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MEDICARE AND FEDERAL HEALTH BENEFITS
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Federal retirees approaching age 65 are faced with a decision about enrolling in Medicare. A number of questions arise, such as:

- Am I eligible for Medicare?
- Should I enroll in Part A (hospital) and Part B (doctors and other providers)?
- What advantage does an enrollee in a Federal Employees Health Benefits Program (FEHBP) plan gain from Medicare enrollment?
- Can Medicare Part B premiums be withheld from my annuity?
- Are my FEHBP plan benefits reduced when I enroll in Medicare?
- Should I participate in the Medicare Prescription Drug plan?

The following information attempts to summarize the relationship between Medicare and the federal retiree. Those not yet age 65 may want to save this information for future reference. If you are being paid Social Security benefits, you should receive information concerning your Medicare enrollment when eligible, most often at age 65. However, if you do not receive Social Security and are eligible for Medicare, you should contact your local Social Security office several months before you reach age 65.

Medicare Part A Eligibility

Public Law 97-248, enacted in 1982, provides Medicare Part A coverage at age 65 without cost for all federal employees actively employed during and after January 1, 1983. You are deemed to have the coverage if you were employed on the day before and day after January 1, 1983, when Medicare deductions began. Therefore, anyone who qualifies for premium-free Medicare Part A should enroll, since it is without cost. Our understanding is that Social Security receipt requires Medicare Part A coverage. Those who retired before January 1, 1983, must either be eligible for a Social Security benefit based on their non-federal employment, or have a spouse with coverage, to obtain Part A without cost. If you are not eligible for premium-free Part A, the monthly premium is $407 for 2015.

A person is eligible for Medicare Part A (hospital insurance) at age 65, if:

1. He or she is eligible for benefits from the Social Security or Railroad Retirement systems (or could receive those benefits if he or she applied); or

2. He or she paid Medicare taxes for 10 years while employed by the federal government; or

3. He or she paid Medicare taxes for a total of 10 years with the federal government and/or other non-federal employers; or

4. He or she was employed by the federal government on January 1, 1983; or

5. His or her spouse is eligible for Medicare Part A.

Medicare Part B Eligibility

Part B is available to anyone age 65 who is either a U.S. citizen residing in the United States or a lawfully admitted alien who has continuously resided in the United States for five years prior to filing an application. You do not have to be eligible for monthly Social Security benefits or Part A in order to obtain Part B.

When deciding whether to enroll in Medicare Part B, you need to balance the monthly premium cost and the fact that the benefits under the program duplicate what you have under the FEHBP. The basic monthly Part B premium for 2014 is $104.90. However, if you are subject to the sliding income scale for Medicare Part B because your individual annual income is more than $85,000, or more than $170,000 for married couples, then your monthly premium cost for Medicare Part B will be as much as $335.70 in 2014, depending on your income. That's a steep price to pay for what is essentially coverage that duplicates what you get under your FEHBP plan.

Medicare Late-Enrollment Penalty

If you wait until after your initial enrollment period to enroll in Medicare Part B, or you re-enroll after a period of coverage termination, the standard monthly premium is increased by 10 percent for every 12 months that you were eligible for enrollment but were not enrolled.

Fee-for-Service Plans

Medicare-eligible retirees enrolled in fee-for-service plans (e.g., Blue Cross-Blue Shield, GEHA, NALC, APWU or Mail Handlers, etc.) would find that Medicare pays first for most services. The FEHBP plan picks up the difference or, in some cases, pays for the services not covered by Medicare. Because the services are provided by physicians or others providing services, Medicare and the FEHBP plan combine to provide nearly complete coverage for all expenses, except prescription drugs. Fee-for-service plans waive most of their deductibles, coinsurance and co-payments (except for prescription drugs) for Part B enrollees. As a result, FEHBP fee-for-service plan enrollees with Parts A and B find that they have little or no out-of-pocket expenses.

