Briefing Paper

for the

Cape Cod Municipal Health Group

- **Parts of Medicare**
- **Medicare Supplement Plans**
- **Medicare Advantage Plans**
- **Medicare Part D Plans, Employer Group Waiver Plans (EGWPs)**
- **Medicare Secondary Payer law**
- **Ch. 32B and retiree coverage**

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I. Parts of Medicare

Medicare: A federal health benefits program for retirees and their spouses who are age 65 and older and who have paid into Medicare for 40 quarters. Medicare has a number of "parts":

- Medicare Part A covers hospital and other facility charges and is "free" to the Medicare eligible retiree.

- Medicare Part B covers professional services and outpatient services. For those who are eligible for Medicare, Part B is optional. There is a monthly premium for Part B. If a retiree does not enroll in Part B when first eligible, there will be a monthly surcharge once the retiree does enroll. See Section IV.

- Medicare Part C. Unlike Part A and Part B, Medicare Part C does not encompass a set of benefits. Rather it is the section that creates the "Medicare Advantage" ("MA") plans. These are plans that *replace* Medicare coverage rather than supplementing Medicare. They have also been referred to in the past as "Medicare risk contract" plans. There are – or were - two types of MA plans: (1) Medicare Advantage HMO plans and (2) Medicare Advantage Private Fee For Service (PFFS) plans. In recent years the federal government has not made PFFS plans financially attractive to health plan organizations, and in Mass. the carriers have discontinued the PFFS plans. With Medicare Advantage plans, the federal government gives the health plan organization money each month to pay for health care services for the members covered under the MA plans. The health plan organization, and not Medicare, pays the health care providers (doctors, hospitals, etc.). Retirees with Part A & Part B are eligible for Medicare Advantage HMO plans provided their primary residence is in the plan's service area. [See page 4]

  When a retiree joins a Medicare Advantage plan, he/she signs over his/her Medicare coverage to the Medicare Advantage plan.

  Examples of Medicare Advantage HMO plans are *BCBS Medicare HMO Blue* and *Tufts Medicare Preferred HMO*.

- Medicare Part D and Medicare Part D Plans
  Medicare Part D became effective as of January 1, 2006 and is optional for Medicare beneficiaries. It provides coverage for prescription drugs for retirees who choose to enroll. Enrollment in Part D is through private Prescription Drug Plans (PDPs) or through Medicare Advantage –Prescription Drug plans (MA-PDs). These are plans that must be approved by the federal government each year. The price to the retiree will vary depending upon the PDP selected.

  Medicare HMO Blue and Tufts Medicare Preferred HMO are Medicare Advantage HMO plans that incorporate Medicare Part D plans. Tufts Medicare Prime

Supplement with PDP Plus is an example of a Medicare supplement plan that incorporates a Medicare Part D Plan (PDP).

Effective January 1, 2015 the BCBS Medex and Managed Blue for Seniors and the Harvard Pilgrim Medicare Enhance plans will have the prescription drug coverage provided by PDPs. They will be self-funded medical plans plus a PDP. These group prescription drug plans provided by an employer are also referred to as Employer Group Waivier Plans or EGWPs (pronounced egg whip).

Retirees covered by CCMHG Senior plans do NOT need to and should NOT purchase Medicare Part D! They will be automatically enrolled in Part D when they are members of one of the CCMHG's senior plans. The cost of Medicare Part D prescription drug plans is included in the rate for each health plan.

II. Medicare Eligibility

Some Massachusetts municipal retirees do not have Medicare eligibility because Massachusetts was one of two states in which municipal employees did not pay into Social Security. MA governmental employers have been taking Medicare deductions from payroll starting with employees hired in April 1986 and later.

- In order to be eligible to have Medicare as the primary payer through the employer's group health plan, the individual qualified to receive the employer's benefits must be (1) retired, (2) age 65 or older and (3) have paid into Medicare for 40 quarters *or* be (1) retired, (2) age 65 or older and (2) have a spouse, former spouse, or deceased spouse who paid into Medicare for at least 40 quarters. Spouses of retirees are eligible for Medicare plans if they are 65 and if either the spouse or the retiree has paid into Medicare for 40 quarters.

- In order to be eligible for a group Medicare supplement plan or group *Medicare Advantage* plan, retirees (and spouses) must have both Medicare Part A & Part B.

