MEDICARE AND EMPLOYER HEALTH COVERAGE

1-800-259-5300

SHIP
Navigating Medicare

LOUISIANA SENIOR HEALTH INFORMATION PROGRAM

WORKING PAST 65

Many people are choosing to delay retirement and continue working past age 65. If you are planning to continue working and have health insurance through your employer, it may be beneficial to delay some or all parts of Medicare, such as Medicare Part A and B, which you can do without penalty.

To delay Medicare Part D, your prescription coverage must be CREDITABLE COVERAGE, which means the drug coverage offered is as good or better than a standard Part D plan. If your drug coverage is NOT CREDITABLE COVERAGE, you will be subject to a penalty when you do elect a Part D plan. Only the plan/company can confirm if it is creditable coverage.

With small employer plans (less than 20 employees), Medicare is the primary payer. The employer health policy does not have to continue to offer benefits and may require you to take Medicare.

Delaying Medicare

PART A: Most people take Medicare Part A when they are first eligible because it is free for 99% of beneficiaries. Individuals who want to keep contributing to their Health Savings Account, or are assessed a Part A premium, may choose to delay Part A enrollment.

PART B: Individuals tend to delay Medicare Part B if they have health coverage through work. Beneficiaries can also delay their guaranteed issue period (open enrollment) for a Medicare Supplement, which lasts six months from when the beneficiary first enrolls in Part B. Beneficiaries are more likely to enroll in Part B when first eligible if their group plan pays secondary to Medicare. If employer medical benefits are limited, Part B may pay for costs not covered by the group plan.

PART D: Many beneficiaries choose to delay Part D if they have coverage elsewhere. Part D creditable coverage is NOT tied to active work, so most other drug coverage is creditable (e.g. group coverage, retiree, VA). Some individuals choose to enroll as soon as they are eligible if Part D offers better coverage and/or lower prices for their prescription drugs.

Retiree Plans

Many companies continue to offer health insurance after an employee retires. Retiree plans vary greatly with a wide range of options including Medicare Advantage plans, Medicare Supplements, and full health coverage.

Retiree plans are not guaranteed renewable, meaning the coverage or contribution can be changed or dropped at any time by an employer.

Since retiree coverage is not tied to active work, an individual must also enroll in Medicare Part B to avoid penalties. Medicare pays primary to retiree plans.

Penalties

PART A: A penalty is only assessed if the beneficiary pays a Part A premium. The penalty is 10% of the premium, paid monthly for twice the number of years enrollment was delayed..

PART B: For each 12 months of delay with no employer coverage, the penalty is 10% of the premium and is paid for each month a beneficiary has Part B coverage..

PART D: A beneficiary accrues a 1% penalty for each month he/she is eligible for Part D but not enrolled and does not have creditable coverage. This penalty is paid monthly once he/she enrolls in a Part D plan.

Health Savings Accounts (HSA) and Medicare

A Health Savings Account (HSA) is a medical savings account in which money can be deposited, tax free, to pay for qualifying medical expenses such as deductibles, co-pays, medical equipment, dental, hearing and visions costs, and prescriptions.

HSAs only work with High Deductible Health Plans (HDHP), as these plans may not be creditable coverage for Medicare Part D. Beneficiaries should check with the plan to determine if it is creditable coverage, and if it is not and the beneficiary delays enrolling in Part D, there may be a penalty assessed. Once enrolled in any part of Medicare, including Part A, beneficiaries are no longer eligible to contribute to an HSA. However, if a beneficiary already has an HSA prior to enrolling in Medicare, they can continue to use the funds already deposited. The beneficiary is responsible for stopping the contributions to their HSA prior to enrolling in any part of Medicare.

Beneficiaries can use HSA funds to pay for medical expenses including Medicare premiums (except Medicare Supplement premiums), Medicare deductibles, co-pays, prescription drugs, and dental, vision and hearing expenses.

COBRA

Cobra (Consolidated Omnibus Budget Reconciliation Act) is a law regulated by the Department of Labor. COBRA requires employers with 20 or more employees to offer former employees and their dependents a temporary continuation of health coverage.

WHO QUALIFIES? To qualify, an individual had to be enrolled in the health coverage prior to the loss of employment. Each family member can decide if they want COBRA coverage.

HOW MUCH DOES COBRA COST? The former employee pays the full health insurance premium including the employee and employer's share, as well as a 2% administrative fee.

HOW LONG DOES COBRA LAST? COBRA coverage generally lasts 18 months and is not tied to active work and would not prevent a Part B penalty. COBRA may be creditable coverage for Medicare Part D.

CAN I HAVE COBRA AND MEDICARE? If you were first enrolled in COBRA and then enrolled in Medicare, your COBRA benefits will end. Delaying enrollment into Medicare while on COBRA could result in enrollment penalty. Dependents who are enrolled in COBRA and not yet eligible for Medicare may continue COBRA coverage.

Medicare Supplement Policies

Medicare Supplement policies, often referred to as "Medigap" or "MedSup," are designed to cover the gaps in Medicare Parts A and B including deductibles and copays.

There are 10 standard policies that are regulated by the federal government. A standard policy means a "Plan G" policy bought from one company will offer the exact same coverage as a "Plan G" from all other companies. The premium amounts, rate increases, customer service and agent availability will differ between the companies.

Remember, **Medicare Supplement Open Enrollment lasts six months following Part B enrollment at age 65 or older**. During this time, beneficiaries can buy any Medigap policy that is offered in the state. Companies cannot deny anyone a policy because of health or age. Rates can vary because of age, gender, geographic area and smoking status, and some policies may have a waiting period for pre-existing conditions.

If a beneficiary wants to enroll in a new plan, or switch to a different plan outside of the six-month open enrollment time frame, the beneficiary will have to go through underwriting where companies will review their medical history.

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