An Introduction to Medicare

Medicare can be confusing, but we’re here to help you and your employees make sense of it all.

This Medicare overview is a great place to start. It goes over the Medicare basics and outlines employees’ options, whether they’re retired or still working past age 65.
What is Medicare?
Medicare is a federal health insurance program through the Centers for Medicare & Medicaid Services (CMS). The Social Security Administration started Medicare to help people pay for their health costs if they’re 65 or older or have certain disabilities. It is mostly paid for by payroll taxes and premiums paid by Medicare beneficiaries.

The Four Parts of Medicare
Part A—Hospital Coverage
(inpatient hospital stays, skilled nursing facilities, hospice, some home health care)
Part B—Medical Coverage
(doctor visits, outpatient care, some home health care)

Parts A and B are known as Original Medicare.

Part C—Medicare Advantage
(from a private company and pays in place of Original Medicare)

Part D—Prescription Drug Coverage

Who is eligible for Medicare?
U.S. citizens or legal residents (for at least five years in a row) who are 65 or older or have certain disabilities are eligible.

When can people enroll?
CMS will automatically enroll people in Original Medicare who already get a Social Security or Railroad check for retirement.

They’ll receive an Original Medicare card in the mail three months before their 65th birthday or their 25th month of disability.

Those who don’t already get a Social Security or Railroad check can enroll during these times.

• Initial Enrollment Period—starts three months before the month they turn 65, includes the month of their birthday and ends three months after the month they turn 65
• Annual Enrollment Period from October 15 to December 7
• Open Enrollment Period from January 1 to March 31
• After a special event, like moving

People don’t have to pay a premium for Part A if they’ve already paid into it through their (or their spouse’s) job for at least 10 years. They have to pay a premium for Part B, and it could be higher if they sign up after their Initial Enrollment Period, unless they’re still working and get health insurance through a job.

Does Medicare pay for everything?
No. Original Medicare only pays about 80 percent of healthcare costs.
Original Medicare

Parts A and B
- Medicare pays a portion of the cost of doctor and hospital services a person uses.
- Medicare beneficiaries with Original Medicare can go to any doctor or hospital that accepts Medicare.

<table>
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<tr>
<th>Part</th>
<th>Premium</th>
<th>Covered Services</th>
<th>You Pay</th>
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<tr>
<td>A</td>
<td>No premium for those who paid Medicare taxes (through a job or a spouse’s job) for at least 10 years</td>
<td>Inpatient care in the hospital, skilled nursing care, hospice, home health care</td>
<td>Depending on the service, possible deductible as well as copayments or coinsurance</td>
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<tr>
<td>B</td>
<td>Monthly premium for Part B</td>
<td>Outpatient care, doctor’s visits and services, diagnostic and lab services, durable medical equipment and more</td>
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Cost Estimate
People who are at least 64 years and 9 months old can estimate the cost they’ll pay for Part A and Part B by using the Medicare Eligibility and Premium Calculator available at Medicare.gov/EligibilityPremiumCalc.

They can also call 1-800-MEDICARE (1-800-633-4227 or TTY 1-877-486-2048).
Medicare Advantage

Part C

Medicare Advantage plans are optional plans that people can purchase from private insurance companies. A Medicare Advantage plan may be the right choice for people who want all their coverage from one place, like the group plan they’re used to.

Here is some key info about Medicare Advantage.

• People must enroll in Parts A and B to sign up for Medicare Advantage.
• They’ll receive Original Medicare Part A and B coverage through the Medicare Advantage plan, and they can choose a plan with Part D (drug coverage).
• Medicare Advantage plans can be bought from a private company, like Health Alliance Medicare.
• The plans have yearly limits on how much you have to pay to keep out-of-pocket costs lower. Original Medicare doesn’t have these.
• Premiums for Medicare Advantage plans are low because the government pays most of the premium to the insurance company on behalf of the member.

• There are different types of Medicare Advantage plans.
  o Health maintenance organization (HMO) plans require members to have a primary care provider (PCP) to oversee their care, and members must receive all of their care from in-network providers unless it’s an emergency or urgent situation.
  o Point of service (POS) plans also require an in-network PCP to oversee care, but members have the freedom to go out-of-network. However, they’ll typically pay more for out-of-network care than for in-network.

• Medicare Advantage plans may offer extra benefits that Original Medicare doesn’t cover.