- Those qualified as Social Security Disabled are also entitled to Medicare and under MGL Ch. 32B must enroll in a Medicare plan.

Medicare coverage is incomplete. There are significant deductibles and coinsurance (gaps in coverage), and not all services are covered. Medicare supplement plans fill in the gaps and supplement the coverage.

** One exception is in the case of Medicare eligible retirees who qualify for a Part D subsidy.*

III. Medicare Secondary Payer (MSP) Law

Employees who are age 65 and older but still actively working are not eligible to have Medicare as the primary payer, i.e. are not eligible for Medicare plans. They must remain on the active employee plans until they retire. They should be instructed to defer their Medicare Part B until they retire.

If the spouse of an active employee is age 65 or older and entitled to Medicare, he/she may not enroll in a Medicare plan through the town or district until the employee retires. The exception to this is if the spouse is also a retiree of the town or district and has eligibility for employer benefits on his/her own.

IV. Types of Medicare Plans

Because Medicare coverage is not comprehensive, most Medicare eligible retirees choose to supplement or replace Medicare to get additional coverage.

The two general categories of Medicare plans are

- Medicare *supplement* plans and
- Medicare *replacement* plans (Medicare Part C plans, a.k.a. Medicare Advantage plans mentioned above).

To be eligible for both of these types of Medicare plans, retirees must have both Medicare Part A and Part B.

A. Medicare Supplement Plans (a/k.a MediGap plans or Medi-wrap plans)

MGL Ch. 32B refers to these plans as Optional Medicare Extension (O.M.E.) plans.

Medicare supplement plans can be offered by BCBS organizations, commercial carriers, or managed care organizations. They fill in the coverage gaps left by Medicare, i.e. Medicare deductibles and coinsurance, and may add additional coverage for some benefits not covered by Medicare. Medicare supplement plans can be insured or self-funded by the employer/Plan Sponsor. The supplement plans are available as non-group plans as well as through employer groups. The non-group supplement plan benefits usually differ from the benefits of group plans.

Retirees who choose a Medicare supplement plan retain their Medicare benefits. For Medicare-covered services, Medicare is the primary payer (pays first) and the health plan pays secondary. For services covered by the health plan but not by Medicare, the health plan is the primary and only payer (except for member copays and/or coinsurance).

Indemnity plan model of Medicare supplement plan - *BCBS Medex, HPHC Medicare Enhance*, and *Tufts Medicare Prime Supplement with PDP Plus* are examples of Medicare supplement plans built on a traditional indemnity plan model, i.e. with

freedom of choice of providers. There is no provider network, and members may live anywhere in the U.S. Medicare participating providers are required to accept the Medicare supplement plan coverage and are prohibited from balance-billing the member for amounts beyond what Medicare and the health plan pays. The CCMHG self-funds *BCBS Medex* and *HPHC Medicare Enhance medical claims only*. Effective 1/1/15 prescription drugs for *Medex* and *Medicare Enhance* are provided by a fully insured Medicare Part D Prescription Drug Plan (PDP). The *Tufts Medicare Prime Supplement* plan is fully insured and incorporates a Medicare PDP.

HMO plan model of Medicare supplement plan – These plans are sometimes called Medi-gap or Medi-wrap HMO plans. If retirees are enrolled in a Medicare HMO supplement plan provided by a managed care organization, ex. *Managed Blue for Seniors*, they receive full benefits if they use network providers. If a member goes out of network, he/she still has his/her Medicare level of benefits. With Medicare supplement HMO plans, the provider network may or may not be the same as the network for the health plan organization's commercial HMO. Medicare is the primary payer for Medicare covered services. The same requirement that providers may not balance-bill that applies to the Medicare indemnity plan supplement model, applies to the Medicare HMO supplement model. The CCMHG purchases *Managed Blue for Seniors* on a fully insured basis, and effective 1/1/15 prescription drug coverage is through a Medicare PDP called Blue Medicare Rx.

B. Medicare Advantage (MA) Plans (*Medicare Part C plans*)*:

Another option for Medicare eligible retirees and their spouses who have Medicare Part A and Part B is a Medicare Advantage plan. These plans replace Medicare rather than supplementing Medicare. When a retiree joins a Medicare Advantage (MA) plan, he/she signs over his/her Medicare benefits to the health plan organization. The health plan organization is at risk for the cost of care which is why these plans used to be referred to as Medicare risk contract plans. Medicare, through the Center for Medicare and Medicaid Services (CMS), pays the organization providing the Medicare Advantage plan a monthly age-adjusted amount per enrolled member. The health plan organization pays the health care providers. Medicare does not pay the providers. CMS approves the benefits and rates that the health plan organization charges for the MA plan. Federal oversight assures that these plans are meeting their obligations.