Generally, you should elect Medicare Part A as soon as you are entitled since the coverage is at no cost to you if you are eligible based on the above criteria. However, you may want to weigh the cost against the benefits with Medicare Part B since the current price is more than $1,200 per year or more for each enrollee. This involves considering your current medical condition and future medical condition, as well as you may be able to predict it. You should review your FEHBP brochure as a starting point. Under "Coordinating Benefits With Other Coverage," your brochure will explain any extra benefits you will receive with Medicare Part A and Medicare Part B. With fee-for-service plans, this will often be excellent coverage. If you are covered by Blue Cross-Blue Shield, for example, all of your medical costs will generally be covered, except for prescription drugs where there is no change. Then, considering your present and future health, you can evaluate whether to enroll in Medicare Part B. You should be aware of any special provisions in your plan. You should also consider that if you do not enroll in Medicare Part B when first eligible, you will generally be subject to a 10-percent penalty for each 12 months you are not enrolled. There is an Open Season enrollment for Medicare Part B from January 1 to March 31 of each year, with coverage effective July 1 of that year. Some retirees with Medicare Parts A and B enroll in their fee-for-service plan's Standard option. The High option usually does not cover enough additional services to justify paying the extra premium, especially with High option plans that have experienced dramatic premium increases. Please note that the GEHA Standard option has a 50-percent co-payment on brand name prescription drugs obtained through the mail-order prescription service. (Generic drugs are $20 per prescription by mail order). If you (or your spouse) use several brand name drugs, you will need to consider the cost of the drugs by mail order against the lower premium for the GEHA Standard option. Also, Blue Cross-Blue Shield Standard option provides mail-order prescription services, reasonable prescription drug co-payments and wider provider choices than their lower priced Basic option.

HMO Enrollees

Those Medicare-eligible retirees enrolled in a health maintenance organization (HMO) plan (Kaiser, Aetna, Humana, etc.) may find they do not need Part B coverage. Since HMOs provide a full range of services to all their subscribers (whether or not enrolled in Medicare), the need for Medicare Part B is not as critical as for fee-for-service enrollees. In addition, because HMOs' co-payments are generally small (such as $15.00-$20.00 per doctor visit), there would probably be little advantage in Part B enrollment. Part B generally would not add enough to the HMO total package of benefits to justify paying the Part B premiums.

Some HMO enrollees are concerned about the 10-percent per year surcharge that applies to those who don't sign up for Medicare during their initial enrollment period. The Medicare Part B late enrollment surcharge, which is permanent, is 10 percent of the monthly Part B premium for each 12-month period the person could have been enrolled in Medicare Part B but was not. Further, the surcharge is recomputed whenever the monthly Medicare Part B premium changes. Two points are noteworthy. First, as long as an enrollee remains with an FEHBP HMO, there is no reason to enroll in Part B, so the surcharge would never come into play. The savings from not paying the Part B premium could more than offset any future penalty if you enroll in one or two years after your initial opportunity. If after one year a person enrolled in Part B, the 10-percent penalty would amount to about $10.49 in 2015. With the penalty, this would be $115.39. There would be a savings of more than $1,200 for the year you were not enrolled in Part B, so these would somewhat balance out over a shorter period. There is a Medicare Part B Open Enrollment Period from January 1 through March 31 of each year, with Part B coverage being effective the following July 1. However, you would probably want to make your choice within a year or two of eligibility, at the latest. If you wait for five or more years, the 10-percent penalty per year could make the cost of Medicare Part B somewhat expensive.

On the other hand, there are five reasons to sign up for Medicare Part B at age 65 even if a person is a retired HMO enrollee. The enrollee would want to sign up for Medicare Part B if he or she travels extensively in the United States. The Part B coverage could be used to help pay for nonemergency medical services while traveling outside of the HMO service area. The Part B coverage also could be used to “go out of network” to see a specialist in cases where the HMO primary care physician will not provide a referral. Part B coverage is necessary if the individual might have the opportunity to enroll in TRICARE For Life (a Medicare supplement plan for retired military personnel and retired reservists) at some point. In addition, Part B coverage will be required if the retired HMO enrollee wants to enroll in a Medicare Advantage plan.

Finally, many HMO enrollees are concerned about the number of FEHBP plans that have left the program in the past several years. An HMO enrollee who is approaching age 65 and lives in an area that is serviced by only one FEHBP HMO plan may want to consider enrolling in a fee-for-service plan and taking Medicare Part B, or taking Medicare Part B in conjunction with the HMO plan as a “hedge” against the future and the 10-percent late enrollment surcharge as described above.

