Enrollment Period)
  - 65th Birthday
  - 3 months before to 3 months after
  - Enroll in Part A, Part B, Medigap, Medicare Advantage and/or Part D

- **AEP** (Annual Enrollment Period)
  - October 15th - December 7th
  - Enroll or change Medicare Advantage, Medigap and/or Part D

- **GEP** (General Enrollment Period)
  - January 1st - March 31st
  - Enroll in Part A and Part B if you did not enroll when you were first eligible

- **SEP** (Special Enrollment Period)
  - Up to 8 months (After qualifying event*)
  - Allows for mid-year changes due to special circumstances (see below)

**Special Enrollment - Special Circumstances**

- Moved out of plan's service area
- Moved within my plan's service area & now have more options available
- Moved back to U.S. after living in foreign country
- Receive assistance from Medicaid
- If you live in a nursing home or medical facility
- End of coverage through employer or union (includes COBRA)
- Lost credible drug coverage or my drug coverage changed & is no longer credible
- Receive assistance from State Pharmaceutical Assistance Program (SPAP)
- Receive assistance from Extra Help
Medicare Eligibility (cont.) – Enrollment Periods

**Initial Enrollment Period (IEP)**

Individuals first become eligible for Parts A & B of Medicare during Initial Enrollment Period. This seven month period begins three months before your 65th birthday’s month and ends three months after. If you enroll a month to three months before you turn 65, your Medicare coverage will start the month you turn 65. If you wait to enroll during your birthday month or after, your coverage will begin one to three months following enrollment. That’s why it’s best to enroll as soon as your enrollment period begins!

![Calendar showing Initial Enrollment Period](calendar_image)

**Annual Enrollment Period (AEP)**

During Annual Enrollment Period, individuals have option to change Medicare plans, its cost, the provider, and even the pharmacy. This opportunity is available to Original Medicare coverage holders that are switching to a Medicare Advantage Plan and those in a Medicare Advantage plan looking to switch to another Medicare Advantage Plan. Before this period begins, it is best to review your current plan so that you can decide to renew or change your plan. If you don’t change the plan, your plan will roll over for the following year.


Special Enrollment Period (SEP)
In most cases, once you’ve chosen a plan, you must stay enrolled in the plan for the calendar year. However, if you’ve experienced a qualifying circumstance such as moving back from foreign country or if your health coverage through an employer or union has ended, you may enroll in Medicare within 8 months following end of coverage. There are other special circumstances that qualify you to enroll under Special Enrollment and it works on a case-by-case basis. You can check with your group health insurance plan administrator or a Medicare representative at 1-800-MEDICARE (1-800-633-4227) for more information.

Automatic Enrollment
There are cases where a person will be automatically enrolled in Part A & Part B (Original Medicare):

- If you are already receiving benefits from Social Security
- If you are already receiving benefits from the Railroad Retirement Board
- If you are younger than 65 years old and have a disability
- If you have Lou Gehrig’s disease, also known as ALS
Coordination of benefits is the sharing of medical claim costs by two or more health plans. Once health plans and/or prescription coverages are chosen, a primary payer is determined and the cost remainder goes to the other plan(s).

In most cases, the primary payer is the private insurance policy and secondary payer is the Medicare plan. However, exceptions do apply, including for employers with less than 20 employees. When an employee turns 65, employees should check with their employers or benefits plan representative to review any changes in coverage, as some Medicare-eligible employees’ plan coverage may change regardless of choosing Medicare coverage.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Condition</th>
<th>Primary Payer</th>
<th>Secondary Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 or older AND covered by a group health plan through active or spousal employment</td>
<td>Employer &lt; 20 employees</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td></td>
<td>Employer/Multi-group Employer with &gt; 20 employees</td>
<td>Group Health Plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has employer retirement plan AND is 65 or older</td>
<td>Individual is entitled to Medicare</td>
<td>Medicare</td>
<td>Retiree Coverage</td>
</tr>
<tr>
<td>Under 65, disabled, and covered by group health plan through employment</td>
<td>Employer &lt; 100 employees</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td></td>
<td>Employer/Multi-group Employer with &gt; 100 employees</td>
<td>Group Health Plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>65 or older OR is disabled and covered by Medicare and COBRA</td>
<td>Individual is entitled to Medicare</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Covered under Workers’ Compensation because of job-related injury/illness</td>
<td>Individual is entitled to Medicare</td>
<td>Workers' Comp for health services related to the injury/illness</td>
<td>Medicare</td>
</tr>
<tr>
<td>End-Stage Renal Disease AND Group Health Plan Coverage</td>
<td>Within first 30 months of eligibility for Medicare</td>
<td>Group Health Plan</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After first 30 months of eligibility for Medicare</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td>End-Stage Renal Disease AND COBRA Continuation Coverage</td>
<td>Within first 30 months of eligibility for Medicare</td>
<td>COBRA</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After first 30 months of eligibility for Medicare</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
</tbody>
</table>
Still have questions about who should pay first or what payers should cover?

