What is the impact of Medicare eligibility on active employees in the State Health Benefits Program?

While most beneficiaries become eligible for Medicare at age 65, Medicare eligibility due to disability or certain specific health conditions can occur at any age. The section discusses the impact of Medicare eligibility on active employees and their family members who are covered under the State Health Benefits program.

Qualifying Mid-Year Event

Medicare entitlement (eligibility plus enrollment) is a qualifying mid-year event. For the employee, this would be consistent with terminating coverage if it is reported within 60 days of the enrollment date. (Termination of the employee's coverage would result in termination of all covered family members.) For a covered family member, it would be consistent with decreasing membership (removing the Medicare-entitled family member) if reported within 60 days of the enrollment date. Beneficiaries may choose to drop the state plan in favor of Medicare. However, before making that decision, they should consider the cost of state health plan coverage, the cost of Medicare, the possible cost of a Medicare supplement or Medicare Health Plan, and coverage needs for family members. They should compare the associated out-of-pocket costs under the state plan versus Medicare as primary payer. Reviewing the results of these comparisons should help in making the best coverage decision.

Coordination of Benefits/Medicare Parts A and B

If a Medicare-eligible active employee (or the active employee's family member) maintains coverage in the State Health Benefits Program, the state program will usually be the primary payer of claims (see End Stage Renal Disease exception).

For most beneficiaries, Medicare Part A (hospital insurance) is free. Because of this, many active employee beneficiaries will enroll in Part A even if they maintain the state program as their primary coverage. However, Medicare Part B (medical insurance) requires the payment of a monthly premium. Beneficiaries who maintain coverage due to current employment are allowed to decline Part B coverage as long as they continue to maintain their active employee coverage. They may exercise a Part B Special Enrollment Period at any time while they are covered based on current employment or during the eight months that follow the loss of that coverage (including retirement). If a Special Enrollment Period is available for enrollment in Part B, there is generally no penalty for late enrollment (enrollment after initial eligibility).

Beneficiaries may contact the Social Security Administration (1-800-772-1213) to address Medicare enrollment questions. Also, the annual "Medicare and You"

publication provides eligibility and enrollment information for beneficiaries. Finally, the Medicare web site (www.medicare.gov) or 1-800-MEDICARE can provide answers to specific Medicare questions.

Medicare Eligibility due to End Stage Renal Disease (ESRD)

There is an exception to the coordination of benefits guidance provided previously. Active employees and their family members who are covered under the State Health Benefits Program and become eligible for Medicare due to ESRD (permanent kidney failure) will maintain primary coverage under the state program during a 30-month coordination period. However, after that period is exhausted, Medicare becomes the primary payer. The end of the coordination period provides an opportunity for enrollment in Medicare Part B (which may be declined without penalty during the coordination period). The Office of Health Benefits monitors Medicare eligibility due to ESRD. Once the coordination period ends, covered employees or their family members must enroll in Medicare Part B to ensure primary payment. The Department of Human Resource Management's (DHRM) Office of Health Benefits will reimburse the cost for any Part B premium required due to the end of the coordination period as long as eligibility due to ESRD continues for active employees or family members. Contact DHRM for instructions to facilitate reimbursement. Failure to enroll in Medicare Part B once it should become the primary payer can result in a gap in coverage.

Medicare and Retiree Coverage

The impact of Medicare eligibility on retiree group participants (those covered based on former employment) differs completely from that of active employees since Medicare almost always becomes the primary payer for retirees. Please refer to the sections of this manual relating to retirees for information about the impact of Medicare eligibility on retiree coverage.

Prescription Drug Coverage – Part D

Prescription drug coverage under all of the health plans offered by the State Health Benefits Program is creditable. That means that it is at least as good as that provided under the Medicare Prescription Drug Program (Part D). It also means that if a beneficiary maintains the state program's creditable coverage without a break of 63 or more days, he/she will not incur a late enrollment penalty if Part D enrollment occurs after initial eligibility.

By law, health plans providing prescription drug coverage must disclose whether the entity's coverage is creditable. Notification must be provided to all Part D-eligible individuals covered under the plan, regardless of whether the coverage is primary or secondary to Medicare, prior to the annual coordinated election period each year. (However, those plans that contract with a Part D plan are exempt from the disclosure requirement, so no notice is required for retirees covered

under the state program's Part D plan.) Medicare-eligible active employees and/or their family members are identified each year for the purpose of satisfying this notice requirement. Agencies will be notified of beneficiaries for whom notices must be provided, along with the notice format.

In addition to the above notice requirement, federal regulations require that creditable coverage disclosure notices are provided as described below:

- Notice must be provided to all new health plan participants (e.g., new employees who enroll in health plan coverage or employees who enroll during open enrollment) to ensure that any Medicare-eligible family members receive this information (since agencies generally have no way to know who is or is not eligible for Medicare). However, if the employee has received a disclosure notice, a separate notice will not be required if a family member is added.
- Notice must be provided upon request by an individual.

Agencies must comply with these requirements.

There are three notice formats.

- The annual notice format supplied by DHRM.
- A general notice to be given to new participants.
- A personalized notice that can be provided upon request.

Links to notice formats are provided below. Disclosure notices should be provided in a hard copy format; an electronic copy will not meet the disclosure requirements. Your method of delivery (e.g., US Postal Service, inter-office mail) should be documented.

Resources:

General Notice of Creditable Coverage for New Participants -
http://www.dhrm.virginia.gov/resources/benefitsadmin/notices.html

Personalized Notice of Creditable Coverage -
http://www.dhrm.virginia.gov/resources/benefitsadmin/notices.html