If you are not entitled to Social Security, you can have Medicare Part B premiums withheld from your federal retirement benefits. A blank form can be completed at your local Social Security office, which is forwarded to Medicare, which then informs OPM. This can often take some time, so you may have to make a quarterly payment, and there may be an adjustment. If you would be entitled to Social Security but lose that entitlement because of the Government Pension Offset (GPO), you may have to waive the theoretical entitlement. This waiver can be cancelled if the GPO changes.

Here's one final reminder. Enrollment in Medicare Part B is neither mandatory nor required. We have received reports that some FEHBP plans (particularly HMOs) insist that federal annuitant enrollees must sign up for Medicare Part B when they become eligible. **This is not true**. As noted above, HMO enrollees may find they do not need Medicare Part B, since HMOs cover most of their enrollees' medical care with only small co-payments. HMO enrollees who do have Part B will often be required to assign their Medicare Part B coverage to the HMO, for reimbursement of services by Medicare for medical services, etc., provided by the HMO.

Medicare and FEHBP Benefits

Remember: When you retire from federal service and enroll in Medicare, Medicare becomes your primary insurer, and your FEHBP plan coverage is secondary. Neither Medicare nor the FEHBP plan can refuse to pay for, or reimburse, an enrollee for benefits provided by their respective coverage(s). While the amount of payment to a provider is usually more limited by law under Medicare than under an FEHBP plan, the benefits are not reduced under either coverage. Keep in mind that Medicare is the primary payer (pays first), and the FEHBP is the secondary payer. Each FEHBP fee-for-service plan brochure contains an explanation of the relationship between the plan and Medicare benefits. For details, see the section titled "Coordinating benefits with other coverage" in your brochure. If the physician charges the Medicare assignment amount or up to 115 percent of the Medicare limiting charge, FEHBP and Medicare will provide very good coverage. However, if you are asked by the physician to sign a “private contract,” you may have to pay significant charges. This is because Medicare will not pay anything when a person signs a “private contract,” and FEHBP plans will not increase their payments beyond what they would have paid if Medicare had paid.

You Don't Have Medicare?

As a result of changes in the Medicare law effective January 1, 1995, annuitants age 65 and older who don't have Medicare Part B must be treated the same as those who do have Part B for benefit payment purposes. That is, the amount doctors and other providers may charge a federal retiree age 65 or older is limited to 15 percent more than the Medicare-approved fee. For more details, see the FEHBP brochure section, "When you are age 65 or over and you do not have Medicare."

Medigap Plans

Since FEHBP plans are far superior to most Medigap policies, annuitants who have Medicare and FEHBP coverage have little need for any type of extra health plan. In most cases, those who do purchase additional policies are wasting money on duplicate coverage.

Medicare Part C-Sponsored Plans

Medicare-eligible annuitants may enroll in Medicare Advantage plans. These plans--also referred to as Medicare Coordinated Care Plans (MCCPs), Medicare Managed Care Plans, Medicare + Choice or Senior Plans--provide services through a Medicare-approved plan. Enrollees pay the Medicare Part B premium or, in some cases, an additional premium, and/or additional fees for prescriptions and other charges.

In 2002, the Office of Personnel Management (OPM) issued regulations allowing FEHBP enrollees who also had Medicare Part B coverage to suspend their FEHBP participation, enroll in a Medicare Advantage Plan, and, if not satisfied, return to the FEHBP during the next open season. These regulations also allow FEHBP enrollees to suspend FEHBP coverage to enroll in TRICARE, TRICARE for Life, the Uniformed Services Family Health Plan, Peace Corps, CHAMPVA and Medicaid or similar state-sponsored programs of medical assistance for the needy.

NARFE neither advocates nor discourages Medicare Advantage plan enrollment. Individual retirees should decide, based on their circumstances, whether to enroll in one of these plans. However, annuitants should keep several cautions in mind when considering a Medicare Advantage plan enrollment. First, both the annuitant and, if he or she is married, the spouse must be eligible to enroll in the Medicare Advantage plan. If a spouse or another family member is not eligible, the FEHBP family enrollment must be retained to provide continued coverage. A spouse cannot obtain a self-only FEHBP enrollment, except in those circumstances where both spouses are federal retirees.