In the case of the CCMHG's M/A plans, Medicare Part D is incorporated into the plans, and the Part D benefits are enhanced by the MA plan.

Medicare Advantage (M/A) HMO plans:

When a retiree joins a M/A HMO plan, he/she agrees to receive all care from the HMO's network of providers except in the case of an emergency or urgent care situations when the member cannot reasonably get to a network provider. *In some cases an M/A HMO plan's provider network is a subset of the full HMO network.*

If a member of an M/A HMO plan seeks care from a non-network provider in a non-emergency/non-urgent situation, he/she will have no benefits.

The federal Balanced Budget Act (BBA) of 1997 relaxed the residency requirements for Medicare risk contract plans and retirees who join these plans are no longer required to live in the service area at least 9 months out of the year; however, they work best for those who live primarily in the M/A plan's service area.

IV. M.G.L. Chapter 32B, Section 18A

What is Section 18A?

Section 18A is a mandatory section of MGL Ch. 32B and was added to the legislation on July 1, 2011, replacing Section 18.

Retirees of MA governmental employers who are Medicare eligible must join the employer's Medicare supplement plan(s) or Medicare Advantage plan(s); "…provided that benefits under said plan and Medicare Part A and Part B together shall be of comparable actuarial value to those under the retiree's existing coverage." The CCMHG had all of its health plans actuarially evaluated by The Segal Company, and it was determined that all of the plans met the comparability test. Under Section 18A, a Medicare eligible retiree may not enroll in a plan offered to active employees. Prior to enactment of Section 18A, Medicare eligible retirees of Mass. governmental employers were the only retirees in the U.S. that were allowed to enroll in active employee plans.

Chapter 32B: Section 18A. Transfer of retiree, spouse or dependent to Medicare health plan *[Text of section as amended by 2011, 68, Sec. 54 effective July 1, 2011. See 2011, 68, Sec. 221. For text effective until July 1, 2011, see above.]*

Section 18A. (a) A retiree, spouse or dependent insured or eligible to be insured under this chapter, if enrolled in Medicare Part A at no cost to the retiree, spouse or dependent or eligible for coverage under Medicare Part A at no cost to the retiree, spouse or dependent, shall be required to transfer to a Medicare health plan offered by the governmental unit under section 11C or section 16, if the benefits under the plan and Medicare Part A and Part B together shall be of comparable actuarial value to those under the retiree's existing coverage, but a retiree or spouse who has a dependent who is not enrolled or eligible to be enrolled in Medicare Part A at no cost shall not be required to transfer to a Medicare health plan if a transfer requires the retiree or spouse to continue the existing family coverage for the dependent in a plan other than a Medicare health plan offered by the governmental unit.

(b) Each retiree shall provide the governmental unit, in such form as the governmental unit shall prescribe, such information as is necessary to transfer to a Medicare health plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health coverage. The governmental unit may, from time to time, request from a retiree, a retiree's spouse or a retiree's dependent, proof certified by the federal government, of eligibility or ineligibility for Medicare Part A and Part B coverage.

(c) The governmental unit shall pay any Medicare Part B premium penalty assessed by the federal government on the retiree, spouse or dependent as a result of enrollment in Medicare Part B at the time of transfer.

Late enrollment in Medicare Part B and the Part B late enrollment penalty
In order to join a Medicare plan the retiree and/or the retiree's spouse must have Medicare Part A and Part B.

When a Medicare eligible retiree enrolls in Medicare Part B after the time when the individual was first eligible to enroll, it is referred to as a "late enrollment". The federal government assesses a Part B premium surcharge (penalty) to late enrollees. Section 18A requires that the *governmental employer* pay the Medicare Part B penalty as a result of late enrollment in Medicare Part B at the time of transfer into the Medicare health benefits supplement or Medicare Advantage plan. The Part B penalty is 10% of the Part B premium for each year in which the retiree was eligible for Part B but did not enroll in Part B. If a retiree became eligible for Part B on his/her 65th birthday but did not enroll until age 70, the Part B penalty would be 5 (years) x 10% or 50% of the Part B premium. This penalty is paid going forward for as long as the retiree is enrolled in Part B and receives benefits through the town/district/county.