It’s important to know how Medicare works with other health plans & pharmacy coverage. Although having more than one plan will lessen your out-of-pocket costs for health services, it does not guarantee that all service costs will be covered by the coverage payers. To find out who pays first and how much of a service is covered, please inquire with all coverage providers or contact your benefits plan administrator.

Important Note:

There are many other situations that factor into whether or not Medicare will pay first that the previous chart couldn’t cover in detail. Special circumstances should be consulted with your insurance provider.
HSA Quick Facts

<table>
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<tr>
<th>What is it?</th>
<th>Savings account with high deductible to help pay for medical expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility?</td>
<td>Anyone enrolled in an IRS qualified High Deductible Health Plan (HDHP)</td>
</tr>
<tr>
<td>Account owner?</td>
<td>You</td>
</tr>
<tr>
<td>Contributors?</td>
<td>You, your employer, family and others. You can no longer contribute after becoming Medicare-eligible.</td>
</tr>
<tr>
<td>Contribution Limit?</td>
<td>Yes - IRS limits contributions each year</td>
</tr>
<tr>
<td>Account transfer with me?</td>
<td>Yes</td>
</tr>
<tr>
<td>Carryover to Following Year?</td>
<td>Yes the money stays until you spend it.</td>
</tr>
<tr>
<td>Account earn interest?</td>
<td>Yes</td>
</tr>
<tr>
<td>Use on ‘other-than-qualified’ expenses?</td>
<td>Yes - at 65. If money is withdrawn before turning 65, money is subject to income tax AND can be subject to a 20% penalty if not using for qualified health expense.</td>
</tr>
<tr>
<td>Apply funds to COBRA/other plan premiums?</td>
<td>Yes - adhere by IRS guidelines</td>
</tr>
</tbody>
</table>

Frequently Asked Questions about HSA’s with Medicare

Q – Can I retain HSA with Medicare?

A – If Medicare coverage was in existence before the set up of an HSA, then a person may keep their HSA. However, HSA contributions must stop once enrolled in Medicare.

Q – Can I delay my enrollment in Medicare to continue my HSA contributions?

A – If not enrolled in Social Security and you/your spouse are still working with employer group coverage, you may delay enrollment in Parts A & B.

Q – What should I do if planning to enroll in Medicare?

A – If Medicare is deferred at 65 when first eligible, you will need to stop HSA contributions up to 6 months before Medicare enrollment.

Q – Do I pay taxes on HSA?

A – When you turn 65, you can withdraw HSA money tax-free. If money is used for qualifying medical expenses, funds are also penalty-free.

Q – What do I do if I have excess HSA contributions during the year?

A – Excess contributions are treated as taxable income and should be withdrawn before taxes are due. Otherwise there’s a 6% penalty.
When you lose insurance coverage through an employer, you may be offered COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage from your former employer. When it comes to coordination of benefits between COBRA and Medicare, it depends on which you had first. Although it is possible to attain COBRA coverage if you already have Medicare, it is usually not possible to keep COBRA once you become eligible for Medicare. If you have Medicare Part A or B and you become eligible for COBRA, you must be allowed to enroll. COBRA may be kept for services that Medicare does not cover, such as dental or vision coverage. In most cases, Medicare is your primary insurance and COBRA is secondary.