Second, if the retiree is not satisfied with the Medicare Advantage Plan coverage, re-enrollment in his or her FEHBP can only be done during the annual Open Season. Some annuitants have enrolled in Medicare Advantage plans, found them not to their liking, then discovered that they had to wait a considerable period of time before FEHBP re-enrollment. Also, the Medicare Advantage plan may have restrictions on when you can return to traditional Medicare, which you should check on before you enroll.

Finally, not all Medicare Advantage plans provide the same level of coverage usually provided by FEHBP plans. Prospective Medicare Advantage plan enrollees should carefully review the plan to ensure that the benefits important to them are included.

Why Don't My FEHBP Premiums Decrease When I Sign Up for Medicare Parts A and B?

Many people ask this question. They assume that, because Medicare is paying the preponderant share of their medical and hospital expenses, their FEHBP plans are paying out a lot less for them than they do for people who are not covered by Medicare. Therefore, they reason that their own FEHBP premiums should be reduced because of Medicare having assumed the role of the primary insurer. People often ask for separate FEHBP coverage for Medicare-eligible enrollees, or self-plus-one coverage, again assuming they will pay a lower premium than other retirees and employees pay.

There is no provision in law for an FEHBP-Medicare option. One thing to remember is that the FEHBP covers people over their lifetime in many medical circumstances. The plans do not charge different rates as your health and family circumstances change. These are group plans covering all group members.

More important, however, the facts of the matter do not support creation of an FEHBP-Medicare option. Data from OPM show that there is not enough significant savings in the FEHBP because retirees are covered by Medicare. Therefore, the answer to the question, "Why don't my FEHBP premiums decrease when I sign up for Medicare?", is that there are not enough savings to the FEHBP because of enrollment in Medicare to justify lower the FEHBP premium, yet.

Following are OPM actuarial data comparing the cost to the FEHBP for active employee enrollees, Medicare annuitant enrollees, and non-Medicare annuitant enrollees for calendar year 2012. Note that the cost associated with Medicare annuitant enrollees is the average cost to the FEHBP *after* Medicare has paid. The data are displayed by costs related to self-only coverage enrollments and self-and-family enrollments.

Based on these data, the cost to the FEHBP for active employee enrollees is:

	Fee for Service	HMO
Self-Only Coverage	$ 5,827	$5,799
Self-and-Family Coverage	$14,515	$13,936

The cost to the FEHBP for Medicare annuitant enrollees after Medicare pays is:

	Fee for Service	HMO
Self-Only Coverage	$ 4,952	$6,947
Self-and-Family Coverage	$10,925	$13,437

And the cost to the FEHBP for non-Medicare eligible annuitant enrollees is:

	Fee for Service	HMO
Self-Only Coverage	$11,230	$11,474
Self-and-Family Coverage	$18,610	$20,506

The Medicare enrollees in the self-and-family coverage do cost the FEHBP slightly less than the other types of enrollees. But these savings are spread across all enrollee premiums, including the much higher-costing non-Medicare eligible annuitant enrollees. The self-only coverage for the Medicare group costs.

FEHBP fee-for-service plans waive some deductibles, coinsurance and co-payments in recognition of the savings that accrue for Medicare annuitant enrollees.

Since FEHBP premiums are based on fee-for-service plans' FEHBP claims experience, administrative expenses

and a modest profit of 1 percent or less, there are insufficient savings related to the Medicare factor to justify a change in the law to create an FEHBP Medicare in FEHBP plans.

Moreover, this cost to the FEHBP experience will not shift in favor of the Medicare annuitant enrollees. We know that 50 percent of all FEHBP enrollees are current employees, and 50 percent of all FEHBP enrollees are retiree and survivor annuitants. Data from the Department of Health and Human Services, Administration on Aging (AOA) ,indicate that there are more older people living longer in the United States than ever before. The following information is derived from the AOA report, "A Profile on Older Americans: 2011."

In 2013, there were 44.7 million people age 65 and older living in the United States. This represents a growth of 24 percent in the age 65 and older population since 2003. The older population itself is getting older. In 2013, the 65-74 age group (25.2 million) was 10 times larger than in 1900. The 75-84 age group in 2013 (13.4 million) was 70 % larger than in 1900. The 85-plus age group (6 million) was 49 times larger than in 1900. The 44.7 million people age 65 and older in 2013 are projected to grow to nearly 82.3 million by 2040.