Part B premiums by income

If your yearly income in 2012 was		**You pay (in 2014)**
File individual tax return	**File joint tax return**	
$85,000 or less	$170,000 or less	$104.90
above $85,000 up to $107,000	above $170,000 up to $214,000	$146.90
above $107,000 up to $160,000	above $214,000 up to $320,000	$209.80
above $160,000 up to $214,000	above $320,000 up to $428,000	$272.70

above $214,000	above $428,000	$335.70

High income seniors and Part B premium
The monthly Medicare Part B premium will be higher for retirees with annual income above $85,000 ($170,000 for couples filing a joint tax return). Most Medicare beneficiaries will pay the standard Part B premium. The same is true for Medicare Part D, i.e. those with incomes higher than $85,000 for an individual, will pay higher Part D premiums. See information below.

Part B penalties and overall employer costs –
Even with the Part B penalty costs for the employer, Section 18A is financially beneficial for governmental employers because of the lower cost of Medicare plans compared to plans for active employees and because of the inefficiencies of health plans in coordinating benefits with Medicare for Medicare eligible retirees on active employee plans. Over time the Part B penalty costs will reduce and eventually disappear as future retirees enroll in Medicare Part B when they are first eligible to do so and as these retirees eventually predominate in the retiree population. The Part B penalties are paid only on those who have already retired who did not enroll in Medicare Part B when first eligible.

Part D premiums and penalties for late enrollment-
Since Medicare Part D is available through and administered by private prescription drug plans approved by CMS, the premiums vary by plan. As with Medicare Part B, the beneficiaries with higher incomes must pay a premium adjustment based on their income. The premium adjustment is called the Income-Related Monthly Adjustment Amount (IRMAA). When Medicare beneficiaries enroll late in Medicare Part D, there is a Part D penalty unless the retiree, prior to enrolling in Part D, was enrolled in a prescription drug plan that was determined to be actuarially as good as Medicare Part D. The CCMHG's Medex, Medicare Enhance, and Managed Blue for Seniors were actuarially tested every year since 2006 and have consistently been determined to have prescription drug plans at least as good as Medicare Part D. Although Ch. 32B, S. 18A imposes requires the governmental employer to pay the penalties for late enrollment in Medicare Part B, there is no such requirement for payment of the penalties that might be associated with late enrollment in Medicare Part D.

Medicare Letters of Creditable Coverage

The purpose of this notice is to inform health plan members who are or will be eligible for Medicare in 2014 and 2015 whether or not the prescription drug coverage offered by the Plan Sponsor (CCMHG) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Since as of January 1, 2015 all CCMHG Senior plans will incorporate Medicare prescription drug coverage, i.e. Medicare Part D, CCMHG employers will no longer

have to send the Creditable Coverage letter to members of the Senior plans. Employer must still send the letters to (1) *active employees* who are or will be age 65 and Medicare eligible in 2015, (2) employees with covered spouses age 65 or older in 2015 who are enrolled in the active employee plans, and (3) to the extent know to the employer, to employees with dependents (spouse and/or children) who are Social Security Disabled and Medicare eligible..

Ch. 32B and retiree eligibility for health benefits

Retirees must be receiving a MA government pension in order to be eligible for contributory health benefits.

According to a MA Supreme Judicial Court ruling in 1996 upholding the Appeals Court decision in McDonald *v.* Town of Southbridge, a retiree who was *eligible* for health benefits as an employee at the time he/she retired is determined to be eligible for benefits as a retiree. McDonald was eligible at the time of retirement but chose to go on his spouse's plan. Later he wished to come onto the Town's plan and was denied. The SJC ruled that a retiree does not need to have been enrolled as an employee to be eligible as a retiree, and the implication was that the retiree did not need to take coverage at time of retirement in order to be eligible later as a retiree. The SJC went on to say that towns and districts may adopt reasonable rules and regulations under MGL Ch.32B, Section 14 to administer retiree coverage provided those rules and regulations are "not inconsistent with" Ch. 32B. The Court pointed to the rules and regulations of the Group Insurance Commission (805 CMR 9.00) as reasonable. Any regulations a city or town may consider for adoption affecting only retirees would not require prior bargaining under Ch. 150E.