Medicare does not consider COBRA as creditable coverage. Any employee and/or their spouse that are turning 65 or older must enroll in Medicare Part B within 8 months after the loss of employment and/or coverage through the employer. Any employee and/or their spouse that are turning 65 or older must enroll in Medicare Advantage (Part C) or a prescription drug (Part D) plan within 2 months after the loss of employment and/or coverage through the employer. Any enrollment after the Enrollment Period will be subjected to penalties. To learn more about COBRA, visit the U.S. Department of Labor’s website.
When an employer offers group health insurance to Medicare-aged individuals, the employer must abide by 3 main Medicare requirements - **Medicare Secondary Payer Requirements**, **Medicare Part D Notice Requirements**, & **Medicare Nondiscrimination Requirements**.

**Medicare Part D Notice Requirements**
- If an employer offers prescription drug coverage, the employer must provide a notice prior to October 15th each year that notifies employees if the coverage is ‘creditable’ under law.
- Within 60 days of each plan year, employers must complete an online disclosure to Center for Medicare and Medicaid Services to report whether the coverage offered is ‘creditable’.

**Medicare Secondary Payer Requirements**
When an individual has both an employer-sponsored health plan and Medicare, there is a coordination of benefit coverage on which coverage pays first and which pays the remainder. Refer to our chart in our Coordination of Benefits section that lists the most common situations where an individual has both Medicare and other insurance, and which pays first.

**Medicare Nondiscrimination Requirements**
- Employers with 20 or more employees are required by law to offer workers and their spouses who are age 65 or older the same health benefits that are offered to younger employees.
- Employers are prohibited from encouraging or offering incentives to Medicare-eligible employees to enroll in Medicare instead of the employer-sponsored group health plan. However, the Equal Employment Opportunity Commission (EEOC) has stated that offering Medicare-eligible employees a choice between either group health insurance coverage or the reimbursement of Medicare Part B premiums is generally lawful as long as the choice creates an advantageous option available only to the Medicare-eligible employees.
Penalties

In some cases, delaying your enrollment in Medicare can subject you to a penalty. Read more below to learn about circumstance in which you can face penalties.

**Part A Penalty**

Part A is premium-free if you or your spouse worked and paid taxes for at least 10 years. If you have to pay a premium, the penalty for late enrollment is 10%. You pay this for double the amount of years that you were eligible for Part A and didn’t enroll.

*(Example: If you were eligible for Part A for 3 years and didn’t sign up, you’ll pay the increased premium penalty for 6 years.)*

**Part B Penalty**

If you became eligible for Part B and didn’t sign up, you will be subject to a penalty of an additional monthly premium of up to 10% for each full 12-month period that you didn’t enroll. *You pay this penalty for as long as you have Part B.*

*(Example: If you were eligible for Part B for 2 years and didn’t sign up, you’ll pay an increased 20% premium penalty for the rest of your coverage.)*

**Part D Penalty**

Medicare imposes a late enrollment penalty of 63 or more days without credible prescription drug coverage. The penalty for not enrolling in a Part D/Prescription Drug Plan on time is dependent on when you sign up. Medicare calculates the amount by multiplying 1% of the National Base Beneficiary Premium times the number of months without coverage. The premium is rounded to nearest $.10.

*(Example: If you were eligible for Part D in May 2015 and didn’t sign up during IEP, but later completed Open Enrollment with coverage starting on January 2018, you’d pay a monthly late enrollment penalty of **$10.90** for 2018. Then for 2019 it would be a **$10.30** penalty.)*
Medicare is complex and constantly evolving with rules and regulations. That’s why it’s best to partner with a certified agent who specializes in Medicare.

For employers with Medicare-eligible employees, there are many factors that add to the complexity of group health insurance and their coverage options. Haylor, Freyer & Coon Benefits Advisors help you select the best primary coverage for your employees, as well as help you explore affordable supplemental coverage options such as prescription drug coverage or vision plans.

Call Haylor, Freyer & Coon to receive quality service and expert advice today!
Sources:

- https://www.cms.gov/Medicare/Medicare.html - Centers for Medicare & Medicaid Services
- https://www.ssa.gov/medicare/ - Social Security Administration
- https://www.usa.gov/medicare - United States Government webpage of Medicare
- https://www.medicarerights.org – Medicare Rights

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