We have an aging population that is growing larger and an aging population that is living longer. In 2013, 43.0 percent of older persons assessed their health as excellent or very good, compared to 55 % for persons ages 45-64. Chronic medical conditions increase with age. Most older persons have at least one chronic condition, and many have multiple conditions. Thirty-seven percent of older persons reported suffering from some type of disability. Consequently, older people need more medical and hospital services than younger people.

In 2012, 6.8 million people age 65 and over stayed in a hospital overnight at least one night during the year. Among this group of older adults, 11 percent stayed ovenight 1 time, 3 percent stayed overnight 2 times, and 2 percent stayed overnight 3 or more times. This is approximately double the number of overnight hospital stays for the population age of 45 to 64 who had 6 percent stay overnight 1 time, 1 percent stay overnight 2 times and 1 percent stay overnight 3 or more times. Older persons averaged more office visits with doctors in 2012. Among people age 75 and over, 23 percent had 10 or more visits to a doctor or other health care professional in the past 12 months compared to 14 percent among people age 45 to 64.

In conclusion, we have an older population (age 65 and older) that is growing. The people within the group are living longer than ever before. They go to the hospital more frequently, and they stay longer. They go to the doctor more frequently. In addition, OPM also reports that the age 65 and older FEHBP group uses the prescription drug benefit 150 percent more frequently than people under age 65. There is no Medicare prescription drug benefit to offset this cost to the FEHBP. All of this means that the cost to the FEHBP will continue to grow for the age 65 and older population regardless of their Medicare status. People with Medicare will cost less than people age 65 and older without Medicare, but with minimal or no savings to the FEHBP.

2015 Medicare Premiums and Deductibles

	2014	201544
Part B Monthly Premium	$104.90	$104.90
Part B Annual Deductible	$147.00	$147.00
Part A Hospital Deductible - First 60 Days	$1,216.00	$1,260.00
Hospital Co-payment per day for days 61-90	$304.00	$315.00
Hospital Co-payment per day for 60 lifetime reserve days	$608.00	$630.00
Skilled Nursing Facility Co-payment per day for days 21-100	$152.00	$157.50
Part A Monthly Premium if purchased	$426.00	$407.00

Standard monthly premium for Part B is $104.90 in 2015. Individuals with an annual income of more than

$85,000 (or more than $170,000 for married couples) will pay monthly premiums of $146.90 to $335.70, depending on income reported on 2013 federal tax returns.

Medicare Prescription Drug Plan

If your FEHBP covers at least as much as a Medicare Prescription Drug plan, and if you join a Medicare Prescription Drug plan later than your first opportunity, your monthly premium may not be higher for the Medicare Prescription Drug plan. You will not be subject to the 1 percent monthly penalty if you do not enroll in the Medicare Prescription Drug plan at first opportunity in this case. There is a notice concerning this as soon as you open your 2015 FEHBP brochure, which you should retain.

You would want to keep your FEHBP prescription drug coverage, which is part of your FEHBP enrollment and should be superior to the Medicare Prescription Drug coverage. Medicare suggests the only retirees enrolled in an FEHBP plan who could benefit from the Medicare Prescription Drug plan are those whose high drug costs may make it worthwhile to pay extra Medicare premiums. Premiums for the Medicare prescription drug plan average $32.42 per month, or about $398.00 per year. However, if your gross adjusted income for 2013 was more than $85,000 for an Individual filer or $170,000 for joint filers you will be charged an EXTRA AMOUNT on top of the monthly premium for the plan you enroll in. Retirees with FEHBP coverage need to determine if they pay more than that under their current FEHBP plan for prescription drug co-payments and deductibles before they join the Medicare drug plan.

There may also be a yearly deductible for the Medicare drug program you choose. For 2015, most Medicare Part D plans will still have a yearly coverage gap -- the "Donut Hole " -- which starts after costs for benefits reach $2,960. After that amount, the Part D enrollees must pay all prescription drug charges (there will be a 45 percent charge for covered brand name drugs and 65 percent of the plans cost for generic) until out-of-pocket expenses reach $4,700.00. After that amount is reached, the enrollees only pay the small coinsurance for the remainder of the year. However, if your income is less than $17,505 (single) or $23,595 (married), and you have limited assets of $13,440 (single) or $26,860 (married), some of these costs may not apply.