For example, our Health Alliance Medicare Advantage plans include these perks and more.

  o Assist America global emergency services
  o Virtual visits
  o Fitness center reimbursements
  o Interactive health tools
  o 24-hour Anytime Nurse Line
There are two ways to get Part D coverage to help cover drug costs. Some private companies, like Health Alliance Medicare, offer Medicare Advantage plans with built-in prescription coverage. Other companies offer stand-alone Prescription Drug Plans (PDPs). PDPs pair with Original Medicare or Medicare Supplement plans.

People who don’t enroll in Part D when they become eligible for Medicare may have to pay a penalty later, called the Late Enrollment Penalty. If they’re still getting drug coverage through a group plan or another source the government says is as good as or better than Medicare, known as creditable coverage, they won’t have to pay the penalty later.
Medicare Supplement

Medigap
Private insurance companies also sell Medicare Supplement plans designed to help fill in the gaps of Original Medicare.

- People must enroll in Parts A and B to qualify for Medicare Supplement plans.
- Medicare Supplement plans help pay the costs that Original Medicare doesn’t pay, like coinsurance, copayments and deductibles.
- These plans generally only cover healthcare services that Original Medicare covers.
- Insurance companies can only offer standardized policies identified by letters A through D, F, G, and K through N.
- Although there are lots of options, each plan covers the same basic services, no matter which company provides it. Premiums vary by plan option and company.
- People can’t have both a Medicare Supplement and Medicare Advantage plan.
Employees Who Work Past Age 65
What if someone is covered because they (or a spouse) are still working?
If people have healthcare coverage through their (or their spouse’s) current employment, they can keep the health plan they have and enroll in Medicare when they retire.

- **If your group has 20 or more employees**, your employees may consider delaying their enrollment in Parts A and B. If they keep medical coverage through their (or their spouse’s) job and wait to get Part A and/or Part B, they’ll have eight months from when they retire or lose employer coverage to elect Part A and Part B without a penalty.

- **If your group has fewer than 20 employees**, those who are eligible should enroll in Parts A and B because Medicare is primary, which means Medicare pays on claims before their group coverage does.

Employees who continue receiving creditable drug coverage from their (or their spouse’s) group plan after they become eligible for Part D coverage won’t have to pay a penalty for late enrollment.

What if my Medicare-eligible employees have a health savings account (HSA)?
Your employees can’t be covered by any part of Medicare and contribute to their HSAs. If they want to keep making contributions to their account, they can delay both Parts A and B until they no longer have coverage through your group plan. Employees should contact a tax professional for more information.

Take the Next Step in Group Coverage
You can give your retirees more options and help alleviate the stress of finding a plan by adding a Medicare Advantage plan to your group coverage. It doesn’t have to cost you anything, and if you choose the right carrier, it can be a hassle-free addition to your existing coverage.

The workforce is more age-diverse today, and you may have active employees over age 65. If you have fewer than 20 total employees, a Medicare Advantage group plan may give you additional options for your older employees.

Read our white paper 6 Reasons to Add a Medicare Advantage Plan to Your Group Coverage for more on why you should consider adding Medicare coverage to your group plan.

If You Have Medicare-Eligible Employees on Your Group Plan
Employees should talk to your HR or benefits office before choosing to leave your group plan or enroll in Medicare. If they have spouses or dependents covered under your group plan, they’ll need to make arrangements for them to be covered on your group plan or on an individual plan.

Health Alliance offers individual and group Medicare plans to meet a range of needs and budgets. To learn more or get started, go to HealthAlliance.org or call 1-800-851-3379.
Helpful Terms

**Coinsurance**: The percentage of the cost people pay each time they use a medical service covered by their plan.

**Copayment**: The set dollar amount (like $20) people pay at the doctor’s office, pharmacy or hospital.

**Deductible**: The amount people pay before their benefits kick in. Some plans have separate medical and pharmacy deductibles.

**Formulary**: A list of medicines covered by the health plan. Medicines on a formulary are typically grouped by drug class (meaning they work in a similar way) or by the medical problem they treat.

**Network**: The doctors, clinics and hospitals a health plan works with to provide discounted services to its members.

**Preauthorization**: A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Preauthorization is required for certain services before you receive them, except in an emergency.

**Premium**: The monthly fee for coverage.

**Provider**: A doctor, nurse, physician assistant or other health care professional, a medical group, a durable medical equipment supplier, a hospital or other health care facility delivering health care services.

**Out-of-Pocket Maximum**: The most a person will pay in a benefit period, usually a year, before their plan pays 100 percent of covered expenses. It’s also called a yearly limit.